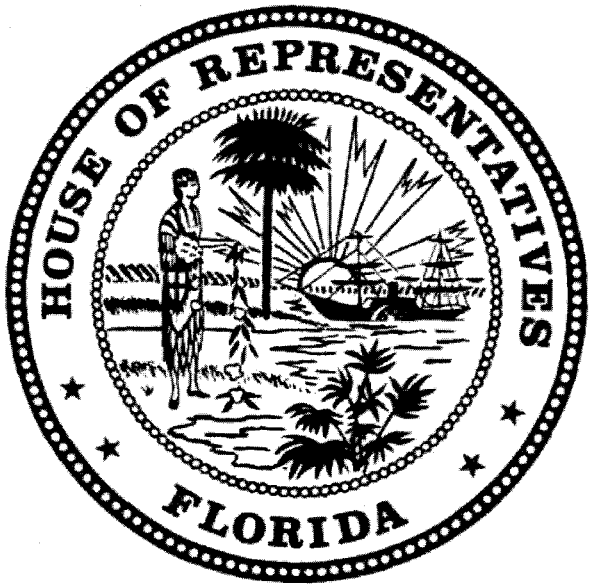


# Health & Human Services Committee

**Thursday, March 23, 2017**
**9:00 AM – 12:00 PM**
**Morris Hall (17 HOB)**

**Richard Corcoran**
**Speaker**

**W. Travis Cummings**
**Chair**

# Committee Meeting Notice

## HOUSE OF REPRESENTATIVES

### Health & Human Services Committee

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|---|---|
| **Start Date and Time:** | Thursday, March 23, 2017 09:00 am |
| **End Date and Time:** | Thursday, March 23, 2017 12:00 pm |
| **Location:** | Morris Hall (17 HOB) |
| **Duration:** | 3.00 hrs |

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

CS/HB 61 Emergency Services for an Unintentional Drug Overdose by Health Innovation Subcommittee, Lee, Peters
CS/HB 101 Certificates of Nonviable Birth by Health Quality Subcommittee, Cortes, B.
HB 103 Public Records/Nonviable Birth Records by Cortes, B.
CS/HB 249 Drug Overdoses by Health Quality Subcommittee, Rommel, Gruters
CS/HB 363 Temporary Care of a Child by Civil Justice & Claims Subcommittee, White, Williams
CS/HB 543 Regulation of Nursing by Health Innovation Subcommittee, Pigman
CS/HB 557 Prescription Drug Monitoring Program by Health Quality Subcommittee, Duran
CS/HB 577 Discount Plan Organizations by Health Innovation Subcommittee, Pigman
HB 7073 Ratification of Rules of the Department of Elder Affairs by Children, Families & Seniors Subcommittee, Grant, M.

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Wednesday, March 22, 2017.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Wednesday, March 22, 2017.

**NOTICE FINALIZED on 03/21/2017 4:07PM by Iseminger.Bobbye**

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 61 Emergency Services for an Unintentional Drug Overdose
**SPONSOR(S):** Health Innovation Subcommittee, Lee, Jr.
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Innovation Subcommittee | 12 Y, 0 N, As CS | Royal | Poche |
| 2) Health & Human Services Committee | | Royal | Calamas |

## SUMMARY ANALYSIS

The Agency for Health Care Administration (AHCA) regulates hospitals under ch. 395, F.S. and the general licensure provisions of part II of ch. 408, F.S.

Section 395.1041, F.S. requires all hospitals offering emergency services to provide care to every person seeking emergency care regardless of the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay. Hospitals cannot refuse to accept a person with an emergency medical condition if the service is within that hospital's capability and capacity. Persons requiring care beyond the hospital's capability or capacity must be transferred to another facility that can provide the needed services.

CS/HB 61 amends s. 395.1041, F.S., to require a hospital with an emergency department to develop a best practices policy to reduce readmissions for unintentional drug overdoses by connecting patients who have experienced unintentional overdoses with substance abuse treatment services. The bill allows hospitals to determine what should be included in the policy, but the bill provides express authority to include several items in the policy.

The bill does not appear to have a fiscal impact on state or local governments.

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Substance Abuse

Substance abuse affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[1] Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[2] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[3] Brain imaging studies of persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning, memory, and behavior control.[4]

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[5] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[6]

*Opioid Abuse*

Opioids are commonly abused, with an estimated 15 million people worldwide suffering from opioid dependence.[7] Drug overdose is now the leading cause of injury-related death in the United States.[8] Florida is in the midst of an opioid crisis.[9] In 2015, Florida ranked fourth in the nation with 3,228 deaths from drug overdoses[10], and at least one opioid caused 2,530 of those deaths.[11] Statewide, in 2015, heroin caused 733 deaths, fentanyl caused 705, oxycodone caused 565, and hydrocodone caused 236. Deaths caused by heroin and fentanyl increased more than 75% statewide when compared with 2014.[12]

Drug overdose deaths doubled in Florida from 1999 to 2012.[13] Over the same time period, drug overdose deaths occurred at a rate 13.2 deaths per 100,000 persons.[14] The crackdown on "pill mills"

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[1] World Health Organization. *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited March 1, 2017).
[2] Substance Abuse and Mental Health Services Administration, *Substance Use Disorders,* available at: http://www.samhsa.gov/disorders/substance-use (last visited March 1, 2017).
[3] National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, available at: https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited March 1, 2017).
[4] Id.
[5] Supra, FN 2.
[6] Id.
[7] WORLD HEALTH ORGANIZATION, *Information Sheet on Opioid Overdose*, November 2014. http://www.who.int/substance_abuse/information-sheet/en/ (last visited March 13, 2107).
[8] Trust for America's Health, *The Facts Hurt: A State-by-State Injury Prevention Policy Report 2015,* available at: http://healthyamericans.org/reports/injuryprevention15/ (last visited March 11, 2017).
[9] *Palm Beach County Sober Homes Task Force Report 2017*, Jan. 1, 2017, available at: http://www.sa15.state.fl.us/stateattorney/SoberHomes/_content/SHTFReport2017.pdf (last visited March 1, 2017).
[10] Centers for Disease Control and Prevention. *Drug Overdose Death Data*, available at: https://www.cdc.gov/drugoverdose/data/statedeaths.html (last visited March 11, 2017).
[11] Florida Department of Law Enforcement. *Drugs Identified in Deceased Persons by Florida Medical Examiners-2015 Annual Report,* available at: https://www.fdle.state.fl.us/cms/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2015-Annual-Drug-Report.aspx (last visited on March 11, 2017).
[12] Id. at pg. 3.
[13] Florida Department of Health, *Special Emphasis Report: Drug Poisoning (Overdose) Deaths, 1999-2012*, available at: http://www.floridahealth.gov/statistics-and-data/florida-injury-surveillance-system/_documents/CDC-Special-Emphasis-Drug-poisoning-overdose-1999-2012-B-Poston-FINAL.pdf (last visited on March 11,2017).

dispensing prescription opioid drugs, such as oxycodone and hydrocodone, reduced the rate of death attributable to prescription drugs[15], but may have generated a shift to heroin use, contributing to the rise in heroin addiction.[16]

Opioid overdose can occur when an individual deliberately misuses a prescription opioid or an illicit drug such as heroin.[17] It can also occur when a patient takes an opioid as directed, but the prescriber miscalculated the opioid dose, an error was made by the dispensing pharmacist, or the patient misunderstood the directions for use.[18] Opioid overdose is life threatening and requires immediate emergency attention.[19]

Between 2004 and 2009, emergency department visits nationally involving the nonmedical use of pharmaceuticals increased 98.4%, from 627,291 visits to 1,244,679 visits.[20] In 2009, almost one million emergency room visits nationally involved illicit drugs, either alone or in combination with other drugs.[21] From 2008 to 2011, about half of all emergency department visits nationally for both unintentional and self-inflicted drug poisoning involved drugs in the categories of analgesics[22], antipyretics[23], and antirheumatics[24] or sedatives, hypnotics, tranquilizers, and other psychotropic agents.[25] Opiates or related narcotics, including heroin and methadone, accounted for 14% of emergency department visits nationally for unintentional drug poisoning from 2008 to 2011.[26] In Florida, there were approximately 21,700 opioid-related emergency department visits in 2014.[27]

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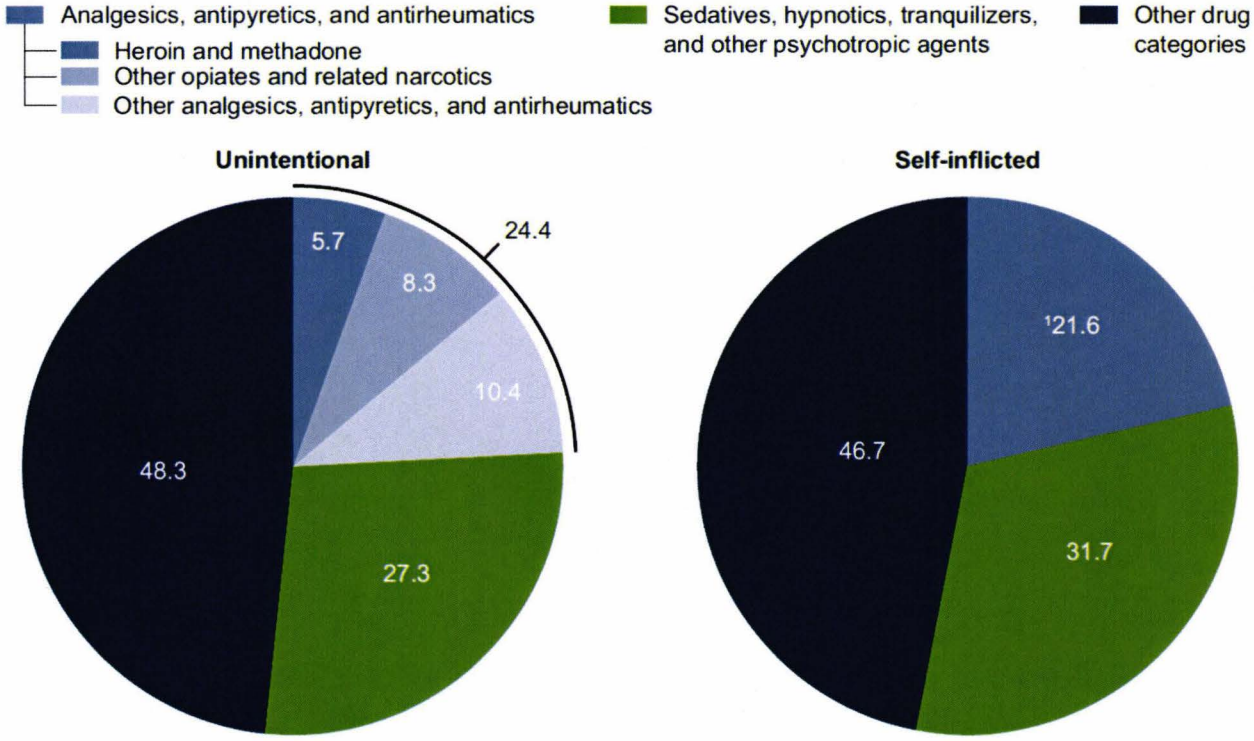
[14] Id.
[15] Supra, FN 11 at pg. 1.
[16] Supra, FN 9, at pg. 1.
[17] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Opioid Overdose Prevention Toolkit*, Rev. 2016, *available at*, http://store.samhsa.gov/shin/content//SMA16-4742/SMA16-4742.pdf (last visited March 13, 2017).
[18] Id.
[19] Id.
[20] National Institute on Drug Abuse, *Drug-Related Hospital Emergency Room Visits,* available at: https://www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits (last visited March 9, 2017).
[21] Id.
[22] Analgesics are drugs that produce insensibility to pain.
[23] Antipyretics are drugs that reduce fever.
[24] Antirheumatics are drugs that alleviate or prevent inflammation or pain in muscles, joints, or fibrous tissue.
[25] Albert, M. et al. *Emergency Department Visits for Drug Poisoning: United States, 2008–2011*, NCHS Data Brief No. 196, April 2015, available at: https://www.cdc.gov/nchs/data/databriefs/db196.htm
[26] Id.
[27] Weiss, A.J., et al., *Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009-20014*, HCUP Statistical Brief #219, January 2017, available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf

Percentage of Emergency Department Visits for Drug Poisoning, By Intent and Drug Category: United States, 2008–2011




SOURCE: CDC/NCHS, National Hospital Ambulatory Medical Care Survey, 2008–2011.[28]

Substance Abuse Treatment in Florida

In the early 1970s, the federal government furnished grants to states to a develop continuum of care for individuals and families affected by substance abuse.[29] The grants provided separate funding streams and requirements for alcoholism and drug abuse. In response, the Florida Legislature enacted Chapters 396, F.S., (alcohol) and 397, F.S. (drug abuse).[30] In 1993, legislation combined Chapters 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act ("the Marchman Act").[31] The Marchman Act supports substance abuse prevention and remediation through a system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

*Licensed Service Components*

The Department of Children and Families (DCF) licenses substance abuse treatment components under ch. 397, F.S., which include prevention, intervention, and clinical treatment services.[32] Clinical treatment is a professionally directed, deliberate, and planned regimen of services and interventions that are designed to reduce or eliminate the misuse of drugs and alcohol and promote a healthy, drug-

[28] Id.
[29] Department of Children and Families, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5 (on file with the Health Innovation Subcommittee).
[30] Id.
[31] S. 2, ch. 93-39, Laws of Fla., codified in ch. 397, F.S.
[32] S. 397.311(25), F.S.

free lifestyle. "Clinical treatment services" include, but are not limited to, the following service components:

- Addictions receiving facility services;
- Day or night treatment, with or without community housing;
- Detoxification;
- Intensive inpatient treatment or outpatient treatment;
- Medication-assisted treatment for opiate addiction;
- Non-intensive outpatient treatment; and
- Residential treatment.[33]

All private and publicly-funded entities providing substance abuse services must be licensed, unless exempt. Exemptions are available for:

- Hospitals or hospital-based components licensed under ch. 395, F.S.;
- Nursing facilities, as defined in s. 400.021, F.S.;
- Substance abuse education programs established pursuant to s. 1003.42, F.S.;
- Facilities or institutions operated by the federal government;
- Physicians or physician assistants licensed under ch. 458 or ch. 459, F.S.;
- Psychologists licensed under ch. 490, F.S.;
- Social workers, marriage and family therapists, or mental health counselors licensed under ch. 491, F.S.;
- Facilities licensed under ch. 393, F.S., which, in addition to providing services to persons with developmental disabilities, also provide services to persons developmentally at-risk as a consequence of exposure to alcohol or legal or illegal drugs while in utero; and
- Crisis stabilization facilities licensed under s. 394.875, F.S.[34]

*Rights of Individuals Receiving Substance Abuse Treatment*

Section 397.501, F.S., establishes statutory rights of individuals receiving substance abuse services, including the right to dignity, non-discriminatory services, quality services, confidentiality, counsel and habeas corpus. In particular, s. 397.501(7) prohibits service providers from disclosing records containing the identity, diagnosis, and prognosis of and services provided to any individual without written consent of the individual. The law provides certain exceptions to the disclosure of such information without consent.[35] The law makes service providers who violate these rights liable for damages, unless acting in good faith, reasonably, and without negligence.

Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.[36]

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[33] S. 397.311(25)(a), F.S.
[34] S. 397.405, F.S.
[35] Disclosure is permitted to:
- Health service providers in cases of medical emergency if the information is necessary to provide services to the individual;
- DCF for the purposes of scientific research;
- Comply with state-mandated child abuse and neglect reporting;
- Comply with a valid court order;
- Report crimes that occur on program premises or against staff;
- Federal, state or local governments for audit purposes; or
- Third party payors providing financial assistance or reimbursement.

[36] Substance Abuse and Mental Health Services Administration. http://www.integration.samhsa.gov/clinical-practice/sbirt (last visited on March 9, 2017).

SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.[37]

SBIRT consists of three major components[38]:

- Screening — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
- Brief Intervention — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.
- Referral to Treatment — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

Access to Emergency Services and Care

The Agency for Health Care Administration (AHCA) regulates hospitals under ch. 395, F.S. and the general licensure provisions of part II of ch. 408, F.S. AHCA must maintain a list of hospital providing emergency services and care and the services that the hospital is capable of providing.[39] Emergency services and care means medical screening, examination and evaluation by a physician, or by authorized personnel under the supervision of a physician, to determine if an emergency medical condition exists, and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.[40]

Section 395.1041, F.S., requires all hospitals offering emergency services to provide care to every person presenting to the hospital requesting emergency care regardless of the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. A hospital is prohibited from refusing to render emergency services unless a determination is made after screening, examining and evaluating the patient that he or she is not suffering from an emergency or the hospital does not have the capability or capacity to render emergency services. A hospital must transfer persons requiring care beyond the hospital's capability or capacity to another facility that can provide the needed services. AHCA may deny, revoke, or suspend the license of a hospital or impose an administrative fine up to $10,000 for violating s. 395.1041, F.S. or any rules adopted thereunder.[41]

In addition, hospitals participating in the Medicare program must comply with the requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA) to provide emergency services to anyone regardless of their insurance status or ability to pay.[42] EMTALA also requires hospitals that do not have the capability to treat the patient's medical condition to transfer the patient to a hospital with the capability to treat the patient. Florida's state law regarding access to emergency services and care is closely aligned with EMTALA.

Immunity from Prosecution for Drug-related Overdoses

Section 893.21(2), F.S., immunizes a person who experiences a drug-related overdose and is in need of medical assistance from being charged, prosecuted or penalized for possession of a controlled substance if the evidence of possession was obtained as a result of the overdose and the need for medical assistance. The law also immunizes a person, acting in good faith, who seeks medical assistance for a person experiencing a drug-related overdose from being charged, prosecuted or

[37] Substance Abuse and Mental Health Services Administration. SBIRT Factsheet. Available at: http://www.integration.samhsa.gov/sbirt/SBIRT_Factsheet_ICN904084.pdf (last visited on March 9,2017).
[38] Supra, FN 36.
[39] Section 395.1041(2), F.S.
[40] Section 395.002(9), F.S.
[41] Section 395.1041(5), F.S.
[42] 42 U.S. Code § 1395dd

penalized for possession of a controlled substance if the evidence for possession was obtained as a result of seeking medical assistance.[43]

**Effect of Proposed Changes**

CS/HB 61 amends s. 395.1041, F.S to require a hospital with an emergency department to develop a best practices policy to reduce readmissions for unintentional drug overdoses. The goal of the policy is to connect patients that experience unintentional drug overdoses with substance abuse treatment services.

The bill allows hospitals to determine what should be included in its best practices policy. However, bill expressly authorizes several items that may be included in the policy:

- A process for obtaining patient consent to disclose to patient's next of kin and the primary care physician or practitioner who prescribed a controlled substance of the patient's overdose, her or his location, and the nature of the substance or controlled substance involved in the overdose.
- A process for providing information to the patient or the patient's next of kin regarding licensed substance abuse treatment providers and voluntary and involuntary commitment procedures for mental health or substance abuse treatment.
- Controlled substance prescribing guidelines for emergency department health care practitioners.
- The use of licensed or certified behavioral health professionals or peer specialists in emergency departments to encourage the patient to voluntarily seek substance abuse treatment.
- The use of Screening, Brief Intervention, and Referral to Treatment protocols in the emergency department.

Hospitals that fail to develop a best practices policy to reduce readmissions for unintentional drug overdoses are subject to discipline by AHCA.[44]

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

B. SECTION DIRECTORY:

**Section 1:** Amends s. 394.1041, F.S., relating to access to emergency services and care.
**Section 2:** Provides an effective date of July 1, 2017.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

[43] S. 893.21(1), F.S.
[44] Supra, FN 41.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals may incur costs associated with developing the best practices policy. The bill may also create more demand for substance abuse treatment services.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 14, 2017, the Health Innovation Subcommittee adopted an amendment that:

- Requires a hospital with an emergency department to develop a best practices policy to reduce readmissions for unintentional drug overdoses, which may include, at the hospital's discretion, the following:
  - A process for obtaining patient consent to disclose to the patient's next of kin and the primary care physician or practitioner who prescribed a controlled substance of the patient's overdose, her or his location, and the nature of the substance or controlled substance involved in the overdose.
  - A process for providing information to the patient or the patient's next of kin regarding licensed substance abuse treatment providers and voluntary and involuntary commitment procedures for mental health or substance abuse treatment.
  - Controlled substance prescribing guidelines for emergency department health care practitioners.
  - The use of licensed or certified behavioral health professionals or peer specialists in emergency departments to encourage the patient to voluntarily seek substance abuse treatment.
  - The use of Screening, Brief Intervention, and Referral to Treatment protocols in the emergency department.
- Removed the requirement for a hospital providing emergency services to a person that has experienced an unintentional drug overdose to arrange for certain health care professionals to assess the patient's need for further treatment.

- Removed the requirement that an attending physician providing emergency services to a person that has experienced an unintentional drug overdose to make certain disclosures, provide certain information and attempt to ensure substance abuse treatment.
- Removed the immunization of a person who has experienced an unintentional drug overdose and is need of emergency services from being charged, prosecuted, or penalized for possession of a controlled substance if the evidence for such possession was obtained as a result of the overdose and need for emergency services and care as such immunization exists under current law.

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 emergency services for an unintentional drug overdose; amending s. 395.1041, F.S.; requiring a hospital with an emergency department to develop a best practices policy to reduce readmissions for unintentional drug overdoses; authorizing the policy to include certain processes, guidelines, and protocols; providing an effective date.

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

Section 1. Subsection (6) of section 395.1041, Florida Statutes, is amended to read:

395.1041 Access to emergency services and care.—

(6) RIGHTS OF PERSONS BEING TREATED.—

(a) A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

(b) Each hospital with an emergency department shall

develop a best practices policy to reduce readmissions for unintentional drug overdoses. The policy may include, but is not limited to:

1. A process to obtain the patient's consent to notify the patient's next of kin, and each physician or health care practitioner who prescribed a controlled substance to the patient, regarding the patient's overdose, her or his location, and the nature of the substance or controlled substance involved in the overdose.

2. A process for providing the patient or the patient's next of kin with information about licensed substance abuse treatment services, voluntary admission procedures under part IV of chapter 397, involuntary admission procedures under part V of chapter 397, and involuntary commitment procedures under chapter 394.

3. Guidelines for emergency department health care practitioners authorized to prescribe controlled substances to reduce the risk of opioid use, misuse, and addiction.

4. The use of licensed or certified behavioral health professionals or peer specialists in the emergency department to encourage the patient to seek substance abuse treatment.

5. The use of Screening, Brief Intervention, and Referral to Treatment protocols in the emergency department.

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

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 61 (2017)

Amendment No.

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Lee offered the following:

**Amendment (with title amendment)**

Remove line 26 and insert:

develop a best practices policy to promote the prevention of

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

Remove line 6 and insert:

promote the prevention of unintentional drug overdoses;

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 101 Certificates of Nonviable Birth
**SPONSOR(S):** Health Quality Subcommittee; Cortes and others
**TIED BILLS:** HB 103 **IDEN./SIM. BILLS:** SB 672

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Quality Subcommittee | 13 Y, 0 N, As CS | Siples | McElroy |
| 2) Health Care Appropriations Subcommittee | 14 Y, 0 N | Mielke | Pridgeon |
| 3) Health & Human Services Committee | | Siples | Calamas |

## SUMMARY ANALYSIS

CS/HB 101 creates the "Grieving Families Act" which allows the parents of a pregnancy that results in a fetal demise to request and be issued a "certificate of nonviable birth." The bill defines "nonviable birth" as an unintentional, spontaneous fetal demise occurring after the 9th week of gestation but before the completion of the 20th week of gestation of a pregnancy that has been verified by health care practitioner.

The bill requires certain health care practitioners who attend or diagnose a nonviable birth, or the health care facility at which it occurs, to advise the parent:

- That the parent may request the preparation of a certificate of nonviable birth;
- That the parent may obtain a certificate of nonviable birth by contacting the Office of Vital Statistics;
- How the parent may contact the Office of Vital Statistics to request the certificate of nonviable birth; and
- That the certificate of nonviable birth is available as a public record when held by an agency.

Upon the request of a parent, certain health care practitioners and health care facilities that attend or diagnose a nonviable birth must register the nonviable birth with the Bureau of Vital Statistics, electronically or on a form prescribed by the Department of Health within 30 days of receipt of such request. The bill prohibits the Bureau of Vital Statistics from including the certificate of nonviable birth in its calculations of live birth statistics.

The bill prohibits the use of a certificate of nonviable birth to establish or maintain a civil cause of action for bodily injury, civil injury, or wrongful death against any person or any entity.

The bill has an insignificant, indeterminate positive fiscal impact on DOH and a significant, indeterminate negative fiscal impact on DOH which can be absorbed within existing resources. The bill has no fiscal impact on local governments.

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Present Situation**

**Vital Statistics in Florida**

The Florida Vital Statistics Act directs the Department of Health (DOH), to establish the Bureau of Vital Statistics (Bureau)[1] under the direction of a state registrar for the uniform and efficient registration, compilation, storage, and preservation of all vital records[2] in this state.[3] DOH is also responsible for establishing registration districts throughout the state and appointing a local registrar of vital statistics for each registration district.

Registration of Live Births

Within five days of each live birth in this state, a certificate of live birth must be filed with the local registrar of the district in which the birth occurred.[4] The state registrar may receive the registration of the birth certificate electronically through facsimile or other electronic transfer.

Registration of Deaths

A certificate for each death or fetal death[5] that occurs in Florida must be filed within 5 days after such death and prior to the final disposition of the dead body or fetus.[6] Final disposition means the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or fetus.[7] The registration of the death certificate may be submitted via DOH's electronic death registration system to the Bureau on a form prescribed by DOH, or to the local registrar of the district in which the death occurred.

Stillbirth Registration

DOH must issue a certificate of birth resulting in stillbirth upon the request of any parent listed on a fetal death certificate.[8] A stillbirth is an unintentional, intrauterine fetal death after a gestational age of not less than 20 completed weeks.[9] There must be a fetal death certificate on file with bureau.[10] The certificate of birth resulting in stillbirth must be issued within 60 days of the request and a parent may request the certificate of birth resulting in stillbirth regardless of the date the fetal death certificate was issued.[11] The certificate of birth resulting in stillbirth may not be used to pursue a civil cause of action against a person or an entity for bodily injury, personal injury, or wrongful death.[12]

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[1] Although the statute refers to an Office of Vital Statistics, it has been established as the Bureau of Vital Statistics within DOH.
[2] A vital record is defined as certificates or reports of birth, death, fetal death, marriage, dissolution of marriage, certain name changes, and data related thereto. Section 382.001(17), F.S.
[3] Section 382.003, F.S.
[4] Section 382.013, F.S.
[5] Section 382.002(8), F.S., a "fetal death" is a death prior to the complete expulsion or extraction of a product of human conception from its mother if the 20th week of gestation has been reached and the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
[6] Section 382.008, F.S.
[7] Section 382.002(9), F.S.
[8] Section 382.005, F.S.
[9] Section 382.002(16), F.S.
[10] *Id.*
[11] *Id.*
[12] *Id.*

A healthcare practitioner or health care facility required to register the fetal death, must advise the parent of the stillborn child that they may request a certificate of birth resulting in stillbirth and how to receive such certificate.[13] The parent must also be advised that the certificate of birth resulting in stillbirth is a public record if it is held by an agency.[14]

The certificate of birth resulting in stillbirth contains the date of the stillbirth, the county in which the stillbirth occurred, the name of the stillborn child, the state file number of the corresponding certificate of fetal death, and a statement that the certificate is not proof of live birth.

**Loss of Pregnancy: Miscarriages**

A miscarriage occurs when there is a sudden unexpected loss of a pregnancy before it reaches the 20th week of gestation.[15] It is estimated that anywhere between 10 to 15 percent of known or clinically recognized pregnancies will end in miscarriage.[16] However, the exact number of miscarriages that occur is unknown because many occur before a woman knows she is pregnant. The majority of miscarriages occur in the first trimester (13 weeks) of a pregnancy.[17]

Stephanie Saboor Grieving Parents Act

In 2003, the Legislature enacted the "Stephanie Saboor Grieving Parents Act (Act)." The Act requires certain health care practitioners and health care facilities having custody of fetal remains following a spontaneous fetal demise after a gestation of less than 20 completed weeks to notify the mother of her option to arrange for the burial or cremation of the fetal remains.[18] The notification may provide other options including a ceremony, a certificate, or common burial of fetal remains. The mother may also choose to allow the health care practitioner or health care facility to follow the procedures provided by s. 381.0098, F.S., for the handling of fetal remains.[19]

Florida law does not contain a provision for a certificate of death, registration, or any other official recognition of death for a miscarriage.

**Effect of Proposed Changes**

HB 101 creates the "Grieving Families Act" which allows the parents of a pregnancy that results in a fetal demise to request and be issued a "certificate of nonviable birth." The bill defines "nonviable birth" as an unintentional, spontaneous fetal demise occurring after the 9th week of gestation but before the completion of the 20th week of gestation of a pregnancy that has been verified by a health care practitioner.

The bill directs nurses and certified midwives who attend or diagnose a nonviable birth, as well as hospitals and birthing centers at which a nonviable birth occurs, to advise the parent:

- That the parent may request the preparation of a certificate of nonviable birth;

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[13] *Id.*
[14] *Id.*
[15] National Institutes of Health, Eunice Kennedy Shriver National Institute of Child Health and Human Development, *Pregnancy Loss: Condition Information, What is pregnancy loss/miscarriage?, available at* https://www.nichd.nih.gov/health/topics/pregnancyloss/conditioninfo/Pages/default.aspx (last visited February 9, 2017). The loss of a pregnancy after the 20th week of gestation is called a stillbirth.
[16] U.S. Dep't of Health and Human Services, Office of Women's Health, *Pregnancy: Pregnancy Loss*, (last rev. Sept. 27, 2010), *available at* https://www.womenshealth.gov/pregnancy/you-are-pregnant/pregnancy-loss.html (last visited February 9, 2017).
[17] American Pregnancy Association, *Miscarriage,* (updated August 2016), *available at* http://americanpregnancy.org/pregnancy-complications/miscarriage/ (last visited February 9, 2017).
[18] Chapter 2003-52, Laws of Fla., codified at s. 383.33625, F.S. The health care practitioners required to advise the mother of her options for the fetal remains include physicians, nurses, or midwives that have custody of the fetal remains.
[19] Fetal remains of a nonviable birth of less than 20 weeks gestation would be considered "biomedical waste," which is governed by s. 381.0098, F.S.

- That the parent may obtain a certificate of nonviable birth by contacting the Office of Vital Statistics;
- How the parent may contact the Office of Vital Statistics to request the certificate of nonviable birth; and
- That the certificate of nonviable birth is available as a public record when held by an agency.[20]

Within 30 days of a receipt of a request from a parent, those health care practitioners and health care facilities required to advise a parent of the availability of the certificate of nonviable birth must file a registration of nonviable birth with the State Registrar or a local registrar. The registration may be filed in the state's electronic death registration system or on a file prescribed by DOH.

The bill authorizes the State Registrar to receive certificates of nonviable birth, in the same manner as it receives the certificates of death and certificates of fetal death.

To order a certificate of nonviable birth, a parent's request must be on a form prescribed by DOH, which must include the date of the nonviable birth and the county in which the nonviable birth occurred. DOH must issue the certificate of nonviable birth within 60 days of the receipt of the request from a parent listed on the registration. A parent may request a certificate of nonviable birth regardless of the date on which the nonviable birth occurred. The Office of Vital Statistics must inform any parent who requests a certificate of nonviable birth that a copy of the document is available as a public record.

The bill requires DOH to promulgate a rule for the form, content, and process for the certificate of nonviable birth. The certificate of nonviable birth must contain the date of the nonviable birth, the county in which the nonviable birth occurred, and the name of the fetus provided on the registration of nonviable birth submitted by the attending healthcare practitioner or the healthcare facility at which the nonviable birth occurred. If the fetus does not have a name, the Office of Vital Statistics is directed to indicate "baby boy" or "baby girl" and the last name of the parents on the certificate of nonviable birth. If the sex of the fetus is not known, the Office of Vital Statistics is directed to indicate the name "baby" and the last the name of the parents on the certificate of nonviable birth. The certificate must state, "This certificate is not proof of a live birth," on its front.

The Office of Vital Statistics may not use a certificate of nonviable birth in the calculation of live birth statistics. The bill provides that the certificate of nonviable birth and the statutory definition of nonviable birth may not be used to establish, bring, or support a civil cause of action seeking damages against any person or entity for bodily injury, personal injury, or wrongful death for a nonviable birth.

The bill authorizes DOH to collect fees of at least $3 but no more than $5 for the processing and filing of the certificate of nonviable birth.

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

B. SECTION DIRECTORY:

**Section 1:** Provides a bill title.
**Section 2:** Amends s. 382.002, F.S., relating to definitions.
**Section 3:** Amends s. 382.008, F.S., relating to death, fetal death, and nonviable birth registration.
**Section 4:** Amends s. 382.0085, F.S., relating to stillbirth registration.
**Section 5:** Creates s. 382.0086, F.S., relating to certificate of nonviable birth.
**Section 6:** Amends s. 382.0255, F.S., relating to fees.
**Section 7:** Provides an effective date of July 1, 2017.

[20] Pursuant to s. 119.011(2), F.S., an "agency" means any state, county, district, authority, or municipal officer, department division, board, bureau, commission, or other separate unit of government created or established by law including the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill authorizes DOH to collect a fee of at least $3 but no more than $5 for the certificate of nonviable birth. The estimated revenue is indeterminate. However, the following provides some potential scenarios of what revenues may be.

Using historical data on actual live births from the DOH Florida Vital Statistics Annual Report 2015[21], the average number of resident pregnancies is estimated assuming between 10 and 15 percent of pregnancies end in a miscarriage. Assuming half of miscarriages occur between weeks 9 and 20, it is estimated that half of the parents of these miscarriages will request a certificate of nonviable birth.

For estimating purposes the average of calendar year 2012 - 2015 data was utilized.

Based on these assumptions, average revenues are estimated for a $3 and $5 fee, are as follows:

| Assuming 10% of pregnancies end in miscarriage | | | | |
|---|---|---|---|---|
| Estimated total pregnancies | Estimated miscarriages | Estimated miscarriages 9-20 weeks | Estimated certificates requested | Estimated revenue generated with $3.00 fee |
| 242,313 | 24,231 | 12,116 | 6,058 | $18,173 |

| Assuming 15% of pregnancies end in miscarriage | | | | |
|---|---|---|---|---|
| Estimated total pregnancies | Estimated miscarriages | Estimated miscarriages 9-20 weeks | Estimated certificates requested | Estimated revenue generated with $5.00 fee |
| 256,566 | 38,485 | 19,242 | 9,621 | $48,106 |

Revenues received from the processing and filing fee are deposited in the Planning and Evaluation Trust Fund. As the population of Florida increases, revenues received by the DOH may increase.

2. Expenditures:

DOH indicates that it will incur costs to modify the electronic system used for the registration and certification of vital statistics, the development of forms, and database changes. The cost for modification to the system is estimated to be $50,000.[22] The nonrecurring expenditure can be absorbed within existing agency resources. It is likely that expenditures will be offset by revenues.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

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[21] Department of Health, *Florida Vital Statistics Annual Report 2015,* (September 2016), *available at* http://www.flpublichealth.com/VSBOOK/pdf/2015/vscomp.pdf.

[22] Department of Health, *House Bill 101 Agency Legislative Bill Analysis*, (January 9, 2017), on file with the Health Quality Subcommittee.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

For a person experiencing a nonviable birth, a voluntary fee of at least $3 and not more than $5, must be paid for the certificate of nonviable birth.

Healthcare providers and healthcare facilities who are required to registered nonviable births may incur costs related to additional administrative burdens.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill authorizes DOH to adopt rules regarding the form, content, and process for the certificate of nonviable birth.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 15, 2017, the adopted an amendment that made the following changes:

- Narrowed the definition of "nonviable birth" to a fetal demise that occurs after the completion of the 9th week of gestation but prior to the 20th week of gestation of a pregnancy that has been verified by a health care practitioner;
- Authorized the registration of a nonviable birth upon the request of the parent rather than requiring such registration;
- Limited the health care practitioners who are authorized to register a nonviable birth to nurses and certified midwives; and
- Expanded the time in which a nonviable birth must be registered from 5 days to 30 days, when such registration is requested.

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 certificates of nonviable birth; creating the "Grieving Families Act"; amending s. 382.002, F.S.; providing a definition; amending 382.008, F.S.; authorizing the State Registrar of the Office of Vital Statistics of the Department of Health to electronically receive a certificate of nonviable birth; authorizing certain health care practitioners and health care facilities to electronically file a registration of nonviable birth within a specified timeframe; amending s. 382.0085, F.S.; conforming a cross-reference; creating s. 382.0086, F.S.; requiring the Department of Health to issue a certificate of nonviable birth within a specified timeframe upon the request of a parent; requiring the person registering the nonviable birth to advise the parent that a certificate of nonviable birth is available and that the certificate of nonviable birth is a public record; requiring the request for a certificate of nonviable birth to be on a form prescribed by the department and to include certain information; providing requirements for the certificate of nonviable birth; authorizing a parent to request a certificate of nonviable birth regardless of the date on which the nonviable birth occurred; designating the refusal to issue a

certificate of nonviable birth to certain persons as final agency action that is not subject to administrative review; prohibiting the use of certificates of nonviable birth to calculate live birth statistics; prohibiting specified provisions from being used in certain civil actions; authorizing the department to adopt rules; amending s. 382.0255, F.S.; authorizing the department to collect fees for processing and filing a new certificate of nonviable birth; providing an effective date.

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

Section 1. This act may be cited as the "Grieving Families Act."

Section 2. Subsections (14) through (18) of section 382.002, Florida Statutes, are renumbered as subsections (15) through (19), respectively, and a new subsection (14) is added to that section to read:

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

(14) "Nonviable birth" means an unintentional, spontaneous fetal demise occurring after the completion of the 9th week of gestation but prior to the 20th week of gestation of a pregnancy that has been verified by a health care practitioner.

Section 3. Paragraph (b) of subsection (2) of section

382.008, Florida Statutes, is amended, and subsection (7) is added to that section, to read:

382.008 Death, ~~and~~ fetal death, and nonviable birth registration.—

(2)

(b) The State Registrar may receive electronically a certificate of death, ~~or~~ fetal death, or nonviable birth which is required to be filed with the registrar under this chapter through facsimile or other electronic transfer for the purpose of filing the certificate. The receipt of a certificate of death, ~~or~~ fetal death, or nonviable birth by electronic transfer constitutes delivery to the State Registrar as required by law.

(7) Upon the request of a parent of a nonviable birth, a health care practitioner licensed pursuant to chapter 464 or chapter 467 who attends or diagnoses a nonviable birth, or a health care facility licensed pursuant to chapter 383 or chapter 395 at which a nonviable birth occurs, shall electronically file a registration of nonviable birth on the department electronic death registration system or on a form prescribed by the department with the department or local registrar of the district in which the nonviable birth occurred within 30 days after receipt of such request. The certificate of nonviable birth shall be registered with the department if it has been completed and filed in accordance with this chapter or adopted rules.

Section 4. Subsection (9) of section 382.0085, Florida Statutes, is amended to read:

382.0085 Stillbirth registration.—

(9) This section or s. 382.002(17) ~~382.002(16)~~ may not be used to establish, bring, or support a civil cause of action seeking damages against any person or entity for bodily injury, personal injury, or wrongful death for a stillbirth.

Section 5. Section 382.0086, Florida Statutes, is created to read:

382.0086 Certificate of nonviable birth.—

(1) For any nonviable birth in this state, the department shall issue a certificate of nonviable birth within 60 days upon the request of a parent named on the registration of nonviable birth.

(2) The person or entity authorized to register a nonviable birth under this chapter shall advise a parent of a nonviable birth:

(a) That the parent may request the preparation of a certificate of nonviable birth.

(b) That the parent may obtain a certificate of nonviable birth by contacting the Office of Vital Statistics.

(c) How the parent may contact the Office of Vital Statistics to request a certificate of nonviable birth.

(d) That a copy of the original certificate of nonviable birth is available as a public record when held by an agency as

defined in s. 119.011(2).

(3) The request for a certificate of nonviable birth must be on a form prescribed by the department by rule and include the date of the nonviable birth and the county in which the nonviable birth occurred.

(4) The certificate of nonviable birth must contain:

(a) The date of the nonviable birth.

(b) The county in which the nonviable birth occurred.

(c) The name of the fetus, as provided on the registration of nonviable birth pursuant to s. 382.008. If a name does not appear on the original or amended registration of nonviable birth and the requesting parent does not wish to provide a name, the Office of Vital Statistics shall fill in the certificate of nonviable birth with the name "baby boy" or "baby girl" and the last name of the parents as provided in s. 382.013(3). If the sex of the child is unknown, the Office of Vital Statistics shall fill in the certificate of nonviable birth with the name "baby" and the last name of the parents as provided in s. 382.013(3).

(d) The following statement which must appear on the front of the certificate: "This certificate is not proof of a live birth."

(5) A certificate of nonviable birth shall be a public record when held by an agency as defined in s. 119.011(2). The Office of Vital Statistics must inform any parent who requests a

certificate of nonviable birth that a copy of the original certificate of nonviable birth is available as a public record.

(6) A parent may request that the Office of Vital Statistics issue a certificate of nonviable birth regardless of the date on which the nonviable birth occurred.

(7) It is final agency action, not subject to review under chapter 120, for the Office of Vital Statistics to refuse to issue a certificate of nonviable birth to a person who is not a parent named on the nonviable birth registration.

(8) The Office of Vital Statistics may not use a certificate of nonviable birth to calculate live birth statistics.

(9) This section or s. 382.002(14) may not be used to establish, bring, or support a civil cause of action seeking damages against any person or entity for bodily injury, personal injury, or wrongful death for a nonviable birth.

(10) The department shall prescribe by rules adopted pursuant to ss. 120.536(1) and 120.54 the form, content, and process for the certificate of nonviable birth.

Section 6. Paragraph (k) is added to subsection (1) of section 382.0255, Florida Statutes, to read:

382.0255 Fees.—

(1) The department is entitled to fees, as follows:

(k) Not less than $3 or more than $5 for processing and filing a new certificate of nonviable birth pursuant to s.

382.0086.

Section 7. This act shall take effect July 1, 2017.

Amendment No.

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Cortes, B. offered the following:

**Amendment (with title amendment)**

Remove lines 100-127 and insert:

birth is available as a public record.

(e) That a copy of the original certificate of nonviable birth will not include the parentage, marital status of parents, cause of death of the fetus, or any medical information.

(3) The request for a certificate of nonviable birth must be on a form prescribed by the department by rule and include the date of the nonviable birth and the county in which the nonviable birth occurred.

(4) The certificate of nonviable birth must contain:

(a) The date of the nonviable birth.

(b) The county in which the nonviable birth occurred.

(c) The name of the fetus, as provided on the registration of nonviable birth pursuant to s. 382.008. If a name does not appear on the original or amended registration of nonviable birth and the requesting parent does not wish to provide a name, the Office of Vital Statistics shall fill in the certificate of nonviable birth with the name "baby boy" or "baby girl" and the last name of the parents as provided in s. 382.013(3). If the sex of the child is unknown, the Office of Vital Statistics shall fill in the certificate of nonviable birth with the name "baby" and the last name of the parents as provided in s. 382.013(3).

(d) The following statement which must appear on the front of the certificate: "This certificate is not proof of a live birth."

(5) A certificate of nonviable birth shall be a public record. The Office of Vital Statistics must inform any parent who requests a certificate of nonviable birth that:

(a) A copy of the original certificate of nonviable birth is available as a public record; and

(b) The parentage, marital status of the parents, the cause of death of the fetus, and any medical information will not be included in the public record.

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

Remove line 18 and insert:

the certificate of nonviable birth is a public record and exemptions from disclosure

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 103 Public Records/Nonviable Birth Records
**SPONSOR(S):** Cortes
**TIED BILLS:** CS/HB 101 **IDEN./SIM. BILLS:** SB 674

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Quality Subcommittee | 13 Y, 0 N | Siples | McElroy |
| 2) Oversight, Transparency & Administration Subcommittee | 11 Y, 0 N | Moore | Harrington |
| 3) Health & Human Services Committee | | Siples | Calamas |

### SUMMARY ANALYSIS

CS/HB 101 authorizes the Department of Health (DOH) to issue a certificate of nonviable birth upon the request of an authorized parent. A nonviable birth is a pregnancy that unintentionally and spontaneously results in a fetal demise before a gestation period of 20 completed weeks, more commonly known as a miscarriage.

The bill, which is linked with CS/HB 101, creates a public record exemption for certain information that may be collected when issuing a certificate of nonviable birth. Specifically, the bill provides that the cause of death, parentage, marital status, and medical information included in nonviable birth records are confidential and exempt from public disclosure.

The bill provides for repeal of the exemption on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature. It also provides a public necessity statement as required by the State Constitution.

The bill may have an indeterminate negative fiscal impact on DOH.

The bill will become effective on the same date that CS/HB 101 or similar legislation takes effect.

**Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created public record or public meeting exemption. The bill creates a public record exemption; thus, it requires a two-thirds vote for final passage.**

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Current Situation**

Public Records and Open Meetings Requirements

The Florida Constitution provides that the public has the right to access government records and meetings. The public may inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or of persons acting on their behalf.[1] The public also has a right to have notice of and access to meetings of any collegial public body of the executive branch of state government or of any local government.[2] The Legislature's meetings must also be open and noticed to the public, unless there is an exception provided for by the Constitution.[3]

In addition to the Florida Constitution, the Florida Statutes specify conditions under which public access must be provided to government records and meetings. The Public Records Act[4] guarantees every person's right to inspect and copy any state or local government public record.[5] The Sunshine Law[6] requires all meetings of any board or commission of any state or local agency or authority at which official acts are to be taken be noticed and open to the public.[7]

The Legislature, however, may create an exemption to public record or open meetings requirements.[8] An exemption must specifically state the public necessity justifying the exemption[9] and must be tailored to accomplish the stated purpose of the law.[10] There is a difference between records the Legislature has determined to be exempt from the Public Records Act and those which the Legislature has determined to be exempt from the Public Records Act and also confidential.

*Exempt Records*

If a record is exempt, the specified record or meeting, or portion thereof, is not subject to the access requirements of s. 119.07(1), F.S., s. 286.011, F.S., or article I, section 24 of the Florida Constitution. If records are only exempt from the Public Records Act and not confidential, the exemption does not

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[1] FLA. CONST., art. I, s. 24(a).
[2] FLA. CONST., art. I, s. 24(b).
[3] *Id.*
[4] Chapter 119, F.S.
[5] Section 119.011(12), F.S., defines "public record" as all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency. Section 119.011(2), F.S. defines "agency" as any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency. The Public Records Act does not apply to legislative or judicial records, *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992), however, the Legislature's records are public pursuant to section 11.0431, F.S.
[6] Section 286.011, F.S.
[7] Section 286.011(1)-(2), F.S. The Sunshine Law does not apply to the Legislature; rather, open meetings requirements for the Legislature are set out in the Florida Constitution. Article III, section 4(e) of the Florida Constitution provide that legislative committee meetings must be open and noticed to the public. In addition, prearranged gatherings, between more than two members of the Legislature, or between the Governor, the President of the Senate, or the Speaker of the House of Representatives, the purpose of which is to agree upon or to take formal legislative action, must be reasonably open to the public.
[8] FLA. CONST., art. I, s. 24(c).
[9] *Id.*
[10] *Id.*

prohibit the showing of such information, but simply exempts them from the mandatory disclosure requirements in s. 119.07(1)(a), F.S.[11]

*Confidential Records*

The term "confidential" is not defined in the Public Records Act; however, it is used in Article I, s. 24 of the Florida Constitution, which provides that every person has the right to inspect or copy any public record, except with respect to records exempted or specifically made confidential by the Constitution. If information is made confidential in the statutes, the information is not subject to inspection by the public and may be released only to those persons and entities designated in the statute.[12]

Open Government Sunset Review Act

The Open Government Sunset Review Act (OGSR) prescribes a legislative review process for newly created or substantially amended public record or open meetings exemptions.[13] The OGSR provides that an exemption automatically repeals on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption.[14]

The OGSR provides that a public record or open meeting exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[15] An exemption serves an identifiable purpose if it meets one of the following criteria:

- It allows the state or its political subdivisions to effectively and efficiently administer a governmental program, and administration would be significantly impaired without the exemption;
- It protects sensitive personal information, the release of which would be defamatory or would jeopardize an individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt; or
- It protects trade or business secrets.[16]

In addition, the Legislature must find that the identifiable public purpose is compelling enough to override Florida's open government public policy and that the purpose of the exemption cannot be accomplished without the exemption.[17]

The OGSR also requires specific questions to be considered during the review process.[18] In examining an exemption, the OGSR asks the Legislature to question the purpose and necessity of reenacting the exemption. If, in reenacting an exemption, the exemption is expanded, then a public necessity statement and a two-thirds vote for passage are required.[19] If the exemption is reenacted without

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[11] See, *Williams v. City of Minneola*, 575 So. 2d 683 (Fla. 5th DCA 1991), rev. denied, 589 So. 2d 289 (Fla. 1991), in which the court observed that pursuant to s. 119.07(3)(d), F.S, [now s. 119.071(2)(c), F.S.] "active criminal investigative information" was exempt from the requirement that public records be made available for public inspection. However, as stated by the court, "the exemption does not prohibit the showing of such information." *Id.* at 686.

[12] *WFTV, Inc. v. School Board of Seminole*, 874 So. 2d 48 (Fla. 5th DCA 2004), rev. denied, 892 So. 2d 1015 (Fla. 2004). See also, 04-09 Fla Op. Att'y Gen. (2004) and 86-97 Fla Op. Att'y Gen. (1986).

[13] Section 119.15, F.S. Section 119.15(4)(b), F.S., provides that an exemption is considered to be substantially amended if it is expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System. Section 119.15(2), F.S.

[14] Section 119.15(3), F.S.

[15] Section 119.15(6)(b), F.S.

[16] *Id.*

[17] *Id.*

[18] Section 119.15(6)(a), F.S. The questions are: What specific records or meetings are affected by the exemption? Whom does the exemption uniquely affect, as opposed to the public? What is the identifiable public purpose or goal of the exemption? Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how? Is the record or meeting protected by another exemption? Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[19] FLA. CONST., art. I, s. 24(c).

substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to sunset, the previously exempt records will retain their exempt status unless provided for by law.[20]

Vital Records

The Bureau of Vital Records (bureau), which is housed within the Department of Health (DOH), is statutorily required to develop and maintain a uniform and efficient system of registering, compiling, storing, and preserving all vital records[21] in this state.[22] Under current law, the following records compiled by the bureau are confidential and exempt from public inspection:

- All birth records, except for those over 100 years old that are not sealed pursuant to a court order;[23]
- Information relating to cause of death in all death and fetal death records;[24] and
- The parentage, marital status, and medical information of fetal death records.[25]

Although these records are exempt from public inspection, the records may be made available for health research purposes, as approved by DOH.

Certificates of Nonviable Birth

CS/HB 101 authorizes the bureau to issue a certificate of nonviable birth upon the request of a parent who experiences an unintentional, spontaneous fetal demise before a gestation period of 20 completed weeks, more commonly known as a miscarriage.

**Effect of Proposed Changes**

The bill creates a public record exemption for certain information that may be collected to issue a certificate of nonviable birth. Specifically, the bill adds nonviable birth records to the existing exemption for death and fetal death records. Therefore, information collected regarding the cause of death, parentage, marital status, and medical information related to a nonviable birth will be confidential and exempt from public record requirements.

The bill provides that the public record exemption is subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2022, unless saved from repeal through reenactment by the Legislature.

The bill provides a public necessity statement as required by the State Constitution, which states that the exemption is necessary to protect the privacy rights of an individual undergoing a nonviable birth and such exemptions currently exist for death and fetal death records. The public necessity statement also provides that public disclosure of such information may discourage such an individual from seeking medical care from a licensed health care practitioner or health care facility.

The bill takes effect on the same date that CS/HB 101 or similar legislation takes effect, if such legislation is adopted in the same legislative session.

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[20] Section 119.15(7), F.S.
[21] A vital record is defined as certificates or reports of birth, death, fetal death, marriage, dissolution of marriage, certain name changes, and data related thereto. Section 382.002(17), F.S.
[22] Section 382.003, F.S.
[23] Section 382.025(1), F.S. *See also*, ss. 382.013 and 382.017, F.S., which involve specific situations in which a new birth certificate may be issued and the original birth certificate remains confidential and exempt from public inspection.
[24] Section 382.008(6), F.S. However, pursuant to s. 382.025(2)(b), F.S., all portions of a death certificate cease to be exempt from the provisions of s.119.07(1), F.S., 50 years after the date of death.
[25] *Id.*

B. SECTION DIRECTORY:

**Section 1:** Amends s. 382.008, relating to death and fetal death registration.

**Section 2**: Provides a public necessity statement.

**Section 3**: Provides a contingent effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill may create an insignificant, negative impact on DOH for costs associated with training staff on a new public record exemption. The costs, however, would be absorbed, as part of the day-to-day responsibilities of DOH.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   **Vote Requirement**

   Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created public record or public meeting exemption. The bill creates new exemptions; thus, it requires a two-thirds vote for final passage.

**Public Necessity Statement**

Article I, s. 24(c) of the State Constitution requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill creates a new public record exemption; thus, it includes a public necessity statement.

**Breadth of Exemption**

Article I, s. 24(c) of the State Constitution requires a newly created public record or public meeting exemption to be no broader than necessary to accomplish the stated purpose of the law. The bill creates a public record exemption for certain information contained in and related to nonviable birth records, which does not appear to be in conflict with the constitutional requirement that the exemption be no broader than necessary to accomplish its purpose.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rulemaking or rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to public records; amending s. 382.008, F.S.; providing that certain information included in nonviable birth records is confidential and exempt from public records requirements; providing for future legislative review and repeal of the exemption; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Subsection (6) of section 382.008, Florida Statutes, is amended to read:

382.008 Death, ~~and~~ fetal death, and nonviable birth registration.—

(6)(a) The original certificate of death, ~~or~~ fetal death, or nonviable birth shall contain all the information required by the department for legal, social, and health research purposes. All information relating to cause of death in all death, ~~and~~ fetal death, and nonviable birth records and the parentage, marital status, and medical information included in all fetal death and nonviable birth records of this state are confidential and exempt from the provisions of s. 119.07(1), except for health research purposes as approved by the department; nor may copies of the same be issued except as provided in s. 382.025.

(b) This subsection is subject to the Open Government Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that information relating to the cause of death, parentage, marital status, and medical information included in nonviable birth records be held confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Art. I of the State Constitution to protect the privacy rights of an individual undergoing a nonviable birth. Currently, death and fetal death records containing such information are confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Art. I of the State Constitution. The Legislature further finds that the public disclosure of such information may discourage such an individual from seeking medical care from a licensed health care practitioner or health care facility.

Section 3. This act shall take effect on the same date that HB 101 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 103 (2017)

Amendment No.

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Cortes, B. offered the following:

**Amendment**

Remove lines 16-42 and insert:

(6)(a) The original certificate of death or fetal death shall contain all the information required by the department for legal, social, and health research purposes. All information relating to cause of death in all death and fetal death records and the parentage, marital status, and medical information included in all fetal death records of this state are confidential and exempt from the provisions of s. 119.07(1), except for health research purposes as approved by the department; nor may copies of the same be issued except as provided in s. 382.025.

(8)(a) The original certificate of nonviable birth shall contain all the information required by the department for legal, social, and health research purposes. The department may issue a certified copy of an original nonviable birth certificate which includes the confidential and exempt information:

1. To the fetus' parents;

2. To any agency of the state or local government or the United States for official purposes upon approval of the department; or

3. Upon order of any court of competent jurisdiction

(b) All information relating to the cause of death of the nonviable fetus, parentage of the fetus, marital status of the parent, and any medical information included in all nonviable birth records of this state are confidential and exempt from the provisions of s. 119.07(1), and s. 24(a), Art. I of the State Constitution, except for health research purposes as approved by the department.

(c) The department shall authorize the issuance of a certified copy of all or part of any nonviable birth certificates, excluding that portion which is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a) Art. I of the State Constitution, as provided under s. 382.008, to any person requesting it, as provided under s. 382.008, and upon

receipt of a request and payment of the fee prescribed by s. 382.0255.

(d) This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2022, unless reviewed and saved from repeal.

Section 2. The Legislature finds that the cause of death and parentage of the fetus, marital status of the parents, and medical information included in nonviable birth records to be held confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Art. I of the State Constitution to protect the privacy rights of a parent who experiences a nonviable birth records. Medical information, including the cause of death of the fetus as well as any medical information, is sensitive and personal in nature and disclosure of such information may lead to an unwarranted invasion into the lives of parents experiencing a nonviable birth. Disclosure of information regarding the parentage of the fetus and marital status of the parents may discourage individuals that would otherwise request a certificate of nonviable birth from doing so due to real or perceived stigma regarding the nonviability of the fetus, the fetus' parentage or the parents' marital status. Currently, death and fetal death records make such information confidential and exempt from public disclosure. The Legislature finds that the same protections should be afforded to parents

who wish to memorialize a nonviable birth with a certificate of nonviable birth as part of their grieving process.

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 249 Drug Overdoses
**SPONSOR(S):** Health Quality Subcommittee, Rommel and others
**TIED BILLS:** **IDEN./SIM. BILLS:**

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

## SUMMARY ANALYSIS

Drug overdose is now the leading cause of injury-related death in the United States. In Florida, 3,228 people died of a drug overdose in 2015.

Currently, DOH maintains the Emergency Medical Services Tracking and Reporting System (EMSTARS) to collect data on prehospital emergency care from emergency medical services (EMS) providers. Participation in EMSTARS, and the transmission of electronic incident level data from EMS providers to DOH, is voluntary. EMSTARS data includes demographic elements for the provider agency, its personnel, and patients; incident and unit times; situation and scene information; patient care information including vital signs, injury assessment, trauma score, and intervention and procedural information; and outcome and disposition information. Additionally, EMSTARS may collect data elements for overdoses if EMS administers an opioid antagonist.

CS/HB 249 creates s. 401.253, F.S., which requires mandatory reporting of controlled substances overdoses. The mandatory reporting requirement applies to EMTs and paramedics who provide basic and advanced live support services. An EMT or paramedic who treats and releases an individual, or treats and or transports an individual to a medical facility, in response to an emergency call for a suspected or actual overdose of a controlled substance, must report the incident to DOH within 120 hours. The report must contain the date and time of the overdose; the gender and approximate age of the patient, the suspected controlled substances involved; the address of where the patient was picked up or where the overdose took place; whether Narcan, naloxone, or similar anti-overdose treatment was administered; and whether the overdose was fatal or non-fatal.

The bill requires the report to be filed with DOH using EMSTARS or other appropriate method. Within 120 hours of receiving the report, DOH must make it available to law enforcement, public health, fire rescue, and EMS agencies in each county. Additionally, DOH must make quarterly reports to the Council, the Department of Children and Families (DCF), and the Florida Fusion Center that summarize the data it receives, which may be used to maximize the utilization of funding programs for licensed basic and advanced life support service providers, and to disseminate available federal, state and, private funds for local substance abuse treatment services. It is unclear how the Council will use the data to maximize the use of funding, since it is merely advisory.

The bill makes a reporter exempt from civil or criminal liability for reporting, if the report is made in good faith.

The bill will have an insignificant negative fiscal impact on DOH.

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Substance Abuse

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[1] Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[2] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[3] Brain imaging studies of persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[4]

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[5] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[6]

*Opioid Abuse*

Opioids are commonly abused, with an estimated 15 million people worldwide suffering from opioid dependence.[7] Drug overdose is now the leading cause of injury-related death in the United States.[8] In 2015, Florida ranked fourth in the nation with 3,228 deaths from drug overdoses[9], and at least one opioid caused 2,530 of those deaths.[10] Statewide, in 2015, heroin caused 733 deaths, fentanyl caused 705, oxycodone caused 565, and hydrocodone caused 236; deaths caused by heroin and fentanyl increased more than 75% statewide when compared with 2014.[11]

Drug overdose deaths doubled in Florida from 1999 to 2012.[12] Over the same time period, drug overdose deaths occurred at a rate 13.2 deaths per 100,000 persons.[13] The crackdown on "pill mills" dispensing prescription opioid drugs, such as oxycodone and hydrocodone, reduced the rate of death

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[1] WORLD HEALTH ORGANIZATION. *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited March 13, 2017).
[2] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Substance Use Disorders,* available at: http://www.samhsa.gov/disorders/substance-use (last visited March 13, 2017).
[3] NATIONAL INSTITUTE ON DRUG ABUSE, *Drugs, Brains, and Behavior: The Science of Addiction*, available at: https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited March 1, 2017).
[4] Id.
[5] Supra, note 2.
[6] Id.
[7] WORLD HEALTH ORGANIZATION, *Information Sheet on Opioid Overdose*, November 2014. http://www.who.int/substance_abuse/information-sheet/en/ (last visited March 13, 2107).
[8] TRUST FOR AMERICA'S HEALTH, *The Facts Hurt: A State-by-State Injury Prevention Policy Report 2015,* available at: http://healthyamericans.org/reports/injuryprevention15/ (last visited March 11, 2017).
[9] CENTERS FOR DISEASE CONTROL AND PREVENTION, *Drug Overdose Death Data*, available at: https://www.cdc.gov/drugoverdose/data/statedeaths.html (last visited March 11, 2017).
[10] FLORIDA DEPARTMENT OF LAW ENFORCEMENT. *Drugs Identified in Deceased Persons by Florida Medical Examiners-2015 Annual Report,* available at: https://www.fdle.state.fl.us/cms/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2015-Annual-Drug-Report.aspx (last visited on March 11, 2017).
[11] Id. at pg. 3.
[12] FLORIDA DEPARTMENT OF HEALTH, *Special Emphasis Report: Drug Poisoning (Overdose) Deaths, 1999-2012*, available at: http://www.floridahealth.gov/statistics-and-data/florida-injury-surveillance-system/_documents/CDC-Special-Emphasis-Drug-poisoning-overdose-1999-2012-B-Poston-FINAL.pdf (last visited on March 11,2017).
[13] Id.

attributable to prescription drugs,[14] but may have generated a shift to heroin use, contributing to the rise in heroin addiction.[15]

*Emergency Response to Overdose*

Opioid overdose can occur when an individual deliberately misuses a prescription opioid or an illicit drug such as heroin.[16] It can also occur when a patient takes an opioid as directed, but the prescriber miscalculated the opioid dose, an error was made by the dispensing pharmacist, or the patient misunderstood the directions for use.[17] Opioid overdose is life threatening and requires immediate emergency attention.[18]

To treat an opioid overdose, emergency personnel or a physician may administer an opioid antagonist such as Narcan or Nalaxone. An opioid antagonist is a drug that blocks the effects of exogenously administered opioids. Opioid antagonists are used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally.[19] This occurs because opioid antagonists create a stronger bond with opioid receptors than opioids. This forces the opioids from the opioid receptors and allows the transmission of signals for respiration to resume.[20]

From 2004 through 2009, emergency department visits nationally involving the nonmedical use of pharmaceuticals increased 98.4%, from 627,291 visits to 1,244,679 visits.[21] In 2009, almost one million emergency room visits nationally involved illicit drugs, either alone or in combination with other drugs.[22] From 2008 to 2011, about half of all emergency department visits nationally for both unintentional and self-inflicted drug poisoning involved drugs in the categories of analgesics[23], antipyretics[24], and antirheumatics[25] or sedatives, hypnotics, tranquilizers, and other psychotropic agents.[26]

Opiates or related narcotics, including heroin and methadone, accounted for 14% of emergency department visits nationally for unintentional drug poisoning from 2008 to 2011.[27] In Florida, there were approximately 21,700 opioid-related emergency department visits in 2014.[28]

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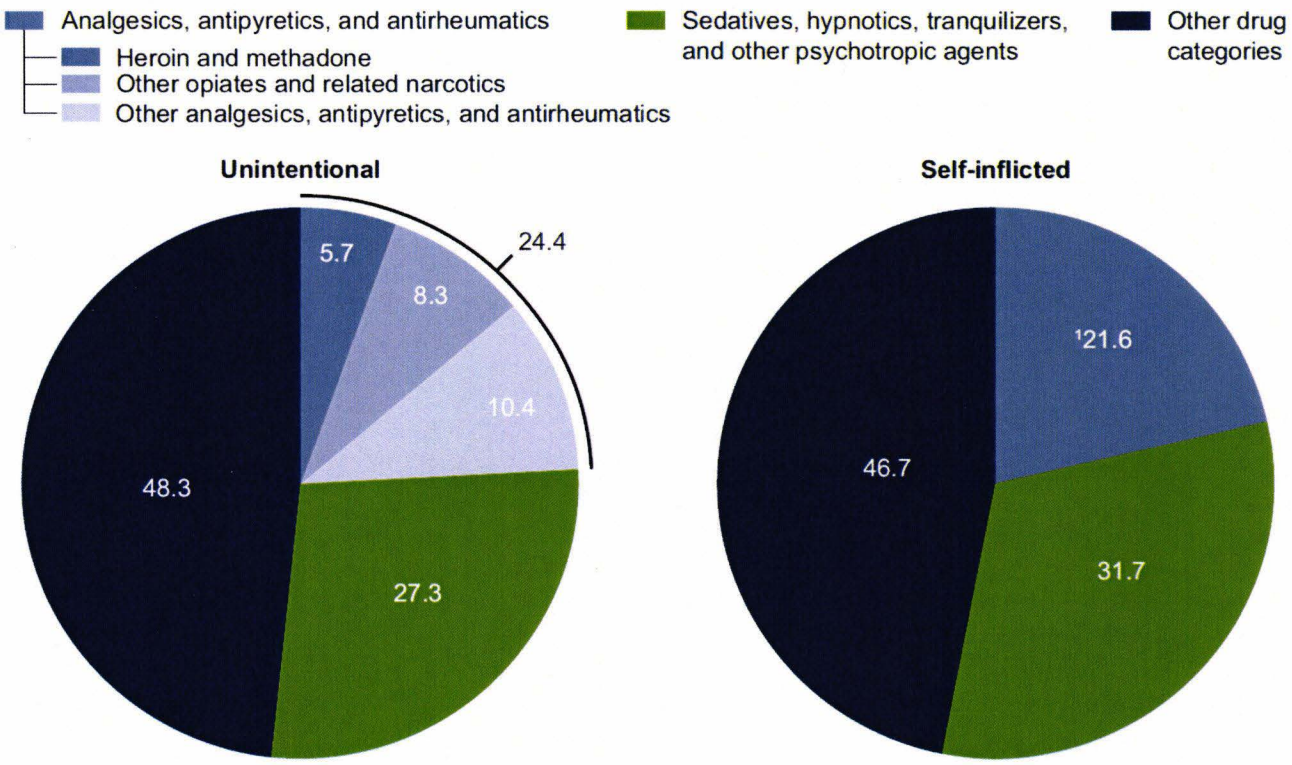
[14] *Supra*, note 10.
[15] WORLD HEALTH ORGANIZATION. *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited March 10, 2017).
[16] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Opioid Overdose Prevention Toolkit*, Rev. 2016, *available at*, http://store.samhsa.gov/shin/content//SMA16-4742/SMA16-4742.pdf (last visited March 13, 2017).
[17] Id.
[18] Id.
[19] HARM REDUCTION COALITION, *Understanding Naloxone,* http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/ (last visited 2/27/15).
[20] HARM REDUCTION COALITION, *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, Fall 2012. http://harmreduction.org/our-work/overdose-prevention/ (last visited 2/27/15).
[21] NATIONAL INSTITUTE ON DRUG ABUSE, *Drug-Related Hospital Emergency Room Visits,* available at: https://www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits (last visited March 9, 2017).
[22] Id.
[23] Analgesics are drugs that produce insensibility to pain.
[24] Antipyretics are drugs that reduce fever.
[25] Antirheumatics are drugs that alleviate or prevent inflammation or pain in muscles, joints, or fibrous tissue.
[26] Albert, M. et al. *Emergency Department Visits for Drug Poisoning: United States, 2008–2011*, NCHS Data Brief No. 196, April 2015, available at: https://www.cdc.gov/nchs/data/databriefs/db196.htm
[27] Id.
[28] Weiss, A.J., et al., *Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009-20014*, HCUP Statistical Brief #219, January 2017, available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf (last visited March 13, 2017).

Percentage of Emergency Department Visits for Drug Poisoning, By Intent and Drug Category: United States, 2008–2011[29]




SOURCE: CDC/NCHS, National Hospital Ambulatory Medical Care Survey, 2008–2011.

Privacy Rights of Individuals Receiving Substance Abuse Treatment

*Florida Protections*

Section 397.501, F.S., establishes statutory rights for individuals receiving substance abuse services, including the right to dignity, non-discriminatory services, quality services, confidentiality, counsel and habeas corpus. In particular, s. 397.501(7), F.S. prohibits service providers from disclosing records containing the identity, diagnosis, and prognosis of and services provided to any individual without written consent of the individual, with certain exceptions.[30] The law makes service providers who violate these rights liable for damages, unless acting in good faith, reasonably, and without negligence.

*Federal Protections of Personal Health Information*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. Privacy rules were initially issued in 2000 by the U.S. Department of Health and Human Services and later modified in 2002.[31] The rules address the use and disclosure of an individual's personal health information and create standards for information security. Only certain entities, "covered entities", are subject to HIPAA's provisions. Covered entities are obligated to meet HIPAA's

[29] Id.
[30] Disclosure is permitted to: health service providers in cases of medical emergency if the information is necessary to provide services to the individual; DCF for the purposes of scientific research; comply with state-mandated child abuse and neglect reporting; comply with a valid court order; report crimes that occur on program premises or against staff; federal, state or local governments for audit purposes; or third party payors providing financial assistance or reimbursement.
[31] UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *The Privacy Rule,* available at http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/ (last visited on March 13, 2017).

requirements to ensure privacy and confidentiality personal health information. These "covered entities" include:[32]

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of any of the above.

Additionally, federal law restricts the disclosure of alcohol and drug patient records maintained by federally assisted alcohol and drug abuse programs which identify a patient as an alcohol or drug abuser.[33] Disclosure of patient-identifying information is permitted in certain cases and patients may consent in writing to the disclosure of such information.[34]

Statewide Drug Policy Advisory Council

In 1999, the Legislature created the Office of Drug Control and the Drug Policy Advisory Council[35] in the Executive Office of the Governor, which the Legislature replaced with the Statewide Drug Policy Advisory Council (the Council)[36] under the Florida Department of Health (DOH) in 2011. Among other things, the Council submits a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives with recommendations.[37]

The Council's 2016 Annual Report concluded that a key problem in combating drug overdoses Florida is that there is "no sustainable process to compile massive amounts of data and information, perform analysis and develop an evidence-based call to action" as a.[38] To improve data collection and surveillance, the Council recommends that DOH collaborate with other agencies, organizations, and institutions to create a comprehensive statewide strategy addressing the fentanyl and heroin overdoses in the state.[39]

DOH Data Systems

*Florida Injury Surveillance Data System*

DOH's Injury Surveillance Data System is a passive data reporting mechanism that utilizes data resources from other agencies and systems, including:

- Vital records (death certificates);
- Hospital discharge data;
- Emergency department discharge data;
- Motor vehicle crash records;
- Behavioral Risk Factor Surveillance System;
- Youth Risk Behavior Surveillance System;
- Child Death Review;
- Uniform Crime Reporting System; and

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[32] UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *For Covered Entities and Business Associates*, available at http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/ (last visited on March 13, 2017).
[33] 42 CFR Part 2.
[34] Disclosure is allowed to comply with state-mandated child abuse and neglect reporting; to report the cause of death; to comply with a valid court order; in cases of medical emergency; to report crimes that occur on program premises or against staff; to entities having administrative control; to qualified service organizations and to outside auditors, evaluators, central registries, and researchers.
[35] Section 397.332, F.S., created by s. 3, ch. 99-187, Law s of Fla.
[36] Section 397.333, F.S., created by s. 8, ch. 2011-51, Laws of Fla.
[37] Section 397.333(3), F.S.
[38] FLORIDA DEPARTMENT OF HEALTH, *Statewide Drug Policy Advisory Council 2016 Annual Report*, (Dec. 1, 2016), p. 4, *available at*, http://www.floridahealth.gov/provider-and-partner-resources/dpac/DPAC-Annual-Report-2016-FINAL.pdf (last visited March 13, 2017).
[39] Id. at 14.

- Emergency medical services.[40]

The Injury Surveillance Data System is used to monitor the frequency of fatal and non-fatal injuries, determine the risk factors for these injuries, evaluate the completeness, timeliness, and quality of data sources, provide information to Florida's injury prevention community for program planning and evaluation, and provide a foundation for injury prevention strategies.[41] One of the injury mechanisms it receives information on is poisoning, which includes drug overdoses;[42] however it is not currently set up to actively receive data regarding overdoses, or any other injury mechanism.[43]

*Emergency Medical Services Tracking and Reporting System (EMSTARS)*

DOH maintains[44] the Emergency Medical Services Tracking and Reporting System (EMSTARS) to collect data on pre-hospital emergency care from EMS providers.[45] This system allows for the collection and analysis of incident level data from EMS agencies for benchmarking and quality improvement initiatives.[46] Participation in the EMSTARS system, and the transmission of electronic incident level data from EMS Providers[47] to DOH, is voluntary.[48] However, the complete provision of incident level data, and full participation in the EMSTARS Program, fulfills EMS Provider prehospital reporting requirements in rule 64J-1.014(1), F.A.C. The data collected by EMSTARS includes:

- All NHTSA "national" data elements for demographic data and EMS event data;
- Other selected elements identified by participants and other stakeholders;
- Demographic elements for the provider agency, its personnel, and patients;
- Incident and unit times;
- Situation and scene information;
- Patient care information including vital signs, injury assessment, trauma score, and intervention and procedural information; and
- Outcome and disposition information.[49]

Additionally, EMSTARS collects minimal data elements for overdoses, especially if EMS administers an opioid antagonist.[50]

The electronic patient care records submitted by licensed EMS agencies to EMSTARS are confidential and exempt pursuant to s. 401.30(4), F.S.

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[40] FLORIDA DEPARTMENT OF HEALTH, *Florida Injury Surveillance Data System*, http://www.floridahealth.gov/statistics-and-data/florida-injury-surveillance-system/index.html (last visited March 13, 2017).
[41] Id.
[42] FLORIDA DEPARTMENT OF HEALTH, *External Cause of Injury Intent and Mechanism Classifications and Descriptions*, (Sept. 8, 2008), *available at*, http://www.floridahealth.gov/statistics-and-data/florida-injury-surveillance-system/_documents/icd-code-explanations.pdf (last visited March 13, 2017).
[43] Florida Department of Health, Agency Analysis of 2017 House Bill 249, p. 6, (Jan. 17, 2017) (on file with Health and Human Services Committee staff).
[44] In 2004,DOH signed a memorandum of understanding to participate in a national project that would standardize data collection for EMS agencies nationwide. The National Emergency Medical Services Information System is the national repository used to aggregate and analyze prehospital data from all participating states.
[45] FLORIDA DEPARTMENT OF HEALTH, *The Basic Facts: Prehospital EMS Tracking and Reporting System*, p. 1, *available at*, http://www.floridaemstars.com/docs/EMSTARSFactSheet_102314.pdf (last visited March 13, 2017).
[46] Id.
[47] There are 147 participating EMS agencies. FLORIDA DEPARTMENT OF HEALTH, *Florida EMS Agencies Participating in EMSTARS, available at*, http://www.floridaemstars.com/docs/partagencies.pdf (last visited March 13, 2017).
[48] *Supra*, note 45.
[49] Id.
[50] *Supra*, note 43.

Emergency Medical Technicians and Paramedics

An emergency medical technician (EMT) a person who is certified by DOH to perform basic life support.[51] A defines paramedic is a person who is certified by DOH to perform basic and advanced life support.[52] EMTs and paramedics are regulated by DOH, under ch. 401, Part III, F.S

EMTs and paramedics care for sick or injured patients in an emergency medical setting and often work closely with police and firefighters during an emergency situation.[53] Some of the typical duties of an EMT or paramedic are:

- Responding to 911 calls for emergency medical assistance;
- Assessing a patient's condition and determining a course of treatment;
- Helping transfer patients to the emergency department of a healthcare facility and report their observations and treatment to the staff; and
- Creating a patient care report, documenting the medical care given to the patient.[54]

Currently, there are 35,315 certified EMTs and 29,731 certified paramedics in Florida.[55]

**Effect of Proposed Changes**

Legislative Findings, Intent, and Goals

CS/HB 249 makes a finding that substance abuse and drug overdose is a major health problem that affects the lives of many people, and multiple service systems that leads to profoundly disturbing consequences. The bill also makes a finding that these overdoses are a crisis and stress financial, health care, and public safety resources. Additionally, it makes a finding that a central databases that could quickly help address this problem does not currently exist.

The bill also states legislative intent to require the collaboration of local, regional, and state agencies, service systems, and program offices to address the needs of the public, to establish a comprehensive system addressing the problems associated with drug overdoses, and to reduce duplicative requirements across local, county, state, and health care agencies.

The bill also states a legislative intent to maximize the efficiency of financial, public education, health professional, and public safety resources and to utilize funding programs for the dissemination of available federal, state, and private funds through contractual agreements with licensed basic or advanced life support service providers, community-based organizations or units of state or local government that deliver local substance abuse services.

The goals of the act are identified as:

- Discouraging substance abuse and overdoses by quickly identifying the type of drug involved, the age of the individual involved, and the areas where drug overdoses pose a potential risk to the public, schools, workplaces, and communities; and

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[51] Section 401.23(11), F.S.; section 401.23(7), F.S., defines "basic life support" as, the assessment or treatment through the use of techniques described in the Emergency Medical Technician Basic National Standard Curriculum or the National EMS Education Standards of the U.S. Department of Transportation.

[52] Section 401.23(17), F.S.; section 401.23(1), F.S., defines "advanced life support" as, the assessment or treatment by a qualified person through the use of techniques such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, cardiac defibrillation, and other techniques described in the EMT-Paramedic National Standard Curriculum or the National EMS Education Standards.

[53] U.S. BUREAU OF LABOR STATISTICS, EMTs AND PARAMEDICS, http://www.bls.gov/ooh/Healthcare/EMTs-and-paramedics.htm#tab-2 (last visited March 16, 2017).

[54] Id.

[55] FLORIDA DEPARTMENT OF HEALTH, DIVISION OF MEDICAL QUALITY ASSURANCE, *Annual Report and Long-Range Plan: Fiscal Year 2015-2016,* available at http://mqawebteam.com/annualreports/1516/#12 (last visited March ).

- Providing a central data point so that data can be shared between the health care community and municipal, county, and state agencies to quickly identify needs and provide short and long term solutions while protecting and respecting the rights of individuals.

Mandatory Overdose Reporting

The bill creates s. 401.253, F.S., which requires mandatory reporting of controlled substances overdoses. The bill defines "overdose" as a condition which includes, but is not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death from the consumption or use of a controlled substance that requires medical attention, assistance, or treatment, and a clinical suspicion of a drug overdose such as respiratory depression, unconsciousness, or an altered mental state which is not explained by another condition.

The mandatory reporting requirement applies to EMTs and paramedics who provide basic and advanced live support services. An EMT or paramedic who treats and releases an individual, or treats and or transports an individual to a medical facility, in response to an emergency call for a suspected or actual overdose of a controlled substance, must report the incident to DOH within 120 hours. The report must contain:

- The date and time of the overdose;
- The approximate age and gender of the patient,
- The suspected controlled substances involved in the overdose;
- The address of where the patient was picked up or where the overdose took place;
- Whether Narcan, naloxone, or similar anti-overdose treatment was administered; and
- Whether the overdose was fatal or non-fatal.

Anyone who files a report in good faith is not subject to civil or criminal liability for making the report.

*Use of Report*

The bill requires the report to be filed with DOH within 120 hours. Within 120 hours of receiving the report, DOH must make it available to law enforcement, public health, fire rescue, and EMS agencies in each county.

Additionally, DOH must make quarterly reports to the Council, the Department of Children and Families (DCF), and the Florida Fusion Center[56] that summarizes the data it receives. The Council, DCF, and DOH may use the reports to maximize the utilization of funding programs for basic and advanced life support service providers, and to disseminate available federal, state and, private funds for local substance abuse treatment services. It is unclear how the Council will use the data to maximize the use of funding, since it is merely advisory.

B. SECTION DIRECTORY:

**Section 1:** Provides legislative findings and intent
**Section 2:** Creates s. 401.253, F.S., relating to mandatory reporting of controlled substance overdoses.
**Section 3:** Provides an effective date of October 1, 2017

[56] The Fusion Center, housed within the Florida Department of Law Enforcement, is a collaborative effort of state and federal agencies working in partnership with local partners to share resources, expertise, and/or information to better identify, detect, prevent, apprehend and respond to criminal and terrorist activity utilizing an all crimes/all hazards approach. FLORIDA DEPARTMENT OF LAW ENFORCEMENT, *The Florida Fusion Center*, http://www.fdle.state.fl.us/cms/FFC/FUSION-Center-Home.aspx (last visited March 16, 2017).

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The reporting methods could require acquisition of new or additional software to collect and aggregate data.[57] DOH estimates it will cost $20,000 to $50,000 to make the technology changes to implement the reporting requirements of the bill.[58]

   In addition, DOH may experience a recurring increase in workload associated with additional data they must collect from EMTs and paramedics and the quarterly reports it must make to the Council.[59] The impact is indeterminate at this time; therefore, DOH cannot calculate the full fiscal impact, but notes that it could be significant.[60]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Public EMS providers could incur additional costs related to enhanced reporting requirements. [61]

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Mandatory reporters will have to take time away from other work to comply with the reporting requirements in the bill.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

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[57] *Supra*, note 43.
[58] Email from Paul Runk, Director, Office of Legislative Planning, Florida Department of Health, email RE: Fwd: cost of NCBP integration (Mar. 16, 2017) (on file with Health and Human Services Committee staff).
[59] *Supra*, note 43.
[60] Id.
[61] Id.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 15, 2017, the Health Quality Subcommittee adopted an amendment to the bill, which:

- Removed the requirement for a central data point in each county;
- Limited the reporting requirement to basic and advanced life support service providers who respond to an emergency call for a suspected or actual overdose; and revised the information that must be reported;
- Removed requirements for law enforcement to collect, distribute, and maintain the data;
- Required the report to be made to the DOH within 120 hours and identified how the reports to DOH may be made;
- Required DOH to make data available within 120 hours to law enforcement and public health, fire rescue, and EMS agencies in each county;
- Required DOH to produce quarterly reports to specified entities and make the reports immediately available to specified county-level agencies; and
- Removed criminal penalties for failure to report.

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 drug overdoses; providing legislative findings and intent; creating s. 401.253, F.S.; requiring certain persons to report controlled substance overdoses; defining the term "overdose"; providing requirements for such reports; providing immunity for persons who make such reports in good faith; requiring sharing of data with specified entities; providing for use of such data; providing an effective date.

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

Section 1. (1) The Legislature finds that substance abuse and drug overdose is a major health problem that affects the lives of many people, multiple service systems, and leads to such profoundly disturbing consequences as permanent injury or death. Heroin, opiates, illegal drug, and accidental overdoses are a crisis and stress the financial, health care, and public safety resources because there are no central databases that can quickly help address this problem. Quick data collection will allow all agencies to focus on specific age groups, areas, criminal behavior, and needed public education and prevention with the maximum utilization of resources. Further, it is the intent of the Legislature to require the collaboration of local,

regional, and state agencies, service systems, and program offices to address the needs of the public; to establish a comprehensive system addressing the problems associated with drug overdoses; and to reduce duplicative requirements across local, county, state, and health care agencies.

(2) It is the goal of the Legislature in this act to:

(a) Discourage substance abuse and accidental or intentional overdoses by quickly identifying the type of drug involved, whether prescription or illegal, the age of the individual involved, and the areas where drug overdoses pose a potential risk to the public, schools, workplaces, and communities.

(b) Provide a central data point so that data can be shared between the health care community and municipal, county, and state agencies to quickly identify needs and provide short and long-term solutions while protecting and respecting the rights of individuals.

(3) It is the intent of the Legislature in this act to maximize:

(a) The efficiency of financial, public education, health professional, and public safety resources so that these resources may be concentrated on areas and groups in need.

(b) The utilization of funding programs for the dissemination of available federal, state, and private funds through contractual agreements with licensed basic life support

service providers, advanced life support service providers, community-based organizations, or units of state or local government that deliver local substance abuse services in accordance with the intent of this act and s. 397.321(4), Florida Statutes.

Section 2. Section 401.253, Florida Statutes, is created to read:

401.253 Mandatory reporting of controlled substance overdoses.—

(1)(a) The basic life support service or advanced life support service which treats and releases, or transports to a medical facility, in response to an emergency call for a suspected or actual overdose of a controlled substance shall report such incident within 120 hours to the department using the Emergency Medical Service Tracking and Reporting System, or other appropriate method, including, but not limited to, ESSENCE, the Washington/Baltimore High Intensity Drug Trafficking Overdose Detection Mapping Application Program, or other program identified by the department in rule.

(b) The data collected by the department shall be made available within 120 hours to law enforcement, public health, fire rescue, and emergency medical service agencies in each county.

(c) For purposes of this section, the term "overdose" means a condition, including, but not limited to, extreme

physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of any controlled substance that requires medical attention, assistance or treatment, and clinical suspicion for drug overdose, such as respiratory depression, unconsciousness, or altered mental status, without other conditions to explain the clinical condition.

(2) A person who reports an overdose of a controlled substance under this section shall include in the report:

(a) The date and time of overdose.

(b) The gender and approximate age of the person receiving attention or treatment.

(c) The suspected controlled substances involved in the overdose.

(d) The approximate address of where the person was picked up or where the overdose took place.

(e) Whether Narcan, naloxone, or similar anti-overdose treatment was administered.

(f) Whether the overdose was fatal or nonfatal.

(3) A person who reports information to or from the department pursuant to this section in good faith is not subject to civil or criminal liability for making the report.

(4) The department shall produce a quarterly report to the Statewide Drug Policy Advisory Council, the Department of Children and Families, and the Florida FUSION Center summarizing

the raw data received pursuant to this section. Such reports shall also be made immediately available to the county-level agencies described in paragraph (1)(b). The Statewide Drug Policy Advisory Council, the Department of Children and Families, and the department may use these reports to maximize the utilization of funding programs for licensed basic life support service providers or advanced life support service providers, and for the dissemination of available federal, state, and private funds for local substance abuse services in accordance with s. 397.321(4).

Section 3. This act shall take effect October 1, 2017.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Rommel offered the following:

**Amendment (with title amendment)**

Remove lines 58-97 and insert:

401.253 Reporting of controlled substance overdoses.—

(1)(a) A basic life support service or advanced life support service which treats and releases, or transports to a medical facility, in response to an emergency call for a suspected or actual overdose of a controlled substance may report such incidents to the department. Such reports must be made using the Emergency Medical Service Tracking and Reporting System, or other appropriate method with secure access, including, but not limited to, the Washington/Baltimore High Intensity Drug Trafficking Overdose Detection Mapping

Application Program, or other program identified by the department in rule. If a basic life support service or advanced life support service reports such incidents, it shall use best efforts to make the report to the department within 120 hours.

(b) The data collected by the department shall be made available within 120 hours to law enforcement, public health, fire rescue, and emergency medical service agencies in each county.

(c) For purposes of this section, the term "overdose" means a condition, including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of any controlled substance that requires medical attention, assistance or treatment, and clinical suspicion for drug overdose, such as respiratory depression, unconsciousness, or altered mental status, without other conditions to explain the clinical condition.

(2)(a) A report of an overdose of a controlled substance under this section shall include:

1. The date and time of overdose.

2. The approximate address of where the person was picked up or where the overdose took place.

3. Whether an emergency opioid antagonist, as defined in s. 381.887, was administered.

4. Whether the overdose was fatal or nonfatal.

(b) A report of an overdose of a controlled substance under this section shall also include, if the reporting mechanism permits:

1. The gender and approximate age of the person receiving attention or treatment.

2. The suspected controlled substance involved in the overdose.

(3) A basic life support service or advanced life support service that reports information to or from the department pursuant to this section in good faith is not subject to civil or criminal liability for making the report.

(4) Failure to report an overdose under this section is not grounds for disciplinary action or penalties pursuant to s. 401.411(1)(a).

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

Remove lines 4-8 and insert:

F.S.; permitting certain entities to report controlled substance overdoses to the Department of Health; defining the term "overdose"; providing requirements for such reports; providing immunity for persons who make reports in good faith; providing that a failure to report is not a basis for licensure discipline; requiring sharing of data with specified

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 363 Temporary Care of a Child
**SPONSOR(S):** Civil Justice & Claims Subcommittee; White; Williams and others
**TIED BILLS:** None **IDEN./SIM. BILLS:** SB 200

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Children, Families & Seniors Subcommittee | 14 Y, 0 N | Tuszynski | Brazzell |
| 2) Civil Justice & Claims Subcommittee | 9 Y, 4 N, As CS | Stranburg | Bond |
| 3) Health & Human Services Committee | | Tuszynski TT | Calamas CC |

## SUMMARY ANALYSIS

Families are often confronted with circumstances, such as drug abuse, illness, unemployment, or homelessness, which, if not appropriately addressed, can lead to abuse, neglect, or abandonment of their children. Safe Families for Children works to support such families in crisis in three areas of Florida: Naples, Orlando, and Tampa Bay. The organization assists parents with finding safe temporary placements to ensure their children do not enter the child welfare system while parents work to reestablish a safe and stable living environment.

The bill creates s. 409.1761, F.S., which authorizes organizations to provide assistance to families in crisis by finding volunteer respite families to care for children not in the child welfare system.

The bill authorizes the parent of a minor child to execute a contract for care to delegate certain powers regarding the care and custody of the child to a volunteer respite family that is screened and trained by certain nonprofit organizations. The delegation does not change parental rights, obligations, or authority regarding custody, visitation, or support unless determined by a court to be in the best interests of the child. The bill includes various requirements to ensure child safety. It:

- Prohibits a parent or agent from receiving compensation related to the delegation of care and custody;
- Limits the contract for care to a period of 6 months;
- Requires that either both parents sign the contract for care or notice be provided to a noncustodial parent;
- Specifies requirements for the execution, form, and revocation of the contract for care;
- Requires nonprofit organizations that assist with the temporary placement of a child with a volunteer respite family to conduct background screenings, provide support services and training to the families, maintain certain records, and register with the Department of Children and Families (DCF); and
- Authorizes DCF to provide information regarding temporary care programs to parents during a child protective investigation, if appropriate.

The bill also exempts the nonprofit organization assisting with the placement and the volunteer respite family from licensure and regulation by DCF. However, the bill does not prevent DCF or law enforcement from investigating allegations of abandonment, abuse, neglect, unlawful desertion of a child, or human trafficking.

The bill does not have a fiscal impact on state or local government.

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

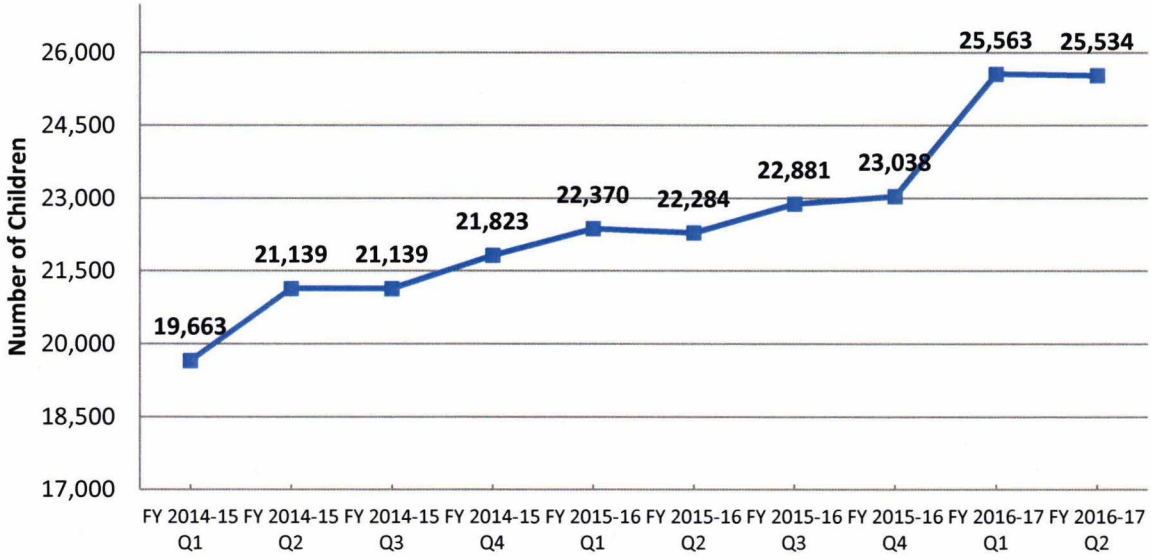
A. EFFECT OF PROPOSED CHANGES:

Child Welfare System

Families are often confronted with circumstances, such as drug abuse, illness, domestic violence, unemployment, mental health issues, or homelessness, which, if not appropriately addressed, can lead to abuse, neglect, or abandonment of their children.[1] Parents in crisis may be unable to simultaneously deal with both the crisis and parenting due to the lack of family or supportive relationships.[2] This type of social isolation combined with the stress of a crisis can increase the likelihood of child abuse, often through child neglect as a parent must choose between addressing the immediate crisis and adequately caring for his or her child.[3]

The Department of Children and Families (DCF) and contracted community-based lead agencies administer the Florida child welfare system under ch. 39, F.S. The child welfare system identifies families whose children are in danger of suffering or have suffered abuse, abandonment, or neglect and works with those families to address the problems that are endangering children, if possible. If the problems cannot be ameliorated, the child welfare system finds safe out-of-home placements for children, such as relative and non-relative caregivers, foster families, or adoptive families.[4] As of December 31, 2016, there were 25,534 children under the supervision of DCF in out-of-home care.[5] Generally, out-of-home placements have been increasing for the past few years:[6]

**Florida Child Welfare System Out-of-Home Placement: September 2014 - December 2016**




[1] Murray, K, et al., *Safe Families for Children's Program Model and Logic Model Description Report,* unpublished presentation, University of Maryland School of Social Work (2012) (on file with Children, Families, & Seniors Subcommittee).
[2] *Id.* at pg. 4.
[3] *Id.* at pg. 2.
[4] *See* s. 39.001(1), F.S.
[5] "Out-of-home care" includes both children in board-paid foster care and those receiving protective supervision in the home of a relative or approved non-relative after a removal. Children under protective supervision in the home of a relative or approved non-relative after removal are considered "out-of-home," as they are entitled to the same safeguards as board-paid foster children. *See* Florida Department of Children and Families, DCF Quick Facts, *2016-17 Quarter 2 Program Data*, http://www.dcf.state.fl.us/general-information/quick-facts/cw/ (last visited February 8, 2017).
[6] Department of Children and Families, DCF Quick Facts, available at http://www.dcf.state.fl.us/general-information/quick-facts/ (last visited February 10, 2017).

*Prevention*

DCF's child welfare program works in partnership with local communities and the courts to ensure the safety, timely permanency, and well-being of children.

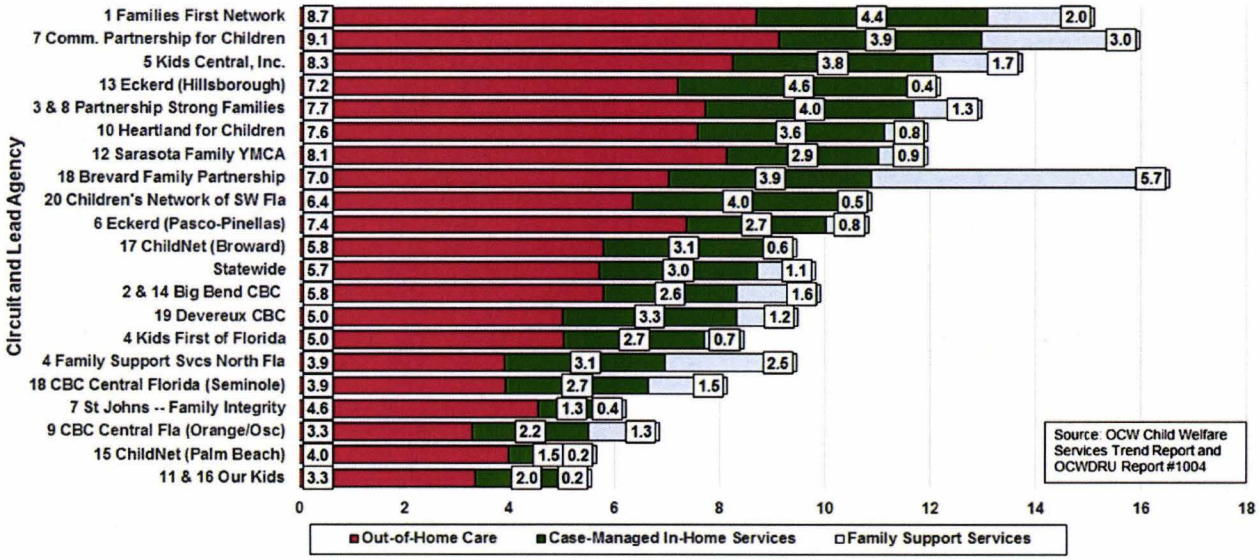
Child welfare services seek to prevent child abandonment, abuse, and neglect.[7] DCF's practice model is based on the safety of the child within his or her home, prioritizing the use of in-home services such as parenting coaching and counseling to maintain and strengthen that child's natural supports in his or her home environment. DCF provides these child welfare and related services throughout the state by contracting with lead agencies, also known as community-based-care organizations (CBCs).[8]

DCF offers preventive services[9] to families to avoid removal of children from their homes, [10] called Family Support Services (FSS). FSS are used when an investigator has determined that children in the family are safe but have a high or very high risk level and potential of removal. These services are designed to reduce risk and prevent removal by:[11]

- Strengthening protective factors in the family;
- Enhancing the social and emotional well-being of each child and family;
- Enabling families to use other resources and opportunities in the community; and
- Assisting families with creating and strengthening family resource networks.

The rate of FSS services provided varies by CBC. As of December 2016, the variation ranged from a low as 0.2 children per 1,000 (11th,16th, and 13th circuits) to a high of 5.7 children per 1,000 (18th Circuit).[12]

**Children Receiving Services by Type – Rates per 1,000 Child Population**[13]




[7] S. 39.001(8), F.S.
[8] Community-Based Care, The Department of Children and Families, accessible at http://www.myflfamilies.com/service-programs/community-based-care (last accessed January 28, 2017).
[9] S. 39.01(60), F.S., "Preventive services" means social services and other supportive and rehabilitative services provided to the parent or legal custodian of the child and to the child for the purpose of averting the removal of the child from the home or disruption of a family which will or could result in the placement of a child in foster care.
[10] S. 39.401(7), F.S.
[11] Department of Children and Families, Operating Procedures, CFOP 170-1, Family Support Services, May 30, 2016, available at http://www.dcf.state.fl.us/admin/publications/policies.asp?path=CFOP%20170-xx%20Child%20Welfare (last accessed February 10, 2017).
[12] Department of Children and Families, Child Welfare Key Indicators Monthly Report, pg. 24, January 2017, available at http://centerforchildwelfare.fmhi.usf.edu/qa/cwkeyindicator/KI_Monthly_Report_January_2017_Final.pdf (last accessed March 18, 2017).
[13] Id.

However, when a child cannot safely remain at home, DCF works to keep the child safe out of home while providing services to reunify the child and family as soon as it is safe to do so.

Ultimately, if a child's home remains unsafe and the court is unable to reunify the child with his or her family, the child welfare system works to find an adoptive family for the child.

*Types of Placements and Licensure*

For children who cannot safely remain in their own homes, the child welfare system finds an appropriate out-of-home placement. The placements range from temporary placement with a family member to a permanent adoptive placement with a family previously unknown to the child. Family foster homes,[14] residential child-caring agencies, and child-placing agencies[15] must be licensed by DCF.[16] However, the following placements do not require licensure by DCF:

- Relative caregivers, such as a grandmother or aunt;
- Non-relative caregivers, such as a neighbor or family friend;
- An adoptive home which has been approved by DCF or by a licensed child-placing agency for children placed for adoption; and
- Persons or neighbors who care for children in their homes for less than 90 days.[17]

Licensed entities must comply with DCF rules pertaining to:

- Operation, conduct, and maintenance of these homes;
- Provision of food, clothing, educational opportunities, services, equipment, and individual supplies to assure the healthy physical, emotional, and mental development of the children served;
- Appropriateness, safety, cleanliness, and general adequacy of the premises, including fire prevention and health standards, to provide for the physical comfort, care, and well-being of the children served;
- Ratio of staff to children required to provide adequate care and supervision of the children served; and
- In the case of foster homes, the maximum number of children in the home and good moral character of personnel based upon screening, education, training, and experience requirements.[18]

*Background Screening*

Level 2 background screening[19] is required for child welfare system personnel,[20] including all owners, operators, employees, and volunteers working in a child-placing agency, family foster home, or residential child-caring agency.[21] Family members and persons between the ages of 12 and 18 residing with the owner or operator of a family foster home or agency must also undergo a delinquency record check, but such record check does not require fingerprinting.[22]

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[14] S. 409.175(2)(e), F.S., defines a "family foster home" as a private residence in which children who are unattended by a parent or legal guardian are provided 24-hour care. Such homes include emergency shelter family homes and specialized foster homes for children with special needs. A family foster home does not include a person who cares for a child of a friend for a period not to exceed 90 days, a relative who cares for a child and does not receive reimbursement for such care from the state or federal government, or an adoptive home which has been approved by the department or by a licensed child-placing agency for children placed for adoption.
[15] S.409.175(2)(d), F.S., defines a "child-placing agency" as any person, corporation or agency, public or private that receives a child for placement and places or arranges for the placement of a child in a family foster home, residential child-caring agency, or adoptive home.
[16] S. 409.175, F.S.
[17] Id.
[18] Id.
[19] S. 409.175(2)(k), F.S.
[20] S. 409.175(6)(a), F.S.
[21] S. 409.175(2)(i), F.S.
[22] *Id.*

A level 2 background screening involves a state and national fingerprint-based criminal record check through the Florida Department of Law Enforcement (FDLE) and the Federal Bureau of Investigation (FBI).[23] Level 2 background screenings require that a person has not been arrested for and awaits final disposition, has not been found guilty of, or entered a plea of nolo contendere to crimes related to sexual misconduct, child or adult abuse, murder, manslaughter, battery, assault, kidnapping, weapons, arson, burglary, theft, robbery, or exploitation.[24] DCF processes the background screenings through the Care Provider Background Screening Clearinghouse for individuals working in the child welfare system, who are required by law to be background screened.

*Care Provider Background Screening Clearinghouse*

The Care Provider Background Screening Clearinghouse[25] (clearinghouse) is a statewide system that enables specified state agencies, such as DCF and the Agency for Persons with Disabilities, to submit requests for level 2 background screenings for statutorily defined purposes, such as licensure or license-related employment. The level 2 screening results are provided to the requesting agency, not the individual or employer organization, and are also retained in the clearinghouse.

There are several benefits to utilizing the clearinghouse, including significant cost savings due to use of existing screenings, access to a screened individual's Florida public criminal record, and immediate notification of an employee or licensee arrest in Florida due to the active monitoring of the record.

Safe Families Model

In 2002, the Safe Families for Children (SFFC) program originated in Chicago as a ministry of the LYDIA Home Association, a Christian social service organization. The program created a model in which parents in crisis without family or support relationships had a place to go for help without entering the child welfare system and losing custody of their children.[26] The model includes placing a child with an unpaid volunteer host family, allowing a parent the time and space to deal with whatever issues brought them to SFFC, such as hospitalization, or a longer-term crisis, such as drug treatment or incarceration. By temporarily placing the child with a host family, SFFC hopes to reduce the risk of child abuse and neglect, as well as provide a safe place for a child.[27] One of the main tenets of this model is the creation of networks and relationships to help care for the child and stabilize the family.[28]

These private, voluntary placements require that the parent sign an agreement with terms and conditions of the arrangement, including what the parent will need to do to be reunified with their children and how the program will respond if the parent is unable to complete performance.[29] The parent thereafter delegates care and custody of the child to the host volunteer family.

According to SFFCC, parents retain full legal custody of children, volunteer families are screened and supported, and there is an average length of stay of 6 weeks.[30] Volunteers and families served often continue a relationship after reunification has occurred, reducing social isolation and providing ongoing support.[31]

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[23] s. 435.04, F.S.
[24] s. 435.04(2), F.S.
[25] s. 435.12, F.S.
[26] *Supra* note 1, pg. 3.
[27] *Id.*
[28] *Supra* note 1, pg. 5.
[29] The Florida Senate, Committee on Children, Families, and Elder Affairs, *Issue Brief 2010-304: "Temporary Parents" as an Alternative to the Foster Care System (September 2009)*, at 2, *available at* http://archive.flsenate.gov/data/Publications/2010/Senate/reports/interim_reports/pdf/2010-304cf.pdf (last accessed February 8, 2017).
[30] Safe Families for Children, How Safe Families Works, *available at*: http://safe-families.org/about/how-safe-families-works/ (last accessed February 8, 2017).
[31] *Id.*

Programs based on the SFFC model are active in 70 cities in the U.S., Canada, and the U.K.,[32] with 9 U.S. states codifying similar models in statute.[33] SFFC models operate in three Florida areas: Naples, Orlando, and Tampa Bay.[34]

Safe Families in Illinois, in conjunction with the Illinois Department of Children & Family Services, is currently being evaluated in a randomized control evaluation by the University of North Carolina School of Social Work. Safe Families in the United Kingdom is being evaluated[35] by the Dartington Social Research Unit.[36] The U.S. Department of Health and Human Service Child Welfare Information Gateway only lists one 2014 article describing, but not evaluating, the SFFC model,[37] and SFFC is not currently listed with the California Evidence Based Clearinghouse for Child Welfare.[38]

*Liability and Insurance*

Should a child become ill or injured while in the care of a SFFC volunteer host family, the host family may have limited personal liability pursuant to the federal Volunteer Protection Act[39] (VPA) and Florida Volunteer Protection Act[40] (FVPA). The VPA provides that a volunteer of a nonprofit organization is not liable for harm caused by his or her act or omission if:

- The volunteer was acting within the scope of his or her responsibilities for the organization; and
- The harm was not caused by willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by the volunteer.[41]

The FVPA also provides immunity from civil liability if the volunteer was acting with good faith within the scope of his or her duties, as an ordinary reasonable person would have acted under the same or similar circumstances, and the harm was not caused by wanton or willful misconduct.[42] Neither the VPA nor the FVPA provide immunity to the nonprofit organization itself.

**Effect of Proposed Changes**

HB 363 creates s. 409.1761, F.S., to expressly allow the SFFC model to be used in Florida and provide parameters for its use. The bill states that the purpose of the statute is to prevent the entry of a child at risk of abuse or neglect into the child welfare system.

The bill establishes requirements for a "qualified nonprofit organization," defined as a Florida private nonprofit organization that assists parents by providing temporary respite care for children by volunteer respite families under a contract for care. The nonprofit organization must:

- Comply with the best practice standards of a "qualified association," which means an association that publishes and requires compliance with standards for operating a program that assists parents in providing temporary respite care for a child by a volunteer respite family.
- Identify appropriate and safe placements for children based on the results of the background screenings and home visits.

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[32] Safe Families for Children, About Us, available at http://safe-families.org/about/ (last accessed February 8, 2017).
[33] Indiana (Burns Ind. Code Ann. § 29-3-9-1); Kansas (K.S.A. § 38-2403); Kentucky (KRS § 403.352); Maine (18-A M.R.S. § 5-104); Mississippi (Miss. Code Ann. § 93-31-3); Oklahoma (10 Okl. St. § 700); Oregon (ORS § 109.056); West Virginia (W. Va. Code § 49-8-3); and Wisconsin (Wis. Stat. § 48.979).
[34] Safe Families for Children, Locations, *available at* http://safe-families.org/about/locations/ (last visited February 9, 2017).
[35] https://www.dartington.org.uk/projects/view/9
[36] Safe Families for Children, About Us, Impact, available at http://safe-families.org/about/impact/ (last accessed February 10, 2017).
[37] U.S. Department of Health and Human Services, Child Welfare Information Gateway, Library, https://library.childwelfare.gov/cwig/ws/library/ (last accessed February 11, 2017).
[38] California Evidence Based Clearinghouse for Child Welfare, http://www.cebc4cw.org/ (last accessed February 10, 2017).
[39] Volunteer Protection Act of 1997, 42 U.S.C. § 14501 *et seq.*
[40] s. 768.1355, F.S.
[41] 42 U.S.C. § 14503.
[42] s. 768.1355(1), F.S.

- Train volunteer families that will serve as volunteer respite families under a contract for care.
- Provide ongoing services and resources to support the minor child, parents, and volunteer respite families.

In addition, the organization must ensure that Level 2 background screenings are conducted on the employees and volunteers of the organization as well as members of the volunteer respite families who are 18 years of age or older. All members of the volunteer family household between 12 and 18 years of age are not required to be fingerprinted but must be screened for delinquency records. DCF must inform the organization if such screened persons are eligible to volunteer with children pursuant to s. 409.175, F.S., and ch. 435, F.S. [43]

A qualified nonprofit organization must maintain records on each volunteer respite family and child served. These records must include:
- The name and age of the child;
- The name, address, telephone number, e-mail address, and other contact information for the child's volunteer respite family;
- A copy of the contract for respite care executed pursuant to the act; and
- Proof of the volunteer respite family's compliance with the personnel screening requirements of the act.

The organization must also provide an annual report to DCF including:
- The name, address, telephone number, e-mail address, and other contact information of the organization;
- The name of the organization's director;
- The names and addresses of the officers and members of the governing body of the organization;
- The total number of approved volunteer respite families currently working with the organization and the total number of children served the previous fiscal year; and
- A copy of its agreement or certification with a qualified association for the purpose of providing volunteer respite services pursuant to the act.

The bill requires the organization to provide the qualified association with data to show that the organization is in substantial compliance with the standards set by the qualified association, immediately notify DCF of any suspected or confirmed incident of abuse, neglect, or other maltreatment of a child while in the care of one of the organization's respite families and make available to DCF at any time all records relating to the program and children cared for by the organization's volunteer respite families to ensure compliance with the provisions of statute.

*Contract for Care*

The bill authorizes a parent of a minor child to delegate the care of the child to a volunteer respite family by executing a contract for care. The bill prohibits the parent and the agent from receiving any compensation related to the delegation of care and custody.

The contract for care may not exceed a period of 6 months, and may not delegate the power to consent to marriage or adoption of the child, the performance or inducement of an abortion on or for the child, or the termination of parental rights of the child.

The contract for care must be signed by both parents, if both parents are living and have shared custody of the child. If the parents do not have shared custody, the parent with sole custody may

[43] S. 409.175, F.S., outlines the licensure requirements DCF must apply to family foster homes, residential child-caring agencies, and child placing agencies including level 2 background screening under ch. 435, F.S. Chapter 435, F.S., details the requirements of background screening in Florida including level 2 screening which involves State and Federal level criminal background checks with 52 specific offenses that are disqualifying for employment by DCF or other agency that requires level 2 screening..

execute the contract but must notify the noncustodial parent at the last known address within 5 days. Notification is not required to a parent whose parental rights have been terminated. The contract for care must also be signed by all household members of the volunteer respite family 18 years of age and older and by a representative of the nonprofit organization attesting that the volunteer respite family has successfully completed the required training and background screening. Finally, the contract for care must be witnessed by two people and notarized.

The bill details the requirements of a contract for care to include sixteen distinct pieces of information relating to the identity of the child and parent(s), the identity of the volunteer respite family, delegated and non-delegated powers, expiration date, and the health, education, normalcy, and discipline of the child.

Any parent with custodial rights may revoke the contract for care prior to its expiration, and the volunteer respite family must return the child to the custody of the revoking parent as soon as reasonably possible.

The bill further specifies that the execution of a contract for care does not deprive a parent of parental rights, obligations, or authority regarding custody, visitation, or support.

*Child Welfare Investigations*

The bill permits DCF, during a child protective investigation that does not result in an out-of-home placement, to provide information to a parent regarding temporary respite care services by a qualified nonprofit organization. This aligns with the statutory requirement that DCF provide information on family support resources and prevention services in the community.

The execution of a contract for care authorized by the bill after using such community services may not be construed as abandonment, abuse, or neglect without other evidence or except as otherwise provided by law. However, the bill does not prevent DCF or law enforcement from investigating allegations of abuse, abandonment, neglect, unlawful desertion of a child, or human trafficking.

B. SECTION DIRECTORY:

**Section 1:** Creates s. 409.1761, F.S., relating to organizations providing respite care for children not in the child welfare system.

**Section 2:** Provides an effective date of July 1, 2017.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill requires notarization of a contract for care for the temporary care of a minor child. The cost of notarial services varies but is expected to be insignificant. Additionally, a custodial parent that is required to provide notice to a noncustodial parent of the delegation of care and custody may incur approximately $6.74 in postage costs. The bill requires a qualified nonprofit organization to complete a criminal history record check on certain individuals at $44 per individual.[44] Also, additional fees may be charged by each live scan[45] provider for their services.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. The bill does not appear to have an effect local or county government.

2. Other:

It is well settled that the interest of parents in the care, custody, and control of their children is perhaps the oldest of the recognized fundamental liberty interests protected by the Due Process Clause of the Fourteenth Amendment to the United States Constitution.[46] The United States Supreme Court has explained the fundamental nature of this right is rooted in history and tradition:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.[47]

These constitutional protections extend to the parenting interests of custodial and non-custodial parents alike.[48] The bill gives parents an additional method for exercising this fundamental liberty interest, in the context of family crisis. To the extent that the bill authorizes delegation of the care and custody of a minor child to a volunteer respite family through a contract for care without the consent of both parents, such delegation may be challenged by a nonconsenting parent.

B. RULE-MAKING AUTHORITY:

The bill does not create rulemaking authority or a need for rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

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[44] The cost breakdown is $20 for the state and national criminal history checks and $24 for 5 year fingerprint retention in the Care Provider Screening Clearinghouse.
[45] Live Scan is an inkless electronic fingerprinting technology, allowing the electronic recording, storage, and transmission of fingerprints.
[46] *Troxel v. Granville,* 530 U.S. 57, 65 (2000).
[47] *Wisconsin v. Yoder*, 406, U.S. 205, 232 (1972).
[48] *See Stanley v. Illinois*, 405 U.S. 645(1972); *Caban v. Mohammed*, 441 U.S. 380 (1979).

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 8, 2017, the Civil Justice & Claims Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment:

- Defined the term "qualified association," which publishes and requires compliance with minimum best practices standards for operating a program that assists parents in providing temporary respite care for a child by a volunteer respite family; and
- Revised the duties of a qualified nonprofit organization, requiring the organization to establish its program under a qualified association, provide background screening for employees and volunteer respite family members, provide training to the volunteer respite families, maintain and provide various records to the qualified association and the DCF.

This analysis is drafted to the committee substitute as passed by the Civil Justice & Claims Subcommittee.

A bill to be entitled

An act relating to the temporary care of a child; creating s. 409.1761, F.S.; providing legislative findings; authorizing qualified nonprofit organizations to establish programs to provide temporary respite care for children; providing definitions; providing duties and recordkeeping requirements for such organizations; providing screening requirements for certain persons; authorizing a parent to enter into a contract for care to provide temporary respite care for a child; specifying the form and execution of the contract; authorizing inspection of documents by the Department of Children and Families; providing eligibility; authorizing the department to refer a child for such care; providing applicability; providing an effective date.

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

Section 1. Section 409.1761, Florida Statutes, is created to read:

409.1761 Organizations providing respite care for children not in the child welfare system.—The Legislature finds that in circumstances in which a parent of a minor child is temporarily

unable to provide care for the child, but does not need the full support of the child welfare system, a less intrusive alternative to supervision by the department or involvement by the judiciary should be available. A qualified nonprofit organization may establish a program to assist parents in providing temporary respite care for a child by a volunteer respite family.

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

(a) "Parent" means the parent or parents who are required to sign the contract for care under subparagraph (3)(a)1.

(b) "Qualified association" means an association that establishes, publishes, and requires compliance with minimum best practice standards for operating a program that assists parents in providing temporary respite care for a child by a volunteer respite family.

(c) "Qualified nonprofit organization" or "organization" means a private Florida nonprofit organization that:

1. Assists parents by providing temporary respite care for children through the use of volunteer respite families who are under a contract for care and in compliance with the best practice standards of a qualified association.

2. Provides assistance and support to parents and training and support for volunteer respite families.

(d) "Volunteer respite family" means an individual or a family who voluntarily agrees to provide, without compensation,

temporary respite care for a child, with the assistance of a qualified nonprofit organization, pursuant to a contract for care with the child's parent.

(e) "Volunteer respite home" means the home of a volunteer respite family.

(2) DUTIES OF A QUALIFIED NONPROFIT ORGANIZATION.—A qualified nonprofit organization that provides services assisting parents in providing temporary respite care for their children through the use of volunteer respite families shall:

(a) Establish its program under an agreement or certification with a qualified association.

(b) Before allowing personnel, members of the volunteer respite home, or other program volunteers to have contact with a child, work with the department to ensure that background screenings of the personnel of the organization and members of the volunteer respite home are conducted in compliance with the screening requirements in s. 409.175 and chapter 435. Persons required to be screened pursuant to this paragraph include:

1. Employees of the organization who will have direct contact with children while assisting parents in providing temporary respite care.

2. Members of the volunteer respite family or persons residing in the volunteer respite home who are older than 12 years of age. However, members of a volunteer respite family or persons residing in the volunteer respite home who are between

the ages of 12 years and 18 years are not required to be fingerprinted but must be screened for delinquency records.

(c) Train all volunteer respite families. The training must include:

1. A discussion of the rights, duties, and limitations in providing temporary care for a child under a contract for care authorized under this section;

2. An overview of program processes, including intake processes, and working with third party service providers, including schools and medical professionals;

3. General safety requirements, including prevention of sudden infant death syndrome, supervision of children, and water and pool safety;

4. Instruction on appropriate and constructive disciplinary practices, including the prohibition of physical punishment and discipline that is severe, humiliating, or frightening, or is associated with food, rest, or toileting;

5. Abuse and maltreatment reporting requirements, including proper cooperation with the department;

6. Confidentiality; and

7. Building a healthy relationship with a child's biological family.

(d) Be solely responsible for ongoing supervision of each placement of a child with a volunteer respite family.

(e) Maintain records on each volunteer respite family and

child served, including, but not limited to:

1. The name and age of the child;

2. The name, address, telephone number, e-mail address, and other contact information for the child's parents;

3. The name, address, telephone number, e-mail address, and other contact information for the child's volunteer respite family;

4. A copy of the contract for respite care executed pursuant to this section; and

5. Proof of the volunteer respite family's compliance with the personnel screening requirements under this section.

(f) Provide the following information to the department on an annual basis:

1. The name, address, telephone number, e-mail address, and other contact information of the organization.

2. The name of the organization's director.

3. The names and addresses of the officers and members of the governing body of the organization.

4. The total number of approved volunteer respite families currently working with the organization and the total number of children served the previous fiscal year.

5. A copy of its agreement or certification with a qualified association for the purpose of providing volunteer respite services pursuant to this section.

(g) Provide the qualified association with data and other

information as required by the qualified association to demonstrate that the qualified nonprofit organization is in substantial compliance with standards set by the qualified association.

(h) Immediately notify the department of any suspected or confirmed incident of abuse, neglect, or other maltreatment of a child while in the care of one of the organization's volunteer respite families.

(i) Make available to the department or qualified association at any time for inspection all records relating to the program and children cared for by the organization's volunteer respite families to ensure compliance with this section and standards established by any entity with which the organization is affiliated.

(3) CONTRACT FOR CARE.—Before a volunteer respite family cares for a child, the child's parent must enter into a written contract for care with the volunteer respite family. Under a contract for care, the parent may delegate to the volunteer respite family any of the powers regarding the care and custody of the child, except the power to consent to the marriage or adoption of the child, the performance of or inducement of an abortion on or for the child, or the termination of parental rights to the child. Authorization for the volunteer respite family to consent to routine and emergency medical care on behalf of the parent shall be granted only upon the separate

consent of the parent pursuant to s. 743.0645.

(a) The contract for care must at a minimum:

1. Be signed by the parent or both parents if both parents are living and have shared responsibility and timesharing of the child pursuant to law or a court order. If the parents do not have shared responsibility and timesharing of the child, the parent having sole custody of the child has the authority to enter into the contract for care but shall notify the noncustodial parent in writing of the name and address of the volunteer respite family. Such notification must be provided by certified mail, return receipt requested, to the noncustodial parent at his or her last known address within 5 days after the contract for care is signed. Notification to a noncustodial parent whose parental rights have been terminated is not required.

2. Be signed by all members of the volunteer respite family who are 18 years of age or older.

3. Be signed by a representative of the organization who assisted with the child's placement with the volunteer respite family.

4. Be signed by two subscribing witnesses.

5. Be acknowledged by the parent or parents, as applicable under subparagraph 1., and the representative of the qualified nonprofit organization before a notary public.

(b) The contract for care must include:

1. A statement that the contract does not deprive the parent of any parental or legal authority regarding the care and custody of the child or supersede a court order regarding the care and custody of the child.

2. A statement that the contract may be revoked or withdrawn at any time by the parent and that custody of the child shall be returned to the parent as soon as reasonably possible.

3. The basic services and accommodations provided by the volunteer respite family and organization.

4. Identification of the child, the parent, and the members of the volunteer respite family, including contact information for all parties.

5. Identification of the organization, including contact information for the organization and the organization's primary contact person.

6. A statement regarding disciplinary procedures that are used by the volunteer respite family and expectations regarding interactions between the volunteer respite family and the child, including any known behavioral or emotional issues, and how such issues are currently addressed by the child's parent.

7. A statement of the minimum expected frequency of contact between the parent and the child, expectations for the volunteer respite family to facilitate any reasonable request for contact with the child outside of the established schedule,

and the minimum expected frequency of contact between the parent and the volunteer respite family to discuss the child's well-being and health.

8. A statement regarding the child's educational needs, including the name and address of the child's school and the names of the child's teachers.

9. A list of extracurricular, religious, or community activities and programs in which the child participates.

10. A list of any special dietary or nutritional requirements of the child.

11. A description of the child's medical needs, including any diagnoses, allergies, therapies, treatments, or medications prescribed to the child and the expectations for the volunteer respite family to address such medical needs.

12. A statement that the volunteer respite family agrees to act in the best interests of the child and to consider all reasonable wishes and expectations of the parent concerning the care and comfort of the child.

13. A statement that all appropriate members of the volunteer respite family have successfully completed the personnel screening requirements pursuant to paragraph (2)(b).

14. The expiration date of the contract for care, which may not be more than 6 months after the date of execution.

15. A statement that the goal of the organization, volunteer respite family, and parent is to return the child

receiving temporary respite care to the parent as soon as the situation requiring such care has been resolved.

16. A requirement that the volunteer respite family immediately notify the parent of the child's need for medical care.

(4) INSPECTION OF DOCUMENTS.—The department may, at any time, inspect any documents held by the organization relating to children placed pursuant to this section.

(5) ELIGIBILITY.—A child who has been removed from a parent due to abuse or neglect and placed in the custody of the department is not eligible for temporary respite care pursuant to this section.

(6) DUTIES OF DEPARTMENT.—The department may refer a child to an organization under this section if the department determines that the needs of the child or the needs of the child's parent do not require an out-of-home safety plan pursuant to s. 39.301(9) or other formal involvement of the department and that the child and the child's family may benefit from the temporary respite care and services provided by the organization.

(7) APPLICABILITY.—Placement of a child under this section without additional evidence does not constitute abandonment, abuse, or neglect, as those terms are defined in s. 39.01, and is not considered to be placement of the child in foster care. However, nothing in this section prevents the department or a

law enforcement agency from investigating allegations of abandonment, abuse, neglect, unlawful desertion of a child, or human trafficking.

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

COMMITTEE/SUBCOMMITTEE ACTION

| | | |
|---|---|---|
| ADOPTED | ____ | (Y/N) |
| ADOPTED AS AMENDED | ____ | (Y/N) |
| ADOPTED W/O OBJECTION | ____ | (Y/N) |
| FAILED TO ADOPT | ____ | (Y/N) |
| WITHDRAWN | ____ | (Y/N) |
| OTHER | | |

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative White offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

Section 1. Section 409.1761, Florida Statutes, is created to read:

409.1761 Organizations providing respite care for children not in the child welfare system.—The Legislature finds that in circumstances in which a parent of a minor child is temporarily unable to provide care for the child, but does not need the full support of the child welfare system, a less intrusive alternative to supervision by the department or involvement by the judiciary should be available. A qualified nonprofit organization may establish a program to assist parents in

providing temporary respite care for children through the use of volunteer respite families.

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

(a) "Parent" means the parent or parents who are required to sign the contract for care under subparagraph (3)(a)1.

(b) "Qualified association" means an association that publishes minimum best practice standards for operating a qualified nonprofit organization and establishes and requires compliance with those best practice standards.

(c) "Qualified nonprofit organization" or "organization" means a private Florida nonprofit organization that:

1. Is in compliance with the best practice standards of a qualified association.

2. Assists parents by providing temporary respite care for children through the use of volunteer respite families who are under a contract for care.

3. Provides assistance and support to parents and training and support for volunteer respite families.

(d) "Volunteer respite family" means an individual or a family who voluntarily agrees to provide, without compensation, temporary respite care for a child, with the assistance of a qualified nonprofit organization, pursuant to a contract for care with the child's parent.

(e) "Volunteer respite home" means the home of a volunteer respite family.

(2) DUTIES OF A QUALIFIED NONPROFIT ORGANIZATION.—A qualified nonprofit organization shall:

(a) Establish its program under an agreement or certification with a qualified association.

(b) Verify that the department has conducted background screenings as set forth in s. 409.175 and chapter 435, of the following persons before such persons have contact with a child:

1. Employees of the organization who will have direct contact with children while assisting parents in providing temporary respite care.

2. Members of the volunteer respite family and persons residing in the volunteer respite home who are 12 years of age or older. However, members of a volunteer respite family and persons residing in the volunteer respite home who are between the ages of 12 years and 18 years are not required to be fingerprinted but must be screened for delinquency records.

(c) Train all volunteer respite families. The training must include:

1. A discussion of the rights, duties, and limitations in providing temporary care for a child;

2. An overview of program processes, including intake triage processes;

3. Working with third party service providers, including schools and medical professionals;

4. General safety requirements, including the prevention of sudden infant death syndrome, proper supervision of children, and water and pool safety;

5. Instruction on appropriate and constructive disciplinary practices, including the prohibition of physical punishment and discipline that is severe, humiliating, or frightening, or is associated with the deprivation of food, rest, or toileting;

6. Abuse and maltreatment reporting requirements, including proper cooperation with the department;

7. Confidentiality; and

8. Building a healthy relationship with a child's parents.

(d) Be solely responsible for ongoing supervision of each child placed with a volunteer respite family.

(e) Maintain records on each volunteer respite family and child served, including, but not limited to:

1. The name and age of the child;

2. The name, address, telephone number, e-mail address, and other contact information for the child's parents;

3. The name, address, telephone number, e-mail address, and other contact information for the child's volunteer respite family;

4. A copy of the contract for care executed pursuant to this section; and

5. Proof that the volunteer respite family has met all the personnel screening requirements conducted by the department under this section.

(f) Provide the following information to the department on an annual basis:

1. The name, address, telephone number, e-mail address, and other contact information of the organization.

2. The name of the organization's director.

3. The names and addresses of the officers and members of the governing body.

4. The total number of volunteer respite families currently working with the organization and the total number of children who were provided temporary respite care in the previous fiscal year.

5. A copy of its agreement or certification with a qualified association for the purpose of providing volunteer respite services pursuant to this section.

(g) Provide the qualified association with data and other information as required by the qualified association to demonstrate that the qualified nonprofit organization is in substantial compliance with the minimum best practice standards published by the qualified association.

(h) Immediately notify the department of any suspected or confirmed incident of abuse, neglect, or other maltreatment of a child while in the care of a volunteer respite family.

(i) Make available to the department or qualified association at any time for inspection all records relating to the program and children cared for by the organization's volunteer respite families to ensure compliance with this section and standards established by any entity with which the organization is affiliated.

(3) CONTRACT FOR CARE.—Before a volunteer respite family cares for a child, the child's parent must enter into a written contract for care with the volunteer respite family. The contract for care may not exceed 6 months in duration and may only be extended for one 6-month period. Under a contract for care, the parent may delegate to the volunteer respite family any of the powers regarding the care and custody of the child, except the power to consent to the marriage or adoption of the child, the performance of or inducement of an abortion on or for the child, or the termination of parental rights to the child. Authorization for the volunteer respite family to consent to routine and emergency medical care on behalf of the parent shall be granted only upon the separate consent of the parent pursuant to s. 743.0645.

(a) The contract for care must at a minimum:

1. Be signed by the parent or both parents if both parents are living and have shared responsibility and timesharing of the child pursuant to law or a court order. If the parents do not have shared responsibility and timesharing of the child, the

parent having sole custody of the child has the authority to enter into the contract for care but shall notify the noncustodial parent in writing of the name and address of the volunteer respite family. Such notification must be provided by certified mail, return receipt requested, to the noncustodial parent at his or her last known address within 5 days after the contract for care is signed. Notification to a noncustodial parent whose parental rights have been terminated is not required.

2. Be signed by all members of the volunteer respite family who are 18 years of age or older.

3. Be signed by the representative of the organization who assisted with the child's placement with the volunteer respite family.

4. Be signed by two subscribing witnesses.

5. Be acknowledged by the parent or parents, as applicable under subparagraph 1., and a representative of the qualified nonprofit organization.

(b) The contract for care must include:

1. A statement that the contract does not deprive the parent of any parental or legal authority regarding the care and custody of the child or supersede a court order regarding the care and custody of the child.

2. A statement that the contract may be revoked or withdrawn at any time by the parent and that custody of the

child shall be returned to the parent as soon as reasonably possible.

3. The basic services and accommodations provided by the volunteer respite family and organization.

4. Identification of the child, the parent, and the members of the volunteer respite family, including contact information for all parties.

5. Identification of the organization, including contact information for the organization and the representative who assisted with the child's placement.

6. A statement regarding disciplinary procedures that are used by the volunteer respite family and expectations regarding interactions between the volunteer respite family and the child. The statement must identify the child's known behavioral or emotional issues and how such issues are addressed by the child's parent.

7. A statement of the minimum expected frequency of contact between the parent and the child, expectations for the volunteer respite family to facilitate any reasonable request for contact with the child outside of the established schedule, and the minimum expected frequency of contact between the parent and the volunteer respite family to discuss the child's well-being and health.

8. A statement regarding the child's educational needs, including the name and address of the child's school and the names of the child's teachers.

9. A list of extracurricular, religious, or community activities and programs in which the child participates.

10. A list of any special dietary or nutritional requirements of the child.

11. A description of the child's medical needs, including any diagnoses, allergies, therapies, treatments, or medications prescribed to the child and the expectations for the volunteer respite family to address such medical needs.

12. A statement that the volunteer respite family agrees to act in the best interests of the child and to consider all reasonable wishes and expectations of the parent concerning the care and comfort of the child.

13. A statement that all appropriate members of the volunteer respite family have successfully met the personnel screening requirements pursuant to paragraph (2)(b).

14. An expiration date for each contract for care, which may not exceed 6 months in duration, not including an authorized extension.

15. A statement that the goal of the organization, volunteer respite family, and parent is to return the child receiving temporary respite care to the parent as soon as the situation requiring such care has been resolved.

16. A requirement that the volunteer respite family immediately notify the parent of the child's need for medical care.

(4) INSPECTION OF DOCUMENTS.—The department may, at any time, inspect any documents held by the organization relating to children placed pursuant to this section.

(5) ELIGIBILITY.—A child who has been removed from a parent due to abuse or neglect and placed in the custody of the department is not eligible for temporary respite care pursuant to this section.

(6) DUTIES OF DEPARTMENT.—The department may refer a child to an organization under this section if the department determines that the needs of the child or the needs of the child's parent do not require an out-of-home safety plan pursuant to s. 39.301(9) or other formal involvement of the department and that the child and the child's family may benefit from the temporary respite care and services provided by the organization.

(7) APPLICABILITY.—Placement of a child under this section without additional evidence does not constitute abandonment, abuse, or neglect, as those terms are defined in s. 39.01, and is not considered to be placement of the child in foster care. However, nothing in this section prevents the department or a law enforcement agency from investigating allegations of

abandonment, abuse, neglect, unlawful desertion of a child, or human trafficking.

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

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

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to the temporary care of a child; creating s. 409.1761, F.S.; providing legislative findings; providing definitions; authorizing qualified nonprofit organizations to establish programs to provide temporary respite care for children; providing duties and recordkeeping requirements for such organizations; providing screening requirements for certain persons; requiring notification to the Department of Children and Families under certain circumstances; authorizing a volunteer respite family to enter into a contract for care to provide temporary respite care for a child; specifying the duration of a contract for care; specifying the form and execution of the contract; authorizing inspection of documents by the Department of Children and Families; providing eligibility; authorizing the department to refer a

child for such care; providing applicability; providing an effective date.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 543 Regulation of Nursing
**SPONSOR(S):** Health Innovation Subcommittee; Pigman
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 328

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Innovation Subcommittee | 11 Y, 0 N, As CS | Siples | Poche |
| 2) Health Care Appropriations Subcommittee | 15 Y, 0 N | Mielke | Pridgeon |
| 3) Health & Human Services Committee | | Siples | Calamas |

## SUMMARY ANALYSIS

To address a nursing shortage in Florida, legislation has been enacted over the past several years to ensure the availability of quality nursing education programs. CS/HB 543 builds on this legislation.

Current law requires a nursing education program to meet a certain graduate passage rate on the licensure examination. If the program fails to do so, it may be placed on probation for up to two years. CS/HB 543 authorizes the Board of Nursing (BON) to grant a one-year extension to a nursing education program that is on probation for failure to meet the graduate passage rate if the program is progressing towards meeting the rate. However, the BON retains the authority to terminate a program after the two year probation period, or any extension thereof.

The bill requires any nursing education program that is on probation to notify its students and applicants of its status in writing. The notice must also provide information on the implications of the program's probationary status on the student or applicant and his or her employment and educational opportunities.

The bill removes a requirement that a nursing school must require a student who does not take the licensure examination within six months of graduation to enroll in and successfully complete a licensure examination preparatory course.

The bill also prohibits a nursing education program that was terminated or closed from reapplying for approval for 3 years. This also applies to a nursing education program that is terminated for failing to obtain the required accreditation by July 2019 or within 5 years after the date of enrollment of its first students. The bill authorizes the BON to adopt rules related to nursing curriculum, nursing program implementation, and reapplication procedures for terminated or closed programs.

The bill authorizes the BON to perform an on-site evaluation of a nursing education program applicant to verify its compliance with application requirements.

The bill eliminates the annual reports required by the Office of Program Policy Analysis and Government Accountability (OPPAGA) on the status of nursing education programs, but retains the requirement that the Florida Center on Nursing issue the annual report and include an assessment of the progress towards accreditation for certain nursing programs.

Advanced Registered Nurse Practitioners (ARNPs) must complete 3 hours of continuing education related to the safe and efficient prescription of controlled substances. The bill broadens who may offer such continuing education to any entity approved by the Board of Nursing. The bill also deletes obsolete language related to the certification of ARNPs.

The bill has an insignificant, indeterminate negative fiscal impact on the BON, which can be absorbed within existing resources. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2017, except as otherwise expressly provided.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Current Situation**

Regulation of Advanced Registered Nurse Practitioners

Part I of ch. 464, F.S., governs the licensure and regulation of advanced registered nurse practitioners (ARNPs) in Florida. Nurses are licensed by the Department of Health (DOH) and are regulated by the Board of Nursing (BON).[1] There are 26,691 actively licensed ARNPs in Florida.[2]

In Florida, an ARNP is a licensed nurse who is certified in advanced or specialized nursing practice and may practice as a certified registered nurse anesthetist, a certified nurse midwife, or a nurse practitioner.[3] Advanced or specialized nursing practice includes the performance of advanced-level nursing acts approved by the BON, which by virtue of postbasic specialized education, training, and experience are appropriately performed by an ARNP.[4] In addition to advanced or specialized nursing practices, ARNPs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[5]

The BON establishes the eligibility criteria for an applicant to be certified as an ARNP and the applicable regulatory standards for ARNP nursing practices.[6] To be certified as an ARNP, the applicant must be licensed as a registered nurse, have a master's degree in a clinical nursing specialty area with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a board-approved nursing specialty board.[7] The nursing specialty board must:

- Attest to the competency of nurses in a clinical specialty area;
- Require nurses to take a written examination prior to certification;
- Require nurses to complete a formal program prior to eligibility for examination;
- Maintain program accreditation or a review mechanism that adheres to criteria which are substantially equivalent to requirements in Florida; and
- Identify standards or scope of practice statements appropriate for each nursing specialty.[8]

Within the framework of the written protocol, an ARNP may:

- Prescribe, dispense, administer, or order any drug;[9]
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by board rule;

[1] Pursuant to s. 464.004, F.S., the Board of Nursing is comprised of 13 members appointed by the Governor and confirmed by the Senate who serve 4-year terms. The Board is comprised of three licensed practical nurses who have practiced for at least four years, seven members who are registered numbers who have practiced for at least 4 years; three Florida residents who have never been licensed as nurses, are not connected to the practice of nursing, and have no financial interest in any health care facility, agency, or insurer; and seven members who are registered nurses who have practiced at least four years. Among the seven members who are registered nurses, there must be at least one must be an ARNP, one nurse educator of an approved program, and one nurse executive.
[2] E-mail correspondence with the Department of Health on February 2, 2017 (on file with the staff of the Health Innovation Subcommittee). This number includes all active licenses, including out of state practitioners.
[3] S. 464.003(3), F.S.
[4] S. 464.003(2), F.S.
[5] Id.
[6] S. 464.012(2), F.S.
[7] S. 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.
[8] Rule 64B9-4.002(3), F.A.C.
[9] Controlled substances may only be prescribed or dispensed if the ARNP has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.

- Order diagnostic tests and physical and occupational therapy;
- Order any medication for administration to a patient in certain licensed health care facilities;
- Perform certain acts within his or her specialty; and
- Perform medical acts authorized within the framework of an established protocol.[10]

All nurses are required to complete at least 30 hours of continuing education biennially as a condition of license or certificate renewal.[11] As a part of these 30 hours, ARNPs must complete 3 hours of continuing education on the safe and effective prescription of controlled substances, offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit, the American Nurses Credentialing Center, the American Association of Nurse Anesthetists, or the American Association of Nurse Practitioners.

Nursing Education Programs

To be licensed as a registered nurse (RN) or a practical nurse (LPN) in this state, an individual must, among other things, graduate from an accredited or a BON-approved nursing program or its equivalent.[12] A registered nurse is authorized to practice professional nursing[13] and an LPN is authorized to practice practical nursing.[14]

Nursing programs in Florida are offered by public school districts, Florida colleges, state universities, private institutions licensed by the Commission for Independent Education, private institutions that are members of the Independent Colleges and Universities of Florida (ICUF), and Pensacola Christian College, which is statutorily authorized by s. 1005.06(1)(e), F.S.[15]

*Board-Approved Nursing Education Programs*

To be an approved program, an educational institution must apply to DOH. An application to become an approved program must document compliance with program standards for faculty qualifications, clinical training requirements, written policies for faculty, signed agreements with clinical training sites in the curriculum plan, and curriculum and instruction requirements.[16]

An application deemed complete by the DOH is forwarded to the BON for approval. Within 90 days of receipt of the application by the DOH, the BON must approve the application or notify the applicant of the intent to deny the application. If noticed of the intent to deny, the applicant may request a hearing under chapter 120, F.S.[17]

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[10] S.s 464.012(3),(4), and 464.003(2), F.S.
[11] S. 464.013(3), F.S.
[12] S. 464.008(1)(c), F.S.
[13] The practice of professional nursing means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skills, including observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; teaching and counseling of the ill, injured, or infirm; promotion of wellness, maintenance of health, prevention of illness in others; and the administration of medication and treatment as authorized or prescribed. A RN is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing. (Ss. 464.003(20) and (22), F.S.)
[14] The practice of practical nursing means the performance of selected acts in the care of the ill, injured, or infirm; the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, or a licensed dentist. An LPN is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing (Ss. 464.003(16) and (19), F.S.).
[15] This section of law exempts schools from the Commission for Independent Education's licensure requirements if the institution: had been so exempted prior to 2001; is incorporated in this state; the institution's credits or degrees are accepted for credit by at least three colleges that are fully accredited by an agency recognized by the U.S. Department of Education; the institution was exempt under that category prior to July 1, 1982; and the institution does not enroll any students who receive state or federal financial aid. Only two institutions in Florida, Pensacola Christian College and Landmark Baptist College, are subject to this exemption. Landmark Baptist College does not offer a nursing program.
[16] S. 464.019(1), F.S.
[17] S. 464.019(2), F.S.

An approved program's curriculum must consist of at least 50 percent clinical training for an associate's degree RN program or at least 40 percent clinical training for a bachelor's degree RN program.[18] No more than 50 percent of an approved program's clinical training may consist of clinical simulation.[19]

Approved programs must submit an annual report by November 1 of each year to the BON. The report must document application and enrollment, student retention rates, and accreditation status.[20] The BON must publish on its website for each program its:

- Accreditation status;
- Probationary status;
- Graduate passage rate on the National Council on State Boards of Nursing Licensing Examination (NCLEX) for the most recent two calendar years;
- Student retention rates;
- Annual report summary; and
- Application documentation.[21]

If the nursing education program fails to submit its annual report, the director of the nursing education program must appear before the BON, at its next regularly scheduled meeting, to explain the reason for the delay. If the annual report is not submitted within six months of its due date, the BON must terminate the program.[22]

*Accountability Requirements*

An approved program may not have a graduate passage rate for first-time takers who sit for the licensure examination within six months of graduation that is 10 percentage points or more below the national average for two consecutive years.[23] If a program fails to meet the required graduate passage rate, the program is placed on probation by the BON and the program must present a plan for remediation to the BON, which includes specific benchmarks for achieving the required graduate passage rate. If a program on probation does not achieve the required graduate passage rate for any one calendar year during the two calendar years it is on probation, the BON must terminate the program.[24] However, the BON is authorized to extend the probationary status for an additional year if the program demonstrates progress toward the graduate passage rate goal by meeting the majority of the benchmarks established in the remediation plan.[25]

*Accredited Nursing Education Programs*

To qualify as an accredited program, a nursing education program must be accredited by a specialized nursing accrediting agency that is nationally recognized by the United States Secretary of Education to accredit nursing education programs.[26] Because accredited programs have to meet stringent criteria to maintain program accreditation, many of the statutory requirements for approved programs are not applicable to accredited programs.[27] However, an accredited program is subject to the accountability requirements.

If an accredited program ceases to be accredited, it must, within 10 business days, provide written notice to the BON, its students and applicants, and its clinical training sites.

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[18] S. 464.019(1)(b), F.S.
[19] S. 464.019(1)(c), F.S.
[20] S. 464.019(3), F.S.
[21] S. 464.019(4), F.S.
[22] S. 464.019(5), F.S.
[23] Id.
[24] Id.
[25] Id.
[26] S. 464.003(1), F.S.
[27] S. 464.019(9), F.S.

In 2014, legislation was enacted that required all nursing education programs that prepare students to be RNs to become accredited by July 1, 2019, or within 5 years after the enrollment of the program's first students.[28]

Accredited programs' accreditation status and graduate NCLEX passage rates must be published on the BON website.[29]

*Reform of Nursing Education Programs*

In 2009, the Legislature created a statutory framework for the approval of nursing education programs.[30] Prior to 2009, the BON had the authority to prescribe the process by rule. The new law:

- Established standards for faculty qualifications, clinical training and clinical simulation requirements, and curriculum and instruction requirements;
- Required all nursing education programs to submit an annual report to the BON, including information that the BON must publish on its website;
- Required the BON to place an approved nursing education program on probation if its graduate passage rate fell 10 percent or more below the national average passage rate on the NCLEX for two consecutive years;
- Required the BON to terminate a program if the approved nursing education program's graduates failed to achieve compliance within the next two consecutive years; and
- Required the Florida Center on Nursing and the Office of Program Policy Analysis and Government Accountability (OPPAGA) to monitor the implementation of the new approval process and to annually report to the Governor and the Legislature regarding the approval process, nursing program availability and quality, and the BON's compliance with the law.

In 2010, the Legislature made additional changes to the nursing education program approval process to address implementation issues.[31] These changes included:

- Requiring the BON to approve or deny a nursing education program application within 90 days after receipt of a complete application;
- Specifying that a program may be removed from probation if its graduates attain the required passage rate after one calendar year during the probation period;
- Making the passage rate requirement adopted in 2009 prospective so that it would apply beginning with the 2010 calendar year; and
- Clarifying that the graduate passage rate must be 10 percentage points or more below the national average passage rate on the NCLEX for two consecutive years, rather than 10 percent below the national average passage rate.

In 2014, the Legislature made additional revisions to the requirements for nursing education programs.[32] These revisions included:

- Authorizing the BON to adopt rules for documenting nursing education program accreditation;
- Requiring all nursing education programs that prepare students as RNs to be accredited by a nationally recognized accreditation agency by July 2019, or within 5 years of the date of enrollment of the program's first students;
- Requiring the Florida Center for Nursing and OPPAGA to submit the annual report to the Governor and the Legislature until January 2020;

[28] Chapter 2014-92, Laws of Fla.
[29] Supra, note 21.
[30] Chapter 2009-168, Laws of Fla.
[31] Chapter 2010-37, Laws of Fla.
[32] Chapter 2014-92, Laws of Fla.

- Limiting the graduate passage rate requirement to only those students who take the licensure examination for the first time within six months of graduation;
- Requiring an approved program to require any graduate who does not take the licensure examination within six months of graduation to enroll in and successfully complete a licensure examination preparatory course;
- Requiring programs on probation to develop and submit a remediation plan for attaining the required graduate passage rate, including benchmarks; and
- Authorizing the BON to extend a nursing education program's probationary status for one additional year if the program shows adequate progress towards the achieving the graduate passage rate by meeting a majority of the benchmarks established in the remediation plan.

*Current Status of Nursing Education Programs*

Since 2009, the BON has approved 303 new nursing programs. Currently, the total number of nursing education programs is 350,[33] which is down from the 369 open nursing programs in 2015. Overall, there has been a 105 percent increase in the number of nursing education programs since 2009. Of the nursing education programs in this state, 93 are accredited.[34]

In 2015, 128 nursing education programs (or 42 percent) had graduate passage rates that were 10 percent or below the national average rate.[35] The majority of these programs were associate degree programs; however, 27 percent were practical nursing programs and 10 percent were Bachelor of Science in nursing programs. Of the 128 programs that failed to meet the graduate passage rate:

- 14 were placed on probation;
- 11 were terminated by the BON;
- 11 were exempt from being placed on probation because they were accredited;
- 55 were not on probation, but were at risk of being placed on probation if their graduate passage rate continues to be 10 percent or more below the national average in 2016; and
- 37 closed.[36]

According to OPPAGA, the majority of the nursing programs that failed to meet the graduate passage rate requirement were relatively new and unaccredited.[37]

In 2016, there were 42 programs on probation for failing to meet the graduate exam passage rate and 50 nursing education programs closed.[38] Of those 50 closed programs, 37 programs closed voluntarily and 13 programs were terminated by the BON; 22 of these programs were on probation immediately prior to their termination or closure.

## Effect of Proposed Changes

Advanced Registered Nurse Practitioners

The bill deletes an obsolete provision of law that permitted a nurse to be certified as an ARNP if he or she completed a formal postbasic educational program of at least one academic year, the primary purpose of which is to prepare a nurse for advanced or specialized practice. Currently, to obtain

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[33] OPPAGA, *Review of Florida's Nursing Education Programs, 2016*, Report No. 17-03 (January 2017), *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1703rpt.pdf (last visited February 15, 2017). The total number takes into account new approvals, terminations, and closures of nursing education programs that have occurred since 2009.
[34] Id. 40 bachelor's degree programs, 43 associate degree programs, and 10 practical nursing programs are accredited.
[35] OPPAGA, *Approximately 42% of Nursing Programs Had a Licensure Exam Passage Rate Below the Required Legislative Standard in 2015*, Report No. 16-05 (July 2016), *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1605rpt.pdf (last visited February 18, 2017).
[36] Id.
[37] Id.
[38] Supra, FN 37.

certification as an ARNP in this state, an applicant must have a master's degree in a nursing clinical specialty area and hold a current national advanced practice certification from a board-approved nursing specialty board.[39] Due to the current graduate education and certification standards, the option to obtain certification as an ARNP by completing an additional postbasic educational program of at least one academic year is no longer in use.[40]

The bill eliminates the requirement that specific entities offer the continuing education course on safe and effective prescription of controlled substances and requires such courses to be approved by the BON. As a result, ARNPs will likely have more opportunities to satisfy this continuing education requirement as more BON-approved entities provide the course.

Nursing Education Programs

For a nursing education program applicant, the bill authorizes the Board of Nursing (BON) to perform an onsite inspection of the nursing education program to document the applicant's compliance with program requirements.

The bill amends the accountability requirements for nursing schools by:

- Including all first-time test takers in the calculation of the graduate passage rate, rather than limiting it to only those that are within six months of graduation;
- Eliminating a requirement that an approved program require a graduate who does not take the licensure examination within six months of graduate to complete a licensure examination preparatory course;
- Clarifying that the BON has the authority to extend a nursing education program's probationary status for another calendar year if, during the two calendar years following its placement on probationary status, it fails to achieve the required passage rate but has demonstrated progress toward meeting the graduate passage rate goal;
- Clarifying that the BON retains the authority to terminate a nursing education program if it declines to grant an extension of probationary status or if the program fails to achieve the required graduation passage rate at the end of any such extension.
- Authorizing the BON to terminate a program if the program director fails to appear before the BON to explain the reason for the delay in submitting the required annual report, or if the program fails to submit an annual report within six months after it is due; and
- Requiring a nursing education program, whether accredited or non-accredited, that is on probationary status to disclose the program's status, in a written format, to students and applicants. The written notification must include an explanation of the implication of the program's probationary status on employment and educational opportunities, as well as the prospects for a student wishing to matriculate to university.

The bill exempts accredited schools from the requirement to appear before the BON if they fail to timely submit the annual report.

The bill prohibits a nursing education program that is terminated or closed from seeking program approval under its original name or a new name for at least 3 years after the program is closed or terminated.

If a nursing education program fails to meet the accreditation requirements, the program must be terminated and may not apply for reapproval under its original name or a new program name for at least 3 years after the program is termination.

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[39] The bills provides that the proposed provision is effective after the Nurse Licensure Compact takes effect on December 31, 2018, or upon enactment of the Nurse Licensure Compact into law by 28 states, whichever occurs first.

[40] DOH, *Agency Legislative Bill Analysis for HB 543*, dated January 15, 2017, (on file with the Health Innovation Subcommittee).

The BON is authorized to adopt rules related to the nursing curriculum and nursing program implementation plans, which may include a description of the various types and uses of simulation technology and limitations on its use. The bill also authorizes the BON to adopt rules related to program termination or closure under this section and the procedure for the subsequent approval of a program that was terminated or closed.

The bill eliminates the annual reports due to the Governor and the Legislature by OPPAGA related to nursing education programs; however, the Florida Center on Nursing must continue to provide such reports until January 2020. Additionally, the Florida Center for Nursing must include in its annual report an assessment of the compliance of nursing programs that are required to be accredited.

The bill provides an effective date of July 1, 2017, except as otherwise expressly provided in the bill. The bill's provision updating the requirements for ARNP licensure will supersede the Nurse Licensure Compact when it becomes effective on December 31, 2018, or upon enactment of the Nurse Licensure Compact in 28 states.[41]

B. SECTION DIRECTORY:

**Section 1:** Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners; fees; controlled substance prescribing.
**Section 2:** Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners; fees; controlled substance prescribing.
**Section 3:** Amends s. 464.013, F.S., relating to renewal of license or certificate.
**Section 4:** Amends s. 464.019, F.S., relating to approval of nursing education programs.
**Section 5:** Provides an effective date of July, 1, 2017, except as otherwise expressly provided in the bill.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The DOH may experience a recurring increase in workload associated with conducting optional on-site evaluations of nursing education program applicants. The Board of Nursing anticipates on-site evaluations of applicants to be infrequent and current resources can absorb costs associated with these evaluations.[42]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

[41] In 2016, the Legislature enacted the Nurse Licensure Compact which authorized Florida to join a multistate compact for nurses to practice in this state and other member state with a multistate license. *See* ch. 2016-139, Laws of Fla.
[42] Email from Joe Baker, Board of Nursing Executive Director, on file with Health Care Appropriations Subcommittee staff (3/7/17).

Nursing students that do not take the licensure exam within six months of graduation may realize cost savings by no longer being subject to a mandatory licensure examination preparatory course.

A nursing education program that is terminated or closed may incur costs or experience economic losses due to the 3-year waiting period imposed by the bill before it may reapply for approval.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The rule-making authority for the BON created by the bill is sufficient to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 22, 2017, the Health Innovation Subcommittee adopted an amendment that restored the authority of the BON to exclude the test score of certain students who transfer from a terminated nursing education program to an approved or accredited nursing education program from the calculation of the graduate passage rate of the program receiving the transferring students.

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 the regulation of nursing; amending s. 464.012, F.S.; removing an obsolete qualification to satisfy certification requirements for an advanced registered nurse practitioner; amending s. 464.013, F.S.; requiring certain continuing education courses to be approved by the Board of Nursing; removing a requirement that certain continuing education courses be offered by specified entities; amending s. 464.019, F.S.; authorizing the board to conduct certain on-site evaluations; removing a limiting criterion from the requirement to measure graduate passage rates; removing a requirement that certain nursing program graduates complete a specific preparatory course; clarifying circumstances when programs in probationary status must be terminated; providing that accredited and nonaccredited nursing education programs must disclose probationary status; requiring notification of probationary status to include certain information; prohibiting a terminated or closed program from seeking program approval for a certain time; authorizing the board to adopt certain rules; requiring accredited programs to meet program accountability requirements and requirements to provide notification of probationary status; removing

requirements that the Office of Program Policy Analysis and Government Accountability perform certain tasks; requiring the Florida Center for Nursing to make an annual assessment of compliance by nursing programs with certain accreditation requirements; requiring the center to include its assessment in a report to the Governor and the Legislature; removing the requirement that the Office of Program Policy Analysis and Government Accountability perform specified duties under certain circumstances; requiring the termination of a program under certain circumstances; providing effective dates.

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

Section 1. Subsection (1) of section 464.012, Florida Statutes, is amended to read:

464.012 Certification of advanced registered nurse practitioners; fees; controlled substance prescribing.—

(1) Any nurse desiring to be certified as an advanced registered nurse practitioner shall apply to the department and submit proof that he or she holds a current license to practice professional nursing and that he or she meets one or more of the following requirements as determined by the board:

~~(a) Satisfactory completion of a formal postbasic~~

~~educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.~~

(a) ~~(b)~~ Certification by an appropriate specialty board. Such certification shall be required for initial state certification and any recertification as a registered nurse anesthetist, psychiatric nurse, or nurse midwife. The board may by rule provide for provisional state certification of graduate nurse anesthetists, psychiatric nurses, and nurse midwives for a period of time determined to be appropriate for preparing for and passing the national certification examination.

(b) ~~(c)~~ Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills. For applicants graduating on or after October 1, 1998, graduation from a master's degree program shall be required for initial certification as a nurse practitioner under paragraph (4)(c). For applicants graduating on or after October 1, 2001, graduation from a master's degree program shall be required for initial certification as a registered nurse anesthetist under paragraph (4)(a).

Section 2. Effective December 31, 2018, or upon enactment of the Nurse Licensure Compact into law by 26 states, whichever occurs first, subsection (1) of section 464.012, is amended to read:

464.012 Certification of advanced registered nurse

practitioners; fees; controlled substance prescribing.—

(1) Any nurse desiring to be certified as an advanced registered nurse practitioner shall apply to the department and submit proof that he or she holds a current license to practice professional nursing or holds an active multistate license to practice professional nursing pursuant to s. 464.0095 and that he or she meets one or more of the following requirements as determined by the board:

~~(a) Satisfactory completion of a formal postbasic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.~~

(a)~~(b)~~ Certification by an appropriate specialty board. Such certification shall be required for initial state certification and any recertification as a registered nurse anesthetist, psychiatric nurse, or nurse midwife. The board may by rule provide for provisional state certification of graduate nurse anesthetists, psychiatric nurses, and nurse midwives for a period of time determined to be appropriate for preparing for and passing the national certification examination.

(b)~~(c)~~ Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills. For applicants graduating on or after October 1, 1998, graduation from a master's degree program shall be required for initial certification as a nurse

practitioner under paragraph (4)(c). For applicants graduating on or after October 1, 2001, graduation from a master's degree program shall be required for initial certification as a registered nurse anesthetist under paragraph (4)(a).

Section 3. Subsection (3) of section 464.013, Florida Statutes, is amended to read:

464.013 Renewal of license or certificate.—

(3) The board shall by rule prescribe up to 30 hours of continuing education biennially as a condition for renewal of a license or certificate.

(a) A nurse who is certified by a health care specialty program accredited by the National Commission for Certifying Agencies or the Accreditation Board for Specialty Nursing Certification is exempt from continuing education requirements. The criteria for programs must be approved by the board.

(b) Notwithstanding the exemption in paragraph (a), as part of the maximum 30 hours of continuing education ~~hours~~ required under this subsection, advanced registered nurse practitioners certified under s. 464.012 must complete at least 3 hours of continuing education on the safe and effective prescription of controlled substances. Such continuing education courses must be approved by the board and ~~must be offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award~~

~~Category 1 credit, the American Nurses Credentialing Center, the American Association of Nurse Anesthetists, or the American Association of Nurse Practitioners and~~ may be offered in a distance learning format.

Section 4. Paragraph (b) of subsection (2), subsection (5), subsection (8), paragraph (a) of subsection (9), and subsection (10) of section 464.019, Florida Statutes, are amended, paragraph (d) is added to subsection (7) of that section, and paragraph (e) is added to subsection (11) of that section, to read:

464.019 Approval of nursing education programs.—

(2) PROGRAM APPROVAL.—

(b) Following the department's receipt of a complete program application, the board may conduct an on-site evaluation if necessary to document the applicant's compliance with subsection (1). Within 90 days after the department's receipt of a complete program application, the board shall:

1. Approve the application if it documents compliance with subsection (1); or

2. Provide the educational institution with a notice of intent to deny the application if it does not document compliance with subsection (1). The notice must specify written reasons for the board's denial of the application. The board may not deny a program application because of an educational institution's failure to correct an error or omission that the

department failed to provide notice of to the institution within the 30-day notice period under paragraph (a). The educational institution may request a hearing on the notice of intent to deny the program application pursuant to chapter 120.

(5) ACCOUNTABILITY.—

(a)1. An approved program must achieve a graduate passage rate for first-time test takers which ~~who take the licensure examination within 6 months after graduation from the program that~~ is not more than 10 percentage points lower than the average passage rate during the same calendar year for graduates of comparable degree programs who are United States educated, first-time test takers on the National Council of State Boards of Nursing Licensing Examination, as calculated by the contract testing service of the National Council of State Boards of Nursing. ~~An approved program shall require a graduate from the program who does not take the licensure examination within 6 months after graduation to enroll in and successfully complete a licensure examination preparatory course pursuant to s. 464.008.~~ For purposes of this subparagraph, an approved program is comparable to all degree programs of the same program type from among the following program types:

a. Professional nursing education programs that terminate in a bachelor's degree.

b. Professional nursing education programs that terminate in an associate degree.

c. Professional nursing education programs that terminate in a diploma.

d. Practical nursing education programs.

2. Beginning with graduate passage rates for calendar year 2010, if an approved program's graduate passage rates do not equal or exceed the required passage rates for 2 consecutive calendar years, the board shall place the program on probationary status pursuant to chapter 120 and the program director shall appear before the board to present a plan for remediation, which shall include specific benchmarks to identify progress toward a graduate passage rate goal. The program must remain on probationary status until it achieves a graduate passage rate that equals or exceeds the required passage rate for any 1 calendar year. The board shall deny a program application for a new prelicensure nursing education program submitted by an educational institution if the institution has an existing program that is already on probationary status.

3. Upon the program's achievement of a graduate passage rate that equals or exceeds the required passage rate, the board, at its next regularly scheduled meeting following release of the program's graduate passage rate by the National Council of State Boards of Nursing, shall remove the program's probationary status. If the program, during the 2 calendar years following its placement on probationary status, does not achieve the required passage rate for any 1 calendar year, the board

~~shall terminate the program pursuant to chapter 120. However,~~ ~~the board~~ may extend the program's probationary status for 1 additional year, provided ~~if~~ the program has demonstrated ~~demonstrates~~ adequate progress toward the graduate passage rate goal by meeting a majority of the benchmarks established in the remediation plan. If the program is not granted the 1-year extension or fails to achieve the required passage rate by the end of such extension, the board shall terminate the program pursuant to chapter 120.

(b) If an approved program fails to submit the annual report required in subsection (3), the board shall notify the program director and president or chief executive officer of the educational institution in writing within 15 days after the due date of the annual report. The program director shall appear before the board at the board's next regularly scheduled meeting to explain the reason for the delay. The board shall terminate the program pursuant to chapter 120 if the program director fails to appear before the board, as required under this paragraph, or if the program ~~it~~ does not submit the annual report within 6 months after the due date.

(c) A nursing education ~~An approved~~ program, whether accredited or nonaccredited, which has been placed on probationary status shall disclose its probationary status in writing to the program's students and applicants. The notification must include an explanation of the implications of

the program's probationary status on student and applicant employment and educational opportunities, including the prospects a student wishing to matriculate at a university will face.

(d) If students from a program that is terminated pursuant to this subsection transfer to an approved or an accredited program under the direction of the Commission for Independent Education, the board shall recalculate the passage rates of the programs receiving the transferring students, excluding the test scores of those students transferring more than 12 credits.

(7) PROGRAM CLOSURE.—

(d) A program that is terminated or closed under this section may not seek program approval under its original name or a new program name for a minimum of 3 years after the date of termination or closing.

(8) RULEMAKING.—The board does not have rulemaking authority to administer this section, except that the board shall adopt rules that prescribe the format for submitting program applications under subsection (1) and annual reports under subsection (3), and to administer the documentation of the accreditation of nursing education programs under subsection (11). The board may adopt rules related to the nursing curriculum and nursing program implementation plans, which may include definitions of the various types and uses of simulation technology and limitations on the technology's use. The board

may also adopt rules related to program termination or closure under this section and the procedure for a program that is terminated or closed under this section to seek subsequent program approval. The board may not impose any condition or requirement on an educational institution submitting a program application, an approved program, or an accredited program, except as expressly provided in this section.

(9) APPLICABILITY TO ACCREDITED PROGRAMS.—

(a) Subsections (1)-(3), paragraph (4)(b), and paragraph (5)(b) ~~subsection (5)~~ do not apply to an accredited program.

(10) IMPLEMENTATION STUDY.—The Florida Center for Nursing ~~and the education policy area of the Office of Program Policy Analysis and Government Accountability~~ shall study the administration of this section and submit reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives annually by January 30, through January 30, 2020. The annual reports shall address the previous academic year; provide data on the measures specified in paragraphs (a) and (b), as such data becomes available; and include an evaluation of such data for purposes of determining whether this section is increasing the availability of nursing education programs and the production of quality nurses. The department and each approved program or accredited program shall comply with requests for data from the Florida Center for Nursing ~~and the education policy area of the Office of Program Policy~~

~~Analysis and Government Accountability~~.

(a) The Florida Center for Nursing ~~education policy area of the Office of Program Policy Analysis and Government Accountability~~ shall evaluate program-specific data for each approved program and accredited program conducted in the state, including, but not limited to:

1. The number of programs and student slots available.

2. The number of student applications submitted, the number of qualified applicants, and the number of students accepted.

3. The number of program graduates.

4. Program retention rates of students tracked from program entry to graduation.

5. Graduate passage rates on the National Council of State Boards of Nursing Licensing Examination.

6. The number of graduates who become employed as practical or professional nurses in the state.

(b) The Florida Center for Nursing shall evaluate the board's implementation of the:

1. Program application approval process, including, but not limited to, the number of program applications submitted under subsection (1); the number of program applications approved and denied by the board under subsection (2); the number of denials of program applications reviewed under chapter 120; and a description of the outcomes of those reviews.

2. Accountability processes, including, but not limited to, the number of programs on probationary status, the number of approved programs for which the program director is required to appear before the board under subsection (5), the number of approved programs terminated by the board, the number of terminations reviewed under chapter 120, and a description of the outcomes of those reviews.

(c) The Florida Center for Nursing shall complete an annual assessment of compliance by programs with the accreditation requirements of subsection (11), include in the assessment a determination of the accreditation process status for each program, and submit the assessment as part of the report required by this subsection ~~For any state fiscal year in which The Florida Center for Nursing does not receive legislative appropriations, the education policy area of the Office of Program Policy Analysis and Government Accountability shall perform the duties assigned by this subsection to the Florida Center for Nursing~~.

(11) ACCREDITATION REQUIRED.—

(e) A nursing education program that fails to meet the accreditation requirements shall be terminated and is ineligible for reapproval under its original name or a new program name for a minimum of 3 years after the date of termination.

Section 5. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2017.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Pigman offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

Section 1. Effective upon becoming a law, paragraph (k) is added to subsection (3) of section 381.4018, Florida Statutes, to read:

381.4018 Physician workforce assessment and development.—

(3) GENERAL FUNCTIONS.—The department shall maximize the use of existing programs under the jurisdiction of the department and other state agencies and coordinate governmental and nongovernmental stakeholders and resources in order to develop a state strategic plan and assess the implementation of

such strategic plan. In developing the state strategic plan, the department shall:

(k) Follow the federal requirements and may adopt rules necessary for the implementation of the federal Conrad 30 Waiver Program established under section 214(l) of the Immigration and Nationality Act.

Section 2. Paragraph (e) of subsection (4) of section 395.3025, Florida Statutes, is amended to read:

395.3025 Patient and personnel records; copies; examination.—

(4) Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative, but appropriate disclosure may be made without such consent to:

(e) The department ~~agency~~ upon subpoena issued pursuant to s. 456.071, but the records obtained thereby must be used solely for the purpose of the department ~~agency~~ and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the department ~~agency~~ requests copies of the records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records must be sealed and must not be available to the public pursuant to s. 119.07(1) or any other statute providing access to records, nor may they be available to the public as part of the record of investigation for and prosecution in disciplinary

proceedings made available to the public by the agency or the appropriate regulatory board. However, the department ~~agency~~ must make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause.

Section 3. Paragraph (a) of subsection (1) and subsection (2) of section 456.013, Florida Statutes, are amended and subsections (14) and (15) are added to that section to read:

456.013 Department; general licensing provisions.—

(1)(a) Any person desiring to be licensed in a profession within the jurisdiction of the department shall apply to the department in writing to take the licensure examination. The application shall be made on a form prepared and furnished by the department. The application form must be available on the Internet ~~World Wide Web~~ and the department may accept electronically submitted applications beginning July 1, 2001. The application shall require the date of birth and the social security number of the applicant, except as provided in paragraph (b). The form shall be supplemented as needed to reflect any material change in any circumstance or condition stated in the application which takes place between the initial filing of the application and the final grant or denial of the license and which might affect the decision of the department. If an application is submitted electronically, the department may require supplemental materials, including an original

signature of the applicant and verification of credentials, to be submitted in a nonelectronic format. An incomplete application shall expire 1 year after initial filing. In order to further the economic development goals of the state, and notwithstanding any law to the contrary, the department may enter into an agreement with the county tax collector for the purpose of appointing the county tax collector as the department's agent to accept applications for licenses and applications for renewals of licenses. The agreement must specify the time within which the tax collector must forward any applications and accompanying application fees to the department.

(2) Before the issuance of a ~~any~~ license, the department shall charge an initial license fee as determined by the applicable board or, if there is no board, by rule of the department. Upon receipt of the appropriate license fee, the department shall issue a license to a ~~any~~ person certified by the appropriate board, or its designee, as having met the licensure requirements imposed by law or rule. ~~The license shall consist of a wallet-size identification card and a wall card measuring 6 1/2 inches by 5 inches.~~ The licensee shall surrender the license to the department ~~the wallet-size identification card and the wall card~~ if the ~~licensee's~~ license was ~~is~~ issued in error or is revoked.

(14) The department may not renew the license of a person or establishment that has not fully paid the fines and costs as described within the timeframe listed in a final order imposing discipline unless the licensing board, or the department if there is no board, has granted the licensee additional time to pay the fines and costs imposed by the final order.

(15) A board, or the department if there is no board, may not grant a license to a person or establishment that has not paid the fines and costs as described within the timeframe listed in a final order imposing discipline; that has allowed the person's or establishment's license, regulated under chapter 456, to become delinquent or void; or that has relinquished such a license in any way, until such time as the total amount of the fines and costs imposed by the final order, the delinquency fee, and any other fees resulting from failure to timely renew a license are paid in full. This subsection does not prevent a board, or the department if there is no board, from reinstating or granting a license with conditions that allow for the full payment of the fines and costs listed in the final order imposing discipline.

Section 4. Subsections (7), (8), (9), (10), and (11) of section 456.025, Florida Statutes, are renumbered as subsections (8), (9), (10), (11), and (12), respectively, and subsection (7) is added to that section, to read:

456.025 Fees; receipts; disposition.—

(7) When the department determines, based on long-range estimates of revenue, that a profession's trust fund moneys exceed the the cost of regulating the profession, the board of the profession, or the department if there is no board, may adopt rules to implement a waiver of initial application fees, initial licensure fees, unlicensed activity fees, or renewal fees for the profession for a period not to exceed 2 years.

Section 5. Subsection (3) of section 456.065, Florida Statutes, is amended to read:

456.065 Unlicensed practice of a health care profession; intent; cease and desist notice; penalties; enforcement; citations; fees; allocation and disposition of moneys collected.—

(3) Because all enforcement costs should be covered by professions regulated by the department, the department shall impose, upon initial licensure and each licensure renewal, a special fee of $5 per licensee to fund efforts to combat unlicensed activity. Such fee shall be in addition to all other fees collected from each licensee. The department shall make direct charges to the Medical Quality Assurance Trust Fund by profession. The department shall seek board advice regarding enforcement methods and strategies. The department shall directly credit the Medical Quality Assurance Trust Fund, by profession, with the revenues received from the department's efforts to enforce licensure provisions. The department shall

include all financial and statistical data resulting from unlicensed activity enforcement as a separate category in the quarterly management report provided for in s. 456.025. For an unlicensed activity account, a balance which remains at the end of a renewal cycle may, with concurrence of the applicable board and the department, be transferred to the operating fund account of that profession. If the special fee is insufficient to cover the costs of unlicensed activity enforcement for a profession, with the concurrence of the applicable board and the department, a transfer may be made from the operating fund of that profession to the unlicensed activity category within the profession's cash balance to cover the deficit. The department shall also use these funds to inform and educate consumers generally on the importance of using licensed health care practitioners.

Section 6. Paragraph (a) of subsection (1) of section 458.3265, Florida Statutes, is amended to read:

458.3265 Pain-management clinics.—

(1) REGISTRATION.—

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

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American

Osteopathic Association for a period of 6 years from successful completion of such residency program.

b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department. ~~unless:~~

3. A clinic that meets one or more of the following conditions and notifies the department of the met conditions is exempt from registration fees and is exempt from paragraphs (c) - (m), subsections (2) and (3), and rules adopted under subsection (4):

a. The ~~That~~ clinic is licensed as a facility pursuant to chapter 395;

b. The majority of the physicians who provide services in the clinic primarily provide surgical services;

c. The clinic is owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. The clinic is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. The clinic does not prescribe controlled substances for the treatment of pain;

f. The clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. The clinic is wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. The clinic is wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

Section 7. Subsection (2) of section 458.348, Florida Statutes, is repealed.

Section 8. Paragraph (a) of subsection (1) of section 459.0137, Florida Statutes, is amended to read:

459.0137 Pain-management clinics.—

(1) REGISTRATION.—

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

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department. ~~unless:~~

3. A clinic that meets one or more of the following conditions and notifies the department of the met conditions is exempt from registration fees and is exempt from paragraphs (c) - (m), subsections (2) and (3), and rules adopted under subsection (4):

a. The ~~That~~ clinic is licensed as a facility pursuant to chapter 395;

b. The majority of the physicians who provide services in the clinic primarily provide surgical services;

c. The clinic is owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. The clinic is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. The clinic does not prescribe controlled substances for the treatment of pain;

f. The clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. The clinic is wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. The clinic is wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

Section 9. Subsections (1) and (3) of section 464.012, Florida Statutes, is amended to read:

464.012 Certification of advanced registered nurse practitioners; fees; controlled substance prescribing.—

(1) Any nurse desiring to be certified as an advanced registered nurse practitioner shall apply to the department and submit proof that he or she holds a current license to practice professional nursing and that he or she meets one or more of the following requirements as determined by the board:

~~(a) Satisfactory completion of a formal postbasic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.~~

(a) ~~(b)~~ Certification by an appropriate specialty board. Such certification shall be required for initial state certification and any recertification as a registered nurse anesthetist, psychiatric nurse, or nurse midwife. The board may by rule provide for provisional state certification of graduate nurse anesthetists, psychiatric nurses, and nurse midwives for a period of time determined to be appropriate for preparing for and passing the national certification examination.

(b) ~~(c)~~ Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills. For applicants graduating on or after October 1, 1998, graduation from a master's degree program shall be required for initial certification as a nurse practitioner under paragraph (4)(c). For applicants graduating on or after October 1, 2001, graduation from a master's degree program shall be required for initial certification as a registered nurse anesthetist under paragraph (4)(a).

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol which must be maintained onsite at the location or locations at which an advanced registered nurse practices. In the case of multiple supervising physicians in the same group, an advanced registered nurse practitioner must enter into a supervisory protocol with at least one physician within the physician group practice. ~~that is~~

~~filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols.~~ A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

(a) Prescribe, dispense, administer, or order any drug; however, an advanced registered nurse practitioner may prescribe or dispense a controlled substance as defined in s. 893.03 only if the advanced registered nurse practitioner has graduated from a program leading to a master's or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills.

(b) Initiate appropriate therapies for certain conditions.

(c) Perform additional functions as may be determined by rule in accordance with s. 464.003(2).

(d) Order diagnostic tests and physical and occupational therapy.

(e) Order any medication for administration to a patient in a facility licensed under chapter 395 or part II of chapter

400, notwithstanding any provisions in chapter 465 or chapter 893.

Section 10. Effective December 31, 2018, or upon enactment of the Nurse Licensure Compact into law by 26 states, whichever occurs first, subsections (1) and (3) of section 464.012, Florida Statutes, as amended by section 8 of chapter 2016-139, section 12 of chapter 2016-224, and section 7 of chapter 2016-231, Laws of Florida, is amended to read:

464.012 Certification of advanced registered nurse practitioners; fees; controlled substance prescribing.—

(1) Any nurse desiring to be certified as an advanced registered nurse practitioner shall apply to the department and submit proof that he or she holds a current license to practice professional nursing or holds an active multistate license to practice professional nursing pursuant to s. 464.0095 and that he or she meets one or more of the following requirements as determined by the board:

~~(a) Satisfactory completion of a formal postbasic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.~~

(a) ~~(b)~~ Certification by an appropriate specialty board. Such certification shall be required for initial state certification and any recertification as a registered nurse anesthetist, psychiatric nurse, or nurse midwife. The board may

by rule provide for provisional state certification of graduate nurse anesthetists, psychiatric nurses, and nurse midwives for a period of time determined to be appropriate for preparing for and passing the national certification examination.

(b) ~~(c)~~ Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills. For applicants graduating on or after October 1, 1998, graduation from a master's degree program shall be required for initial certification as a nurse practitioner under paragraph (4)(c). For applicants graduating on or after October 1, 2001, graduation from a master's degree program shall be required for initial certification as a registered nurse anesthetist under paragraph (4)(a).

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol which must be maintained onsite at the location or locations at which an advanced registered nurse practices. In the case of multiple supervising physicians in the same group, an advanced registered nurse practitioner must enter into a supervisory protocol with at least one physician within the physician group practice. ~~that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory~~

~~standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols.~~ A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

(a) Prescribe, dispense, administer, or order any drug; however, an advanced registered nurse practitioner may prescribe or dispense a controlled substance as defined in s. 893.03 only if the advanced registered nurse practitioner has graduated from a program leading to a master's or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills.

(b) Initiate appropriate therapies for certain conditions.

(c) Perform additional functions as may be determined by rule in accordance with s. 464.003(2).

(d) Order diagnostic tests and physical and occupational therapy.

(e) Order any medication for administration to a patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893.

Section 11. Subsection (3) of section 464.013, Florida Statutes, is amended to read:

464.013 Renewal of license or certificate.—

(3) The board shall by rule prescribe up to 30 hours of continuing education biennially as a condition for renewal of a license or certificate.

(a) A nurse who is certified by a health care specialty program accredited by the National Commission for Certifying Agencies or the Accreditation Board for Specialty Nursing Certification is exempt from continuing education requirements. The criteria for programs must be approved by the board.

(b) Notwithstanding the exemption in paragraph (a), as part of the maximum 30 hours of continuing education ~~hours~~ required under this subsection, advanced registered nurse practitioners certified under s. 464.012 must complete at least 3 hours of continuing education on the safe and effective prescription of controlled substances. Such continuing education courses must be approved by the board and ~~must be offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit, the American Nurses Credentialing Center, the American Association of Nurse Anesthetists, or the American Association of Nurse Practitioners and~~ may be offered in a distance learning format.

Section 12. Paragraph (b) of subsection (2), subsection (5), subsection (8), paragraph (a) of subsection (9), and

subsection (10) of section 464.019, Florida Statutes, are amended, paragraph (d) is added to subsection (7) of that section, and paragraph (e) is added to subsection (11) of that section, to read:

464.019 Approval of nursing education programs.—

(2) PROGRAM APPROVAL.—

(b) Following the department's receipt of a complete program application, the board may conduct an on-site evaluation if necessary to document the applicant's compliance with subsection (1). Within 90 days after the department's receipt of a complete program application, the board shall:

1. Approve the application if it documents compliance with subsection (1); or

2. Provide the educational institution with a notice of intent to deny the application if it does not document compliance with subsection (1). The notice must specify written reasons for the board's denial of the application. The board may not deny a program application because of an educational institution's failure to correct an error or omission that the department failed to provide notice of to the institution within the 30-day notice period under paragraph (a). The educational institution may request a hearing on the notice of intent to deny the program application pursuant to chapter 120.

(5) ACCOUNTABILITY.—

(a)1. An approved program must achieve a graduate passage rate for first-time test takers which ~~who take the licensure examination within 6 months after graduation from the program that~~ is not more than 10 percentage points lower than the average passage rate during the same calendar year for graduates of comparable degree programs who are United States educated, first-time test takers on the National Council of State Boards of Nursing Licensing Examination, as calculated by the contract testing service of the National Council of State Boards of Nursing. ~~An approved program shall require a graduate from the program who does not take the licensure examination within 6 months after graduation to enroll in and successfully complete a licensure examination preparatory course pursuant to s. 464.008.~~ For purposes of this subparagraph, an approved program is comparable to all degree programs of the same program type from among the following program types:

a. Professional nursing education programs that terminate in a bachelor's degree.

b. Professional nursing education programs that terminate in an associate degree.

c. Professional nursing education programs that terminate in a diploma.

d. Practical nursing education programs.

2. Beginning with graduate passage rates for calendar year 2010, if an approved program's graduate passage rates do not

equal or exceed the required passage rates for 2 consecutive calendar years, the board shall place the program on probationary status pursuant to chapter 120 and the program director shall appear before the board to present a plan for remediation, which shall include specific benchmarks to identify progress toward a graduate passage rate goal. The program must remain on probationary status until it achieves a graduate passage rate that equals or exceeds the required passage rate for any 1 calendar year. The board shall deny a program application for a new prelicensure nursing education program submitted by an educational institution if the institution has an existing program that is already on probationary status.

3. Upon the program's achievement of a graduate passage rate that equals or exceeds the required passage rate, the board, at its next regularly scheduled meeting following release of the program's graduate passage rate by the National Council of State Boards of Nursing, shall remove the program's probationary status. If the program, during the 2 calendar years following its placement on probationary status, does not achieve the required passage rate for any 1 calendar year, the board ~~shall terminate the program pursuant to chapter 120. However, the board~~ may extend the program's probationary status for 1 additional year, provided ~~if~~ the program has demonstrated ~~demonstrates~~ adequate progress toward the graduate passage rate goal by meeting a majority of the benchmarks established in the

remediation plan. If the program is not granted the 1-year extension or fails to achieve the required passage rate by the end of such extension, the board shall terminate the program pursuant to chapter 120.

(b) If an approved program fails to submit the annual report required in subsection (3), the board shall notify the program director and president or chief executive officer of the educational institution in writing within 15 days after the due date of the annual report. The program director shall appear before the board at the board's next regularly scheduled meeting to explain the reason for the delay. The board shall terminate the program pursuant to chapter 120 if the program director fails to appear before the board, as required under this paragraph, or if the program ~~it~~ does not submit the annual report within 6 months after the due date.

(c) A nursing education ~~An approved~~ program, whether accredited or nonaccredited, which has been placed on probationary status shall disclose its probationary status in writing to the program's students and applicants. The notification must include an explanation of the implications of the program's probationary status on student and applicant employment and educational opportunities, including the prospects a student wishing to matriculate at a university will face.

(d) If students from a program that is terminated pursuant to this subsection transfer to an approved or an accredited program under the direction of the Commission for Independent Education, the board shall recalculate the passage rates of the programs receiving the transferring students, excluding the test scores of those students transferring more than 12 credits.

(7) PROGRAM CLOSURE.—

(d) A program that is terminated or closed under this section may not seek program approval under its original name or a new program name for a minimum of 3 years after the date of termination or closing.

(8) RULEMAKING.—The board does not have rulemaking authority to administer this section, except that the board shall adopt rules that prescribe the format for submitting program applications under subsection (1) and annual reports under subsection (3), and to administer the documentation of the accreditation of nursing education programs under subsection (11). The board may adopt rules related to the nursing curriculum and nursing program implementation plans, which may include definitions of the various types and uses of simulation technology and limitations on the technology's use. The board may also adopt rules related to program termination or closure under this section and the procedure for a program that is terminated or closed under this section to seek subsequent program approval. The board may not impose any condition or

requirement on an educational institution submitting a program application, an approved program, or an accredited program, except as expressly provided in this section.

(9) APPLICABILITY TO ACCREDITED PROGRAMS.—

(a) Subsections (1)-(3), paragraph (4)(b), and paragraph (5)(b) ~~subsection (5)~~ do not apply to an accredited program.

(10) IMPLEMENTATION STUDY.—The Florida Center for Nursing ~~and the education policy area of the Office of Program Policy Analysis and Government Accountability~~ shall study the administration of this section and submit reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives annually by January 30, through January 30, 2020. The annual reports shall address the previous academic year; provide data on the measures specified in paragraphs (a) and (b), as such data becomes available; and include an evaluation of such data for purposes of determining whether this section is increasing the availability of nursing education programs and the production of quality nurses. The department and each approved program or accredited program shall comply with requests for data from the Florida Center for Nursing ~~and the education policy area of the Office of Program Policy Analysis and Government Accountability~~.

(a) The Florida Center for Nursing ~~education policy area of the Office of Program Policy Analysis and Government Accountability~~ shall evaluate program-specific data for each

584 approved program and accredited program conducted in the state,
585 including, but not limited to:
586 1. The number of programs and student slots available.
587 2. The number of student applications submitted, the
588 number of qualified applicants, and the number of students
589 accepted.
590 3. The number of program graduates.
591 4. Program retention rates of students tracked from
592 program entry to graduation.
593 5. Graduate passage rates on the National Council of State
594 Boards of Nursing Licensing Examination.
595 6. The number of graduates who become employed as
596 practical or professional nurses in the state.
597 (b) The Florida Center for Nursing shall evaluate the
598 board's implementation of the:
599 1. Program application approval process, including, but
600 not limited to, the number of program applications submitted
601 under subsection (1); the number of program applications
602 approved and denied by the board under subsection (2); the
603 number of denials of program applications reviewed under chapter
604 120; and a description of the outcomes of those reviews.
605 2. Accountability processes, including, but not limited
606 to, the number of programs on probationary status, the number of
607 approved programs for which the program director is required to
608 appear before the board under subsection (5), the number of

approved programs terminated by the board, the number of terminations reviewed under chapter 120, and a description of the outcomes of those reviews.

(c) The Florida Center for Nursing shall complete an annual assessment of compliance by programs with the accreditation requirements of subsection (11), include in the assessment a determination of the accreditation process status for each program, and submit the assessment as part of the report required by this subsection ~~For any state fiscal year in which The Florida Center for Nursing does not receive legislative appropriations, the education policy area of the Office of Program Policy Analysis and Government Accountability shall perform the duties assigned by this subsection to the Florida Center for Nursing~~.

(11) ACCREDITATION REQUIRED.—

(e) A nursing education program that fails to meet the accreditation requirements shall be terminated and is ineligible for reapproval under its original name or a new program name for a minimum of 3 years after the date of termination.

Section 13. Section 465.0195, Florida Statutes, is created to read:

465.0195 In-state sterile compounding permit.—Before any pharmacy or outsourcing facility located in this state dispenses, creates, delivers, ships, or mails, in any manner, a

compound sterile product, the pharmacy or outsourcing facility must hold a sterile compounding permit.

(1) An application for a sterile compounding permit shall be submitted on a form furnished by the board. The board may require such information as it deems reasonably necessary to carry out the purposes of this section.

(2) If the board certifies that the application complies with the applicable laws and rules of the board governing pharmacies, the department shall issue the permit.

(3) A permit may not be issued unless a licensed pharmacist is designated to supervise the compounding and dispensing of all drugs dispensed by the permittee.

(4) The permittee shall notify the department within 10 days after any change in the designation of the supervising licensed pharmacist. A permittee that employs or otherwise uses registered pharmacy technicians must have a written policy and procedures manual specifying the duties, tasks, and functions that a registered pharmacy technician is allowed to perform.

(5) The board may adopt by rule standards of practice for sterile compounding. In adopting the standards of practice, the board shall consider the pharmaceutical standards in chapter 797 of the United States Pharmacopoeia and may consider any authoritative professional standards. In adopting standards of practice for an outsourcing facility, the board shall consider the Current Good Manufacturing Practice regulations enforced by

the United States Food and Drug Administration and may consider any authoritative professional standards.

(6) All provisions relating to pharmacy permits in ss. 465.022 and 465.023 apply to permits issued pursuant to this section.

Section 14. Subsection (2) of section 465.027, Florida Statutes, is amended to read:

465.027 Exceptions.—

(2) This chapter shall not apply to a manufacturer, or its agent, holding an active permit as a manufacturer under chapter 499, or a third party logistics provider holding an active permit under chapter 499, and engaged solely in the manufacture or distribution of dialysate, drugs, or devices necessary to perform home renal dialysis on patients with chronic kidney failure, if the dialysate, drugs, or devices are:

(a) Approved or cleared by the United States Food and Drug Administration; and

(b) Delivered in the original, sealed packaging after receipt of a physician's order to dispense to:

1. A patient with chronic kidney failure, or the patient's designee, for the patient's self-administration of the dialysis therapy; or

2. A health care practitioner or an institution for administration or delivery of the dialysis therapy to a patient with chronic kidney failure.

Section 15. Subsections (1), (3), and (4) of section 468.803, Florida Statutes, are amended, and paragraph (f) is added to subsection (5) of that section, to read:

468.803 License, registration, and examination requirements.—

(1) The department shall issue a license to practice orthotics, prosthetics, or pedorthics, or a registration for a resident to practice orthotics or prosthetics, to qualified applicants. Licenses shall be granted independently in orthotics, prosthetics, or pedorthics, but a person may be licensed in more than one such discipline, and a single prosthetist-orthotist license may be granted to persons meeting the requirements for both a prosthetist and an orthotist license. Registrations shall be granted ~~independently~~ in orthotics or prosthetics, or ~~and~~ a person may, if approved by the board, hold a single registration ~~be registered~~ in both fields ~~at the same time~~.

(3) A person seeking to attain the required orthotics or prosthetics experience in this state must be approved by the board and registered as a resident by the department. For a 12-month residency, a registration may be held in each practice field, and the board may not approve a second registration until at least one year after the issuance of the first registration. For an 18-month residency, ~~Although~~ a registration may be held in both practice fields concurrently~~, the board shall not~~

~~approve a second registration until at least 1 year after the issuance of the first registration~~. Notwithstanding subsection (2), an applicant who has been approved by the board and registered by the department in one practice field may apply for registration in the second practice field without an additional state or national criminal history check during the period in which the first registration is valid. Each registration is valid for 2 years from the date of issuance unless otherwise revoked by the department upon recommendation of the board. The board shall set a registration fee not to exceed $500 to be paid by the applicant. A registration may be renewed once by the department upon recommendation of the board for a period no longer than 1 year, as such renewal is defined by the board by rule. The registration renewal fee shall not exceed one-half the current registration fee. To be considered by the board for approval of registration as a resident, the applicant must have:

(a) A Bachelor of Science or higher-level postgraduate degree in Orthotics and Prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; or

(b) A Bachelor of Science or higher-level postgraduate degree in Orthotics and Prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.

(4) The department may develop and administer a state examination for an orthotist license, ~~or~~ a prosthetist license, or a prosthetist-orthotist license, or the board may approve the existing examination of a national standards organization. The examination must be predicated on a minimum of a baccalaureate-level education and formalized specialized training in the appropriate field. Each examination must demonstrate a minimum level of competence in basic scientific knowledge, written problem solving, and practical clinical patient management. If developed and administered by the department, the board shall require an examination fee not to exceed the actual cost of ~~to the board in~~ developing, administering, and approving the examination, which fee must be paid by the applicant. To be considered by the board for examination, the applicant must have:

(a) For an examination in orthotics:

1. A Bachelor of Science or higher-level postgraduate degree in Orthotics and Prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved orthotics internship of 1 year of qualified experience, as determined by the board, or an orthotic residency program recognized by the board.

(b) For an examination in prosthetics:

1. A Bachelor of Science or higher-level postgraduate degree in Orthotics and Prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved prosthetics internship of 1 year of qualified experience, as determined by the board, or a prosthetic residency program recognized by the board.

(c) For an examination leading toward a prosthetic-orthotist license:

1. A Bachelor of Science or higher-level postgraduate degree in Orthotics and Prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in orthotics and prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved orthotics-prosthetics internship of at least 1 year of qualified experience, as determined by the board, or an orthotics-prosthetics residency program recognized by the board.

(5) In addition to the requirements in subsection (2) and (4), to be licensed as:

(f) A prosthetist-orthotist, the applicant must pay a fee not to exceed $1,000 and must have:

1. Completed the mandatory courses; and

2. Passed the state prosthetics examination and orthotics examination or the board-approved prosthetics examination and the board-approved orthotics examination. If a board-approved combined examination becomes available, the combined examination will also meet the requirements under this subparagraph.

Section 16. Subsection (7) of section 480.041, Florida Statutes, is amended to read:

480.041 Massage therapists; qualifications; licensure; endorsement.—

(7) The board shall deny an application for a new license and the department shall deny the ~~or~~ renewal of a license if an applicant has been convicted or found guilty of, or enters a plea of guilty or nolo contendere to, regardless of adjudication, a violation of s. 796.07(2)(a) which is reclassified under s. 796.07(7) or a felony offense under any of the following provisions of state law or a similar provision in another jurisdiction:

(a) Section 787.01, relating to kidnapping.

(b) Section 787.02, relating to false imprisonment.

(c) Section 787.025, relating to luring or enticing a child.

(d) Section 787.06, relating to human trafficking.

(e) Section 787.07, relating to human smuggling.

(f) Section 794.011, relating to sexual battery.

(g) Section 794.08, relating to female genital mutilation.

(h) Former s. 796.03, relating to procuring a person under the age of 18 for prostitution.

(i) Former s. 796.035, relating to the selling or buying of minors into prostitution.

(j) Section 796.04, relating to forcing, compelling, or coercing another to become a prostitute.

(k) Section 796.05, relating to deriving support from the proceeds of prostitution.

(l) Section 796.07(4)(a)3., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, relating to prohibiting prostitution and related acts.

(m) Section 800.04, relating to lewd or lascivious offenses committed upon or in the presence of persons less than 16 years of age.

(n) Section 825.1025(2)(b), relating to lewd or lascivious offenses committed upon or in the presence of an elderly or disabled person.

(o) Section 827.071, relating to sexual performance by a child.

(p) Section 847.0133, relating to the protection of minors.

(q) Section 847.0135, relating to computer pornography.

(r) Section 847.0138, relating to the transmission of material harmful to minors to a minor by electronic device or equipment.

(s) Section 847.0145, relating to the selling or buying of minors.

Section 17. Paragraph (b) and (c) of subsection (3) of section 486.102, Florida Statutes, are amended, and paragraph (d) is added to that subsection, to read:

486.102 Physical therapist assistant; licensing requirements.—To be eligible for licensing by the board as a physical therapist assistant, an applicant must:

(3)

(b) Have been graduated from a school giving a course for physical therapist assistants in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapist assistants in this country, as recognized by the appropriate agency as identified by the board, and passed to the satisfaction of the board an examination to determine her or his fitness for practice as a physical therapist assistant as hereinafter provided; ~~or~~

(c) Be entitled to licensure without examination as provided in s. 486.107; or

(d) Have been enrolled between July 1, 2014, and July 1, 2016, in a physical therapy assistant school in this state which was accredited at the time of enrollment; and

1. Has graduated or will graduate from such school no later than July 1, 2018; and

2. Has passed to the satisfaction of the board an examination to determine his or her fitness for practice as a physical therapy assistant as provided in s. 486.104.

Section 18. Paragraph (c) of subsection (3) and subsection (4) of section 491.005, Florida Statutes, is amended to read:

491.005 Licensure by examination.—

(3) MARRIAGE AND FAMILY THERAPY.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual cost to the department for the purchase of the examination from the Association of Marital and Family Therapy Regulatory Board, or similar national organization, the department shall issue a license as a marriage and family therapist to an applicant who the board certifies:

(c) Has had at least 2 years of clinical experience during which 50 percent of the applicant's clients were receiving marriage and family therapy services, which must be at the post-master's level under the supervision of a licensed marriage and family therapist with at least 5 years of experience, or the equivalent, who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major emphasis in marriage and family therapy or a closely related field that did not include all the coursework required under sub-subparagraphs

(b)1.a.-c., credit for the post-master's level clinical experience shall not commence until the applicant has completed a minimum of 10 of the courses required under sub-subparagraphs (b)1.a.-c., as determined by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques. Within the 2 ~~3~~ years of required experience, the applicant shall provide direct individual, group, or family therapy and counseling, to include the following categories of cases: unmarried dyads, married couples, separating and divorcing couples, and family groups including children. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual per applicant cost to the department for purchase of the National Clinical Mental Health Counseling Examination, an examination managed by the National Board for Certified Counselors or its successor ~~from the Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors or a similar national organization~~, the department shall issue a license as a mental health counselor to an applicant who the board certifies:

(a) Has submitted an application and paid the appropriate fee.

(b)1. Has a minimum of an earned master's degree from a mental health counseling program accredited by the Council for the Accreditation of Counseling and Related Educational Programs that consists of at least 60 semester hours or 80 quarter hours of clinical and didactic instruction, including a course in human sexuality and a course in substance abuse. If the master's degree is earned from a program related to the practice of mental health counseling that is not accredited by the Council for the Accreditation of Counseling and Related Educational Programs, then the coursework and practicum, internship, or fieldwork must consist of at least 60 semester hours or 80 quarter hours and meet the following requirements:

a. Thirty-three semester hours or 44 quarter hours of graduate coursework, which must include a minimum of 3 semester hours or 4 quarter hours of graduate-level coursework in each of the following 11 content areas: counseling theories and practice; human growth and development; diagnosis and treatment of psychopathology; human sexuality; group theories and practice; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; social and cultural foundations; counseling in community settings; and substance abuse. Courses in research, thesis or dissertation

work, practicums, internships, or fieldwork may not be applied toward this requirement.

b. A minimum of 3 semester hours or 4 quarter hours of graduate-level coursework in legal, ethical, and professional standards issues in the practice of mental health counseling, which includes goals, objectives, and practices of professional counseling organizations, codes of ethics, legal considerations, standards of preparation, certifications and licensing, and the role identity and professional obligations of mental health counselors. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

c. The equivalent, as determined by the board, of at least 1,000 hours of university-sponsored supervised clinical practicum, internship, or field experience as required in the accrediting standards of the Council for Accreditation of Counseling and Related Educational Programs for mental health counseling programs. This experience may not be used to satisfy the post-master's clinical experience requirement.

2. If the course title which appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant shall be required to provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course.

Education and training in mental health counseling must have been received in an institution of higher education which at the time the applicant graduated was: fully accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation; publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada; or an institution of higher education located outside the United States and Canada, which at the time the applicant was enrolled and at the time the applicant graduated maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as mental health counselors. The burden of establishing that the requirements of this provision have been met shall be upon the applicant, and the board shall require documentation, such as, but not limited to, an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country.

(c) Has had at least 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling that did not include all the coursework required under sub-subparagraphs (b)1.a.-b., credit for the post-master's level clinical experience shall not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a.-b., as determined by the board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) Has passed a theory and practice examination provided by the department for this purpose.

(e) Has demonstrated, in a manner designated by rule of the board, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

Section 19. Subsection (2) of section 491.009, Florida Statutes, is amended to read:

491.009 Discipline.—

(2) The board ~~department~~, or, in the case of certified master social workers ~~psychologists~~, the department ~~board~~, may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

Section 20. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2017.

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

Remove everything before the enacting clause and insert: An act relating to the regulation of health care practitioners; amending s. 384.4018, F.S.; requiring the department to follow federal requirements in the implementation of a specified program; amending s. 395.3025, F.S.; authorizing the disclosure of certain patient records to the department, rather than the Agency for Health Care Administration; requiring the department, rather than the agency, to make certain patient records available under certain circumstances; amending s. 456.013, F.S.; requiring applications for a licensure examination include the applicant's date of birth; removing provisions related to

the size and format of licenses; prohibiting the issuance of or renewal of certain licenses by regulatory boards or the department to applicants or licensees who have not paid all the fines and costs in the timeframe imposed by certain final orders; amending s. 456.025, F.S.; authorizing the department to waive certain fees when trust fund moneys exceed a certain amount; amending s. 456.065, F.S.; authorizing a transfer from the operating fund of a profession to cover a deficit in the unlicensed activity category; amending s. 458.3265, F.S.; removing an exemption from registration for certain pain management clinics; exempting certain pain management clinics from complying with operation requirements of the department; exempting certain pain management clinics from registration fees; amending s. 458.348, F.S.; repealing a provision that required establishment of standards by a joint committee for protocols for advanced registered nurse practitioners; amending s. 459.0137, F.S.; removing an exemption from registration for certain pain management clinics; exempting certain pain management clinics from complying with operation requirements of the department; exempting certain pain management clinics from registration fees; amending s. 464.012, F.S.; removing an obsolete qualification to satisfy certification requirements for an advanced registered nurse practitioner; requiring the supervisory protocol to be maintained at the practice location of the advanced registered nurse practitioner; authorizing an

advanced registered nurse practitioner works with a physician group to enter into one supervisory protocol; removing the requirement that the supervisory protocol be filed with the Board of Nursing; removing the requirement that the board refer licensees who submit noncompliant supervisory protocols to the Department of Health; amending s. 464.013, F.S.; requiring certain continuing education courses to be approved by the Board of Nursing; removing a requirement that certain continuing education courses be offered by specified entities; amending s. 464.019, F.S.; authorizing the board to conduct certain on-site evaluations; removing a limiting criterion from the requirement to measure graduate passage rates; removing a requirement that certain nursing program graduates complete a specific preparatory course; clarifying circumstances when programs in probationary status must be terminated; providing that accredited and nonaccredited nursing education programs must disclose probationary status; requiring notification of probationary status to include certain information; prohibiting a terminated or closed program from seeking program approval for a certain time; authorizing the board to adopt certain rules; requiring accredited programs to meet program accountability requirements and requirements to provide notification of probationary status; removing requirements that the Office of Program Policy Analysis and Government Accountability perform certain tasks; requiring the Florida Center for Nursing to make

an annual assessment of compliance by nursing programs with certain accreditation requirements; requiring the center to include its assessment in a report to the Governor and the Legislature; removing the requirement that the Office of Program Policy Analysis and Government Accountability perform specified duties under certain circumstances; requiring the termination of a program under certain circumstances; creating s. 465.0195, F.S.; requiring a pharmacy or outsourcing facility to obtain a permit before engaging in specified activities related to sterile compounding; providing requirements for the permit application; providing requirements for the employment of certain individuals; authorizing the Board of Pharmacy to adopt by rule standards of practice for sterile compounding; requiring the board to consider certain standards and regulations in adopting such rules; providing applicability; amending 465.027, F.S.; providing an exemption an exception to certain third party logistics providers who distribute dialysis drugs or supplies; amending s. 468.803, F.S.; revising the registration requirements for orthotics and prosthetics; providing for a combined license in prosthetics and orthotics; providing license requirements; amending 480.041, F.S.; requiring the department, rather than the Board of Massage Therapy, to deny the renewal of a license under certain circumstances; amending s. 486.102, F.S.; providing requirements for certain physical therapy assistant licensure applicants; amending s. 491.005; F.S.;

revising the amount of clinical experience required for a license to provide marriage and family therapy; revising the licensure examination; amending s. 491.009, F.S.; authorizing the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, rather than the department, to enter an order denying licensure or impose penalties against an applicant for licensure under certain circumstances; authorizing the department, rather than the board, to enter an order denying licensure or impose penalties against an applicant for licensure as a certified master social worker under certain circumstances; deleting a provision granting such authority to the board in the case of a psychologist; providing an effective date.

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 557 Prescription Drug Monitoring Program
**SPONSOR(S):** Health Quality Subcommittee; Duran
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 840

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Quality Subcommittee | 14 Y, 0 N, As CS | Siples | McElroy |
| 2) Health Care Appropriations Subcommittee | 13 Y, 0 N | Mielke | Pridgeon |
| 3) Health & Human Services Committee | | Siples | Calamas |

## SUMMARY ANALYSIS

In 2009, the Legislature created the Prescription Drug Monitoring Program (PDMP) within the Department of Health (DOH). The PDMP employs a database to monitor the prescribing and dispensing of certain controlled substances. Dispensers of controlled substances listed in Schedule II, III, or IV must report certain information to the PDMP database, including the name of the prescriber, the date the prescription is filled and dispensed, and the name, address, and date of birth of the person to whom the controlled substance is dispensed. Currently, dispensers must report dispensing controlled substances to the database within seven days of dispensing the controlled substances via the internet or other DOH-approved format, such as on a disc or regular mail.

Dispensing and administering controlled substances are exempt from PDMP reporting in certain health care settings where the risk of controlled substances being overprescribed or diverted is low. These health care settings include a licensed hospital, nursing home, ambulatory surgical center, hospice, intermediate care facility for the developmentally disabled, rehabilitative hospital, and assisted living facility.

Beginning January 1, 2018, CS/HB 557 reduces the amount of time a dispenser has to report the dispensing of a controlled substance to the PDMP database to the close of the next business day after the controlled substance is dispensed.

The bill requires PDMP reporting to be completed via the DOH-approved electronic system, and eliminates DOH authority to approve other options for submission.

The bill also requires the patient to be present and receiving care for the reporting exemption for a rehabilitation hospital, assisted living facility, or nursing home to apply.

The bill authorizes certain health care employees of the U.S. Veterans' Administration to access the PDMP database in manner established by DOH. Such access is limited to the authorized employee's review of his or her patient's controlled substance prescription history.

The bill may have an insignificant, negative fiscal impact on DOH that can be absorbed with existing resources and has no fiscal impact on local governments.

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Present Situation**

Prescription Drug Monitoring Program

Prescription Drug Monitoring Programs (PDMPs) are state-run electronic databases used to track the prescribing and dispensing of certain controlled prescription drugs to patients.[1] PDMPs are designed to monitor this information for suspected abuse or diversion and provide prescribers and pharmacists with critical information regarding a patient's controlled substance prescription history.[2] As of September 2015, 49 states either had an operational PDMP database.[3]

Chapter 2009-197, Laws of Fla., established Florida's PDMP within the Department of Health (DOH), and is codified in s. 893.055, F.S. The PDMP uses an electronic database system to monitor the prescribing and dispensing of certain controlled substances.[4] The PDMP database became operational in September of 2011, when it began receiving prescription data from pharmacies and dispensing practitioners.[5]

*PDMP Reporting Requirements*

Dispensers of controlled substances listed in Schedule II, III, or IV of the Florida Comprehensive Drug Abuse Prevention and Control Act must report specified information to the PDMP database:[6]

- The name of the prescribing practitioner, the practitioners federal Drug Enforcement Administration (DEA) registration number, the practitioner's National Provider Identification (NPI) or other appropriate identifier, and the date of the prescription;
- The date the prescription was filled and the method of payment, such as cash by an individual or third-party payment;
- The full name, address, and date of birth of the person for whom the prescription was written;
- The name, national drug code, quantity, and strength of the controlled substance dispensed;
- The full name, federal DEA registration number, and address of the pharmacy, other location, or other practitioner from which the controlled substance was dispensed;
- The name of the pharmacy or practitioner, other than a pharmacist, dispensing the controlled substance and the practitioner's NPI; and
- Other appropriate identifying information as determined by DOH rule.[7]

Dispensers must report dispensing a specified controlled substance to the PDMP database within seven days.[8] As of June 30, 2016, approximately 96 percent of pharmacies required to report data to

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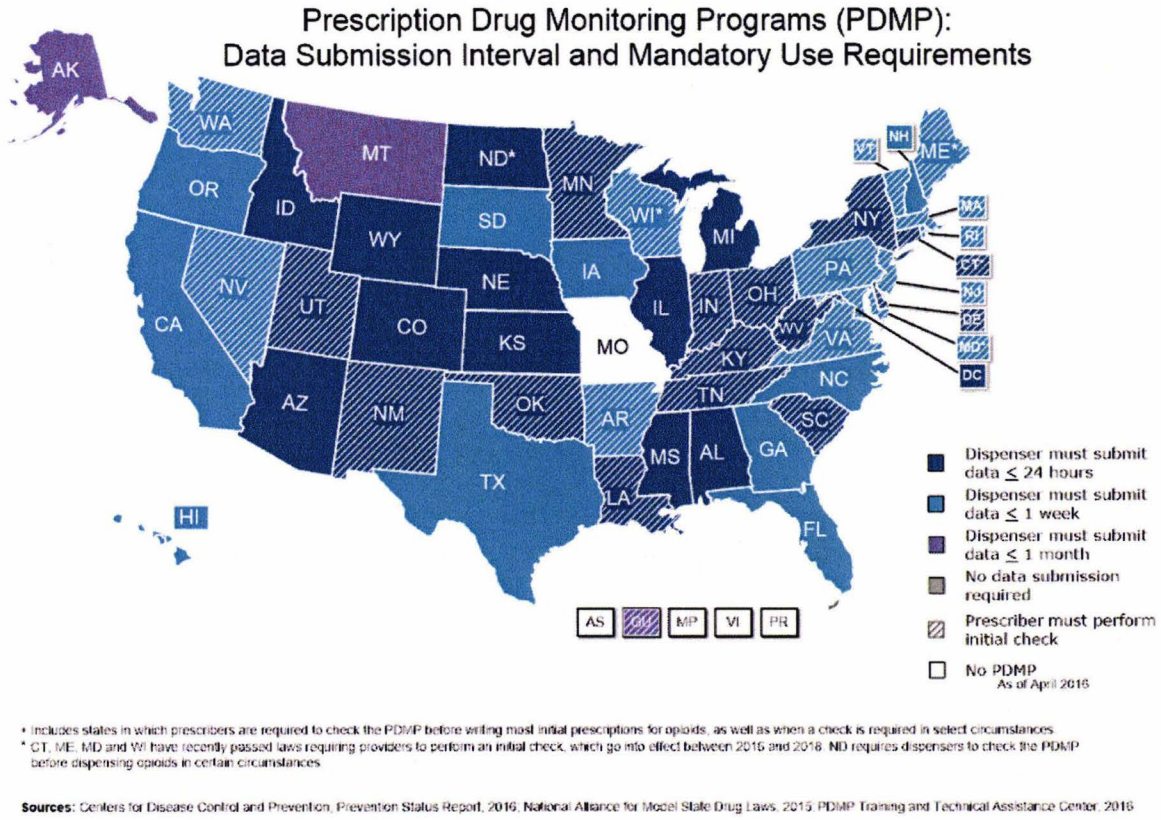
[1] Centers for Disease Control and Prevention, *Prescription Drug Monitoring Programs*, *available at* http://www.cdc.gov/drugoverdose/pdmp/ (last visited March 17, 2017).
[2] *Id.*
[3] National Alliance for Model State Drug Laws, *2015 Annual Review of Prescription Monitoring Programs*, (September 2015), *available at* http://www.namsdl.org/IssuesandEvents/2015%20Annual%20Review%20of%20Prescription%20Monitoring%20Programs.pdf (last visited March 20, 2017). Missouri is the only state without a PDMP. Legislation was filed in December 2016 to establish a program. *See http://www.senate.mo.gov/17info/BTS_Web/Bill.aspx?SessionType=R&BillID=57095432* (last visited March 17, 2017).
[4] Section 893.055(2)(a), F.S.
[5] Florida Department of Health, Electronic-Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE), 2015-2016 Prescription Drug Monitoring Program Annual Report, (December 1, 2016), *available at* http://www.floridahealth.gov/statistics-and-data/e-forcse/_documents/2016PDMPAnnualReport.pdf (last visited March 17, 2017).
[6] Section 893.055(3), F.S.; controlled substances listed in Schedule II, III, or IV can be found in s. 893.03(2)-(4), F.S.
[7] *Id.*
[8] Section 893.055(4), F.S.

the PDMP had uploaded information into the system within the seven-day statutory limit.[9] Of those, 66 percent reported the information within 24 hours.[10] The time in which a dispenser must submit information to the PDMP varies across the nation. As indicated below, some states require the dispenser to submit data within 24 hours, others (like Florida) allow up to 7 days, and two allow the dispenser up to a month to submit the data:[11]




In Florida, more than 6,500 dispensers have reported to the PDMP creating the more than 198 million dispensing records that are maintained in the PDMP system.[12]

*Exemptions from PDMP Reporting Requirements*

The purpose of the PDMP is to track the dispensing of prescribed controlled substances to provide information to subsequent prescribing physicians and prevent the overprescribing of such substances, and also to prevent the diversion of such substances. However, there are some circumstances in which there is inherently a low risk of controlled substances being overprescribed or diverted, and in those circumstances, the law exempts practitioners from having to report the dispensing of controlled substances. Specifically, the following acts are not required to be reported:

- A health care practitioner administering a controlled substance directly to a patient if the amount of the controlled substance is adequate to treat the patient during that particular treatment session;
- A pharmacist or health care practitioner administering a controlled substance to a patient or resident receiving care as a patient at a hospital, nursing home, ambulatory surgical center,

[9] *Supra* note 5.
[10] *Id.*
[11] National Conference of State Legislatures, "Prescription Drug Monitoring Programs," (June 1, 2016), *available at* http://www.ncsl.org/research/health/prescription-drug-monitoring-programs-postcard.aspx (last visited March 20, 2017).
[12] *Supra* note 5.

hospice, or intermediate care facility for the developmentally disabled which is licensed in this state;
- A practitioner administering or dispensing a controlled substance in the health care system of the Department of Corrections;
- A practitioner administering a controlled substance in the emergency room of a licensed hospital;
- A health care practitioner administering or dispensing a controlled substance to a person under the age of 16;
- A pharmacist or a dispensing practitioner dispensing a one-time, 72-hour emergency resupply of a controlled substance to a patient; and
- A rehabilitative hospital, assisted living facility, or nursing home dispensing a certain dosage of a controlled substance, as needed, to a patient as ordered by the patient's treating physician.[13]

*Access to PDMP Data*

Direct access to the PDMP database is presently limited by law to a pharmacy, prescriber, or dispenser.[14] A pharmacy, prescriber, or dispenser has access to information in the PDMP database that relates to a patient of that pharmacy, prescriber, or dispenser, as needed, for reviewing the patient's controlled substance prescription history.[15] Currently, the only prescribers authorized to access the PDMP database are Florida-licensed health care practitioners.[16] Health care practitioners who work for the United States Veterans Affairs (VA) in one of its facilities in Florida are not required to be licensed in Florida. The VA requires that a health care practitioner have an active, unrestricted license to practice from any state to practice at any one of its facilities nationwide.[17] Therefore, a health care practitioner practicing in a VA facility in Florida who is licensed in another state would not have access to the PDMP database.

Health care practitioners began accessing the PDMP database on October 17, 2011.[18] As of June 30 2016, 36,718 health care practitioners, or 23.7 percent of all licensed health care practitioners, were registered to use the PDMP Database.[19] Pharmacists have had the highest utilization rate of the PDMP; from July 1, 2015 to June 30, 2016, 54.5 percent of pharmacists were registered to use the PDMP and 90.1 percent of pharmacists registered to use the PDMP had queried it.[20] From July 1, 2015 to June 30, 2016, in-state prescribers issued 37,048,030 controlled substance prescriptions to 7,387,884 Florida residents.[21] During that same timeframe, 28,984 registered health care practitioners queried the PDMP database 27,501,266 times.[22]

In Florida, indirect access to the PDMP database is provided to:

- DOH and its relevant health care regulatory boards;
- The Attorney General for Medicaid fraud cases involving prescribed controlled substances;

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[13] Section 893.055(5). F.S.
[14] Section 893.055(7)(b), F.S.
[15] *Id.*
[16] Section 893.055(1)(d), F.S., defines health care practitioner for the purpose of the PDMP program as those practitioners who are subject to licensure or regulation by DOH under ch. 458, F.S., (Medicine), ch. 459, F.S., (Osteopathic Medicine), ch. 461, F.S., (Podiatric Medicine), ch. 462, F.S., (Naturopath), ch. 463, F.S., (Optometry), ch. 464, F.S., (Nursing), ch. 465, F.S., (Pharmacy), or ch. 466, F.S., (Dentistry).
[17] U.S. Department of Veterans Affairs, "VA Careers: Credentialing at VA," *available at* http://www.vacareers.va.gov/careers/physicians/credentialing.asp (last visited March 20, 2017).
[18] Florida Department of Health, Electronic-Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE), 2012-2013 Prescription Drug Monitoring Program Annual Report, Dec. 1, 2013, available at www.floridahealth.gov/reports-and-data/e-forcse/news-reports/_documents/2012-2013pdmp-annual-report.pdf (last visited March 17, 2017).
[19] *Supra* note 5 at p. 10.
[20] *Id.* at p. 10, 18.
[21] *Id.* at p. 14.
[22] *Id.* at p. 18.

- A law enforcement agency during active investigations regarding potential criminal activity, fraud, or theft regarding prescribed controlled substances; and
- A patient or the legal guardian or designated health care surrogate of an incapacitated patient, for verifying the accuracy of database information.[23]

Entities with indirect access to the PDMP database may request information from the PDMP program manager that is otherwise confidential and exempt from public disclosure under s. 893.0551, F.S.[24] Prior to release, the PDMP program manager must verify that the request is authentic and authorized with the requesting organization.[25]

*Public Records Exemption for Information in the PDMP Database*

Section 893.0551, F.S.,[26] provides that personal information of a patient and certain information concerning health care practitioners contained in the PDMP database are confidential and exempt from s. 119.07(1), F.S., and article I, section 24 of the Florida Constitution.[27] The statute makes confidential and exempt identifying information, including, but not limited to, the name, address, telephone number, insurance plan number, government-issued identification number, provider number, Drug Enforcement Administration number, or any other unique identifying number of a patient, patient's agent, health care practitioner or practitioner as defined in s. 893.055, F.S., or an employee of the practitioner who is acting on behalf of and at the direction of the practitioner, a pharmacist, or a pharmacy, which is contained in the PDMP database.

Any agency or person that obtains information pursuant to s. 893.0551, F.S., must maintain the confidential and exempt status of that information.[28]

**Effect of Proposed Changes**

Beginning January 1, 2018, CS/HB 557 reduces the amount of time a pharmacy or dispenser has to report the dispensing of a controlled substance to the PDMP database from seven days after the controlled substance is dispensed to no later than the end of the next business day after the controlled substance is dispensed.

The bill requires the controlled substance reporting by pharmacies or dispensers to be done via the department-approved electronic system, and eliminates the authority of the department to approve other methods of submission, such as submission by disc or by regular mail.

The bill clarifies that the exemption to the reporting required under this section provided to a rehabilitation hospital, assisted living facility, or nursing homes, applies only while the patient is present and receiving care as ordered by the patient's treating physician.

The bill authorizes employees of the U.S. Department of Veterans' Affairs (VA) who provide health care services and have authority to prescribe controlled substances to access the PDMP database in a manner prescribed by DOH. The access is limited to information related to the patient of authorized VA employee and may only be accessed to review such patient's controlled substance prescription history.

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

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[23] Section 893.055(7)(c), F.S.
[24] *Id.*
[25] *Id.*
[26] The public records exemption was established in 2009 in conjunction with the PDMP. See s. 1, ch. 2009-197, Laws of Fla. Additionally, the public records exemption was reauthorized in 2014. See .s 1 ch. 2014-156, Laws of Fla.
[27] Section 893.0551(2), F.S.
[28] Section 893.0551(6), F.S. However, a law enforcement agency with lawful access to such information is permitted to disclose confidential and exempt information received from DOH to a criminal justice agency as part of an active investigation of a specific violation of law. Section 893.0551(4).

B. SECTION DIRECTORY:

**Section 1:** Amends s. 893.055, F.S., relating to prescription drug monitoring program.
**Section 2**: Provides an effective date for a specific requirement of the bill.
**Section 3:** Provides an effective date of July 1, 2017.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH may incur insignificant costs associated with rulemaking to amend current rules to align with the statutory changes proposed by the bill. Current budget authority is adequate to absorb such costs.[29]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A pharmacy or dispenser may incur additional costs associated with meeting the new requirement to report the dispensing of a controlled substance by the end of the next business day.

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.

[29] Department of Health, *2017 Agency Legislative Bill Analysis: House Bill 557*, January 27, 2017, (on file with the Health Quality Subcommittee).

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 22, 2017, the Health Quality Subcommittee adopted an amendment that:

- Requires a dispenser to report to the PDMP by the end of the next business day after the controlled substance is dispensed, rather than 24 hours;
- Requires the submission of reports to be made via the electronic system approved by the DOH, rather than via the internet; and
- Authorizes certain health care employees of the U.S. Department of Veterans' Affairs to access the PDMP in limited circumstances and for limited purposes.

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 the prescription drug monitoring program; amending s. 893.055, F.S.; revising requirements for reporting the dispensing of controlled substances; limiting an exception to reporting requirements for certain facilities dispensing controlled substances; authorizing certain employees of the United States Department of Veterans Affairs access to certain information in the prescription drug monitoring program's database; specifying when a revised reporting requirement takes effect; providing an effective date.

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

Section 1. Subsection (4), paragraph (g) of subsection (5), and paragraphs (a) and (b) of subsection (7) of section 893.055, Florida Statutes, are amended to read:

893.055 Prescription drug monitoring program.—

(4) Each time a controlled substance is dispensed to an individual, the controlled substance shall be reported to the department through the system as soon thereafter as possible, but no later than the close of the next business day ~~not more than 7 days~~ after the day ~~date~~ the controlled substance is dispensed unless an extension is approved by the department for

cause as determined by rule. A dispenser must meet the reporting requirements of this section by submitting via the department-approved electronic system ~~providing~~ the required information concerning each controlled substance that it dispensed ~~in a department-approved, secure methodology and format. Such approved formats may include, but are not limited to, submission via the Internet, on a disc, or by use of regular mail~~.

(5) When the following acts of dispensing or administering occur, the following are exempt from reporting under this section for that specific act of dispensing or administration:

(g) A rehabilitative hospital, assisted living facility, or nursing home dispensing a certain dosage of a controlled substance, as needed, to a patient while the patient is present and receiving care as ordered by the patient's treating physician.

(7)(a) A practitioner or pharmacist who dispenses a controlled substance must submit the information required by this section in an electronic ~~or other~~ method in an ASAP format approved by rule of the department unless otherwise provided in this section. The cost to the dispenser in submitting the information required by this section may not be material or extraordinary. Costs not considered to be material or extraordinary include, but are not limited to, regular postage, electronic media, regular electronic mail, and facsimile charges.

(b) A pharmacy, prescriber, or dispenser, or the designee of a pharmacy, prescriber, or dispenser, shall have access to information in the prescription drug monitoring program's database which relates to a patient of that pharmacy, prescriber, or dispenser in a manner established by the department as needed for the purpose of reviewing the patient's controlled substance prescription history. An employee of the United States Department of Veterans Affairs who provides health care services pursuant to such employment and has the authority to prescribe controlled substances shall have access to the information in the program's database in a manner established by the department. Such access is limited to the information that relates to a patient of such employee and may only be accessed for the purpose of reviewing the patient's controlled substance prescription history. Other access to the program's database shall be limited to the program's manager and to the designated program and support staff, who may act only at the direction of the program manager or, in the absence of the program manager, as authorized. Access by the program manager or such designated staff is for prescription drug program management only or for management of the program's database and its system in support of the requirements of this section and in furtherance of the prescription drug monitoring program. Confidential and exempt information in the database shall be released only as provided in paragraph (c) and s. 893.0551. The program manager,

designated program and support staff who act at the direction of or in the absence of the program manager, and any individual who has similar access regarding the management of the database from the prescription drug monitoring program shall submit fingerprints to the department for background screening. The department shall follow the procedure established by the Department of Law Enforcement to request a statewide criminal history record check and to request that the Department of Law Enforcement forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check.

Section 2. The requirement that the dispensing of a controlled substance be reported to the Department of Health no later than the next business day in s. 893.055(4), Florida Statutes, as amended by this act, shall take effect January 1, 2018.

Section 3. This act shall take effect July 1, 2017.

Amendment No.

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Pigman offered the following:

**Amendment (with title amendment)**

Between lines 15 and 16, insert:

Section 2. Paragraphs (a), (b), (c), (d), (e), (f), and (g) of subsection (1) of section 456.44, Florida Statutes, are redesignated as paragraphs (b), (c), (d), (e), (f), (g), and (h), respectively, and paragraph (a) is added to that subsection, and subsection (4) is added to that section to read:

456.44 Controlled substance prescribing.—

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

(a) "Acute pain" means the normal, predicted, physiological and time-limited response to an adverse chemical,

thermal, or mechanical stimulus associated with surgery, trauma, or acute illness.

(4) For the initial prescription of opioids for the treatment or alleviation of acute pain, the prescription must be limited to a quantity not to exceed 5 days.

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

Remove lines 2-3 and insert:

An act relating to controlled substance prescribing; amending s. 456.44, F.S.; defining acute pain; limiting prescribing in certain circumstances; amending s. 893.055, F.S.; revising

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 577 Discount Plan Organizations
**SPONSOR(S):** Health Innovation Subcommittee; Pigman
**TIED BILLS:** **IDEN./SIM. BILLS:** CS/SB 430

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Innovation Subcommittee | 13 Y, 0 N, As CS | Tuszynski | Poche |
| 2) Insurance & Banking Subcommittee | 15 Y, 0 N | Peterson | Luczynski |
| 3) Health & Human Services Committee | | Tuszynski TT | Calamas CC |

## SUMMARY ANALYSIS

Regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR), within the Department of Financial Services (DFS), regulates insurers and other risk bearing entities under the Insurance Code.

Discount Medical Plan Organizations (DMPOs) offer discount medical plans, in exchange for fees, dues, charges, or other consideration, which provide access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. Discount medical plans are not considered insurance under ch. 627, F.S., health maintenance organizations under chapter 641, F.S., or prepaid limited health plans under part I of ch. 636, F.S. The Legislature established the regulatory scheme for DMPOs in 2004, which includes licensure, forms and rate filings and approval, disclosure requirements, and penalties.

The bill renames a "Discount Medical Plan" and a "Discount Medical Plan Organization" a "Discount Plan" and a "Discount Plan Organization" (DPO), and clarifies the definition of a "Discount Plan" to exclude any plan that does not charge a fee to members. The bill removes all rate and form filing and approval requirements for DPOs. To increase flexibility in marketing and reduce administrative barriers on DPOs, the bill:

- Defines "first page", upon which certain disclosures must appear, to mean the first page of any marketing material that first includes information describing benefits;
- Allows DPOs to delegate functions to marketers and binds DPOs to the actions of those marketers within the scope of the delegation; and
- Allows marketers and DPOs to commingle certain information on forms, advertisements, marketing materials, or brochures.

To maintain consumer protections for potential members and members of Discount Plans, the bill:

- Changes the disclosure requirements by requiring acknowledgement and acceptance of the disclosures before enrollment and creating visibility and follow up requirements for disclosures made by electronic means or telephone;
- Requires third-party entities that enter into contracts with providers to administer or provide a Discount Plan platform to providers' patients to be licensed as a DPO; and
- Establishes new cancellation and reimbursement requirements for DPOs to disallow any charges beyond the effective cancellation date, require pro rata reimbursement of charges paid by a member for the months beyond the effective cancellation date, and require pro rata reimbursement for members who cancel during an open enrollment period, upon return of his or her discount card.

The bill also makes extensive conforming changes to the chapter to reflect the new names.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of upon becoming law.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Office of Insurance Regulation

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR), within the Department of Financial Services (DFS), regulates insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Insurance Code (Code).[1]

All persons who transact insurance in the state must comply with the Insurance Code.[2] OIR has the power to collect, propose, publish, and disseminate any information relating to the subject matter of the Code,[3] and may investigate any matter relating to insurance.[4] The specific chapters that comprise the Code are:

Chapter 624, F.S. – Insurance Code: Administration and General Provisions
Chapter 625, F.S. – Accounting, Investments, and Deposits by Insurers
Chapter 626, F.S. – Insurance Field Representatives and Operations
Chapter 627, F.S. – Insurance Rates and Contracts
Chapter 628, F.S. – Stock and Mutual Insurers; Holding Companies
Chapter 629, F.S. – Reciprocal Insurers
Chapter 630, F.S. – Alien Insurers: Trusteed Assets; Domestication
Chapter 631, F.S. – Insurer Insolvency; Guaranty of Payment
Chapter 632, F.S. – Fraternal Benefit Societies
Chapter 634, F.S. – Warranty Associations
Chapter 635, F.S. – Mortgage Guaranty Insurance
Chapter 636, F.S. – Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations
Chapter 641, F.S. – Health Care Service Programs
Chapter 648, F.S. – Bail Bond Agents
Chapter 651, F.S. – Continuing Care Contracts

Discount Medical Plans and Organizations

Discount Medical Plan Organizations (DMPOs)[5] offer Discount Medical Plans,[6] in exchange for fees, dues, charges, or other consideration, which provide access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. For example, a member might pay a DMPO a monthly fee of $25 to access a network of providers who have contracted with the DMPO to offer discounts on certain procedures; the member chooses one of these contracted providers and has a $500 procedure done for $425, which is the 15 percent discounted rate provided in the plan.

[1] S. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[2] S. 624.11, F.S.
[3] S. 624.307(4), F.S.
[4] S. 624.307(3), F.S.
[5] S. 636.202(2), F.S.
[6] S. 636.202(1), F.S.

Discount Medical Plans are not considered insurance under chapter 627, F.S., health maintenance organizations under chapter 641, F.S., or prepaid limited health plans under part I of chapter 636, F.S.[7]

*Regulation of DMPOs*

The Legislature established the regulatory scheme for DMPOs in 2004, creating part II of ch. 636, F.S., titled "Discount Medical Plan Organizations."[8] Regulation of DMPOs involves licensure, form and rate filings and approval, procedures for examinations and investigations by OIR, prohibited activities, required disclosures to plan members, tracking of providers, annual report filing, minimum capital requirements, a process for suspension and revocation of licenses, and other penalties.[9]

To obtain a license, a prospective DMPO must file an application with OIR for approval and pay a $50 licensure fee.[10] The application must include corporate formation documents, a copy of the form of all contracts for the provision of services, financial statements, and other information OIR may reasonably require.[11] If approved, OIR must issue a license for 1 year, and each year thereafter the DMPO must renew its license and pay a $50 fee.[12] The statute exempts from DMPO licensure requirements a provider who provides discounts to his or her own patients, such as a dentist who discounts routine procedures for current active patients.[13]

A DMPO must file all charges to members with OIR, and any charge to members that is more than $30 per month or $360 per year must be approved by OIR.[14] A DMPO is also required to file and get approval by OIR for all forms, including advertisements, marketing materials, and brochures, before using them.[15] DMPOs must make the following disclosures on the first page, written in 12-point font, of any advertisement, marketing material, and brochure, to any prospective member:[16]

- The plan is not insurance.
- The plan provides discounts at certain health care providers for medical services.
- The plan does not make payments directly to the providers of medical services.
- The plan member is obligated to pay for all health care services but will receive a discount from those providers who have contracted with the DMPO.
- The name and address of the licensed DMPO.

If a member cancels his or her membership in a plan within the first 30 days of the effective date of enrollment, the DMPO must reimburse all periodic charges upon return of the discount card to the DMPO and any portion of a one-time processing fee in excess of $30.[17] If a DMPO fails to comply with the provisions of part II of ch. 636, F.S., OIR may levy administrative penalties of $100 per violation, not to exceed $75,000 in aggregate,[18] or $500 per day for the first 10 days and $1,000 for each day after the 10th day for failure to file the required annual report.[19] OIR may also suspend a DMPO's authority to enroll new members, or revoke a DMPO's license.[20]

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[7] Id.
[8] Ch. 2004-297, Laws of Fla.
[9] Part II of Ch. 636, F.S.
[10] S. 636.204(2) and (5), F.S.
[11] S. 636.204(2)(a),(b),(c),(f),(i), and (m), F.S.
[12] S. 636.204(3), F.S.
[13] S. 636.204(6), F.S.
[14] S. 636.216(1), F.S.
[15] Ss. 636.216(3) and 228(1), F.S.
[16] S. 636.212, F.S.
[17] S. 636.208, F.S.
[18] S. 636.223, F.S.
[19] S. 636.218, F.S.
[20] S. 636.222, F.S.

*Complaints against DMPOs*

From January 2014 through December 2016, there were 35 complaints filed against DMPOs.[21] The majority of these complaints concerned refunds after cancellation of a plan, confusion regarding the difference in insurance and a Discount Medical Plan, and provider network adequacy.[22]

**Effect of the Bill**

The bill renames a "Discount Medical Plan" and a "Discount Medical Plan Organization" to a "Discount Plan" and a "Discount Plan Organization" (DPO). Plans may use the old plan and organization monikers until June 30, 2018, allowing such plans and organizations enough time to make changes to plan and marketing materials. The bill clarifies the definition of a "Discount Plan" to exclude from licensure requirements any plan that does not charge a fee to its members. The bill also requires third-party entities that enter contracts with providers to administer or provide a Discount Plan platform to providers' patients to be licensed as a DPO.

The bill eliminates all required form filing and approval by OIR for DPOs, repeals the requirement for DPOs to file all member charges with OIR, and removes the requirement that all charges greater than $30 per month or $360 per year be approved by OIR. These changes will remove administrative burdens on DPOs and OIR relating to form and rate filing. Removing the requirement for the approval of charges over a certain amount by OIR will further reduce administrative burdens and introduce a free-market approach to the determination of charges for Discount Plan products.

The bill makes changes to the disclosure requirements of DPOs. The bill:

- Defines "first page," upon which the disclosures must appear, to be the page of any advertisement, marketing material, or brochure that first includes information describing benefits.
- Requires a DPO or a DPO's marketer to provide the required disclosures to a prospective member and require the member to acknowledge and accept the disclosures before enrolling. This protects members by requiring that the prospective member must affirmatively acknowledge and accept the required disclosures before enrolling in a Discount Plan.
- Requires disclosures made by electronic means to include the required disclosures and to be presented in a readable font size and color.
- Requires disclosures made by telephone to include all required disclosures, and to be followed up with written disclosures provided to the member.
- Allows additional disclosures beyond the statutory requirement.

These changes in disclosure requirements allow DPOs more flexibility in the design and presentation of advertising and marketing materials. The changes maintain consumer protections by requiring acknowledgment and acceptance of the disclosures before allowing enrollment and requiring visibility and follow-up requirements for disclosures made by electronic means or telephone.

The bill creates further consumer protections by establishing new requirements for cancellation and reimbursement after cancellation of Discount Plans. Under these new requirements, DPOs must:

- Cancel a membership on or before 30 days after receipt of a request to cancel;
- Refrain from charging a member any fee after the effective date of cancellation;
- Provide pro rata reimbursement of periodic charges to a member after cancellation of his or her membership;

[21] Email from Elizabeth Boyd, Legislative Affairs Director, Office of Chief Financial Officer, FW: DMPO Complaints, (Feb. 13, 2017).
[22] Redacted Consumer Requests for Assistance from the Department of Financial Services (on file with Health Innovation Subcommittee staff).

- Provide pro rata reimbursement of all periodic charges for a member who cancels his or her membership, consistent with open enrollment rules established by an employer or association, upon return of the discount card to the DPO; and
- Maintain an accurate record of each member in a form accessible to OIR for the duration of the agreement and for 5 years thereafter, to include membership materials provided, the discount plan issued, and charges billed and paid.

The bill changes how Discount Plans can be marketed. The bill explicitly allows a DPO to delegate functions to a marketer and states the DPO will be bound to the actions of marketers within the scope of that delegation which do not comply with statute. The bill also allows a marketer or Discount Plan Organization selling a Discount Plan with medical services and other services to commingle those products on a single page of forms, advertisements, marketing materials, or brochures. This change allows DPOs and Discount Plan marketers to offer multiple products within one form or on the same marketing materials, further reducing administrative burdens on DPOs.

The bill makes extensive conforming changes to the chapter to reflect the new names.

The bill is effective upon becoming a law.

B. SECTION DIRECTORY:

**Section 1:** Retitles chapter 636, F.S., from "Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations" to "Prepaid Limited Health Service Organizations and Discount Plan Organizations."
**Section 2:** Retitles part II of chapter 636, F.S., from "Discount Medical Plan Organizations" to "Discount Plan Organizations."
**Section 3:** Amends s. 636.202, F.S., relating to definitions.
**Section 4:** Amends s. 636.204, F.S., relating to license required.
**Section 5:** Amends s. 636.206, F.S., relating to examinations and investigations.
**Section 6:** Amends s. 636.208, F.S., relating to fees; charges; reimbursement.
**Section 7:** Amends s. 636.212, F.S., relating to disclosures.
**Section 8:** Amends s. 636.214, F.S., relating to provider agreements.
**Section 9:** Amends s. 636.216, F.S., relating to form filings.
**Section 10:** Amends s. 636.228, F.S., relating to marketing of discount medical plans.
**Section 11:** Amends s. 636.230, F.S., relating to bundling discount medical plans with other products.
**Section 12:** Amends s. 636.232, F.S., relating to rules.
**Section 13:** Amends s. 408.9091, F.S., relating to Cover Florida Health Care Access Program.
**Section 14:** Amends s. 408.910, F.S., relating to Florida Health Choices Program.
**Section 15:** Amends s. 627.64731, F.S., relating to leasing, renting, or granting access to participating provider.
**Section 16:** Amends s. 636.003, F.S., relating to definitions.
**Section 17:** Amends s. 636.205, F.S., relating to issuance of license; denial.
**Section 18:** Amends s. 636.207, F.S., relating to applicability of part.
**Section 19:** Amends s. 636.210, F.S., relating to prohibited activities of a discount medical plan organization.
**Section 20:** Amends s. 636.218, F.S., relating to annual reports.
**Section 21:** Amends s. 636.220, F.S., relating to minimum capital requirements.
**Section 22:** Amends s. 636.222, F.S., relating to suspension or revocation of license; suspension of enrollment of new members; terms of suspension.
**Section 23:** Amends s. 636.223, F.S., relating to administrative penalty.
**Section 24:** Amends s. 636.224, F.S., relating to notice of change of name or address of discount medical plan organization.
**Section 25:** Amends s. 636.226, F.S., relating to provider name listing.

**Section 26:** Amends s. 636.234, F.S., relating to service of process on a discount medical plan organization.
**Section 27:** Amends s. 636.236, F.S., relating to surety bond or security deposit.
**Section 28:** Amends s. 636.238, F.S., relating to penalties for violation of this part.
**Section 29:** Amends s. 636.240, F.S., relating to injunctions.
**Section 30:** Amends s. 636.244, F.S., relating to unlicensed discount medical plan organizations.
**Section 31:** Provides an effective date of upon becoming a law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   OIR may realize a decrease in regulatory workload due to removal of the rate and form filing and approval requirement for Discount Plans and removal of the approval requirement for Discount Plan charges above $30 per month or $360 per year.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

DPOs should realize administrative efficiencies from the elimination of several filing requirements and other regulations. DPOs may be more likely to charge more than $30 per month or $360 per year, since OIR approval is no longer required.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 7, 2017, the Health Innovation Subcommittee adopted one amendment to HB 577. The amendment:

- Removed the requirement that providers offering discounted services to their own patients for a fee to obtain and maintain a DPO license;
- Required a third-party entity that contracts with a provider to administer or provide a Discount Plan platform for the provider's patients to be licensed as a DPO;
- Restructured and clarified language regarding disclosures in Discount Plans to require:
  - A DPO or marketer to provide the required disclosures to a prospective member and require the member to acknowledge and accept the disclosures before enrolling;
  - Disclosures made by electronic means to include the required disclosures and to use a readable font size and color; and
  - Disclosures made by telephone to include all required disclosures, and to be followed up with written disclosures provided to the member.
- Eliminated form filing with and approval by OIR for DPOs;
- Required a DPO to maintain accurate records of each member in a form accessible by OIR for the duration of the agreement and for 5 years thereafter, to include membership materials provided, the discount plan issued, and charges billed and paid;
- Created new reimbursement rules that require a DPO to:
  - Cancel a membership on or before 30 days after receipt of a request to cancel;
  - Refrain from charging a member any fee after the effective date of cancellation;
  - Provide pro rata reimbursement of periodic charges to a member after cancellation of his or her membership; and
  - Provide pro rata reimbursement of all periodic charges for a member who cancels his or her membership, consistent with open enrollment rules established by an employer or association, upon return of the discount card to the DPO.

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 discount plan organizations; revising the titles of ch. 636, F.S., and part II of ch. 636, F.S.; amending s. 636.202, F.S.; revising definitions; amending s. 636.204, F.S.; conforming provisions to changes made by the act; providing an exception for providers under certain circumstances; amending s. 636.206, F.S.; conforming provisions to changes made by the act; providing record keeping requirements for discount plan organizations; amending s. 636.208, F.S.; conforming provisions to changes made by the act; revising a specified condition for a member to receive a reimbursement of certain charges after cancelling a membership in a discount plan organization; amending s. 636.212, F.S.; requiring discount plan organizations or marketers to provide prospective members with certain disclosures; requiring prospective members to acknowledge the receipt and acceptance of such disclosures before enrolling in a discount plan; specifying what a first page is for the purpose of a disclosure requirement on certain materials relating to a discount plan; providing requirements for disclosures made in writing, by electronic means, and by telephone; amending s. 636.214, F.S.; making a technical change;

conforming provisions to changes made by the act; amending s. 636.216, F.S.; deleting provisions relating to requirements to file with and obtain approval from the Department of Financial Services of certain charges and forms; conforming provisions to changes made by the act; amending s. 636.228, F.S.; conforming provisions to changes made by the act; authorizing a discount plan organization to delegate functions to its marketers; providing that the discount plan organization is bound to acts of its marketers within the scope of delegation; amending s. 636.230, F.S.; authorizing a marketer or discount plan organization to commingle certain products on a single page of certain documents; deleting a requirement for discount medical plan fees to be provided in writing under certain circumstances; amending s. 636.232, F.S.; revising the authority for the Financial Services Commission to adopt rules; amending ss. 408.9091, 408.910, 627.64731, 636.003, 636.205, 636.207, 636.210, 636.218, 636.220, 636.222, 636.223, 636.224, 636.226, 636.234, 636.236, 636.238, 636.240, and 636.244, 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. Chapter 636, Florida Statutes, entitled "Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations," is retitled "Prepaid Limited Health Service Organizations and Discount Plan Organizations."

Section 2. Part II of chapter 636, Florida Statutes, entitled "Discount Medical Plan Organizations," is retitled "Discount Plan Organizations."

Section 3. Section 636.202, Florida Statutes, is amended to read:

636.202 Definitions.—As used in this part, the term:

(1) "Discount ~~medical~~ plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term ~~"discount medical plan"~~ does not include any product regulated under chapter 627, chapter 641, or part I of this chapter;~~, or~~ any medical services provided through a telecommunications medium that does not offer a discount to the plan member for those medical services; or any plan that does not charge a fee to plan members. Until June 30, 2018, a discount plan may also be referred to as a discount medical plan.

(2) "Discount ~~medical~~ plan organization" means an entity

that ~~which~~, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. Until June 30, 2018, a discount plan organization may also be referred to as a discount medical plan organization.

(3) "Marketer" means a person or entity that ~~which~~ markets, promotes, sells, or distributes a discount ~~medical~~ plan, including a private label entity that ~~which~~ places its name on and markets or distributes a discount ~~medical~~ plan but does not operate a discount ~~medical~~ plan.

(4) "Medical services" means any care, service, or treatment of illness or dysfunction of, or injury to, the human body, including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, and medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions.

(5) "Member" means any person who pays fees, dues, charges, or other consideration for the right to receive the purported benefits of a discount ~~medical~~ plan.

(6) "Provider" means any person or institution that ~~which~~ is contracted, directly or indirectly, with a discount ~~medical~~

plan organization to provide medical services to members.

(7) "Provider network" means an entity that ~~which~~ negotiates on behalf of more than one provider with a discount ~~medical~~ plan organization to provide medical services to members.

Section 4. Subsections (1), (2), (4), and (6) of section 636.204, Florida Statutes, are amended to read:

636.204 License required.—

(1) Before doing business in this state as a discount ~~medical~~ plan organization, an entity must be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with chapter 605, part I of chapter 607, chapter 617, chapter 620, or chapter 865, and must be licensed by the office as a discount ~~medical~~ plan organization or be licensed by the office pursuant to chapter 624, part I of this chapter, or chapter 641.

(2) An application for a license to operate as a discount ~~medical~~ plan organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:

(a) A copy of the applicant's articles of incorporation or other organizing documents, including all amendments.

(b) A copy of the applicant's bylaws.

(c) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount ~~medical~~ plan organization, including any possible conflicts of interest.

(d) A complete biographical statement~~,~~ on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under paragraph (c).

(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.

(f) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members.

(g) A copy of the form of any contract made or arrangement

to be made between the applicant and any person listed in paragraph (c).

(h) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members.

(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may petition the office to accept, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.

(j) A description of the proposed method of marketing.

(k) A description of the subscriber complaint procedures to be established and maintained.

(l) The fee for issuance of a license.

(m) Such other information as the commission or office may reasonably require to make the determinations required by this

part.

(4) Before ~~Prior to~~ licensure by the office, each discount ~~medical~~ plan organization must establish an Internet website so as to conform to the requirements of s. 636.226.

(6) This part does not require ~~Nothing in this part requires~~ a provider who provides discounts to his or her own patients to obtain and maintain a license as a discount ~~medical~~ plan organization. If a provider contracts with a third-party entity to administer or provide a platform for a discount plan, the third-party entity must be licensed as a discount plan organization.

Section 5. Section 636.206, Florida Statutes, is amended to read:

636.206 Examinations and investigations.—

(1) The office may examine or investigate the business and affairs of any discount ~~medical~~ plan organization. The office may order any discount ~~medical~~ plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount ~~medical~~ plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting any examination or investigation must be paid by the discount ~~medical~~ plan organization or applicant. Examinations and investigations must be conducted as provided in chapter 624. For

the duration of the agreement with a member, and for 5 years thereafter, a discount plan organization must maintain an accurate record of each member, including the membership materials provided to the member, the discount plan issued to the member, and the charges billed and paid by the member, in a form accessible to the office during an examination or investigation.

(2) Failure by the discount ~~medical~~ plan organization to pay the expenses incurred under subsection (1) is grounds for denial or revocation.

Section 6. Section 636.208, Florida Statutes, is amended to read:

636.208 Fees; charges; reimbursement.—

(1) A discount ~~medical~~ plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount ~~medical~~ plan.

(2)(a) If the member cancels his or her membership in the discount ~~medical~~ plan organization within the first 30 days after the effective date of enrollment in the plan, the member shall receive a reimbursement of all periodic charges upon return of the discount card to the discount ~~medical~~ plan organization.

(b) If the member cancels his or her membership in the discount plan organization after the first 30 days, the discount plan organization:

1. Must cancel the membership on or before 30 days after receipt of the member's cancellation request.

2. May not charge the member any fees after the effective date of the cancellation of the membership.

3. Must provide a pro rata reimbursement of periodic charges made for months after cancellation date.

(c) If the member cancels his or her membership in the discount plan organization consistent with the open enrollment rules established by an employer or association for a plan having an open enrollment period, the member shall receive a pro rata reimbursement of all periodic charges upon return of the discount card to the discount plan organization.

(3) If the discount ~~medical~~ plan organization cancels a membership for any reason other than nonpayment of fees by the member, the discount ~~medical~~ plan organization must ~~shall~~ make a pro rata reimbursement of all periodic charges to the member.

(4) In addition to the reimbursement of periodic charges for the reasons stated in subsections (2) and (3), a discount ~~medical~~ plan organization shall also reimburse the member for any portion of a one-time processing fee that exceeds $30 per year.

Section 7. Section 636.212, Florida Statutes, is amended to read:

636.212 Disclosures.—A discount plan organization or marketer must provide disclosures to a prospective member and

the prospective member must acknowledge the acceptance of such disclosures before enrolling in a discount plan. A discount plan organization or marketer may make additional disclosures to those described in paragraph (1)(a). ~~The following disclosures must be made in writing to any prospective member and must be on the first page of any advertisements, marketing materials, or brochures relating to a discount medical plan. The disclosures must be printed in not less than 12-point type:~~

(1)(a) A disclosure must include:

1. That the plan is not insurance.

2.~~(2)~~ That the plan provides discounts at certain health care providers for medical services.

3.~~(3)~~ That the plan does not make payments directly to the providers of medical services.

4.~~(4)~~ That the plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization.

5.~~(5)~~ The name and address of the licensed discount ~~medical~~ plan organization.

(b) The first page of any written advertisements, marketing materials, or brochures relating to a discount plan must include the required disclosures in paragraph (a). The first page is the page that first includes the information that describes benefits of the discount plan. The disclosures must be

printed in not less than 12-point type.

(c) Disclosures provided by electronic means must include disclosures required in paragraph (a). The disclosures must be in a font size and color that is readable.

(d) Disclosures made by telephone must include the disclosures in paragraph (a) and the prospective or new member must be provided with written disclosures in accordance with paragraph (b) in the initial written materials provided.

~~If the initial contract is made by telephone, the disclosures required by this section shall be made orally and provided in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.~~

Section 8. Section 636.214, Florida Statutes, is amended to read:

636.214 Provider agreements.—

(1) All providers offering medical services to members under a discount ~~medical~~ plan must provide such services pursuant to a written agreement. The agreement may be entered into directly by the provider or by a provider network to which the provider belongs.

(2) A provider agreement between a discount ~~medical~~ plan organization and a provider must provide the following:

(a) A list of the services and products to be provided at

a discount.

(b) The amount or amounts of the discounts or, alternatively, a fee schedule which reflects the provider's discounted rates.

(c) A statement that the provider will not charge members more than the discounted rates.

(3) A provider agreement between a discount ~~medical~~ plan organization and a provider network must ~~shall~~ require that the provider network have written agreements with its providers which:

(a) Contain the terms described in subsection (2).

(b) Authorize the provider network to contract with the discount ~~medical~~ plan organization on behalf of the provider.

(c) Require the network to maintain an up-to-date list of its contracted providers and to provide that list on a monthly basis to the discount ~~medical~~ plan organization.

(4) The discount ~~medical~~ plan organization shall maintain a copy of each active provider agreement into which it has entered.

Section 9. Section 636.216, Florida Statutes, is amended to read:

636.216 Written agreement ~~Charge or Form filings~~.—

~~(1) All charges to members must be filed with the office and any charge to members greater than $30 per month or $360 per year must be approved by the office before the charges can be~~

~~used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.~~

~~(2)~~ There must be a written agreement between the discount ~~medical~~ plan organization and the member specifying the benefits under the discount ~~medical~~ plan and complying with the disclosure requirements of this part.

~~(3) All forms used, including The written agreement pursuant to subsection (2), must first be filed with and approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.~~

~~(4) A charge or form is considered approved on the 60th day after its date of filing unless it has been previously disapproved by the office. The office shall disapprove any form that does not meet the requirements of this part or that is unreasonable, discriminatory, misleading, or unfair. If such filings are disapproved, the office shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.~~

Section 10. Section 636.228, Florida Statutes, is amended to read:

636.228 Marketing of discount ~~medical~~ plans.—

(1) All advertisements, marketing materials, brochures, and discount cards used by marketers must be approved in writing

~~for such use~~ by the discount ~~medical~~ plan organization.

(2) The discount ~~medical~~ plan organization must ~~shall~~ have an executed written agreement with a marketer before ~~prior to~~ the marketer's marketing, promoting, selling, or distributing the discount ~~medical~~ plan. Such agreement must ~~shall~~ prohibit the marketer from using marketing materials, brochures, and discount cards without the approval in writing by the discount ~~medical~~ plan organization. The discount ~~medical~~ plan organization may delegate functions to its marketers but shall be bound by any acts of its marketers, within the scope of the delegation, which ~~marketers' agency, that~~ do not comply with ~~the provisions of~~ this part.

Section 11. Section 636.230, Florida Statutes, is amended to read:

636.230 Bundling discount ~~medical~~ plans with other products.—A marketer or discount plan organization selling a discount plan with medical services and other services may commingle those products on a single page of forms, advertisements, marketing materials, or brochures ~~When a marketer or discount medical plan organization sells a discount medical plan together with any other product, the fees for the discount medical plan must be provided in writing to the member if the fees exceed $30~~.

Section 12. Section 636.232, Florida Statutes, is amended to read:

636.232 Rules.—The commission may adopt rules to administer this part, including rules for the licensing of discount ~~medical~~ plan organizations; ~~establishing standards for evaluating forms, advertisements, marketing materials, brochures, and discount cards;~~ providing for the collection of data; relating to disclosures to plan members; and defining terms used in this part.

Section 13. Paragraph (b) of subsection (5) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—

(5) PLAN PROPOSALS.—The agency and the office shall announce, no later than July 1, 2008, an invitation to negotiate for Cover Florida plan entities to design a Cover Florida plan proposal in which benefits and premiums are specified.

(b) The agency and the office may announce an invitation to negotiate for the design of Cover Florida Plus products to companies that offer supplemental insurance, discount ~~medical~~ plan organizations licensed under part II of chapter 636, or prepaid health clinics licensed under part II of chapter 641.

Section 14. Paragraph (d) of subsection (2) and paragraph (d) of subsection (4) of section 408.910, Florida Statutes, are amended to read:

408.910 Florida Health Choices Program.—

(2) DEFINITIONS.—As used in this section, the term:

(d) "Insurer" means an entity licensed under chapter 624

which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, an exclusive provider organization as defined in s. 627.6472, ~~or~~ a health maintenance organization licensed under part I of chapter 641, or a prepaid limited health service organization or discount ~~medical~~ plan organization licensed under chapter 636.

(4) ELIGIBILITY AND PARTICIPATION.—Participation in the program is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(d) All eligible vendors who choose to participate and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health maintenance contracts, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid limited health service organizations may sell products and services as authorized under part I of chapter 636, and discount ~~medical~~ plan organizations may sell products and services as authorized under part II of chapter 636.

4. Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

5. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

7. Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

A vendor described in subparagraphs 3.-7. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation and is authorized to provide coverage in the relevant geographic area. Otherwise eligible vendors may be excluded from participating in the program for deceptive or

predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

Section 15. Subsection (11) of section 627.64731, Florida Statutes, is amended to read:

627.64731 Leasing, renting, or granting access to a participating provider.—

(11) This section does not apply to a contract between a contracting entity and a discount ~~medical~~ plan organization licensed or exempt under part II of chapter 636.

Section 16. Paragraph (c) of subsection (7) of section 636.003, Florida Statutes, is amended to read:

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

(7) "Prepaid limited health service organization" means any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. Prepaid limited health service organization does not include:

(c) Any person who is licensed pursuant to part II as a discount ~~medical~~ plan organization.

Section 17. Paragraphs (c) and (d) of subsection (1) of section 636.205, Florida Statutes, are amended to read:

636.205 Issuance of license; denial.—

(1) Following receipt of an application filed pursuant to

s. 636.204, the office shall review the application and notify the applicant of any deficiencies contained therein. The office shall issue a license to an applicant who has filed a completed application pursuant to s. 636.204 upon payment of the fees specified in s. 636.204 and upon the office being satisfied that the following conditions are met:

(c) The ownership, control, and management of the entity are competent and trustworthy and possess managerial experience that would make the proposed operation beneficial to the subscribers. The office may ~~shall~~ not grant or continue to grant authority to transact the business of a discount ~~medical~~ plan organization in this state at any time during which the office has good reason to believe that the ownership, control, or management of the organization includes any person whose business operations are or have been marked by business practices or conduct that is detrimental to the public, stockholders, investors, or creditors.

(d) The discount ~~medical~~ plan organization has a complaint procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

Section 18. Section 636.207, Florida Statutes, is amended to read:

636.207 Applicability of part.—Except as otherwise provided in this part, discount ~~medical~~ plan organizations are

governed by ~~the provisions of~~ this part and are exempt from the Florida Insurance Code unless specifically referenced.

Section 19. Section 636.210, Florida Statutes, is amended to read:

636.210 Prohibited activities of a discount ~~medical~~ plan organization.—

(1) A discount ~~medical~~ plan organization may not:

(a) Use in its advertisements, marketing material, brochures, and discount cards the term "insurance" except as otherwise provided in this part or as a disclaimer of any relationship between discount ~~medical~~ plan organization benefits and insurance;

(b) Use in its advertisements, marketing material, brochures, and discount cards the terms "health plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead a person into believing the discount ~~medical~~ plan was health insurance;

(c) Have restrictions on free access to plan providers, including, but not limited to, waiting periods and notification periods; or

(d) Pay providers any fees for medical services.

(2) A discount ~~medical~~ plan organization may not collect or accept money from a member for payment to a provider for

specific medical services furnished or to be furnished to the member unless the organization has an active certificate of authority from the office to act as an administrator.

Section 20. Subsection (1), paragraphs (b), (c), and (d) of subsection (2), and subsection (3) of section 636.218, Florida Statutes, are amended to read:

636.218 Annual reports.—

(1) Each discount ~~medical~~ plan organization shall ~~must~~ file with the office, within 3 months after the end of each fiscal year, an annual report.

(2) Such reports must be on forms prescribed by the commission and must include:

(b) If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount ~~medical~~ plan organization, including any possible conflicts of interest.

(c) The number of discount ~~medical~~ plan members in the state.

(d) Such other information relating to the performance of the discount ~~medical~~ plan organization as is reasonably required by the commission or office.

(3) Every discount ~~medical~~ plan organization that ~~which~~

fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

Section 21. Section 636.220, Florida Statutes, is amended to read:

636.220 Minimum capital requirements.—

(1) Each discount ~~medical~~ plan organization shall ~~must~~ at all times maintain a net worth of at least $150,000.

(2) The office may not issue a license unless the discount ~~medical~~ plan organization has a net worth of at least $150,000.

Section 22. Section 636.222, Florida Statutes, is amended to read:

636.222 Suspension or revocation of license; suspension of enrollment of new members; terms of suspension.—

(1) The office may suspend the authority of a discount ~~medical~~ plan organization to enroll new members, revoke any license issued to a discount ~~medical~~ plan organization, or order

compliance if the office finds that any of the following conditions exist:

(a) The organization is not operating in compliance with this part.

(b) The organization does not have the minimum net worth as required by this part.

(c) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising.

(d) The organization is not fulfilling its obligations as a ~~medical~~ discount ~~medical~~ plan organization.

(e) The continued operation of the organization would be hazardous to its members.

(2) If the office has cause to believe that grounds for the suspension or revocation of a license exist, the office must ~~shall~~ notify the discount ~~medical~~ plan organization in writing specifically stating the grounds for suspension or revocation and shall pursue a hearing on the matter in accordance with ~~the provisions of~~ chapter 120.

(3) When the license of a discount ~~medical~~ plan organization is surrendered or revoked, such organization must proceed, immediately following the effective date of the order of revocation, to wind up its affairs transacted under the

license. The organization may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

(4) The office shall, in its order suspending the authority of a discount ~~medical~~ plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the discount ~~medical~~ plan organization before ~~prior to~~ reinstatement of its license to enroll new members. The order of suspension is subject to rescission or modification by further order of the office before ~~prior to~~ the expiration of the suspension period. Reinstatement may not be made unless requested by the discount ~~medical~~ plan organization; however, the office may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

Section 23. Section 636.223, Florida Statutes, is amended to read:

636.223 Administrative penalty.—In lieu of suspending or revoking a certificate of authority whenever any discount ~~medical~~ plan organization has been found to have violated any provision of this part, the office may:

(1) Issue and cause to be served upon the organization charged with the violation a copy of such findings and an order requiring such organization to cease and desist from engaging in the act or practice that constitutes the violation.

(2) Impose a monetary penalty of not less than $100 for each violation, but not to exceed an aggregate penalty of $75,000.

Section 24. Section 636.224, Florida Statutes, is amended to read:

636.224 Notice of change of name or address of discount ~~medical~~ plan organization.—Each discount ~~medical~~ plan organization must provide the office at least 30 days' advance notice of any change in the discount ~~medical~~ plan organization's name, address, principal business address, or mailing address.

Section 25. Section 636.226, Florida Statutes, is amended to read:

636.226 Provider name listing.—Each discount ~~medical~~ plan organization must maintain on an Internet website an up-to-date list of the names and addresses of the providers with which it has contracted~~, on an Internet website page~~, the address of which must ~~shall~~ be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount ~~medical~~ plan organization has contracted directly, as well as those who are members of a provider network with which the discount ~~medical~~ plan organization has contracted.

Section 26. Section 636.234, Florida Statutes, is amended to read:

636.234 Service of process on a discount ~~medical~~ plan

organization.—Sections 624.422 and 624.423 apply to a discount ~~medical~~ plan organization as if the discount ~~medical~~ plan organization were an insurer.

Section 27. Section 636.236, Florida Statutes, is amended to read:

636.236 Surety bond or security deposit.—

(1) Each discount ~~medical~~ plan organization licensed pursuant to ~~the provisions of~~ this part shall ~~must~~ maintain in force a surety bond in its own name in an amount not less than $35,000 to be used at the discretion of the office to protect the financial interests of members who may be adversely affected by the insolvency of a discount ~~medical~~ plan organization. The bond must be issued by an insurance company that is licensed to do business in this state.

(2) In lieu of the bond specified in subsection (1), a licensed discount ~~medical~~ plan organization may deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52 having at all times a value of not less than $35,000. If a licensed discount ~~medical~~ plan organization substitutes its deposited securities under this subsection with a surety bond authorized in subsection (1), such deposited securities must ~~shall~~ be returned to the discount ~~medical~~ plan organization no later than 45 days following the effective date of the surety bond.

(3) A ~~No~~ judgment creditor or other claimant of a discount

~~medical~~ plan organization, other than the office or department, does not ~~shall~~ have the right to levy upon any of the assets or securities held in this state as a deposit under subsections (1) and (2).

Section 28. Subsections (2) and (3) of section 636.238, Florida Statutes, are amended to read:

636.238 Penalties for violation of this part.—

(2) A person who operates as or willfully aids and abets another operating as a discount ~~medical~~ plan organization in violation of s. 636.204(1) commits a felony punishable as provided for in s. 624.401(4)(b), as if the unlicensed discount ~~medical~~ plan organization were an unauthorized insurer, and the fees, dues, charges, or other consideration collected from the members by the unlicensed discount ~~medical~~ plan organization or marketer were insurance premium.

(3) A person who collects fees for purported membership in a discount ~~medical~~ plan but purposefully fails to provide the promised benefits commits a theft, punishable as provided in s. 812.014.

Section 29. Subsection (1) of section 636.240, Florida Statutes, is amended to read:

636.240 Injunctions.—

(1) In addition to the penalties and other enforcement provisions of this part, the office may seek both temporary and permanent injunctive relief when:

(a) A discount ~~medical~~ plan is being operated by any person or entity that is not licensed pursuant to this part.

(b) Any person, entity, or discount ~~medical~~ plan organization has engaged in any activity prohibited by this part or any rule adopted pursuant to this part.

Section 30. Section 636.244, Florida Statutes, is amended to read:

636.244 Unlicensed discount ~~medical~~ plan organizations.—Sections ~~The provisions of ss.~~ 626.901-626.912 apply to the activities of an unlicensed discount ~~medical~~ plan organization as if the unlicensed discount ~~medical~~ plan organization were an unauthorized insurer.

Section 31. This act shall take effect upon becoming a law.

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7073 PCB CFS 17-03 Ratification of Rules of the Department of Elder Affairs
**SPONSOR(S):** Children, Families & Seniors Subcommittee, Grant, M.
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 7020

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| Orig. Comm.: Children, Families & Seniors Subcommittee | 10 Y, 0 N | Langston | Brazzell |
| 1) Health & Human Services Committee | | Langston | Calamas |
| 2) Rules & Policy Committee | | | |

### SUMMARY ANALYSIS

PCB CFS 17-03 ratifies an adopted rule promulgated by the Department of Elder Affairs (DOEA) – rule 58M-2.009, F.A.C., titled "Standards of Practice for Professional Guardians" – so that the adopted rule may go into effect.

In 2016, the Legislature passed CS/SB 232 following reports of abuse and inappropriate behavior by professional guardians. The bill directed that the Statewide Public Guardianship Office be renamed the Office of Public and Professional Guardians (OPPG) and expanded the OPPG's oversight of professional guardians, including monitoring and discipline. To implement this new law, DOEA adopted Rule 58M-2.009, F.A.C., establishing standards of practice for professional guardians.

Section 120.54(3), F.S., requires that a rule whose statement of regulatory costs estimates an adverse economic impact exceeding $1 million over the first five years must be ratified by the Legislature before it may go into effect. The SERC that DOEA developed for the adopted rule estimates costs exceeding this threshold. This cost will be borne by wards to pay for the additional work guardians must do to meet requirements regarding fee approval and recordkeeping.

The scope of the bill is limited to this rulemaking procedure and does not adopt the substance of the rule into statute.

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

The bill is effective upon coming law.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Current Situation**

Rulemaking Authority and Legislative Ratification

A rule is an agency statement of general applicability that interprets, implements, or prescribes law or policy.[1] Rulemaking authority is delegated by the Legislature[2] through statute and authorizes an agency to "adopt, develop, establish, or otherwise create"[3] a rule.[4] To adopt a rule, an agency must have a general or specific grant of authority from the Legislature to implement a specific law through rulemaking.[5] The specific statute being interpreted or implemented through rulemaking must provide specific standards and guidelines to preclude the administrative agency from exercising unbridled discretion in creating policy or applying the law.[6]

The formal rulemaking process begins by an agency giving notice of the proposed rule.[7] The notice is published by the Department of State in the Florida Administrative Register.[8] The notice of the proposed rule must include:

- An explanation of the purpose and effect;
- The specific legal authority for the rule;
- The full text of the rule;
- A summary of the agency's statement of estimated regulatory costs, if one is prepared;
- Whether legislative ratification is required; and
- How a party may request a public hearing on the proposed rule.[9]

*Statement of Estimated Regulatory Costs (SERC)*

Agencies must prepare a SERC if the proposed rule will have a negative impact on small business or if the proposed rule is likely to directly or indirectly increase the total regulatory costs by more than $200,000, within one year of the rule's implementation.[10] The SERC must include an economic analysis projecting a proposed rule's adverse effect on specified aspects of the state's economy or increase in regulatory costs, including estimates of:

- The number of people and entities affected by the proposed rule;
- The cost to the governmental entities to implement and enforce the proposed rule;
- Transactional costs likely to be incurred by people, entities, and governmental agencies for compliance; and

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[1] S. 120.52(16), F.S.
[2] *Southwest Florida Water Management District v. Save the Manatee Club, Inc.,* 773 So. 2d 594 (Fla. 1st DCA 2000).
[3] S. 120.52(17), F.S.
[4] A rule is an agency statement of general applicability interpreting, implementing, or prescribing law or policy, including the procedure and practice requirements of an agency as well as certain types of forms. *See* s. 120.52(16), F.S., and *Florida Department of Financial Services v. Capital Collateral Regional Counsel-Middle Region,* 969 So. 2d 527, 530 (Fla. 1st DCA 2007).
[5] S.120.52(8), F.S., and s. 120.536(1), F.S.
[6] *Sloban v. Florida Board of Pharmacy,*982 So. 2d 26, 29-30 (Fla. 1st DCA 2008); *Board of Trustees of the Internal Improvement Trust Fund v. Day Cruise Association, Inc.,* 794 So. 2d 696, 704 (Fla. 1st DCA 2001).
[7] S. 120.54(3)(a)1, F.S..
[8] Ss. 120.54(3)(a)2., 120.55(1)(b)2, F.S.
[9] S. 120.54(3)(a)1., F.S.
[10] S. 120.54(1)(b), F.S.

- An analysis of the proposed rule's impact on small[11] businesses, counties, and cities.[12]

The SERC must analyze a rule's potential impact over the five year period from when the rule goes into effect. The economic analysis should show whether the rule, directly or indirectly is:

- Likely to have an adverse impact on economic growth, private-sector job creation or employment, or private-sector investment;
- Likely to have an adverse impact on business competitiveness,[13] productivity, or innovation; and
- Likely to increase regulatory costs, including any transactional costs.[14]

The law distinguishes between a rule being "adopted" and becoming enforceable or "effective."[15] A rule must be filed for adoption before it may go into effect and cannot be filed for adoption until completion of the rulemaking process.[16] A rule may be adopted but cannot go into effect until ratified by the Legislature if the analysis shows the projected impact of the proposed rule in any one of these areas will exceed $1 million in the aggregate for the five-year period.[17]

Regulation of Guardians

When an individual is unable to make legal decisions regarding his or her person or property, such as due to nonage, a developmental disability, mental illness, or dementia, the court may appoint a guardian to act on his or her behalf regarding his or her person or property or both.[18] Guardians are subject to the requirements of ch. 744, F.S. There are three main types of guardians: family or friends of the ward, professional guardians, and public guardians. The two types of guardians overseen by the Department of Elder Affairs (DOEA) are public and professional guardians. A professional guardian is a guardian who has at any time rendered services to three or more wards as their guardian; however, a person serving as a guardian for two or more relatives is not considered a professional guardian.[19]

In 2016, the Legislature passed and the Governor signed CS/SB 232 following reports of abuse and inappropriate behavior by professional guardians.[20] The bill directed that the Statewide Public Guardianship Office be renamed the Office of Public and Professional Guardians (OPPG) and

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[11] Section 120.541(2)(b)-(e), F.S. A small city has an unincarcerated population of 10,000 or less. A small county has an unincarcerated population of 75,000 or less. A small business employs less than 200 people, and has a net worth of $5 million or less. *See* ss. 120.52(18), (19), and 288.703(6), respectively.
[12] Section 120.541(2)(a), F.S.
[13] Including the ability of those doing business in Florida to compete with those doing business in other states or domestic markets.
[14] S. 120.541(2)(a), F.S.
[15] S. 120.54(3)(e)6., F.S. Before a rule becomes enforceable, thus "effective," the agency first must complete the rulemaking process and file the rule for adoption with the Department of State.
[16] S. 120.54(3)(e), F.S.
[17] S. 120.541(3), F.S.)
[18] S. 744.012(9), F.S.
[19] S. 744.012 F.S
[20] *See, e.g.*, Florida Supreme Court Commission on Fairness, Committee on Guardianship Monitoring, 2003, *available at* http://flcourts.org/core/fileparse.php/260/urlt/guardianshipmonitoring.pdf (last visited March 20, 2017) (reviewed how effectively guardians were fulfilling their duties and obligations. The committee received input from citizens that there was abuse, neglect, and misuse of ward's funds. As a result, the committee stated that, though the majority of guardians are law-abiding and are diligently fulfilling their complex responsibilities, a small percentage are not properly handling guardianship matters, and as a result, monitoring is necessary.); Department of Elder Affairs, Guardianship Task Force – 2004 Final Report, *available at* http://elderaffairs.state.fl.us/doea/pubguard/GTF2004FinalReport.pdf (last visited March 20, 2017) (advocated for additional oversight of professional guardians); Michael E. Miller, *Florida's Guardians Often Exploit the Vulnerable Residents They're Supposed to Protect*, MIAMI NEWTIMES, May 8, 2014, *available at* http://www.miaminewtimes.com/2014-05-08/news/florida-guardian-elderly-fraud/full/ (last visited March 9, 2017) (provided anecdotal evidence of fraud within the guardianship system, noting that the appointed court monitor for Broward County has uncovered hundreds of thousands of dollars that guardians have misappropriated from their wards, and, over the course of two years, Palm Beach County's guardianship fraud hotline has investigated over 100 cases; and Barbara Peters Smith, *the Kindness of Strangers – Inside Elder Guardianship in Florida,* SARASOTA HERALD-TRIBUNE, December 6, 2014, *available at* http://guardianship.heraldtribune.com/default.aspx (last visited March 20, 2017) (three-part series published in December 2014 details abuses occurring in guardianships based on an evaluation of guardianship court case files and interviews with wards, family and friends caught in the system against their will.).

expanded the OPPG's oversight of professional guardians, including monitoring and discipline. The bill directed DOEA to adopt rules relating to OPPG to establish standard of practice for public and professional guardians, receive and investigate complaints, establish procedures for disciplinary oversight, conduct hearings, take administrative action pursuant to ch. 120, F.S., and specify penalties for violations.

On October 18, 2016, DOEA published proposed rules including:[21]

- Rule 58M-2.001, F.A.C., Professional Guardian Registration;
- Rule 58M-2.009, F.A.C., Standards of Practice; and
- Rule 58M-2.011, F.A.C., Disciplinary Action and Guidelines.[22]

The rules were filed for adoption with the Secretary of State on February 9, 2017. Rules 58M-2.001 and 2.011, F.A.C. went into effect on March 1, 2017. However, due to the level of its projected impact, rule 58M-2.009, F.A.C., must be ratified by the Legislature before it may take effect.

Rule 58M-2.009, F.A.C., "Standards of Practice for Professional Guardians"

The standards of practice contained in rule 58M-2.009, F.A.C., include a variety of topics, including requirements pertaining to:

- The professional guardians' relationship with the courts, their wards, friends and family members of their wards, and other service providers;
- Decision making;
- Confidentiality;
- Record keeping;
- The professional guardians' duties and obligations to their wards; and
- The responsibilities of the professional guardian of the property.

DOEA determined that the main economic impact of rule 58M-2.009, F.A.C., was due to requirements that professional guardians receive court approval of their guardianship fees and through increased record keeping requirements that require the professional guardian to:

- Maintain written documentation of all reports from a ward's family, friends, medical service providers or other professionals relevant to a decision made on behalf of a ward (informed consent); and
- Develop a written plan setting forth short-term and long-term objectives for meeting the goals, needs, and preferences of the ward, and maintain the plan in a separate file for each ward, along with other specified documentation.[23]

To determine the economic impact of rule 58M-2.009, F.A.C., DOEA contacted all 506 registered professional guardians and requested their response to a survey to determine the economic impact of the proposed rule. The response rate was 21% (106 professional guardians).

*Increased Costs Related to Court Fees*

Rule 58M-2.009(22), F.A.C., requires all fees related to the duties of a professional guardian to be reviewed and approved by the court.

Of the 106 respondents to the survey, 97.1% indicated that receiving court approval of their guardianship fees is currently part of their standard practice and procedures.[24] The 2.9% of

[21] Notice of Proposed Rule (on file with Health and Human Services Committee staff).
[22] Id.
[23] Department of Elder Affairs, Statement of Estimated Regulatory Costs

respondents who stated that they do not seek court approval of their guardianship fees estimated an increase of one to two hours per ward annually would be necessary to meet the requirement.[25] Based on DOEA's assumptions,[26] it estimated that the requirement that professional guardians receive court approval of their guardianship fees will increase private sector costs $15,113 to $30,225 in the first year of implementation, and $83,505 to $167,011 over the first five years of implementation of the proposed rule.[27]

*Increased Costs Related to Record Keeping*

Rule 58M-2.009(6), F.A.C., requires professional guardians to make decisions on behalf of their wards based on informed consent; to that end, the professional guardian must maintain written documentation of all reports from a ward's family, friends, medical service providers, or other professionals relevant to a decision made on behalf of a ward.[28]

Of the respondents, 78% indicated that this requirement is consistent with their current practices.[29] The 22% of respondents stating they did not maintain this documentation estimated that an increase of between half an hour to eight hours per ward annually would be necessary to meet the requirement. DOEA estimated that the requirements for informed consent will increase private sector costs $187,785 to $381,420 in the first year of implementation, and $1,037,631 to $2,107,588 over the first five years of implementation of the proposed rule.

Rule 58M-2.009(13), F.A.C., requires professional guardians to develop a written plan setting forth short-term and long-term objectives for meeting the goals, needs, and preferences of the ward, and that the plan be maintained in a separate file for each ward, along with other enumerated documentation.

Of the respondents to the survey, 73% indicated that this requirement is consistent with their current practices.[30] The 27% of respondents stating they did not maintain this documentation estimated an increase of one to 15 hours per ward annually would be necessary to meet the requirement. DOEA estimated that the initial and ongoing responsibilities imposed on the professional guardians will increase private sector costs $274,901 to $582,673 in the first year of implementation, and $1,519,001 to $3,219,637 over the first five years of implementation of the proposed rule.

However, factors such as the difficulty of estimating the time necessary to comply with new requirements, variation in the annual rate of growth in the number of guardians, and differences in the number of wards served by new versus more experienced guardians could affect the SERC. Using different, more conservative assumptions, an alternate cost analysis resulted in a total cost of implementation of $1.5 million, which, while substantially less, still exceeds the threshold requiring legislative ratification of the proposed rule.[31]

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[24] Id. The high response rate can be explained in part by the statutory interpretation of s. 744.108, F.S., which has led many judicial circuits around the state to decree that the judicial approval of guardianship fees is required by statute.
[25] Id.
[26] DOEA estimated the average professional guardian hourly fee to be $65, the average caseload among professional guardians to be 15.5 wards, and projected annual increase in registered professional guardians of 5%.
[27] Id.
[28] While the proposed rule would require an expansion of reporting requirements for professional guardians, it is the responsibility of the professional guardian in statute to ensure that the ward is involved to the greatest extent possible with decision-making, including any previously executed advance directives.
[29] *Supra*, note 23.
[30] Id.
[31] These assumptions included: an annual rate of growth in the number of new guardians of 3%; that new guardians would have only 10 wards; that the new guardians would have had a compliance rate similar to existing guardians, and that guardians would need one hour less than the average estimate to comply with fee approval requirements and two hours less to comply with each recordkeeping requirement. (Analysis on file with Health and Human Services Committee staff).

**Effect of Proposed Changes**

PCB CFS 17-03 ratifies Rule 58M-2.009, F.A.C., Standards of Practice for Professional Guardians, solely to meet the condition for effectiveness imposed by s. 120.541(3), F.S. This means that the provisions of this rule will become binding on professional guardians. The bill expressly limits ratification to the effectiveness of the rule. The bill directs the act shall not be codified in the Florida Statutes; it will only be noted in the historical comments to the rule by the Department of State.

The bill is effective upon becoming law.

B. SECTION DIRECTORY:

**Section 1:** Ratifies Rule 58M-2.009, F.A.C.
**Section 2:** Provides that the act goes into effect upon becoming law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

*See*, section I.A., *infra.*

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill meets the final statutory requirement for DOEA to exercise its rulemaking authority concerning the standards of practice for professional guardians. No additional rulemaking authority is required.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the ratification of rules of the Department of Elder Affairs; ratifying a specific rule relating to the standards of practice for professional guardians for the sole and exclusive purpose of satisfying any condition on effectiveness pursuant to s. 120.541(3), F.S., which requires ratification of any rule exceeding the specified thresholds for likely adverse impact or increase in regulatory costs; providing applicability; providing an effective date.

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

Section 1. (1) The following rule is ratified for the sole and exclusive purpose of satisfying any condition on effectiveness imposed under s. 120.541(3), Florida Statutes: Rule 58M-2.009, Florida Administrative Code, titled "Standards of Practice for Professional Guardians" as filed for adoption with the Department of State pursuant to the certification package dated February 9, 2017.

(2) This act serves no other purpose and shall not be codified in the Florida Statutes. After this act becomes law, its enactment and effective dates shall be noted in the Florida Administrative Code, the Florida Administrative Register, or both, as appropriate. This act does not alter rulemaking

authority delegated by prior law, does not constitute legislative preemption of or exception to any provision of law governing adoption or enforcement of the rule cited, and is intended to preserve the status of any cited rule as a rule under chapter 120, Florida Statutes. This act does not cure any rulemaking defect or preempt any challenge based on a lack of authority or a violation of the legal requirements governing the adoption of any rule cited.

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