Health & Families Council

Thursday, April 20, 2006
2:45 PM – 4:45 PM
Reed Hall

Meeting Packet

Allan G. Bense
Speaker

Anna Holliday "Holly" Benson
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Health & Families Council

Start Date and Time:	Thursday, April 20, 2006 02:45 pm
End Date and Time:	Thursday, April 20, 2006 04:45 pm
Location:	Reed Hall (102 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 275 CS Motor Vehicle Insurance for Foster Children by Detert
HB 621 CS Fiscal Intermediary Services Organizations by Grimsley
HB 645 CS Nursing Home Facilities by Gelber
HB 675 CS Sale or Lease of a County, District, or Municipal Hospital by Pickens
HB 685 CS Veterinary Drug Distribution by Coley
HB 715 CS Trauma Services by Grimsley
HB 775 CS Psychology Specialties by Roberson
HB 819 CS Radiologist Assistants by Grant
HB 1033 CS Child Abuse by Vana
HB 1093 CS Physicians by Altman
HB 1231 CS Child Care by Ausley
HB 1247 CS Developmental Disabilities by Kravitz
HB 1319 CS Certification of Swimming Instructors by Goldstein
HB 1327 CS Transition Services for Adolescents and Young Adults with Disabilities by Davis, D.
HB 1365 CS Florida KidCare Program by Davis, M.
HB 1409 CS Florida Health Information Network, Inc. by Benson
HB 1451 CS Public Records by Gannon
HB 1623 CS (IF RECEIVED) -- Youth and Young Adults with Disabilities by Bean
HB 7139 CS Emergency Management by Health Care General Committee
HB 7203 CS Prevention of Obesity by Health Care Regulation Committee
HB 7215 (IF RECEIVED) -- Rural Health Care by Health Care Regulation Committee
HB 7217 Child Support by Future of Florida's Families Committee

Pursuant to Rule 7.22(c), amendments by non-appointed members must be filed by 5:00 p.m., Wednesday, April 19, 2006.

The Chair requests that members of the Council file amendments by 5:00 p.m., Wednesday, April 19, 2006.

NOTICE FINALIZED on 04/18/2006 16:21 by ISEMINGER.BOBBYE

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 275 CS Motor Vehicle Insurance for Foster Children
SPONSOR(S): Detert
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 220

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families Committee	6 Y, 0 N, w/CS	Preston	Collins
2) Insurance Committee	16 Y, 0 N	Cooper	Cooper
3) Health Care Appropriations Committee	15 Y, 0 N	Ekholm	Massengale
4) Health & Families Council		Preston	Moore
5)			

SUMMARY ANALYSIS

Currently, no state-funded program exists to help defray the increased insurance costs associated with foster children becoming licensed to drive.

The bill requires the Department of Children and Families (DCF or the department) to establish a three-year pilot program in Sarasota, DeSoto, Manatee, Pinellas, and Pasco counties to provide funds, to the extent that they are available, to reimburse foster parents, residential facilities, or foster children who live independently for a portion of the increase in the auto insurance premium that occurs when a foster child receives a driver's license and is added to an insurance policy. Through the pilot program, DCF will provide one-half of the amount of the increase, which is incurred as a result of adding the foster child to the motor vehicle insurance policy or less than one-half if another source of funding to pay for the increase is available. The bill provides that the foster child must be encouraged to pay the other half of the increase in insurance costs.

The bill requires the department to develop procedures for operating the pilot, to explore and use other options for funding the premium increase, and to submit an annual report to the Governor and the Legislature, with the first report due January 1, 2007.

The bill provides for a $150,000 appropriation from the General Revenue Fund to the department for implementation of the act for Fiscal Year 2006-2007.

The bill creates an undesignated section of Florida law and goes into effect July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—The bill creates a three-year pilot program. It requires the Department of Children and Families to develop procedures for implementing the pilot program, including the allocation of available funds to eligible recipients.

Safeguard individual liberty—The bill will provide financial assistance to offset a portion of the insurance premium increase that will enable some otherwise eligible foster youth to drive. This may increase the sense of independence of those youth and provide them with a greater ability to conduct their own affairs.

Promote personal responsibility—The bill requires that a foster child be encouraged to pay the remaining half of any increase in automobile insurance premium occurring as a result of being added to a policy upon receiving a driver's license. Paying for this remaining half will likely come from employment that the child would otherwise not have because he/she was not licensed to drive.

Empower families—The bill may enable some foster youth to drive, thus reducing demands on adult caregiver time and increasing the sense of responsibility and independence of the youth, both of which may serve to benefit the whole family unit.

B. EFFECT OF PROPOSED CHANGES:

Background

Young people in the foster care system often face barriers to participating in everyday life experiences common to others their age. These life experiences are important because they are a part of the process of preparing all children for the responsibilities they will assume as adults. The Florida State Youth Advisory Board has long identified the barriers to driving an automobile that are experienced by the children in Florida's foster care system as a concern. Department staff concur that children in foster care who are not able to learn or gain experience driving miss an important part of learning how to be independent, including being able to work.

Currently, Florida law requires every owner or person in charge of a motor vehicle that is operated or driven on the roads of the state to register the vehicle in this state. Florida law also requires every owner or registrant of a motor vehicle, other than a motor vehicle used as a taxicab, school bus or limousine, to be registered and licensed in this state to maintain security in effect continuously throughout the registration or licensing period. That security may be provided by an insurance policy delivered or issued for delivery in this state by an authorized or eligible motor vehicle liability insurer that provides statutorily prescribed benefits and exemptions. Proof that personal injury protection benefits have been purchased when required by statute, that property damage liability coverage has been purchased as required by statute, and that combined bodily liability and property damage liability insurance has been purchased when required by statute, shall be provided in the manner prescribed by law by the applicant at the time of application for registration of any motor vehicle owned. The issuing agent shall refuse to issue registration if such proof of purchase is not provided.[1]

A motor vehicle liability policy to be used as proof of financial responsibility shall be issued to owners or operators, and such policy shall designate all covered motor vehicles and shall insure the owner and any other person as operator, using such motor vehicle(s) with the express or implied permission of

[1] See: ss. 320.02 and 627.733, F.S.

such owner, against loss from the liability imposed by law for damage arising out of the ownership, maintenance, or use of such motor vehicle or motor vehicles.[2]

In addition, motor vehicle liability policies are typically rated by households and include all vehicles to be driven and all licensed drivers living within a household. Those rates assume that a licensed minor living in a household where there is an automobile and available key will be driving that vehicle. Therefore, the only way a foster parent's policy would not be subject to a rate increase when a foster child becomes old enough to drive would be to either allow the minor to obtain only a learner's driver's license or, if the foster child obtains a regular driver's license, to fail to mention to the insurance company that a licensed minor resides in the household and has access to a vehicle insured by the foster parent. Most insurers require a policyholder to report a new driver with a learner's permit residing in the household.

There are two significant obstacles that make it difficult for a foster child to obtain a driver's license. One is the high cost of obtaining auto insurance coverage for minors. The other is the unwillingness of the foster parent or the responsible adult to assume the joint and several liability for damages arising out of the negligence or willful misconduct of the foster child.

Addressing the Insurance Cost Obstacle

Inexperienced teenaged drivers statistically have more auto accidents than experienced adult drivers. Consequently, insurance rates are higher for teenagers, with the exact amount of an increase depending upon the type of auto insurance policy the family has, the type of car(s) the family owns, number of teenagers on the policy, the sex of the covered driver (teenage boys are more expensive to insure), and the location of the family within the state. Some insurance providers may offer discounts for students with better than average grades.

According to some proponents of this bill, there are foster parents or group home representatives willing to assume the liability risk of the foster child and sign the driver's license application, but the high cost of auto insurance coverage presents the greatest obstacle. This increased cost makes it difficult for the foster family to afford auto insurance for the foster child and difficult for the child to obtain his/her own personal auto insurance coverage.

In Florida, the average foster family receives from DCF $455 monthly per foster child aged 13 to 18. According to DCF, this amount has not increased since 2000. Given the cost of auto insurance, this amount is not nearly enough to cover all the costs associated with clothing and feeding a teenager, as well as covering the increased auto insurance costs associated with adding a foster teenager to the policy. The cost of a stand-alone auto insurance policy for a teenager is usually much higher than adding the child to the family policy.

In 2001, the Legislature enacted section 627.746, Florida Statutes, which barred insurance companies from raising the auto insurance rates of foster parents whose foster child obtained a learner's driver's license. However, this provision no longer applies once the foster child obtains a driver's license.

Addressing the Liability Obstacle

According to DCF, the main issue for many foster parents that keeps them from signing the foster child's driver's license application is not the increased cost, but the liability risk that they would assume as a result of signing the child's driver's license application.

Section 322.09, Florida Statutes, requires that when a youth applies for a driver's license, the application must be signed by a parent, guardian, or, when there is no parent or guardian, some other responsible adult. This same section provides that any negligence or willful misconduct of the youth

[2] See: s. 324.151, F.S.

operating a motor vehicle will be imputed to the adult who signed the application. That adult is jointly and severally liable with the youth for any damages caused by such negligent or willful misconduct.

In 2001, the Legislature partially addressed the issue of the liability assumed by signing the foster child's learner's driver's application. Previously, anyone signing the minor's application for a driver's license of any kind (learner's or otherwise) would assume joint and several liability for damages resulting from that minor's negligence or willful misconduct. Section 322.09(4), Florida Statutes, was amended and now provides that a foster parent who signs a learner's driver's license application does not assume liability for damages arising out of the negligence or willful misconduct of that foster child.

However, this liability protection does not extend to the signing of a foster child's driver's license application. A foster parent who signs the driver's license application remains liable for any damages caused by the negligence or willful misconduct of that minor and that liability continues even if that foster child no longer resides with that foster parent.

Proposed Changes

The obstacle of liability associated with signing the foster child's driver's license application does not appear to be addressed by the bill. This bill addresses the increased auto insurance cost obstacle by seeking to subsidize up to half of the increase in the foster family's auto insurance rates that result from adding the foster child to their policy providing that the foster child qualifies for the reimbursement program and someone assumes the risk associated with signing his/her driver's license application.

The bill creates an undesignated section within the Florida Statutes. It requires the Department of Children and Families to establish a three-year pilot program in Sarasota, DeSoto, Manatee, Pinellas, and Pasco Counties for the purpose of reimbursing foster parents, residential facilities, or foster children who live independently, for up to half of the increased auto insurance costs associated with adding a licensed foster child to the auto insurance policy. These reimbursements will come from funds made available by this bill.

To be eligible for reimbursement under the pilot program, the person incurring the cost must submit to DCF appropriate documentation demonstrating the increase in the cost of the insurance. The amount reimbursed will be up to half of that increased cost. The bill provides that the foster child must be encouraged to pay the other half of the increase in insurance cost.

This bill authorizes DCF to setup appropriate procedures to implement this three-year pilot program. The procedures will include, but not be limited to, determining eligibility criteria, providing payments, ensuring that payment is limited to half of the increase, and for allocating available funds to pay for eligible reimbursements. Payments are to be made to eligible persons in the order each is determined eligible until the funds are exhausted.

Available funds include the $150,000 allocated from the General Revenue Fund for the first year of the program, and from the foster children themselves. To the extent possible, DCF shall examine and use other available options for funding up to half the increased auto insurance cost. DCF may look into using funds from the child's master trust fund, social security income, child support payments, and other income that is available to the child.

According to the department, some children have received inheritances that have been placed into their master trust fund. Other children receive social security income, supplemental security income (for disabilities), and/or child support. The amount received each month above the $455 amount paid by the state for the maintenance of the foster child is deposited into the child's master trust fund. The master trust fund may be accessed by the child for specific purposes not covered by Medicaid (i.e., a mental health counselor believes the child needs a trip to Disney World) or for specific educational purposes (i.e., purchasing a computer).

This bill allows DCF to use these and other income sources available to the child in order to pay for half the cost of the auto insurance increase.

This bill requires DCF to report to the Governor and the Legislature about the success and outcome of the pilot program. Starting January 1, 2007, and each year of the program, the report will make a recommendation whether the program should be continued, terminated, or expanded.

C. SECTION DIRECTORY:

Section 1. Amends or creates an unspecified section within the Florida Statutes related to the establishment of a three-year pilot program by the Department of Children and Family Services to pay a portion of the cost associated with motor vehicle insurance for foster children.

Section 2. Provides for a $150,000 appropriation from the General Revenue Fund to the Department of Children and Family Services to implement the act in Fiscal Year 2006-2007 and specifies how the appropriation is to be allocated among the counties included in the pilot.

Section 3. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appropriates $150,000 from the General Revenue Fund to the Department of Children and Family Services for Fiscal Year 2006-2007.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent funding is available, foster parents and residential facilities in the pilot counties will be reimbursed for one-half of the increase in premiums for adding a foster child to their automobile insurance policy. Foster children living independently will also be eligible for reimbursement of half the cost of their automobile insurance policies. This reimbursement may allow more children to obtain insurance, to drive, and to become employed.

Additionally, community-based care providers who are under contract with DCF to provide foster care and related services have estimated the administrative costs associated with overseeing the pilot to be 8 percent. Since the bill specifies that the "payment is limited solely to the additional costs of including the foster child in the insurance policy," the administrative costs of the community based care providers do not appear to have been addressed.

D. FISCAL COMMENTS:

The department has estimated the number of children potentially eligible to receive this coverage in the five county pilot areas to be 278. However, the number of children who will actually participate in the program is estimated by DCF to be no more than 35 in 2006 and 45 in 2007.

Based on estimates supplied by DCF, the cost of insurance per year for an average teenager in the pilot areas would be approximately $2,000 annually.

If all the children identified as potentially eligible for this coverage were to receive it, DCF has estimated the annual cost to be in the range of $300,000. If only the estimated numbers actually expected to participate apply, the cost to provide 50 percent coverage ranges from $29,700 in Fiscal Year 2006-2007 to $53,460 in Fiscal Year 2008-2009. These cost estimates do not include any offsets from master trust funds, social security, or other sources of income. In developing these cost estimates, DCF has included an 8 percent administrative cost, which does not appear to be authorized by the language of the bill.

The department, in addition, will incur unspecified costs relating to the need for staff capacity to develop procedures, determine eligibility, develop payment and monitoring processes, and compile the results of the pilot for the annual report to the legislature.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On December 7, 2005, the Future of Florida's Families Committee adopted two amendments to the bill. The amendments:

- Increase the appropriation for the pilot from $50,000 to $150,000 and specify how the funding is to be allocated among the counties in the pilot.
- Provide that the department shall make payments to eligible persons in the order each is determined to be eligible until the funds have been exhausted.

As amended, the bill was reported favorably as a committee substitute.

CHAMBER ACTION

The Future of Florida's Families Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to motor vehicle insurance for foster children; creating a pilot program to reimburse foster parents, residential facilities, or foster children who live independently a portion of the increased costs of motor vehicle insurance for a foster child who has a driver's license; directing the Department of Children and Family Services to establish the pilot program in Sarasota, DeSoto, Manatee, Pinellas, and Pasco Counties; requiring that the person who incurs the increased cost submit to the department documentation of that increase; requiring that foster children be encouraged to pay the remaining portion of the increase in cost; directing the department to develop procedures for operating the pilot program; requiring the department to submit a report with recommendations to the Governor and the Legislature by a specified date each year of the pilot program; providing

23 an appropriation; providing for apportionment of the
24 appropriation; providing an effective date.
25
26 Be It Enacted by the Legislature of the State of Florida:
27
28 Section 1. (1) The Legislature finds that the increased
29 cost of motor vehicle insurance for a foster child after that
30 child obtains a driver's license is borne by the foster parents,
31 the authorized representative of the residential facility, or
32 the foster child if living independently. This increase in the
33 cost of insurance creates an additional barrier for a foster
34 child in gaining independence and may limit the child's
35 opportunities for obtaining employment. In accordance with these
36 findings, the Department of Children and Family Services shall
37 establish a 3-year pilot program in Sarasota, Desoto, Manatee,
38 Pinellas, and Pasco Counties to pay a portion of the cost of
39 motor vehicle insurance for foster children who have obtained a
40 driver's license.
41 (2) To the extent that funding is available, the pilot
42 program shall provide funds to pay for a portion of the increase
43 in the cost of motor vehicle insurance incurred by foster
44 parents, residential facilities, and foster children living
45 independently. To be eligible for payment under the pilot
46 program, the person incurring the cost must submit to the
47 department appropriate documentation demonstrating the increase
48 in the cost of insurance. The amount of the payment provided to
49 the foster parent, residential facility, or foster child living
50 independently shall be one-half of the amount of the increase in

51 the cost of motor vehicle insurance which is incurred as a
52 result of adding the foster child to the policy or less than
53 one-half if another source of funding is available to pay for
54 the increase. The foster child must be encouraged to pay the
55 other half of the increase in insurance costs.
56 (3) The department shall develop procedures for operating
57 the pilot program, including, but not limited to, determining
58 eligibility, providing the payment, ensuring that payment is
59 limited solely to the additional cost of including the foster
60 child in the insurance policy, and ensuring that the payments
61 are made to eligible persons in the order each person is
62 determined eligible until the funds are exhausted.
63 (4) The department shall examine and use, to the extent
64 possible, other available options for funding the cost of the
65 motor vehicle insurance increase, such as, but not limited to,
66 through the child's master trust fund, social security income,
67 child support payments, and other income available to the child.
68 (5) Beginning January 1, 2007, and continuing for the
69 duration of the pilot program, the department shall submit to
70 the Governor, the President of the Senate, and the Speaker of
71 the House of Representatives an annual report on the success and
72 outcomes achieved by the pilot program, with a recommendation as
73 to whether the pilot program should be continued, terminated, or
74 expanded.
75 Section 2. The sum of $150,000 is appropriated from the
76 General Revenue Fund to the Department of Children and Family
77 Services for the purpose of implementing this act during the
78 2006-2007 fiscal year. This sum shall be apportioned as follows:

79 $110,000 to be divided between Pinellas and Pasco Counties and
80 $40,000 to be divided among Manatee, Sarasota, and Desoto
81 Counties.
82 Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 621 CS Health Maintenance Organizations
SPONSOR(S): Grimsley and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 94

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee	8 Y, 1 N	Brown-Barrios	Brown-Barrios
2) Insurance Committee	16 Y, 0 N, w/CS	Freire	Cooper
3) Health & Families Council		Brown-Barrios	Moore
4)			
5)			

SUMMARY ANALYSIS

The laws regulating health maintenance organizations (HMOs) provide for the regulation of fiscal intermediary services organizations (FISOs). The law is designed to protect funds received from an HMO and held by entities which have an obligation to distribute those funds to health care providers who contract with the HMO. This is primarily done by requiring those entities to apply for registration and to post a fidelity bond and a surety bond with the Office of Insurance Regulation (OIR). The bill revises the definition of who must be registered as a FISO by deleting the exemption for entities that are owned, operated, or controlled by certain licensed entities. As revised, only the licensed entities themselves would be exempt, including hospitals, authorized insurers, third party administrators, prepaid limited health service organizations, and HMOs. Also, the current exemption for physician group practices would be limited to group practices providing services under the scope of licenses of the members of that group practice.

The bill further requires FISOs to comply with additional requirements in order to be registered. These requirements include:

1) Requiring OIR to periodically examine the affairs of any HMO and to take remedial action when necessary;
2) Complying with prompt payment of claims statute;
3) Requiring compliance with treatment authorization and payment of claims; and
4) Requiring compliance with rendering adverse determination statute.

This bill will not have any fiscal impact on the public sector and should have limited fiscal impact on the private sector.

If enacted the bill act takes effect October 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – In order to be registered, fiscal intermediary services organizations (FISOs) will have to comply with additional requirements.

Ensure Lower Taxes -- Entities which are no longer exempt from registration with OIR as a fiscal intermediary service organization would be subject to the expense of obtaining a surety bond and fidelity bond.

B. EFFECT OF PROPOSED CHANGES:

The bill revises the definition of a fiscal intermediary services organization by narrowing certain exemptions from the current definition. By doing so, certain entities that are currently exempt would be required to be licensed as a FISO. Specifically, the bill deletes the exemption for entities that are owned, operated, or controlled by certain licensed entities, so that only the licensed entity itself would be exempt. These licensed entities include hospitals licensed under ch. 395, F.S., insurers licensed under ch. 624, F.S., third party administrators licensed under ch. 626, F.S., prepaid limited health service organizations licensed under ch. 636, F.S., and health maintenance organizations licensed under ch. 641, F.S. Also, the current exemption for entities owned, operated, or controlled by physician group practices is revised to be limited to physician group practices, as defined in s. 456.053(3)(h), F.S., providing services under the scope of licenses of the members of the group practice. In other words, a physician group practice providing fiscal intermediary services to members outside of that group practice would not be exempt from licensure as a FISO.

The bill also amends s. 641.316(6), F.S., to allow the Office of Insurance Regulation (OIR) to deny registration to any fiscal intermediary services organization (FISO) that does not comply with the following additional requirements:

1) Section 641.27, F.S.: Relating to the OIR's right to examine the affairs of any health maintenance organization and to take remedial action when it is necessary.
2) Section 641.3155, F.S.: Regulating the prompt payment of claims.
3) Section 641.3156, F.S.: Relating to treatment authorization and payment of claims.
4) Section 641.51(4), F.S.: Relating to rendering adverse determination.

BACKGROUND

Regulation of Health Maintenance Organizations

OIR regulates health maintenance organization solvency, contracts, rates, and marketing activities under part I of chapter 641, F.S. The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of chapter 641, F.S. Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate of authority and that is otherwise in compliance with the licensure provisions under part I may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers.

Fiscal Intermediary Services Organizations (FISOs)

Legislation in 1997 amended the HMO laws to provide for the regulation of FISOs.[1] At that time, some health care professionals were contracting with unregulated entities to collect payments from HMOs on the providers' behalf and to distribute those funds to the contracting health care providers. There were

[1] s 641.316, F.S.

reported cases of misappropriation of funds by such entities, with no apparent recourse to regulatory agencies. Essentially, the law is designed to protect funds received from an HMO and held by entities which have an obligation to distribute those funds to medical professionals who contract with the HMO. This is primarily done by requiring those entities to apply for registration and to post a fidelity bond and a surety bond with OIR. A fiscal intermediary services organization is defined as:

> [A] person or entity which performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance organizations, other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third party administrator licensed under chapter 626, a prepaid limited health service organization licensed under chapter 636, a health maintenance organization licensed under chapter 641, or physician group practices as defined in s. 456.053(3)(h).[2]

The term fiduciary or fiscal intermediary services means:

> [R]eimbursements received or collected on behalf of health care professionals for services rendered, patient and provider accounting, financial reporting and auditing, receipts and collections management, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations...[3]

The above definition of a FISO exempts physician group practices, but it is not clear that this exemption is limited to providing fiscal intermediary services only to members of that group practice, though that may be the intent. This appears to be a broader exemption than a similar exemption for physician group practices from licensure as an administrator in s. 626.88(1)(o), F.S. (See, Administrators, below.) That statute limits the exemption for physician group practices to providing services under the scope of the license of the members of the group practice. The definition of a FISO also exempts organizations owned, operated, or controlled by various licensed entities, such as hospitals, insurers, third-party administrators, HMOs, etc. In contrast, the exemption from licensure as an administrator includes licensed insurers, HMOs, and certain other entities, but does not exempt subsidiaries or other independent organizations that are owned, operated, or controlled by such licensed entities.

The express legislative intent of the statute is to ensure the financial soundness of FISOs. A FISO which is operated for the purpose of acquiring and administering provider contracts with managed care plans must secure and maintain a fidelity bond and a surety bond. As currently required, a fidelity bond must be maintained in the minimum amount of 10 percent of the funds handled by the FISO during the prior year or $1 million, whichever is less, but not less than $50,000. This bond protects the FISO from loss due to dishonesty of its employees. A surety bond must also be maintained in the minimum amount of 5 percent of the funds handled by the FISO during the prior year or $250,000, whichever is less, but not less than $10,000. The surety bond protects against misappropriation of funds within the FISO's control or custody.

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[2] s. 456.053(3)(f), F.S., provides, "Group practice" means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:

1. In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;

2. For which substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and

3. In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group.

[3] Section 641.316(2)(a), F.S.

A FISO registering with OIR must meet certain application requirements of chapter 641, F.S. that apply to HMOs.[4] These require that a FISO provide OIR with a list of the names, addresses and official capacities of the persons who are responsible for the operations of the company, including officers, directors, and owners of more than 5 percent of the common stock of the company. The listed persons must fully disclose all contracts or arrangements between them and the company, including any conflicts of interest, and must submit autobiographical statements, fingerprints, and an independently performed background report. In general, receiving authority to operate as a FISO is conditioned on OIR being satisfied that the ownership, control and management of the entity is competent and trustworthy, and possesses managerial experience that would make the proposed operation beneficial to its constituents.

There are currently 15 active FISOs registered with OIR. Once a FISO is registered, there is generally no regulatory activity other than periodic review of the surety bonds and fidelity bonds to determine if the amounts are adequate relative to the amount of funds handled annually by the FISO, as required by statute.

HMO Responsibility for Violations of Prompt Pay Law if Payment Obligations are Transferred

A law enacted in 2002 holds HMOs ultimately responsible for compliance with certain statutory requirements related to prompt payment, treatment authorization, and adverse determinations, if the HMO transfers its payment obligations to a licensed administrator.[5] But the law apparently does not hold an HMO responsible for compliance with such requirements if it transfers its payment obligations to an entity other than a licensed administrator.

Specifically, this law provides that if an HMO, through a health care risk contract, transfers to any entity the obligations to pay a provider for any claim arising from services provided to a subscriber, then the HMO remains responsible for any violations of three specified statutes:

- Section 641.3155, F.S., which are the prompt payment requirements;
- Section 641.3156, F.S., which requires HMOs to pay claims for treatment if a provider follows the treatment authorization procedures and receives authorization; and
- Section 641.51(4), F.S., which requires that only a Florida licensed allopathic physician or osteopathic physician may render an adverse determination regarding a service provided by a physician licensed in the state and specifies procedures that must be followed.

The bill also requires FISOs to comply with the above requirements in order to be registered by the OIR.

Senate Committee Staff Interim Project

The "BACKGROUND", provided above, summarizes the report and findings in the 2005 Senate Banking and Insurance Committee staff interim project, *Determining the Sufficiency of Regulation of Third-Party Administrators and Fiscal Intermediary Services Organizations (2005-109)*. The interim project made the following recommendations:

- Expand the requirements of s. 641.234(4), F.S., to hold a health maintenance organization responsible for statutory requirements related to payment to health care providers if the HMO transfers to any entity the obligations to pay providers. The current law may limit this liability to HMO contracts with licensed administrators and limit this responsibility to violations of only certain statutes.
- Narrow the exemption from registration as a FISO for a physician group practice in s. 641.316, F.S., to physician group practices providing fiscal intermediary services to members of the group practice.
- Narrow the exemption from registration as a FISO for licensed insurers, HMOs, administrators, hospitals, and prepaid limited health service organizations to those entities themselves, rather than any entity owned operated, or controlled by such licensed entities.

[4] ss. 641.21(1)(c) and 641.22(6), F.S.
[5] ch. 2002-389, L.O.F.; s. 641.234(4), F.S.

- Alternatively, consider repealing the FISO statute and require entities to be licensed as third party administrators if they provide fiscal intermediary services to providers under contract with HMO.

C. SECTION DIRECTORY:

Section 1. Amends s. 641.316, F.S., relating to the definition and registration requirement of fiscal intermediary services organization.

Section 2. Provides that this act takes effect October 1, 2006.

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:

Entities which are no longer exempt from registration with OIR as a fiscal intermediary services organization would be subject to the expense of obtaining a surety bond and a fidelity bond.

D. FISCAL COMMENTS:

None

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, does not appear to reduce the authority that counties or municipalities have to raise revenue in the aggregate, and does not appear to reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None

B. RULE-MAKING AUTHORITY:

None

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 5, 2006, the Insurance Committee adopted one amendment and reported the bill favorably as a committee substitute. The amendment expands the definition of fiscal intermediary services organizations, and requires FISOs to comply with additional registration requirements.

This analysis reflects the bill as amended.

CHAMBER ACTION

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1 The Insurance Committee recommends the following:
2
3 **Council/Committee Substitute**
4 Remove the entire bill and insert:
5 A bill to be entitled
6 An act relating to fiscal intermediary services
7 organizations; amending s. 641.316, F.S.; redefining the
8 term "fiscal intermediary services organization"; revising
9 registration requirements for fiscal intermediary services
10 organizations; providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Paragraph (b) of subsection (2) and subsection
15 (6) of section 641.316, Florida Statutes, are amended to read:
16 641.316 Fiscal intermediary services.--
17 (2)
18 (b) The term "fiscal intermediary services organization"
19 means a person or entity <u>that</u> ~~which~~ performs fiduciary or fiscal
20 intermediary services to health care professionals who contract
21 with health maintenance organizations other than ~~a fiscal~~
22 ~~intermediary services organization owned, operated, or~~
23 ~~controlled by~~ a hospital licensed under chapter 395, an insurer

24 licensed under chapter 624, a third-party administrator licensed
25 under chapter 626, a prepaid limited health service organization
26 licensed under chapter 636, a health maintenance organization
27 licensed under this chapter, or physician group practices as
28 defined in s. 456.053(3)(h) and providing services under the
29 scope of licenses of the members of the group practice.
30 (6) Any fiscal intermediary services organization, other
31 than ~~a fiscal intermediary services organization owned,~~
32 ~~operated, or controlled by~~ a hospital licensed under chapter
33 395, an insurer licensed under chapter 624, a third-party
34 administrator licensed under chapter 626, a prepaid limited
35 health service organization licensed under chapter 636, a health
36 maintenance organization licensed under this chapter, or
37 physician group practices as defined in s. 456.053(3)(h), and
38 providing services under the scope of licenses of the members of
39 the group practice, must register with the office and meet the
40 requirements of this section. In order to register as a fiscal
41 intermediary services organization, the organization must comply
42 with ss. 641.21(1)(c), ~~and~~ (d), and (j), ~~and~~ 641.22(6), and
43 641.27. The fiscal intermediary services organization must also
44 comply with the provisions of ss. 641.3155, 641.3156, and
45 641.51(4). Should the office determine that the fiscal
46 intermediary services organization does not meet the
47 requirements of this section, the registration shall be denied.
48 In the event that the registrant fails to maintain compliance
49 with the provisions of this section, the office may revoke or
50 suspend the registration. In lieu of revocation or suspension of

51 the registration, the office may levy an administrative penalty
52 in accordance with s. 641.25.
53 Section 2. This act shall take effect October 1, 2006.

HB 645 CS

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 645 CS Nursing Home Facilities
SPONSOR(S): Gelber
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 298

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee	9 Y, 0 N, w/CS	Ciccone	Brown-Barrios
2) Domestic Security Committee	9 Y, 0 N, w/CS	Wiggins	Newton
3) Health Care Appropriations Committee	13 Y, 0 N	Speir	Massengale
4) Health & Families Council		Ciccone	Moore
5)			

SUMMARY ANALYSIS

House Bill 645 CS provides legislative intent to encourage all nursing homes to have emergency electrical power system capacity to allow these facilities to remain fully operational during and after an emergency and to provide care to residents evacuated from other nursing homes.

The committee substitute specifies that the Agency for Health Care Administration (AHCA) implement a 2-year pilot program to reimburse certain nursing home facilities for the costs of installing a quick connect electrical service entry allowing a temporary generator connection. The committee substitute also provides for reimbursement of one-half the cost—up to $15,000—to certain nursing homes for the cost of an electrical generator services contract.

The total cost of providing reimbursements under this committee substitute is estimated to be $4 million. The reimbursement to nursing homes by AHCA, however, is subject to an appropriation.

The committee substitute takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—The committee substitute requires AHCA to implement a 2-year pilot program to reimburse certain nursing home facilities for the installation cost of an emergency generator and to reimburse up to a certain amount for the cost to retain a generator for emergency use.

Empower families—The committee substitute provides increased safety options to individuals and families who either reside in or have family members residing in certain nursing home facilities.

Maintain public security—The committee substitute increases the health, safety, and physical security of nursing home residents who reside in certain facilities before and during an emergency.

B. EFFECT OF PROPOSED CHANGES:

The committee substitute creates s. 400.0627, F.S., providing legislative intent to encourage nursing home facilities to have an emergency electrical power system to allow these facilities to remain fully operational during and after an emergency and to provide care to residents evacuated from other nursing homes.

The Agency for Health Care Administration is required to implement a 2-year pilot program to reimburse nursing home facilities based on certain criteria. Eligible facilities would receive state reimbursement based on available funds for the installation cost of a quick connect electrical service entry system allowing a temporary generator connection. Nursing homes that meet eligibility criteria would also be reimbursed for one-half the cost—up to $15,000—for the cost of a generator services contract.

The effect of the quick connect electrical power system and the contract would be to provide eligible nursing homes, despite utility power outages, with the capacity to remain fully operational during and after an emergency and provide care of residents evacuated from other nursing facilities.

To be eligible for reimbursement, a nursing home facility must meet the following criteria:

- Be located in Broward, Collier, Dade, Monroe, or Palm Beach county.
- Not be in the hurricane evacuation zone in its county.
- Not have been cited for a class I deficiency as defined in s. 400.23(8)(a), F.S., within the last 30 months preceding the application for reimbursement.
- Have the capacity, as determined by AHCA, to receive transferred residents that are evacuated, and agree to receive those transferred residents.
- Have a contract with a company that is able to supply an electrical generator.

BACKGROUND

Hurricane Evacuation Zones

Hurricane evacuation zones are predetermined geographic areas that are likely to experience destruction or severe damage, from storm surge, waves, erosion, or flooding.[1] Depending on the track

[1] According to NOAA, storm surge maps reflect the worst case hurricane storm surge inundation (including astronomical high tide), regardless of the point of where the center of the hurricane (or tropical storm) makes landfall. No single hurricane will necessarily cause all of the flooding represented on evacuation maps. The data reflect only still-water saltwater flooding and do not take into account the effects of pounding waves that ride on top of the storm surge in locations exposed to wave action. Evacuation maps do not show areas that may be flooded by excessive rainfall-they only depict flooding that would occur as a result of the ocean level rising as well as estuaries and rivers that can be affected by hurricane storm surge.

of the storm, the greater the intensity of a storm (tropical storm to Category 5 hurricane) the greater the geographic area that will experience these conditions and, therefore, need to be evacuated. The closer the nursing home is to the coast, the more likely that a nursing home will be located in an evacuation zone.

According to AHCA, there are 677 licensed nursing homes in Florida. During the 2005 hurricane season there were five recorded hurricanes that caused Florida evacuations. There were 21 nursing home facilities that were completely evacuated and four that were partially evacuated with a total of 1,795 patients being displaced. Only one nursing home facility was actually closed or became inactive during the entire 2005 season. There were 51 nursing home facilities that sustained some type of damage from the hurricanes. A total of 239 nursing home facilities lost power and switched to generators during the hurricane season with one additional nursing home facility losing power without the availability of a generator.[2]

AHCA estimates approximately 466 nursing facilities are not located in county hurricane evacuation zones. This represents approximately 57,000 nursing home beds or about 70 percent of capacity.

Requirements for Nursing Home Licensure—Essential Electrical System

Since July 1982, all nursing home facilities licensed under part II of chapter 400, F.S., have been required by rule to have an onsite Essential Electrical System (EES) with an onsite fuel supply of up to 64 hours.[3] The design, installation, operation, and maintenance of this EES is reviewed by AHCA.

The EES supplies electrical service to the three main electrical branches, including the Life Safety branch, the Critical Branch, and the Equipment Branch within 10 seconds of normal service interruption. As required by the National Fire Protection Association (NFPA) standards, these emergency electrical branches provide emergency electrical service to specified electrical components of the facility such as the fire alarm system, the nurse call system, the emergency egress lighting system, the exit lighting system, the magnetic door locking system, and selected critical convenience receptacles and equipment in the facility. In addition, since 1996, all new nursing home facilities and new additions to these facilities have been required to have an EES that supplies electrical power to all ventilating fans, ice making equipment, refrigeration equipment, and selected heating, ventilation, and air conditioning equipment as determined by the facility, for a period up to 72 hours of continuous service at actual load capacity of the generator.

The EES is not required to provide electrical service to the heating, ventilation, and air conditioning (HVAC) equipment of the facility nor to the general lighting or other electrical items not specifically required by the National Fire Protection Association codes and standards.

Deficiency Classifications

Section 400.23, F.S., requires AHCA to evaluate all nursing home facilities against standards and make a determination as to the degree of compliance by each licensee with the established standards adopted in rules. The agency bases its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. Findings of deficient practice are classified according to the nature and the scope of the deficiency.

There are four classes of deficiencies:

- A class I deficiency is a deficiency in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.

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[2] Senate Staff Analysis and Economic Impact Statement SB 298, revised January 23, 2006

[3] FAC 59A-4.133. Of the 669 existing licensed nursing home facilities, there are 30 facilities constructed prior to 1982 that do not have an existing generator system. These facilities house only residents, who do not require any life support systems, and as such, these facilities are in compliance with all state and federal codes and standards through the use of a battery supplied emergency electrical system that supplies emergency power to the life safety components of the facility as required by NFPA 99 for 1-½ hours duration. These components include the fire alarm, nurse call, emergency egress lighting, exit lighting, and locking systems.

- A class II deficiency is a deficiency that has compromised a resident's ability to maintain or accomplish his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- A class III deficiency is a deficiency that will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or accomplish his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- A class IV deficiency is a deficiency that will result in no more than a minor negative impact on the resident.

According to AHCA, data from the most recent 30-month period indicates that 47 facilities have received a class I deficiency. The classification of a deficiency affects the licensure status of the facility. A conditional license is issued if a facility has one or more class I or class II deficiencies, or class III deficiencies not corrected within the time established by the Agency. In addition, a facility that is cited for a class I deficiency, two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency, is placed on a 6-month survey cycle for the next 2-year period.

Evacuation and Transfer of Nursing Home Residents

Section 400.23(2) (g), F.S., requires AHCA to develop rules after consultation with the Department of Community Affairs that require each nursing home to develop a comprehensive emergency management plan (CEMP). At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; post disaster activities, including emergency power, food, and water; post disaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; and responding to family inquiries. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency must ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elder Affairs, the Department of Health, the Agency for Health Care Administration and the Department of Community Affairs. The local emergency management agency must complete its review within 60 days and either approves the plan or advises the facility of necessary revisions.

Rule 59A-4.126, F.A.C., incorporates by reference a publication (AHCA 3110-6006, March 1994) that lists the minimum criteria for a nursing home's CEMP. The CEMP must state the procedures to ensure that emergency power, whether natural gas or diesel, is supplied to the nursing home. If the fuel supply is natural gas, the plan must identify alternate means should loss of power occur that would affect the natural gas system. The plan must state the capacity of the emergency fuel system.

C. SECTION DIRECTORY:

Section 1. Creates s. 400.0627, F.S., providing legislative intent and requires the AHCA to establish a two-year pilot program to provide state financial assistance to eligible nursing home facilities to upgrade their emergency electrical power system capacity.

Section 2. Provides that the committee substitute takes effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   AHCA estimates that the cost of the pilot would be $4 million; approximately 85 nursing home facilities located in the pilot program area would be eligible to participate. This represents approximately 10,200 nursing home beds. The reimbursement cost of the 2-year pilot program is as follows:

   - $2.7 million to reimburse eligible nursing home facilities to upgrade their emergency electrical power system capacity.
   - $1.3 million to reimburse one-half the cost—up to $15,000—of a contract to secure an electrical generator.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If implemented the committee substitute should have a positive economic effect on businesses that develop, sell, rent, install or provide maintenance for large electrical generators.

D. FISCAL COMMENTS:

The committee substitute makes the reimbursement to nursing homes subject to an appropriation by the Legislature.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This committee substitute does not require counties or municipalities to spend funds or to take any action requiring the expenditure of funds. This committee substitute does not reduce the percentage of a state tax shared with counties or municipalities. This committee substitute does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None

B. RULE-MAKING AUTHORITY:

The committee substitute provides that the AHCA may adopt rules to administer the pilot program.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 29, 2006, the Domestic Security Committee adopted an amendment that will reimburse the cost of the pre-designed electrical service entry that allows a quick connection to a temporary electrical generator based on the lowest of three bids secured by the nursing home facility. Each facility must submit copies of the three bids with its request for plan approval to the agency. The committee substitute was reported favorably with committee substitute.

This analysis is drafted to the committee substitute.

CHAMBER ACTION

The Domestic Security Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to nursing home facilities; creating s. 400.0627, F.S.; providing legislative intent; requiring the Agency for Health Care Administration to implement a pilot program to increase the emergency electrical power capacity of nursing home facilities; providing criteria for participation in the program; providing conditions for reimbursement of participating facilities; permitting inspections of certain facilities by the agency; requiring facilities to comply with current codes and standards when modifying emergency electrical power systems; authorizing the agency to adopt rules; providing an effective date.

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

Section 1. Section 400.0627, Florida Statutes, is created to read:

400.0627 Emergency electrical power system capacity.--

23 (1) It is the intent of the Legislature that each nursing
24 home facility in this state be encouraged to have an emergency
25 electrical power system capacity that is sufficient to remain
26 fully operational during and after an emergency in order to
27 maintain the safety and health of the residents of the nursing
28 home facility and, if necessary, to provide care to residents
29 evacuated from other nursing home facilities.
30 (2) By July 1, 2006, the Agency for Health Care
31 Administration shall commence implementation of a 2-year pilot
32 program to provide the capability for increasing the capacity of
33 emergency electrical power systems of nursing home facilities.
34 To participate in the pilot program a nursing home facility
35 must:
36 (a) Be located in Broward County, Collier County, Dade
37 County, Monroe County, or Palm Beach County;
38 (b) Not be located within a hurricane evacuation zone;
39 (c) Not have been cited for a class I deficiency within
40 the 30 months preceding the commencement date of implementation
41 of the pilot program;
42 (d) Be capable of accepting and agree to accept at least
43 30 residents who are transferred from other nursing home
44 facilities pursuant to applicable life safety and firesafety
45 laws as determined by the agency. During any such evacuation,
46 the facility from which the residents are transferred shall
47 provide the receiving facility with the staff required to care
48 for the transferred residents; and
49 (e) Have a contract with a company that is able to supply
50 an electrical generator when needed.

51 (3)(a) A nursing home facility must notify the agency if
52 it seeks to participate in the pilot program. If a facility
53 providing such a notice meets the criteria in subsection (2) and
54 funds are available as specified in paragraph (b), the agency
55 shall reimburse the facility for one-half the cost up to $15,000
56 of the contract described in paragraph (2)(e) to secure an
57 electrical generator within the 2-year duration of the pilot
58 program. The agency shall also reimburse the facility for the
59 cost incurred to install a permanent, predesigned electrical
60 service entry that will allow a quick connection to a temporary
61 electrical generator. The connection must be installed inside a
62 permanent metal enclosure that is rated as suitable for the
63 purpose of providing such an entry, may be located on the
64 exterior of the building, and must be adequate to allow the
65 operation of the facility under normal conditions. Before any
66 such reimbursement, the facility must provide the agency with
67 documentation that the installation is complete and the
68 electrical work associated with the installation was performed
69 by a certified electrical contractor.
70 (b) Reimbursement to a facility under paragraph (a) is
71 available to the extent that funds are appropriated for each of
72 the 2 years of the pilot program. Funds shall be provided to
73 eligible facilities on a first-come, first-served basis.
74 (c) Subject to appropriation, the agency shall reimburse
75 the facility for the cost of the predesigned electrical service
76 entry that allows a quick connection to a temporary electrical
77 generator based on the lowest of three bids secured by the

78 facility. Each facility must submit copies of the three bids to
79 the agency with its request for plan approval.
80 (4) A nursing home facility that participates and is
81 reimbursed for an installation under the pilot program shall
82 ensure the proper safekeeping and maintenance of the
83 installation and allow the agency access as needed to inspect
84 the installation.
85 (5) This section does not require a nursing home facility
86 to participate in the pilot program or to modify the capacity of
87 its existing emergency electrical power system. However, if the
88 existing emergency electrical power system of a nursing home
89 facility is modified as part of an installation for which
90 reimbursement is provided under subsection (3), such system must
91 comply with all current codes and standards.
92 (6) The agency may adopt rules pursuant to ss. 120.536 and
93 120.54 to implement the provisions of this section.
94 Section 2. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 675 CS Public Records and Public Meetings
SPONSOR(S): Pickens
TIED BILLS: **IDEN./SIM. BILLS:** SB 1190

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	11 Y, 0 N, w/CS	Bell	Mitchell
2) Local Government Council	8 Y, 0 N	Nelson	Hamby
3) Governmental Operations Committee	6 Y, 0 N, w/CS	Mitchell	Williamson
4) Health & Families Council		Bell AJB	Moore MM
5)			

SUMMARY ANALYSIS

The bill makes stylistic changes and removes references to sale from the provisions related to the effect of a lease of a public hospital.

The bill provides for the effect of a sale of a public hospital. The bill prohibits the sale of a hospital, unless expressly stated otherwise in the sale documents, from being construed as (1) a transfer of a governmental function from the county, district, or municipality to the private purchaser; (2) constituting a financial interest of the public seller in the private purchaser; or (3) making a private purchaser an integral part of the public seller's decisionmaking process.

The bill further provides that a purchaser of a hospital, who is operating the hospital after the sale, is not "acting on behalf of" the seller, unless the sale document expressly provides to the contrary.

The bill also adds a provision related to public records: the purchaser of a hospital operating after a sale of the hospital may not be construed as an "agency" within the meaning of s. 119.011(2), F.S., unless the sale document expressly provides to the contrary.

The bill amends provisions related to the effect of a lease of a public hospital without providing legislative findings regarding the public necessity for the exemption, which is the reason these provisions were declared unconstitutional.

In creating what appears to be an additional public records exemption, the bill fails to satisfy the constitutional requirement for legislative findings regarding the public necessity for the exemption.

As a public records exemption, the bill will require passage by a two-thirds vote of each house.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill may decrease access to certain public records.

B. EFFECT OF PROPOSED CHANGES:

Background on Public Records and Public Meetings Laws

Section 24(a), Art. I of the State Constitution provides the state's public policy regarding access to government records. The section guarantees every person a right to inspect or copy any public record of the legislative, executive and judicial branches of government, except with respect to records which are exempted or specifically made confidential. Section 24(b) of Art. 1 provides the state's public policy regarding access to government meetings. The section requires that all meetings of the executive branch of state government or of any collegial public body of a county, municipality, school district or special district at which official acts are to be taken or at which public business of such body is to be transacted or discussed shall be open and noticed to the public.

The Legislature may provide by general law passed by two-thirds vote for the exemption of records and meetings from these constitutional requirements. Any such law must state with specificity the public necessity justifying the exemption, and be no broader than necessary to accomplish the stated purpose of the law.

Public policy regarding access to government records and meetings also is addressed in the Florida Statutes. Section 119.07(1), F.S., guarantees every person a right to inspect and copy any state, county or municipal record, and s. 286.011, F.S., requires that all state, county or municipal meetings be open and noticed to the public.

The "Open Government Sunset Review Act"[1] provides that a public records or public meetings exemption may be created or maintained only if it serves an identifiable public purpose, and is no broader than necessary to meet the public purpose that it serves. An identifiable public purpose is served if the exemption meets one of the following purposes and the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption:

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protects sensitive personal information that, if released, would be defamatory or jeopardize an individual's[2] safety; or
- Protects trade or business secrets.

Public Records Requirements of Leased Hospitals

Section 395.3036, F.S., provides that records of a private corporation that leases a public hospital or other public health care facilities are confidential and exempt from s. 119.07(1), F.S., and s.24(a), Art. I of the State Constitution, and the meetings of the governing board of such a corporation are exempt

[1] Section 119.15, F.S.
[2] Only the identity of an individual may be exempted under this provision.

from s. 286.011, F.S., and s. 24(b), Art. I of the State Constitution, when the public lessor complies with the public finance accountability provisions of s. 155.40(5), F.S., with respect to the transfer of any public funds to the private lessee and when the private lessee meets at least three of the following five criteria:

- The public lessor that owns the public hospital or other public health care facility was not the incorporator of the private corporation that leases the public hospital or other health care facility;
- The public lessor and the private lessee do not commingle any of their funds in any account maintained by either of them, other than the payment of the rent and administrative fees or the transfer of funds;
- Except as otherwise provided by law, the private lessee is not allowed to participate, except as a member of the public, in the decision making process of the public lessor;
- The lease agreement does not expressly require the lessee to comply with the requirements of ss. 119.07(1) and 286.011, F.S.; and
- The public lessor is not entitled to receive any revenues from the lessee, except for rental or administrative fees due under the lease, and the lessor is not responsible for the debts or other obligations of the lessee.

Sale or Lease of a Public Hospital

Section 155.40, F.S., authorizes any county, district or municipal hospital organized and existing under the laws of Florida, acting by and through its governing board, to sell or lease the hospital to a for-profit or not-for-profit Florida corporation, and enter into leases or other contracts with a for-profit or not-for-profit Florida corporation for the purpose of operating and managing such hospital and any or all of its facilities. The term of any such lease, contract or agreement and the conditions, covenants and agreements contained therein must be determined by the governing board of the county, district or municipal hospital. The governing board of the hospital must find that the sale, lease or contract is in the best interests of the public and must state the basis of the finding. If the governing board of a county, district or municipal hospital decides to lease the hospital, it must give notice and comply with the requirements of the section.

Section 155.40(6), F.S., provides that, *unless otherwise expressly stated in the lease documents*, the transaction involving the sale or lease of a hospital *may not be construed* as: a transfer of a *governmental function* from the county, district or municipality to the private purchaser or lessee; constituting a financial interest of the public lessor in the private lessee; or making a private lessee an integral part of the public lessor's decisionmaking process. Under s. 155.40(7), F.S., the lessee of a hospital, pursuant to s. 155.40, F.S., or any special act of the Legislature, operating under a lease may not be construed to be "acting on behalf of" the lessor as that term is used in statute, *unless the lease document expressly provides to the contrary.*

When a newspaper and its publisher brought an action against a private lessee of a public hospital seeking mandamus, injunctive and declaratory relief regarding a public records request for the lessee's board minutes, the First District Court of Appeal found that the apparent purpose of ss.155.40(6) and (7), F.S., are to exempt private lessees from the public records and meetings laws as argued by Baker County Medical Services, Inc., in support of its argument for nondisclosure. The court held subsections 155.40(6) and (7), F.S., unconstitutional because there were no legislative findings regarding public necessity for the exemption when the subsection was enacted by the Legislature. See, Baker County Press, Inc. v. Baker County Medical Services, Inc., 870 So.2d 189 (Fla. 1st DCA 2004).

Memorial Hospital-West Volusia, Inc. v. News-Journal Corporation and Tanner Andrews

In 1957, the Florida Legislature created the West Volusia Hospital Authority (the "Authority"), as an independent taxing district (ch. 57-2085, s.1, L.O.F.). The Authority was empowered to establish, construct, operate and maintain such hospitals as in the elected governing board's opinion were necessary for the preservation of the public health, public good, and for the use of the people of the district, and to provide care to the indigent sick residing within the taxing district without charge in those facilities. The Authority developed, owned and operated the West Volusia Memorial Hospital as a publicly-owned hospital. In 1993, the Authority entered into negotiations with Memorial Health Systems (MHS) to lease and operate West Volusia Memorial Hospital. This lease was executed on July 28, 1994.

In December 1994, News-Journal, a Florida corporation which publishes *The News-Journal*, a daily newspaper in Daytona Beach, Florida, filed a complaint in the Circuit Court seeking a declaratory decree that the records of MHS were subject to the Public Records Act and the Sunshine Law. The Circuit Court entered a final judgment in favor of MHS. On appeal, the Fifth District Court of Appeal reversed and held that MHS was subject to the Public Records Act and the Sunshine Law. The court concluded that MHS was "acting on behalf of the Authority." See, News-Journal Corp. v. Memorial Hospital-West Volusia, Inc., 695 So. 2d. 418, (Fla. 5th DCA 1997). The Supreme Court of Florida upheld the Fifth District Court of Appeal, noting that the totality of factors demonstrated that the authorized function of the Authority was transferred and delegated to a private corporation, a lessee. See, Memorial Hospital-West Volusia, Inc. v. News-Journal Corp., 729 So. 2d 373, 383, (Fla. 1999).

On March 23, 2000, MHS advised the Authority that it intended to terminate the lease contract as of midnight September 30, 2000. The Authority was not interested in operating the hospital and eventually worked out a sale agreement with Adventist Health Systems, a not-for-profit Florida corporation, as authorized in s.155.40, F.S. Under the new ownership the name of the hospital was changed to Florida Hospital Deland.

In a recent action, the Circuit Court in Volusia County granted the newspaper's motion for final summary judgment and denied Memorial Hospital-West Volusia, Inc.'s motion for summary judgment.[3] The Circuit Court declared that the public records law applies to the Memorial Health System, *a purchaser (not a lessee) of a public hospital*, when it engaged in the function of operating the hospital and caring for the indigent within the taxing district of the Authority under and pursuant to the terms and conditions of the transfer documents.[4] The Circuit Court ordered that, as of the effective date of the transfer documents, Memorial Health System, *a purchaser (not a lessee) of a public hospital*, must comply with the Public Records and Meetings Laws.[5]

On March 24, 2006, however, the Fifth District Court of Appeal concluded that the public disclosure laws no longer apply because Memorial Hospital-West Volusia, Inc., had purchased the hospital. The Fifth District Court of Appeal reversed the summary judgments entered in favor of the newspaper.

Effect of Proposed Changes

The bill revises the provisions related to the effect of a lease of a public hospital to make stylistic changes to s. 155.40(7), F.S., and remove references to sale in s. 155.40(6), F.S.

The bill expands s. 155.40, F.S., to provide for the effect of a sale of a public hospital. Specifically, the bill tracks the current language related to the lease of a hospital and prohibits the sale of a hospital, unless *expressly* stated otherwise in the sale documents, from being construed as:

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[3] See Memorial Hospital-West Volusia, Inc. v. News-Journal Corp. and Tanner Andrews, Case No. 2002-31972, Seventh Judicial Circuit, Volusia County, (February 16, 2005).
[4] Id.
[5] Id.

- A transfer of a governmental function from the county, district, or municipality to the private purchaser;
- Constituting a financial interest of the public seller in the private purchaser; or
- Making a private purchaser an integral part of the public seller's decisionmaking process.

The bill further tracks the current lease provisions to provide that a purchaser of a hospital, who is operating the hospital after the sale, is not "acting on behalf of" the seller, unless the sale document expressly provides to the contrary.

The bill also adds a public records limitation not currently found in the lease provisions: the purchaser of a hospital operating after a sale of the hospital may not be construed as an "agency" within the meaning of s. 119.011(2), unless the sale document expressly provides to the contrary.

C. SECTION DIRECTORY:

Section 1. - Amends s. 155.40, F.S., to revise provisions related to the effect of a lease of a public hospital and to provide for the effect of the sale of a public hospital.

Section 2. - Provides that the bill takes effect on July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   This bill does not appear to have a fiscal impact on state government revenues.

2. Expenditures:

   This bill may have a fiscal impact on state government expenditures because staff responsible for complying with public records requests will require training relating to the newly created public records exemption.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   This bill does not appear to have a fiscal impact on local government revenues unless the local government is leasing or selling a public hospital.

2. Expenditures:

   This bill does not appear to have a fiscal impact on local government expenditures unless the local government is leasing or selling a public hospital.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill may have a direct economic impact on lessees or purchasers of public hospitals.

D. FISCAL COMMENTS:

The provisions of the bill may impact the lease or sale of public hospitals.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that counties or municipalities have to raise revenue.

2. Other:

   Public Records

   Article 1, section 24(c) of the Florida Constitution contains three requirements for any general law creating an exemption to the constitutional right to inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf: (1) passed by a two-third votes of each house, (2) state with specificity the public necessity justifying the exemption, and (3) be no broader than necessary to accomplish the stated purpose of the law.

   As previously discussed, the First District Court of Appeal previously held s. 155.40(6) and (7), F.S., unconstitutional because there were no legislative findings regarding public necessity for the exemption when the subsection was enacted by the Legislature. It is not clear how the Legislature can simply amend these subsections when they have been found to be unconstitutional.

   In addition, it appears that provisions related to the effect of a sale of a public hospital, which are similar to the provisions related to the effect of a lease of a public hospital, would also require legislative findings regarding public necessity under article 1, section 24(c) of the Florida Constitution.

   As the bill appears to create what the courts have interpreted as public records exemptions, the bill may require a two-thirds vote for passage.

B. RULE-MAKING AUTHORITY:

   The bill does not appear to create, modify, or eliminate rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

   Drafting Issue: Public Necessity Statements

   The sponsor may wish to provide legislative findings regarding the public necessity for the exemption for both the provisions related to the effect of a sale of a public hospital and the provisions related to the effect of a lease of a public hospital.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 8, 2005, the Health Care Regulation Committee adopted a "strike-all" amendment and reported the bill favorably with committee substitute. The amendment provided a public necessity statement for the public records exemption, changed the bill to a public records exemption bill, and provided that the bill will take effect upon becoming law.

On April 17, 2006, the Governmental Operations Committee adopted a "strike-all" amendment and reported the bill favorably with committee substitute. The amendment removed the public records exemption and, instead, provided for the effect of the sale of a public hospital.

The analysis is drafted to the committee substitute.

CHAMBER ACTION

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1 The Governmental Operations Committee recommends the following:
2
3 **Council/Committee Substitute**
4 Remove the entire bill and insert:
5
6 A bill to be entitled
7 An act relating to the sale or lease of a county,
8 district, or municipal hospital; amending s. 155.40, F.S.;
9 providing for the effect of the sale of a public hospital
10 to a private purchaser; providing that the purchaser of a
11 public hospital is not acting on behalf of the public
12 entity seller and is not an agency within the meaning of
13 ch. 119, F.S., unless the sale document expressly provides
14 to the contrary; providing an effective date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Section 155.40, Florida Statutes, is amended to
19 read:
20 155.40 Sale or lease of county, district, or municipal
21 hospital<u>; effect of sale</u>.--
22 (1) In order that citizens and residents of the state may
23 receive quality health care, any county, district, or municipal

24 hospital organized and existing under the laws of this state,
25 acting by and through its governing board, shall have the
26 authority to sell or lease such hospital to a for-profit or not-
27 for-profit Florida corporation, and enter into leases or other
28 contracts with a for-profit or not-for-profit Florida
29 corporation for the purpose of operating and managing such
30 hospital and any or all of its facilities of whatsoever kind and
31 nature. The term of any such lease, contract, or agreement and
32 the conditions, covenants, and agreements to be contained
33 therein shall be determined by the governing board of such
34 county, district, or municipal hospital. The governing board of
35 the hospital must find that the sale, lease, or contract is in
36 the best interests of the public and must state the basis of
37 such finding. If the governing board of a county, district, or
38 municipal hospital decides to lease the hospital, it must give
39 notice in accordance with paragraph (4)(a) or paragraph (4)(b).
40 (2) Any such lease, contract, or agreement made pursuant
41 hereto shall:
42 (a) Provide that the articles of incorporation of such
43 for-profit or not-for-profit corporation be subject to the
44 approval of the board of directors or board of trustees of such
45 hospital;
46 (b) Require that any not-for-profit corporation become
47 qualified under s. 501(c)(3) of the United States Internal
48 Revenue Code;
49 (c) Provide for the orderly transition of the operation
50 and management of such facilities;

51 (d) Provide for the return of such facility to the county,
52 municipality, or district upon the termination of such lease,
53 contract, or agreement; and
54 (e) Provide for the continued treatment of indigent
55 patients pursuant to the Florida Health Care Responsibility Act
56 and pursuant to chapter 87-92, Laws of Florida.
57 (3) Any sale, lease, or contract entered into pursuant to
58 this section prior to the effective date of this act must have
59 complied with the requirements of subsection (2) in effect at
60 the time of the sale, lease, or contract. It is the intent of
61 the Legislature that this section does not impose any further
62 requirements with respect to the formation of any for-profit or
63 not-for-profit Florida corporation, the composition of the board
64 of directors of any Florida corporation, or the manner in which
65 control of the hospital is transferred to the Florida
66 corporation.
67 (4) In the event the governing board of a county,
68 district, or municipal hospital elects to sell or lease the
69 hospital, the board shall:
70 (a) Negotiate the terms of the sale or lease with a for-
71 profit or not-for-profit Florida corporation and publicly
72 advertise the meeting at which the proposed sale or lease will
73 be considered by the governing board of the hospital in
74 accordance with s. 286.0105; or
75 (b) Publicly advertise the offer to accept proposals in
76 accordance with s. 255.0525 and receive proposals from all
77 interested and qualified purchasers.
78

79 Any sale must be for fair market value, and any sale or lease
80 must comply with all applicable state and federal antitrust
81 laws.
82 (5) In the event a hospital operated by a for-profit or
83 not-for-profit Florida corporation receives annually more than
84 $100,000 in revenues from the county, district, or municipality
85 that owns the hospital, the Florida corporation must be
86 accountable to the county, district, or municipality with
87 respect to the manner in which the funds are expended by either:
88 (a) Having the revenues subject to annual appropriations
89 by the county, district, or municipality; or
90 (b) Where there is a contract to provide revenues to the
91 hospital, the term of which is longer than 12 months, the
92 governing board of the county, district, or municipality must be
93 able to modify the contract upon 12 months notice to the
94 hospital.
95
96 A not-for-profit corporation that is subject to this subsection
97 and that does not currently comply with the accountability
98 requirements in this subsection shall have 12 months after the
99 effective date of this act to modify any contracts with the
100 county, district, or municipality in a manner that is consistent
101 with this subsection.
102 (6) Unless otherwise expressly stated in the lease
103 documents, the transaction involving the ~~sale or~~ lease of a
104 hospital shall not be construed as:
105 (a) A transfer of a governmental function from the county,
106 district, or municipality to the private ~~purchaser or~~ lessee;

107 (b) Constituting a financial interest of the public lessor
108 in the private lessee; or
109 (c) Making a private lessee an integral part of the public
110 lessor's decisionmaking process.
111 (7) The lessee of a hospital, under ~~pursuant to~~ this
112 section or any special act of the Legislature, operating under a
113 lease is ~~shall~~ not ~~be construed to be~~ "acting on behalf of" the
114 lessor as that term is used in statute, unless the lease
115 document expressly provides to the contrary.
116 (8) Unless otherwise expressly stated in the sale
117 documents, the transaction involving the sale of a hospital
118 shall not be construed as:
119 (a) A transfer of a governmental function from the county,
120 district, or municipality to the private purchaser;
121 (b) Constituting a financial interest of the public seller
122 in the private purchaser; or
123 (c) Making a private purchaser an integral part of the
124 public seller's decisionmaking process.
125 (9)(a) The purchaser of a hospital, under this section or
126 any special act of the Legislature, operating after a sale of
127 the hospital is not "acting on behalf of" the seller as that
128 term is used in statute, unless the sale document expressly
129 provides to the contrary.
130 (b) The purchaser of a hospital, under this section or any
131 special act of the Legislature, operating after a sale of the
132 hospital shall not be construed as an "agency" within the
133 meaning of s. 119.011(2), unless the sale document expressly
134 provides to the contrary.

135 Section 2. This act shall take effect July 1, 2006.

HB 685 CS

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 685 CS Veterinary Drug Distribution
SPONSOR(S): Coley and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1540

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N, w/CS	Bell	Mitchell
2) Agriculture Committee	10 Y, 0 N	Kaiser	Reese
3) Health Care Appropriations Committee	14 Y, 0 N	Money	Massengale
4) Health & Families Council		Bell AJB	Moore MPM
5)			

SUMMARY ANALYSIS

House Bill 685 CS establishes a new type of prescription drug wholesaler permit, the "limited prescription drug veterinary wholesaler permit" (permit). The permit is required for any person who engages in the distribution, in or into the state to veterinarians, of veterinary prescription drugs and prescription drugs regulated by the Federal Food, Drug, and Cosmetic Act (act).[1] The bill provides several permit requirements, including a $20,000 bond or equivalent surety requirement, and provides parameters for permit holders.

The bill defines any human prescription drug, regulated under the act, as an adulterated drug if it has been returned by a veterinarian to a limited prescription drug veterinary wholesaler. The bill also specifies that no more than 30 percent of drug sales by limited prescription drug veterinary wholesalers may be prescription drugs prescribed for human use. It also requires a limited prescription drug veterinary wholesaler to comply with pedigree paper tracking requirements except under certain circumstances.

The bill requires the Department of Health (DOH) to inspect each limited prescription drug wholesaler. It authorizes DOH to order immediate closures of a limited prescription drug veterinary wholesaler if the department determines that it presents an immediate danger to the public health, safety, or welfare.

The bill provides a fee for a limited prescription drug veterinary wholesaler's permit of not less than $300 or more than $500 annually. DOH estimates that, with the creation of the permit, there will be a yearly loss of $3,000 in trust fund revenue, but will have no effect on current operations.

The effective date of the bill is July 1, 2006.

[1] Section 503(b) of the Federal Food, Drug, and Cosmetic Act regulates pharmaceutical drugs intended for human consumption.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government - The bill creates a new prescription drug wholesaler permit. The new permit allows veterinary wholesalers to provide legend drugs intended for human use, but limits the sales to no more than 30 percent. The bill decreases requirements for veterinary wholesalers that wish to provide legend drugs intended for human use.

B. EFFECT OF PROPOSED CHANGES:

The bill establishes a new type of prescription drug wholesaler permit, the "limited prescription drug veterinary wholesaler permit" (permit). The permit is required for any person who engages in the distribution in or into the state of veterinarian prescription drugs and prescription drugs subject to, or described by section 503(b) of the Federal Food, Drug, and Cosmetic Act[2] to veterinarians. The bill also allows limited veterinary drug wholesalers to sell drugs to the following:

- Licensed veterinarians practicing on a full-time basis.
- Veterinary medicine instructors.
- Law enforcement personnel with service animals.
- Researchers, not involved in clinical use.
- For use in chemical analysis or physical testing, for the purposes of instruction in law enforcement, research, or testing.

The bill provides several permit requirements, including a $20,000 bond or equivalent surety requirement, and provides parameters for permit holders. The bill defines any prescription drug subject to, defined by, or described by section 503(b) of the Federal Food, Drug, and Cosmetic Act, which has been returned by a veterinarian to a limited prescription drug veterinary wholesaler as an adulterated drug.

The bill specifies that no more than 30 percent of drug sales[3] by limited prescription drug veterinary wholesalers may be prescription drugs prescribed for human use. It also requires a limited prescription drug veterinary wholesaler to comply with pedigree paper tracking requirements under section 499.0121, Florida Statutes, except that the permit holder is not required to comply with the pedigree paper requirements of section 499.0121(6)(f), Florida Statutes, upon the wholesale distribution of a prescription drug to a veterinarian.

The bill permits intra-company sale or transfer of prescription drugs from an out of state establishment that is duly licensed to engage in the wholesale distribution of prescription drugs in its state of residence, to a licensed limited prescription drug veterinarian wholesaler. Both wholesalers must operate under the same name, and comply with the recordkeeping requirements of section 499.0121(6), Florida Statutes.

The bill provides a fee for a permit of not less than $300 or more than $500 annually. It also requires the Department of Health (DOH) to inspect each limited prescription drug wholesaler. It authorizes DOH to order immediate closures of a limited prescription drug veterinary wholesaler if the department determines that it presents an immediate danger to the public health, safety, or welfare.

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[2] Section 503(b) of the Federal Food, Drug, and Cosmetic Act regulates pharmaceutical drugs intended for human consumption.

[3] According to a survey conducted by the American Veterinary Distributors Association (AVDA), human drug sales comprise approximately 30 percent of the annual sales volume of veterinary wholesalers who sell all types of veterinary products to veterinarians.

Limited Veterinarian Prescription Drug Wholesaler Permit Requirements

The bill provides the following requirements and conditions under the permit:

- The permit holder must be engaged in the business of wholesaling prescription and veterinary legend drugs on a full-time basis;
- No more than 30 percent of drug sales may be prescription drugs prescribed for human use;
- The permit holder may not be licensed in any state to wholesale prescription drugs subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act to any person who is authorized to sell, distribute, purchase, trade, or use these drugs on or for humans;
- The permit holder must submit a $20,000 bond or equivalent surety;
- The permit holder must maintain a license or permit to engage in wholesale distribution of prescription drugs at all times in compliance with the laws of the state in which it is a resident;
- The permit holder must comply with section 499.0121, Florida Statutes, except that the permit holder is not required to comply with the pedigree paper requirements of section 499.0121(6)(f), Florida Statutes, for wholesale distribution of a prescription drug to a veterinarian; and,
- The permit holder may not return to inventory for subsequent wholesale distribution any drug federally regulated under section 503(b) of the Federal Food, Drug, and Cosmetic Act, which has been returned by a veterinarian.

The effective date of the bill is July 1, 2006.

Overview

The Bureau of Statewide Pharmacy Services of DOH is responsible for regulating the wholesale distribution of drugs intended for human consumption[4] and veterinary legend drugs[5] in Florida under the Florida Drug and Cosmetic Act. The Florida Drug and Cosmetic Act is codified in chapter 499, Florida Statutes.

Under section 499.012, Florida Statutes, "wholesale distributor" is defined to mean any person engaged in wholesale distribution of prescription drugs. Persons or entities that distribute wholesale veterinary prescription drugs must obtain a permit under the Florida Drug and Cosmetic Act.

Currently, wholesalers that distribute drugs to veterinarians must have a prescription drug wholesaler's permit, an out-of-state wholesaler's permit, a retail pharmacy wholesaler's permit, or a veterinary prescription drug wholesaler permit. However, most often wholesalers that distribute drugs to veterinarians register as a prescription drug wholesaler or a veterinary prescription drug wholesaler.

Veterinary prescription drug wholesalers are limited to only distributing prescription drugs developed and intended for animal use. According to an industry representative, some prescription drugs intended for human use do not have an equivalent prescription drug intended for animal use. Because of this deficiency, veterinarians may prescribe human drugs to animals. According to DOH, human medications sold by veterinarians are not on any list of adulterated, counterfeit, or diverted drugs. The human drugs sold by veterinarians include eye ointment, antibiotics, allergy medications, and topical anesthetics.

[4] Section 499.003(25), F.S.
[5] Section 499.0122(1)(c), F.S.

Existing Regulations

Veterinary Prescription Drug Wholesaler Permits
Section 499.01, Florida Statutes, requires a permit for any person or establishment that wishes to operate as a veterinary prescription drug wholesaler. Veterinary prescription drug wholesaler is defined as any person engaged in the wholesale distribution of veterinary prescription drugs in or into Florida.[6]

Prescription Drug Wholesalers
All prescription drug wholesalers are required to post a $100,000 bond and to file an extensive permit application that includes the submission of fingerprint cards for all key individuals associated with the wholesaler's operations in order for a criminal history check to be performed. In addition, each prescription drug wholesaler must have a designated representative who has successfully passed an examination on federal and state laws, and department rules, relating to the wholesale distribution of prescription drugs.

	Prescription Drug Wholesaler	**Limited Veterinary Prescription Drug Wholesaler (proposed permit)**	**Veterinary Prescription Drug Wholesaler**
Type of Prescription Drugs Dispensed	Legend drugs defined or described by section 503(b) of the Federal Food, Drug, and Cosmetic Act.	May dispense up to 30% of sales from legend drugs.	Veterinarian legend drugs only.
Required Deposit	$100,000 bond, certificate of deposit, or letter of credit	$20,000 bond, certificate of deposit, or letter of credit	None required.
Authorized yearly fees	$800 Annually section 499.041(2)(a), Florida Statutes	$300-$500 Annually (proposed legislation)	$500 section 499.041(g), Florida Statutes

Pedigree Papers
Pedigree papers are the key standard for control of the wholesale drug industry designed to prevent drug diversion, fraud, and counterfeiting. They require wholesalers to provide purchasers with a written sales history tracing each drug back to its initial manufacturer. These written histories, commonly referred to as pedigree papers, provide an audit trail and contain specific information about each sales transaction, such as the name and address of each previous purchaser of the drug.

Beginning July 1, 2006, prescription drug wholesalers will be required to pass pedigree papers down to the retail level. Wholesalers who pass pedigree papers to veterinarians are included in this provision.

Florida Drug & Cosmetic Act
Pursuant to the Florida Drug and Cosmetic Act, part I, chapter 499, Florida Statutes, DOH is responsible for administering and enforcing efforts to prevent fraud, adulteration, misbranding, or false advertising in the preparation, manufacture, repackaging, or distribution of drugs, devices and cosmetics. Wholesalers, manufacturers and distributors of drugs or devices must be permitted by the department or otherwise be exempt.[7]

Under the Florida Drug and Cosmetic Act (act), any person who is at least 18 years of age or older, pays a permit fee, and submits specified information may, with certain exceptions, obtain a permit as a

[6] Section 499.003(40), F.S.
[7] Drug marketing is also subject to regulation under the Federal Prescription Drug Marketing Act of 1987, which establishes minimum standards for the prescription drug industry including requirements for an audit trail of sales transactions.

prescription drug wholesaler.[8] The applicant must not have been found guilty of a violation of a law that directly relates to a drug, device, or cosmetic, regardless of adjudication. The applicant must submit information on contact persons for each facility used by the applicant for the storage, handling and distribution of prescription drugs. The permit, once granted, may be renewed biennially.

An out-of-state prescription drug wholesaler distributor located outside of Florida must be permitted by DOH. DOH is authorized to adopt rules that allow out-of-state drug wholesalers to obtain a drug wholesale permit on the basis of reciprocity in Florida to the extent that an out-of-state drug wholesaler possesses a valid permit from another state with requirements that are comparable to those of Florida and can show that the other state from which the wholesaler holds a permit would extend reciprocity under its laws to a Florida-permitted drug wholesaler. According to DOH, there are approximately 450 prescription drug wholesalers located in Florida and 900[9] out-of-state wholesalers, of which less than 10 percent are one of the three large full-line wholesalers or their distribution centers, or major full-line regional wholesalers. The remaining wholesalers are secondary wholesalers that primarily buy and sell among other prescription drug wholesalers rather than to end-users such as hospitals or other health care entities, which include physicians or pharmacies.

The act requires prescription drug wholesalers to maintain records that provide a complete audit trail of prescription drugs from purchase to sale or other disposition. Such records known as "pedigree papers" must include a written statement of all previous sales of the drug that is sold in a wholesale market.

The act specifies criminal penalties for violations relating to activities regulated by DOH under the act. Such criminal offenses are, with few exceptions, punishable as a second-degree misdemeanor.

C. SECTION DIRECTORY:

Section 1. - Amends s. 499.006, F. S., defining a prescription drug returned by a veterinarian to a limited prescription drug veterinary wholesaler as an adulterated drug. Prescription drugs are those regulated by section 503(b) of the Federal Food, Drug, and Cosmetic Act.

Section 2. - Amends s. 499.01, F. S., requiring a permit for any person or establishment that intends to operate as a limited prescription drug veterinary wholesaler. The bill provides that the limited drug veterinary wholesaler permit may not be issued to the address of a health care entity or pharmacy licensed under chapter 465, F. S., except as provided in section 499.01(2)(d), Florida Statutes.

Section 3. - Amends s. 499.012, F. S., establishing a limited prescription drug veterinary wholesaler permit. The bill provides several permit requirements and conditions under the permit, including a $20,000 bond or equivalent surety requirement, and provides permissible transactions under the permit.

Section 4. - Amends s. 499.01221(1)(d) F. S., deleting veterinarians from the group of persons or entities to whom a veterinary legend drug retail establishment may sell veterinary legend drugs. The bill permits a veterinary legend drug retail establishment to only sell veterinary legend drugs to the public.

Section 5. - Amends s. 499.041, F. S., requiring a fee for a limited prescription drug veterinary wholesaler's permit. The bill provides the fee may not be less than $300 or more than $500 annually.

Section 6. - Amends s. 499.065, F. S., requiring DOH to inspect each limited prescription drug veterinary wholesaler; permiting DOH to order the immediate closure of a limited prescription drug

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[8] See ss. 499.01 and 499.012, F.S. The permitting requirements for a number of establishments licensed or permitted by the Department of Health to engage in activities regulated under the Florida Drug and Cosmetic Act are the same. Such establishments include: prescription drug manufacturer; over-the-counter drug manufacturer; compressed medical gas manufacturer; device manufacturer; cosmetic manufacturer; prescription drug wholesaler; compressed medical gas wholesaler; out-of state prescription drug wholesaler; retail pharmacy drug wholesaler; veterinary legend drug retail establishment; medical oxygen retail establishment; complimentary drug distributor; or restricted prescription drug distributor.

[9] According to Department of Health records from 2003.

veterinary wholesaler if DOH determines that it presents an immediate danger to the public health, safety, or welfare.

Section 7. - Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Estimated Revenue	1st Year	2nd Year (Annualized/Recurring)
Decrease in permit fee revenue $300 for est. 10 permits	-3,000	-3,000
Total Estimated Revenue	- $3,000	- $3,000

2. Expenditures:

None

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Under the proposed legislation veterinary wholesalers who wish to offer some legend drugs intended for human use have the option of obtaining a limited veterinary prescription drug wholesaler permit instead of a prescription drug wholesaler permit. Because the limited veterinary prescription drug wholesaler has fewer requirements than the prescription drug wholesaler permit, some cost savings may be realized. Wholesalers who choose to obtain the newly created permit may pass their savings on to their customers.

D. FISCAL COMMENTS:

The Department of Health (DOH) estimates that no more that 10 establishments will apply and qualify to become limited veterinary wholesalers. As a result, the impact, assuming each is currently permitted as a prescription drug wholesaler or out-of-state prescription drug wholesaler, will be a decrease in revenue of $3,000 annually. According to DOH, the $3,000 loss in revenue will have no effect on operations.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None

B. RULE-MAKING AUTHORITY:

The Department of Health has the necessary rulemaking authority to carry out the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On February 22, 2006, the Health Care Regulation Committee adopted one amendment to House Bill 685. The amendment specifies that limited prescription drug veterinary wholesalers can sell prescription drugs to the following:

- Licensed veterinarians practicing on a full-time basis.
- Veterinary medicine instructors.
- Law enforcement personnel with service animals.
- Researchers, not involved in clinical use.
- For use in chemical analysis or physical testing, for the purposes of instruction in law enforcement, research, or testing.

The analysis is drafted to the committee substitute.

CHAMBER ACTION

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1 The Health Care Regulation Committee recommends the following:
2
3 **Council/Committee Substitute**
4 Remove the entire bill and insert:
5 A bill to be entitled
6 An act relating to veterinary drug distribution; amending
7 s. 499.006, F.S.; providing that a drug is adulterated if
8 it is a certain prescription drug that has been returned
9 by a veterinarian to a limited prescription drug
10 veterinary wholesaler; amending s. 499.01, F.S.; requiring
11 a limited prescription drug veterinary wholesaler to
12 obtain a permit for operation from the Department of
13 Health; providing that a permit for a limited prescription
14 drug veterinary wholesaler may not be issued to the
15 address of certain health care entities; amending s.
16 499.012, F.S.; revising permit requirements for a
17 veterinary prescription drug wholesaler that distributes
18 prescription drugs; establishing a permit for a limited
19 prescription drug veterinary wholesaler; providing
20 requirements; providing an exception; amending s.
21 499.0122, F.S.; redefining the term "veterinary legend
22 drug retail establishment"; amending s. 499.041, F.S.;
23 requiring the department to assess an annual fee within a

24 certain monetary range for a limited prescription drug
25 veterinary wholesaler permit; amending s. 499.065, F.S.;
26 requiring the department to inspect each limited
27 prescription drug veterinary wholesaler establishment;
28 authorizing the department to determine that a limited
29 prescription drug veterinary wholesaler establishment is
30 an imminent danger to the public; providing an effective
31 date.
32
33 Be It Enacted by the Legislature of the State of Florida:
34
35 Section 1. Section 499.006, Florida Statutes, is amended
36 to read:
37 499.006 Adulterated drug or device.--A drug or device is
38 adulterated:
39 (1) If it consists in whole or in part of any filthy,
40 putrid, or decomposed substance;
41 (2) If it has been produced, prepared, packed, or held
42 under conditions whereby it could have been contaminated with
43 filth or rendered injurious to health;
44 (3) If it is a drug and the methods used in, or the
45 facilities or controls used for, its manufacture, processing,
46 packing, or holding do not conform to, or are not operated or
47 administered in conformity with, current good manufacturing
48 practices to assure that the drug meets the requirements of ss.
49 499.001-499.081 and that the drug has the identity and strength,
50 and meets the standard of quality and purity, which it purports
51 or is represented to possess;

52 (4) If it is a drug and its container is composed, in
53 whole or in part, of any poisonous or deleterious substance
54 which could render the contents injurious to health;
55 (5) If it is a drug and it bears or contains, for the
56 purpose of coloring only, a color additive that is unsafe within
57 the meaning of the federal act; or, if it is a color additive,
58 the intended use of which in or on drugs is for the purpose of
59 coloring only, and it is unsafe within the meaning of the
60 federal act;
61 (6) If it purports to be, or is represented as, a drug the
62 name of which is recognized in the official compendium, and its
63 strength differs from, or its quality or purity falls below, the
64 standard set forth in such compendium. The determination as to
65 strength, quality, or purity must be made in accordance with the
66 tests or methods of assay set forth in such compendium, or, when
67 such tests or methods of assay are absent or inadequate, in
68 accordance with those tests or methods of assay prescribed under
69 authority of the federal act. A drug defined in the official
70 compendium is not adulterated under this subsection merely
71 because it differs from the standard of strength, quality, or
72 purity set forth for that drug in such compendium if its
73 difference in strength, quality, or purity from such standard is
74 plainly stated on its label;
75 (7) If it is not subject to subsection (6) and its
76 strength differs from, or its purity or quality falls below the
77 standard of, that which it purports or is represented to
78 possess;
79 (8) If it is a drug:

80 (a) With which any substance has been mixed or packed so
81 as to reduce the quality or strength of the drug; or
82 (b) For which any substance has been substituted wholly or
83 in part;
84 (9) If it is a drug or device for which the expiration
85 date has passed; ~~or~~
86 (10) If it is a legend drug for which the required
87 pedigree paper is nonexistent, fraudulent, or incomplete under
88 the requirements of ss. 499.001-499.081 or applicable rules, or
89 that has been purchased, held, sold, or distributed at any time
90 by a person not authorized under federal or state law to do so;
91 or~~.~~
92 (11) If it is a prescription drug subject to, defined by,
93 or described by s. 503(b) of the Federal Food, Drug, and
94 Cosmetic Act which has been returned by a veterinarian to a
95 limited prescription drug veterinary wholesaler.
96 Section 2. Subsection (1) and paragraph (d) of subsection
97 (2) of section 499.01, Florida Statutes, are amended to read:
98 499.01 Permits; applications; renewal; general
99 requirements.--
100 (1) Prior to operating, a permit is required for each
101 person and establishment that intends to operate as:
102 (a) A prescription drug manufacturer;
103 (b) A prescription drug repackager;
104 (c) An over-the-counter drug manufacturer;
105 (d) A compressed medical gas manufacturer;
106 (e) A device manufacturer;
107 (f) A cosmetic manufacturer;

108 (g) A prescription drug wholesaler;
109 (h) A veterinary prescription drug wholesaler;
110 (i) A compressed medical gas wholesaler;
111 (j) An out-of-state prescription drug wholesaler;
112 (k) A nonresident prescription drug manufacturer;
113 (l) A freight forwarder;
114 (m) A retail pharmacy drug wholesaler;
115 (n) A veterinary legend drug retail establishment;
116 (o) A medical oxygen retail establishment;
117 (p) A complimentary drug distributor; ~~or~~
118 (q) A restricted prescription drug distributor; or~~.~~
119 (r) A limited prescription drug veterinary wholesaler.
120 (2)
121 (d) A permit for a prescription drug manufacturer,
122 prescription drug repackager, prescription drug wholesaler,
123 limited prescription drug veterinary wholesaler, or retail
124 pharmacy wholesaler may not be issued to the address of a health
125 care entity or to a pharmacy licensed under chapter 465, except
126 as provided in this paragraph. The department may issue a
127 prescription drug manufacturer permit to an applicant at the
128 same address as a licensed nuclear pharmacy, which is a health
129 care entity, for the purpose of manufacturing prescription drugs
130 used in positron emission tomography or other
131 radiopharmaceuticals, as listed in a rule adopted by the
132 department pursuant to this paragraph. The purpose of this
133 exemption is to assure availability of state-of-the-art
134 pharmaceuticals that would pose a significant danger to the
135 public health if manufactured at a separate establishment

136 address from the nuclear pharmacy from which the prescription
137 drugs are dispensed. The department may also issue a retail
138 pharmacy wholesaler permit to the address of a community
139 pharmacy licensed under chapter 465 which does not meet the
140 definition of a closed pharmacy in s. 499.003.
141 Section 3. Paragraph (g) of subsection (2) of section
142 499.012, Florida Statutes, is amended, and paragraph (h) is
143 added to that subsection, to read:
144 499.012 Wholesale distribution; definitions; permits;
145 applications; general requirements.--
146 (2) The following types of wholesaler permits are
147 established:
148 (g) A veterinary prescription drug wholesaler permit.--A
149 veterinary prescription drug wholesaler permit is required for
150 any person that engages in the distribution of veterinary
151 prescription drugs in or into this state. A veterinary
152 prescription drug wholesaler that also distributes prescription
153 drugs subject to, defined by, or described by s. 503(b) of the
154 Federal Food, Drug, and Cosmetic Act which it did not
155 manufacture must obtain a permit as a prescription drug
156 wholesaler, an ~~or~~ out-of-state prescription drug wholesaler, or
157 a limited prescription drug veterinary wholesaler in lieu of the
158 veterinary prescription drug wholesaler permit. A veterinary
159 prescription drug wholesaler must comply with the requirements
160 for wholesale distributors under s. 499.0121, except those set
161 forth in s. 499.0121(6)(d), (e), or (f).
162 (h) Limited prescription drug veterinary wholesaler
163 permit.--Unless engaging in the activities of and permitted as a

164 prescription drug manufacturer, nonresident prescription drug
165 manufacturer, prescription drug wholesaler, or out-of-state
166 prescription drug wholesaler, a limited prescription drug
167 veterinary wholesaler permit is required for any person that
168 engages in the distribution in or into this state of veterinary
169 prescription drugs and prescription drugs subject to, defined
170 by, or described by s. 503(b) of the Federal Food, Drug, and
171 Cosmetic Act to veterinarians under the following conditions:
172 1. The person is engaged in the business of wholesaling
173 prescription and veterinary legend drugs to persons:
174 a. Licensed as veterinarians practicing on a full-time
175 basis;
176 b. Regularly and lawfully engaged in instruction in
177 veterinary medicine;
178 c. Regularly and lawfully engaged in law enforcement;
179 d. For use in research, not involving clinical use; or
180 e. For use in chemical analysis or physical testing, for
181 the purposes of instruction in law enforcement, research, or
182 testing.
183 2. No more than 30 percent of prescription drug sales may
184 be prescription drugs approved for human use which are subject
185 to, defined by, or described by s. 503(b) of the Federal Food,
186 Drug, and Cosmetic Act.
187 3. The person is not permitted, licensed, or otherwise
188 authorized in any state to wholesale prescription drugs subject
189 to, defined by, or described by s. 503(b) of the Federal Food,
190 Drug, and Cosmetic Act to any person who is authorized to sell,

191 distribute, purchase, trade, or use these drugs on or for
192 humans.
193 4. A limited prescription drug veterinary wholesaler that
194 applies to the department for a new permit or the renewal of a
195 permit must submit a bond of $20,000, or other equivalent means
196 of security acceptable to the department, such as an irrevocable
197 letter of credit or a deposit in a trust account or financial
198 institution, payable to the Florida Drug, Device, and Cosmetic
199 Trust Fund. The purpose of the bond is to secure payment of any
200 administrative penalties imposed by the department and any fees
201 and costs incurred by the department regarding that permit which
202 are authorized under state law and which the permittee fails to
203 pay 30 days after the fine or costs become final. The department
204 may make a claim against such bond or security until 1 year
205 after the permittee's license ceases to be valid or until 60
206 days after any administrative or legal proceeding authorized in
207 ss. 499.001-499.081 which involves the permittee is concluded,
208 including any appeal, whichever occurs later.
209 5. A limited prescription drug veterinary wholesaler must
210 maintain at all times a license or permit to engage in the
211 wholesale distribution of prescription drugs in compliance with
212 laws of the state in which it is a resident.
213 6. A limited prescription drug veterinary wholesaler must
214 comply with the requirements for wholesale distributors under s.
215 499.0121, except that a limited prescription drug veterinary
216 wholesaler is not required to provide a pedigree paper as
217 required by s. 499.0121(6)(f) upon the wholesale distribution of
218 a prescription drug to a veterinarian.

219 7. A limited prescription drug veterinary wholesaler may
220 not return to inventory for subsequent wholesale distribution
221 any prescription drug subject to, defined by, or described by s.
222 503(b) of the Federal Food, Drug, and Cosmetic Act which has
223 been returned by a veterinarian.
224 8. An out-of-state prescription drug wholesaler's permit
225 or a limited prescription drug veterinary wholesaler permit is
226 not required for an intracompany sale or transfer of a
227 prescription drug from an out-of-state establishment that is
228 duly licensed to engage in the wholesale distribution of
229 prescription drugs in its state of residence to a licensed
230 limited prescription drug veterinary wholesaler in this state if
231 both wholesalers conduct wholesale distributions of prescription
232 drugs under the same business name. The recordkeeping
233 requirements of s. 499.0121(6) must be followed for this
234 transaction.
235 Section 4. Paragraph (d) of subsection (1) of section
236 499.0122, Florida Statutes, is amended to read:
237 499.0122 Medical oxygen and veterinary legend drug retail
238 establishments; definitions, permits, general requirements.--
239 (1) As used in this section, the term:
240 (d) "Veterinary legend drug retail establishment" means a
241 person permitted to sell veterinary legend drugs to the public
242 ~~or to veterinarians,~~ but does not include a pharmacy licensed
243 under chapter 465.
244 1. The sale to the public must be based on a valid written
245 order from a veterinarian licensed in this state who has a valid
246 client-veterinarian relationship with the purchaser's animal.

247 2. Veterinary legend drugs may not be sold in excess of
248 the amount clearly indicated on the order or beyond the date
249 indicated on the order.
250 3. An order may not be valid for more than 1 year.
251 4. A veterinary legend drug retail establishment may not
252 purchase, sell, trade, or possess human prescription drugs or
253 any controlled substance as defined in chapter 893.
254 5. A veterinary legend drug retail establishment must sell
255 a veterinary legend drug in the original, sealed manufacturer's
256 container with all labeling intact and legible. The department
257 may adopt by rule additional labeling requirements for the sale
258 of a veterinary legend drug.
259 Section 5. Paragraph (h) is added to subsection (2) of
260 section 499.041, Florida Statutes, to read:
261 499.041 Schedule of fees for drug, device, and cosmetic
262 applications and permits, product registrations, and free-sale
263 certificates.--
264 (2) The department shall assess an applicant that is
265 required to have a wholesaling permit an annual fee within the
266 ranges established in this section for the specific type of
267 wholesaling.
268 (h) The fee for a limited prescription drug veterinary
269 wholesaler's permit may not be less than $300 or more than $500
270 annually.
271 Section 6. Subsections (1) and (3) of section 499.065,
272 Florida Statutes, are amended to read:
273 499.065 Imminent danger.--

274 (1) Notwithstanding s. 499.051, the department shall
275 inspect each prescription drug wholesale establishment,
276 prescription drug repackager establishment, veterinary
277 prescription drug wholesale establishment, limited prescription
278 drug veterinary wholesaler establishment, and retail pharmacy
279 drug wholesaler establishment that is required to be permitted
280 under this chapter as often as necessary to ensure compliance
281 with applicable laws and rules. The department shall have the
282 right of entry and access to these facilities at any reasonable
283 time.
284 (3) The department may determine that a prescription drug
285 wholesale establishment, prescription drug repackager
286 establishment, veterinary prescription drug wholesale
287 establishment, limited prescription drug veterinary wholesaler
288 establishment, or retail pharmacy drug wholesaler establishment
289 that is required to be permitted under this chapter is an
290 imminent danger to the public health and shall require its
291 immediate closure if the establishment fails to comply with
292 applicable laws and rules and, because of the failure, presents
293 an imminent threat to the public's health, safety, or welfare.
294 Any establishment so deemed and closed shall remain closed until
295 allowed by the department or by judicial order to reopen.
296
297 For purposes of this section, a refusal to allow entry to the
298 department for inspection at reasonable times, or a failure or
299 refusal to provide the department with required documentation
300 for purposes of inspection, constitutes an imminent danger to
301 the public health.

302 Section 7. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 715 CS Trauma Services
SPONSOR(S): Grimsley
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N, w/CS	Bell	Mitchell
2) Health Care Appropriations Committee	10 Y, 0 N, w/CS	Money	Massengale
3) Health & Families Council		Bell AJB	Moore
4)			
5)			

SUMMARY ANALYSIS

The 2005 Legislature passed House Bill 497 and House Bill 1697, which provided additional funding to trauma centers through traffic infraction fines and court assessments. Revenues generated through these additional funds are appropriated into the Department of Health (DOH) Administrative Trust Fund, from which up to $7.5 million is earmarked to provide funding for trauma centers on the basis of caseload and the severity of trauma patients. Currently, $1 million has been raised by the increased fee.

House Bill 715 CS addresses the allocation and distribution of trauma center funds. The bill changes a number of provisions related to the distribution and determination of trauma payments to current verified trauma centers. The changes include:

- Changing the way trauma centers determine the severity of patients (by requiring trauma centers to evaluate patients with the International Classification Injury Severity Score (ICISS) instead of the Injury Severity Score (ISS)).
- Providing definitions for ICISS, trauma caseload volume, trauma patient, and local funding contribution.
- Creating a trauma center start-up grant program.

The fiscal impact of the bill is a one-time $500,000 for the creation of a trauma center start-up grant, and is subject to appropriation in the General Appropriations Act.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote Limited Government—The bill provides new definitions and changes the way verified trauma centers determine the severity of trauma patients that may alter the distribution of trauma center funds. The bill provides a one-time appropriation from general revenue of $500,000 for the creation of a trauma center start-up grant.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

In the 2005 session the Legislature passed House Bill 497 and House Bill 1697, both of which provide additional funding to trauma centers through traffic infraction fines and court assessments. House Bill 497 increased the civil penalties for drivers who fail to obey red traffic signals from $60 to $125. HB 1697 allocated funds from mandatory civil penalties to provide financial support to trauma centers throughout the state.

Revenues generated through these additional funds are appropriated into the Department of Health (DOH) Administrative Trust Fund, from which up to $7.5 million is earmarked to provide funding for trauma centers on the basis of caseload and the severity of trauma patients. Currently, $1 million dollars has been raised by the increased fee.

Trauma center funding is weighted based on the severity of trauma patients (40 percent), the trauma caseload volume (40 percent), and availability of local funding contributions (20 percent). The severity of trauma patients and caseload volume is collected and entered into the Department of Health Trauma Registry. The classification currently used to rate severity of trauma is the Injury Severity Score (ISS).

Trauma Registry data is currently verified by DOH staff during the yearly trauma center site survey. The DOH survey takes a very small sample of Trauma Registry records to evaluate trauma staffing and procedures. This survey does not focus on the validity of the Trauma Registry ISS.

Currently, funds collected for distribution to trauma centers are based on the calendar year and not the state fiscal year.

The University of Florida recently published, *A Comprehensive Assessment of the Florida Trauma System*. To improve trauma care in Florida, the report recommended placing trauma centers in Tallahassee and Bay County.

Effects of the Bill

The bill amends ss. 395.4001 and 395.4035, F.S., to address the allocation of trauma center funds. It changes a number of provisions related to the determination and distribution of trauma payments to current verified trauma centers.

The bill changes the standard by which trauma centers report injuries to DOH. Currently the severity of trauma patients is determined and coded with Injury Severity Scores (ISS), which only considers a maximum of three patient injuries. The bill requires trauma severity to be determined by the International Classification Injury Severity Scores (ICISS), the current standard, and other statistically valid and scientifically accepted methods of stratifying a trauma patient's severity of injury, risk of mortality, and resource consumption as adopted by DOH by rule. The impact of the change in injury

determination methodology may change payment calculations for determining the amount of funding allotted to each trauma center.

The bill provides that DOH's Administrative Trust Fund may be used to maximize federal funds available to trauma centers. The total funds distributed to trauma centers may include revenue from DOH's Administrative Trust Fund and federal funds for which revenue from DOH's Administrative Trust Fund is used to meet state or local matching requirements, including Medicaid. Funds collected from traffic infractions and earmarked for trauma centers under ss. 318.14 and 318.18, F. S., will be distributed to trauma centers on a quarterly basis. The data used to distribute trauma funds will be from the most recent year available.

The bill repeals s. 395.4035, F.S., the Trauma Trust Fund. This has no impact on trauma centers because the Trauma Trust Fund has never been used by DOH. Funds collected for distribution to trauma centers have been deposited into either the Emergency Medical Services Trust Fund or the DOH Administrative Trust Fund.

The bill amends s. 395.4001, F. S., to provide definitions for the International Classification Injury Severity Score (ICISS), trauma caseload volume, trauma patient, and local funding contribution. These are new statutory definitions.

Trauma Start-Up Grant

The bill creates s. 395.41, F.S., to establish a trauma start-up grant program. The program recognizes that there is significant up-front investment of capital incurred by hospitals to develop the physical space, equipment, and qualified personnel necessary to provide quality trauma services. The grant program provides a one-time grant of $500,000, to be matched by local contributions, to qualifying hospitals. To qualify for the grant program a hospital must be located in a trauma region that does not currently have a trauma center and be at least 100 miles away from a current trauma center. A hospital must also meet the following criteria:

- Receive local funding contributions.
- Incur start-up costs in excess of the grant funding request.
- Actively pursue the establishment of a residency program in emergency medicine.

Hospitals receiving start-up grant funding have 24 months to become a trauma center or start-up grant funds must be returned.

BACKGROUND

Chapter 395, F.S., defines a trauma center as a facility within a general medical hospital determined by the Department of Health to be in compliance with trauma center verification standards. These centers treat individuals who have incurred blunt or penetrating injuries or burns, and who require immediate medical intervention and treatment. Trauma center patients require urgent, lifesaving care. Trauma centers must be ready at all times and have designated suites reserved to treat patients at all times. Emergency rooms are not trauma centers. A trauma center has dozens of specialists, many of whom are available 24-hours-a-day, seven days a week. Trauma centers have access to air emergency whose job is to be available for the moment a serious accident occurs.

The effectiveness of a trauma center lies in the speed and quality of treatment. Getting a patient definitive care within the first hour, or "golden hour," of injury drastically increases their chances of survival. Trauma mortality is reduced by 15-20 percent when a very seriously injured patient is treated at a trauma center versus a non-trauma center.

Florida's trauma system has been under development since the passage of landmark trauma legislation in the late 1980s. Key components of this system include trauma centers, trauma agencies,

trauma service areas, and trauma regions, as well as trauma transport protocols and trauma triage criteria for emergency medical service providers.

Florida Trauma Registry

The Florida Trauma Registry (FTR) collects patient-level data from the state's twenty-one trauma centers. As a state designated facility, a trauma center must maintain a comprehensive database of those injured patients treated within the hospital. The trauma registry supports the trauma centers' required activities, including performance improvement, outcomes research, and resource utilization as well as providing the state public health system with the necessary data for state-wide planning and injury prevention initiatives.

Comparing the Injury Severity Scores and the International Classification Injury Severity Scores

Characterization of injury severity is crucial to the study and treatment of trauma. The measurement of injury severity began just over 50 years ago with the Abbreviated Injury Scale (AIS), a method developed to grade the severity of individual injuries. The AIS has been modified many times, most recently in 1990, and is the basis for the Injury Severity Score (ISS). The Injury Severity Score (ISS) was, for many decades, the standard summary measure of human trauma. However, it has two weaknesses. First, the ISS considers a maximum of only three of an individual patient's injuries which may not even be the patient's most severe injuries. Second, the ISS requires that all patients have their injuries described using an expensive assessment method unavailable at most hospitals, especially those that do not specialize in trauma.[1]

A more recent approach to injury scoring is based on the *International Classification of Disease, Ninth Edition* (*ICD-9*) codes and is referred to as the *ICD-9* Injury Severity Score (ICISS). The ICISS is a data-driven alternative to ISS that uses empirically-derived injury severity measures, and considers all of an individual patient's injuries rather than just a few. The use of the standard ICD-9 classification scheme adds to the statistical appeal of the ICISS and avoids the need for costly AIS coding.[2]

In terms of methodology, the ICISS uses survival risk ratios (SRRs) calculated for each *ICD-9* discharge diagnosis. SRRs are derived by dividing the number of survivors in each *ICD-9* code by the total number of patients with the same *ICD-9* code. ICISS is calculated as the simple product of the SRRs for each of the patient's injuries.[3] For example, if a population of 1,000 patients with femoral fractures included 100 patients who died, then the single SRR for that particular diagnoses would be .9 or [1-(100/1000)]. A patient with two injuries, one having a SRR of .9 and the other having a SRR of .5, would have a total probability of survival of .9 multiplied by .5, yielding an overall probability of survival of .45.[4]

ICISS has demonstrated a greater reliability than ISS, and offers many advantages for predicting the severity of an illness and injury. The ICISS values may also be used as predictors of resource utilization, and may be used as an assessment tool in quality improvement efforts. Research has shown that benefits of the ICISS over other scoring systems include:[5]

1. It represents a true continuous variable that takes on values between 0 and 1.

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[1] Osler, T., Rutledge, R., et al. ***ICISS*: An International Classification of Disease-9 Based Injury Severity Score.** *Journal of Trauma-Injury Infection & Critical Care.* 41(3):380-388, September 1996. Available online at http://www.jtrauma.com/.

[2] Sposato, E.M. "The End of the Injury Severity Score (ISS) and the Trauma and Injury Severity Score (TRISS): ICISS, an International Classification of Diseases, Ninth Revision-Based Prediction Tool, Outperforms Both ISS and TRISS as Predictors of Trauma Patient Survival, Hospital Charges, and Hospital Length of Stay. *Journal of Trauma Nursing.* Jan-March, 1999. Available online at http://www.allbusiness.com/periodicals/article/350114-1.html

[3] Offner, P. Trauma Scoring Systems. *EMedicine.* 4/25/02. http://www.emedicine.com/med/topic3214.htm

[4] https://jobs.orhs.org/trauma/report-feb-05.pdf

[5] http://www.emedicine.com/med/topic3214.htm and https://jobs.orhs.org/trauma/report-feb-05.pdf

2. It includes all injuries.
3. *ICD-9* codes are readily available and do not require special training or expertise to determine.
4. *ICD-9* has better predictive power when compared to the ISS.
5. ICISS has the potential to better account for the effects of comorbidity on outcome by including the SRR for each comorbidity present.
6. The ICISS outperforms the ISS in predicting other outcomes of interest (e.g., hospital length of stay, hospital charges).
7. Compared to all other available severity adjustment systems, ICISS was most accurate.
8. ICISS can be more precisely population-based.
9. ICISS requires no additional software manipulation of data. ICDMAP-90 software for risk stratification converts International Classification of Disease (ICD) discharge diagnoses to injury severity scores to allow standardized outcome comparison.

C. SECTION DIRECTORY:

Section 1. - Amends s. 395.4001, F.S., providing definitions.

Section 2. - Repeals s. 395.4035, F.S.

Section 3. - Amends s. 395.4036, F.S., providing standards for trauma center funding.

Section 4. - Creates s. 395.41, F.S., establishing a trauma center start-up grant program.

Section 5. - Provides that Section (4) of this act is effective subject to an appropriation in the General Appropriations Act.

Section 6. - Provides the bill will take effect July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires a one time-time appropriation of $500,000 from the General Revenue Fund to be deposited into the Administrative Trust Fund in the Department of Health to fund trauma center start-up grants. Funding is subject to appropriation from the General Appropriations Act (GAA).

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill alters the way trauma centers determine the severity of trauma patients. Forty percent of trauma center funding is distributed by the ISS coded severity of trauma patients. Thus, the bill has the potential to increase or decrease trauma center payments depending on the results of the severity

ranking system. Additionally, 40 percent of trauma center funding is distributed based on trauma caseload Trauma Registry data.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health has sufficient rule making authority to implement the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 15, 2006 the Health Care Regulation Committee adopted a strike-all amendment and reported the bill favorably. The strike all amendment:

- Provides a definition for local funding contribution.
- Clarifies that funding distributions will be made using the most recent trauma patient data available.
- Clarifies that funds collected through traffic fines dedicated to support trauma centers will be distributed on a quarterly basis.
- Removes the proposed audit of trauma data.
- Provides $500,000 for a trauma center start-up grant.

On April 11, 2006, the Health Care Appropriations Committee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all amendment:

- Creates the trauma center startup grant program under section 395.41, Florida Statutes, in lieu of section 395.65, Florida Statutes.
- Includes the pursuit of an internal medicine residency program as one of the allowed prerequisites to grant funding.
- Provides that the creation of a trauma center start-up grant program is subject to appropriation in the General Appropriations Act.

The analysis is drafted to the committee substitute.

CHAMBER ACTION

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1 The Health Care Appropriations Committee recommends the
2 following:
3
4 **Council/Committee Substitute**
5 Remove the entire bill and insert:
6 A bill to be entitled
7 An act relating to trauma services; amending s. 395.4001,
8 F.S.; providing definitions; repealing s. 395.4035, F.S.,
9 to terminate the Trauma Services Trust Fund; amending s.
10 395.4036, F.S.; revising provisions relating to
11 distribution of funds to trauma centers and use thereof;
12 creating s. 395.41, F.S.; establishing a trauma center
13 startup grant program; providing conditions for the
14 receipt of a startup grant; providing limitations; making
15 the trauma center startup grant program subject to an
16 appropriation in the General Appropriations Act; providing
17 a contingent effective date.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Section 395.4001, Florida Statutes, is amended
22 to read:
23 395.4001 Definitions.--As used in this part, the term:

24 (1) "Agency" means the Agency for Health Care
25 Administration.
26 (2) "Charity care" or "uncompensated trauma care" means
27 that portion of hospital charges reported to the agency for
28 which there is no compensation, other than restricted or
29 unrestricted revenues provided to a hospital by local
30 governments or tax districts regardless of method of payment,
31 for care provided to a patient whose family income for the 12
32 months preceding the determination is less than or equal to 200
33 percent of the federal poverty level, unless the amount of
34 hospital charges due from the patient exceeds 25 percent of the
35 annual family income. However, in no case shall the hospital
36 charges for a patient whose family income exceeds four times the
37 federal poverty level for a family of four be considered
38 charity.
39 (3) "Department" means the Department of Health.
40 (4) "Interfacility trauma transfer" means the transfer of
41 a trauma victim between two facilities licensed under this
42 chapter, pursuant to this part.
43 (5) "International Classification Injury Severity Score"
44 means the statistical method for computing the severity of
45 injuries sustained by trauma patients. The International
46 Classification Injury Severity Score shall be the methodology
47 used by the department and trauma centers to report the severity
48 of an injury.
49 (6) ~~(5)~~ "Level I trauma center" means a trauma center that:
50 (a) Has formal research and education programs for the
51 enhancement of trauma care; is verified by the department to be

52 in substantial compliance with Level I trauma center and
53 pediatric trauma center standards; and has been approved by the
54 department to operate as a Level I trauma center.
55 (b) Serves as a resource facility to Level II trauma
56 centers, pediatric trauma centers, and general hospitals through
57 shared outreach, education, and quality improvement activities.
58 (c) Participates in an inclusive system of trauma care,
59 including providing leadership, system evaluation, and quality
60 improvement activities.
61 (7) ~~(6)~~ "Level II trauma center" means a trauma center
62 that:
63 (a) Is verified by the department to be in substantial
64 compliance with Level II trauma center standards and has been
65 approved by the department to operate as a Level II trauma
66 center.
67 (b) Serves as a resource facility to general hospitals
68 through shared outreach, education, and quality improvement
69 activities.
70 (c) Participates in an inclusive system of trauma care.
71 (8) "Local funding contribution" means local municipal,
72 county, or tax district funding exclusive of any patient-
73 specific funds received pursuant to ss. 154.301-154.316, private
74 foundation funding, or public or private grant funding of at
75 least $150,000 received by a hospital or health care system that
76 operates a trauma center.
77 (9) ~~(7)~~ "Pediatric trauma center" means a hospital that is
78 verified by the department to be in substantial compliance with
79 pediatric trauma center standards as established by rule of the

80 department and has been approved by the department to operate as
81 a pediatric trauma center.
82 (10) ~~(8)~~ "Provisional trauma center" means a hospital that
83 has been verified by the department to be in substantial
84 compliance with the requirements in s. 395.4025 and has been
85 approved by the department to operate as a provisional Level I
86 trauma center, Level II trauma center, or pediatric trauma
87 center.
88 (11) ~~(9)~~ "Trauma agency" means a department-approved agency
89 established and operated by one or more counties, or a
90 department-approved entity with which one or more counties
91 contract, for the purpose of administering an inclusive regional
92 trauma system.
93 (12) ~~(10)~~ "Trauma alert victim" means a person who has
94 incurred a single or multisystem injury due to blunt or
95 penetrating means or burns, who requires immediate medical
96 intervention or treatment, and who meets one or more of the
97 adult or pediatric scorecard criteria established by the
98 department by rule.
99 (13) "Trauma caseload volume" means the number of trauma
100 patients reported by individual trauma centers to the Trauma
101 Registry and validated by the department.
102 (14) ~~(11)~~ "Trauma center" means a hospital that has been
103 verified by the department to be in substantial compliance with
104 the requirements in s. 395.4025 and has been approved by the
105 department to operate as a Level I trauma center, Level II
106 trauma center, or pediatric trauma center.

107 (15) "Trauma patient" means a person who has incurred a
108 physical injury or wound caused by trauma and has accessed a
109 trauma center.
110 (16) ~~(12)~~ "Trauma scorecard" means a statewide methodology
111 adopted by the department by rule under which a person who has
112 incurred a traumatic injury is graded as to the severity of his
113 or her injuries or illness and which methodology is used as the
114 basis for making destination decisions.
115 (17) ~~(13)~~ "Trauma transport protocol" means a document
116 which describes the policies, processes, and procedures
117 governing the dispatch of vehicles, the triage, prehospital
118 transport, and interfacility trauma transfer of trauma victims.
119 (18) ~~(14)~~ "Trauma victim" means any person who has incurred
120 a single or multisystem injury due to blunt or penetrating means
121 or burns and who requires immediate medical intervention or
122 treatment.
123 Section 2. Section 395.4035, Florida Statutes, is
124 repealed.
125 Section 3. Subsection (1) of section 395.4036, Florida
126 Statutes, is amended to read:
127 395.4036 Trauma payments.--
128 (1) Recognizing the Legislature's stated intent to provide
129 financial support to the current verified trauma centers and to
130 provide incentives for the establishment of additional trauma
131 centers as part of a system of state-sponsored trauma centers,
132 the department shall utilize funds collected under s.
133 318.18(15) ~~(14)~~ and deposited into the Administrative Trust Fund
134 of the department to ensure the availability and accessibility

135 of trauma services throughout the state as provided in this
136 subsection.
137 (a) Twenty percent of the total funds collected under this
138 subsection during the state fiscal year shall be distributed to
139 verified trauma centers ~~located in a region~~ that have ~~has~~ a
140 local funding contribution as of December 31. Distribution of
141 funds under this paragraph shall be based on trauma caseload
142 volume for the most recent calendar year available.
143 (b) Forty percent of the total funds collected under this
144 subsection shall be distributed to verified trauma centers based
145 on trauma caseload volume for ~~of~~ the most recent ~~previous~~
146 calendar year available. The determination of caseload volume
147 for distribution of funds under this paragraph shall be based on
148 the department's Trauma Registry data.
149 (c) Forty percent of the total funds collected under this
150 subsection shall be distributed to verified trauma centers based
151 on severity of trauma patients for the most recent calendar year
152 available. The determination of severity for distribution of
153 funds under this paragraph shall be based on the department's
154 International Classification Injury Severity Scores or another
155 statistically valid and scientifically accepted method of
156 stratifying a trauma patient's severity of injury, risk of
157 mortality, and resource consumption as adopted by the department
158 by rule, weighted based on the costs associated with and
159 incurred by the trauma center in treating trauma patients. The
160 weighting of scores shall be established by the department by
161 rule ~~scores of 1-14 and 15 plus~~.
162

163 Funds deposited in the department's Administrative Trust Fund
164 for verified trauma centers may be used to maximize the receipt
165 of federal funds that may be available for such trauma centers.
166 Notwithstanding this section and s. 318.14, distributions to
167 trauma centers may be adjusted in a manner to ensure that total
168 payments to trauma centers represent the same proportional
169 allocation as set forth in this section and s. 318.14. For
170 purposes of this section and s. 318.14, total funds distributed
171 to trauma centers may include revenue from the Administrative
172 Trust Fund and federal funds for which revenue from the
173 Administrative Trust Fund is used to meet state or local
174 matching requirements. Funds collected under ss. 318.14 and
175 318.18(15) and deposited in the Administrative Trust Fund of the
176 department shall be distributed to trauma centers on a quarterly
177 basis using the most recent calendar year data available. Such
178 data shall not be used for more than four quarterly
179 distributions unless there are extenuating circumstances as
180 determined by the department, in which case the most recent
181 calendar year data available shall continue to be used and
182 appropriate adjustments shall be made as soon as the more recent
183 data becomes available. ~~Trauma centers may request that their~~
184 ~~distributions from the Administrative Trust Fund be used as~~
185 ~~intergovernmental transfer funds in the Medicaid program.~~
186 Section 4. Section 395.41, Florida Statutes, is created to
187 read:
188 395.41 Trauma center startup grant program.--There is
189 established a trauma center startup grant program.

190 (1) The Legislature recognizes the need for a statewide,
191 cohesive, uniform, and integrated trauma system, and the
192 Legislature acknowledges that the state has been divided into
193 trauma service areas. Each of the trauma service areas should
194 have at least one trauma center; however, some trauma service
195 areas do not have a trauma center because of the significant up-
196 front investment of capital required for hospitals to develop
197 the physical space, equipment, and qualified personnel necessary
198 to provide quality trauma services.
199 (2) An acute care general hospital that has submitted a
200 letter of intent and an application to become a trauma center
201 pursuant to s. 395.4025 may apply to the department for a
202 startup grant. The grant applicant must demonstrate that:
203 (a) There are currently no other trauma centers in the
204 hospital's trauma service area as established under s. 395.402.
205 (b) There is not a trauma center within a 100-mile radius
206 of the proposed trauma center.
207 (c) The hospital has received a local funding contribution
208 as defined under s. 395.4001.
209 (d) The hospital has incurred startup costs in excess of
210 the amount of grant funding requested.
211 (e) The hospital is pursuing the establishment of a
212 residency program in internal medicine or emergency medicine.
213 (3) A hospital receiving startup grant funding that does
214 not become a provisional trauma center within 24 months after
215 submitting an application to become a trauma center must forfeit
216 any state grant funds received pursuant to this section.

217 (4) A hospital that receives startup grant funding may not
218 receive more than $500,000, must ensure that the startup grant
219 funding is matched on a dollar-for-dollar basis with a local
220 funding contribution, and shall receive startup grant funding
221 only one time.
222 Section 5. This act shall take effect July 1, 2006, except
223 that section 395.41, Florida Statutes, as created by this act,
224 shall take effect subject to an appropriation for the trauma
225 center startup grant program in the 2006-2007 General
226 Appropriations Act.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 775 CS Psychologist Specialties
SPONSOR(S): Roberson
TIED BILLS: **IDEN./SIM. BILLS:** SB 1560

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N, w/CS	Hamrick	Mitchell
2) Governmental Operations Committee	5 Y, 1 N, w/CS	Mitchell	Williamson
3) Health & Families Council		Hamrick	Moore
4)			
5)			

SUMMARY ANALYSIS

The bill defines "certified psychology specialist," "board-certified psychology specialist," and "psychology diplomate."

The bill authorizes the Board of Psychology to approve certifying bodies which recognize certified psychology specialists, board-certified psychology specialists, or psychology diplomates. The bill prohibits a licensed psychologist from representing that he or she is a certified psychology specialist, a board-certified psychology specialist, or a psychology diplomate unless that recognition is from a certifying body that has been approved by the Board of Psychology.

The bill as amended provides criteria that a certifying body must require of psychologists in order to be approved by the Board of Psychology. It permits the Board of Psychology to adopt, by rule, an application and an approval process.

The bill provides that a licensed psychologist is permitted to indicate the services they offer, including whether his or her practice is limited to one or more types of services, as long as it accurately reflects their scope of practice.

The fiscal impact of the bill appears to be minimal and limited to the implementation costs for rulemaking and complaint processing.

The bill will take effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – This bill authorizes the Board of Psychology to adopt rules for approving entities that recognize psychology specialists, board-certified psychology specialists, and psychology diplomates.

Safeguard individual liberty – The bill prohibits a licensed psychologist from using certain professional titles unless those titles were conferred by an entity approved by the Board of Psychology.

Promote Personal Responsibility – The bill limits the use of certain professional titles by psychologists.

B. EFFECT OF PROPOSED CHANGES:

CURRENT SITUATION

The Department of Health licenses the practice of psychology, but does not license individuals by specialty. Because of this, the number of individuals in Florida with a specialty in psychology is unknown.

Currently, there are 4,118 licensed psychologists in the state. A licensed psychologist in Florida must have a doctoral degree.[1] The doctoral degree may be in psychology or a doctoral–level degree in psychological education.[2]

The use of psychological "specialties" has implications for the public and the legal system.[3] Some certifying entities require review of credentials, documentation, and a work sample, as well as a comprehensive oral or written examination.[4] Other certifying entities are referred to as "vanity boards" and require very little documentation other than a brief one or two-page application form and a fee.[5]

According to staff with the American Psychology Association, the association recognizes that there is a problem nationally with individuals who hold themselves out as a board-certified specialist or a diplomate, but who have "suspect training" or "vanity credentials."

The American Psychology Association (APA) is exploring the development of criteria that may be used to identify an appropriate certifying body of legitimate psychology specialties. According to staff with the American Psychological Association, the issue has been discussed, but to date has not resulted in policy action by the APA.[6]

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[1] See ss. 490.005(1)(a)1., 490.006(1)(c) and 490.0051(1)(b), F.S.
[2] See s. 490.003(3), F.S.
[3] Psychologists, for example, render opinions to courts on issues such as competency to stand trial.
[4] Frank M. Dattilio & Robert L. Sadoff, How Expert is Your Mental Health Expert?, 27 Pa. Law. 28, 31 (Jan./Feb. 2005) (specifically referencing the American Board of Professional Psychology).
[5] *Id.* at 32.
[6] E-mail from the Deputy Executive Director for Education, the American Psychology Association. (on file with the Health Care Regulation Committee).

Psychology Licensing and Specialties

Chapter 490, Florida Statutes, is the Psychological Services Act.[7] The Psychological Services Act creates the Board of Psychology within the Department of Health.[8] The Board of Psychology is responsible for certifying that applicants meet the criteria for licensure by examination[9] or licensure by endorsement.[10] The Department of Health then issues the applicant a license[11] as a psychologist.[12] There is, however, no authority for the Board of Psychology to recognize specialties in psychology. As such, licensed psychologists may use a psychological specialty recognized by a private entity or certifying body as long as the use of the specialty recognition does not violate any statutory disciplinary standards.[13]

EFFECTS OF THE BILL

The bill defines "certified psychology specialist," "board-certified psychology specialist," or "psychology diplomate" as a psychologist with special competency which has been recognized by an approved certifying body. This special competency must have been acquired through an organized sequence of formal education, training, experience, and professional standing.

The bill authorizes the Board of Psychology to approve certifying bodies which recognize certified psychology specialists, board-certified psychology specialists, or psychology diplomates. The bill as amended provides that a certifying body must require psychologists to meet the following criteria in order to be approved by the Board of Psychology:

- A minimum of three years of experience as a psychologist.
- Peer review of applicants.
- Additional education which may include self-study.
- Adherence to standards established by the certifying body.

The bill permits the Board of Psychology to adopt, by rule, an application and an approval process for licensed psychologists who have a specialty from a recognized certifying body.

The bill prohibits a licensed psychologist from representing that he or she is a certified psychology specialist, board-certified psychology specialist, or psychology diplomate unless that recognition is from a certifying body that has been approved by the Board of Psychology.

The bill permits a licensed psychologist to indicate the services offered, including whether his or her practice is limited to one or more types of services, as long as it accurately reflects their scope of practice.

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[7] Fla. Stat. § 490.001 (2005).
[8] Fla. Stat. § 490.004 (2005) (The Board of Psychology is composed of seven members appointed by the Governor and confirmed by the Senate. Five members of the Board of Psychology must be state-licensed psychologists and two members must be citizens with no connection to the practice of psychology. Members of the Board of Psychology serve four year terms.).
[9] Fla. Stat. § 490.005 (2005).
[10] Fla. Stat. § 490.006 (2005).
[11] *See, e.g.,* § 490.005(1) (2005).
[12] *See*, e.g., § 490.003(4) (2005) (defining the "practice of psychology" as the observation, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health).
[13] *See, e.g.,* Fla. Stat. § 490.009(1)(d) (2005) (false, deceptive, or misleading advertising).

BACKGROUND

What is the Practice of Psychology?

Section 490.003(4), Florida Statutes, defines the "practice of psychology" as the observation, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health. The ethical practice of psychology includes, but is not limited to:

- Psychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning, including evaluation of mental competency to manage one's affairs and to participate in legal proceedings;
- Counseling, psychoanalysis, all forms of psychotherapy, sex therapy, hypnosis, biofeedback, and behavioral analysis and therapy;
- Psychoeducational evaluation, therapy, remediation, and consultation; and
- Use of psychological methods to diagnose and treat mental, nervous, psychological, marital, or emotional disorders, illness, or disability, alcoholism and substance abuse, and disorders of habit or conduct, as well as the psychological aspects of physical illness, accident, injury, or disability, including neuropsychological evaluation, diagnosis, prognosis, etiology, and treatment.

American Psychology Association

The American Psychology Association (APA) defines "psychology" as the study of the mind and behavior. The discipline embraces all aspects of the human experience — from the functions of the brain to social actions and from child development to care for the aged. In every conceivable setting from scientific research centers to mental health care services, "the understanding of behavior" is the enterprise of psychologists.

There are 53 professional divisions in the APA, which include such areas as:

- Developmental Psychology
- School Psychology
- Rehabilitation Psychology
- Psychotherapy
- Psychology of Religion
- Clinical Neuropsychology
- Exercise and Sport Psychology
- Trauma Psychology
- Behavioral Analysis

The American Board of Professional Psychology and Certifying Bodies

The American Board of Professional Psychology (ABPP) certifies specialties in psychology. They were incorporated in 1947 with the support of the American Psychological Association. ABPP governs several separately incorporated specialty examining boards and currently recognizes thirteen specialty boards:[14]

1. The American Board of Cognitive and Behavioral Psychology

[14] According the ABPP, it should be noted that the practice activities in any specialty seldom are exclusive to the specialty and that most practice activities are shared with the general practice of professional psychology. The pattern of practice activities, including limiting the scope of practice, and focusing upon more complex or unique problems or technologies is more relevant in defining a specialty together with advanced education, training, and experience.

2. The American Board of Clinical Psychology
3. The American Board of Clinical Child and Adolescent Psychology
4. The American Board of Clinical Health Psychology
5. The American Board of Clinical Neuropsychology
6. The American Board of Counseling Psychology
7. The American Board of Family Psychology
8. The American Board of Forensic Psychology
9. The American Board of Group Psychology
10. The American Board of Psychoanalysis in Psychology
11. The American Board of Rehabilitation Psychology
12. The American Board of School Psychology
13. The American Board of Organizational and Business Consulting Psychology

The ABPP provides the following criteria that may be used by an organization to determine the competency of certifying bodies that provide certified specialties in the profession of psychology:[15]

- National in scope, appropriately incorporating standards of the profession and collaborating closely with organizations related to specialization in psychology.
- Have clearly described purposes, related by-laws, policies, and procedures which are accountable to the public, its certified specialists, and the profession.
- Develop and implement examinations designed to assess the competencies required to provide quality services in the specialties it certifies.
- Not be a governmental, membership, advocacy, or accrediting body.
- Have organizational and financial stability with professional and office support staff.
- Be governed by a single, national in scope, not-for-profit corporation comprised of a certified specialist Trustee (Board Member) from each of its multiple, member Specialty Boards as well as public member representation. The multiple board structure provides a continuing peer review of the organization's activities. The governing board has formal procedures for the selection and tenure of Trustees.

Several other entities certify psychologists in various specialty areas. The Council of Specialties in Professional Psychology (CoSPP) is a non-profit joint venture, initially sponsored by the American Psychological Association (APA) and the ABPP, to represent and support the development and functioning of recognized specialties in professional psychology.

Recently, the council has proposed that an inter-organizational effort be formed to develop competency-based criteria for specialty certification in order to protect the public. The proposed criteria included a single certification board per specialty requirement and an oversight mechanism to insure quality and the consistency of such boards.[16]

C. SECTION DIRECTORY:

Section 1. Creates section 490.0149, Florida Statutes, to provide a definition; to limit the use of certain specialty titles; to require approval of certifying bodies; to provide criteria for approving a certifying body; to authorize rulemaking; and to allow offered or limited services to be indicated.

Section 2. Provides an effective date of July 1, 2006.

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[15] American Board of Professional Psychology. Standards for the Purpose and Structure of a Body Certifying Psychologists as Specialists in Professional Psychology. http://www.abpp.org/brochures/general_brochure.htm (April 5, 2006).

[16] Council of Specialties in Professional Psychology. President's Highlights. http://www.cospp.org/president.html (April 18, 2006).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   This bill does not appear to have a fiscal impact on state government revenues.

2. Expenditures:

   This bill appears to have a minimal fiscal impact on state government expenditures through increased rulemaking, entity processing, and complaint processing costs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   This bill does not appear to have a fiscal impact on local government revenues.

2. Expenditures:

   This bill does not appear to have a fiscal impact on local government expenditures.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill will have a direct economic impact on the representation and advertising of psychologists who have recognized specialties.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that counties municipalities have to raise revenue.

2. Other:

   First Amendment

   To the extent this bill permits restrictions on professional advertising, it may be subject to challenge under the First Amendment of the United States Constitution. Courts, however, have previously upheld similar restrictions.

B. RULE-MAKING AUTHORITY:

The bill provides the Board of Psychology adequate rule-making authority to implement the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

An amendment will be offered in the Health and Families Council to clarify the criteria that the Board of Psychology must use to approve a certifying body.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 4, 2006, the Health Care Regulation Committee adopted a "strike-all" amendment and reported the bill favorably with committee substitute:

- Removed the specific mention of the American Board of Professional Psychology as a recognized agency;
- Added a definition of specialist or diplomate;
- Provided criteria that the Board of Psychology must use in establishing specific criteria for the approval of certifying bodies; and
- Made a more specific reference to "certified psychology specialists" or "psychology diplomate" and removed the general reference to "specialist" or "diplomate".

On April 17, 2006, the Governmental Operations Committee adopted a "strike-all" amendment and reported the bill favorably with committee substitute:

- Removed school psychologists from the bill;
- Expanded the defined terms; and
- Narrowed the rulemaking authority of the Board of Psychology through a revised process that provides a certifying body must require psychologists to meet certain criteria in order to be approved as a certifying body by the Board of Psychology.

This analysis is drafted to the committee substitute.

CHAMBER ACTION

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1 The Governmental Operations Committee recommends the following:
2 **Council/Committee Substitute**
3 Remove the entire bill and insert:
4 A bill to be entitled
5 An act relating to psychology specialties; creating s.
6 490.0149, F.S.; providing a definition; specifying the
7 circumstances under which a psychologist may hold himself
8 or herself out as a certified psychology specialist,
9 board-certified psychology specialist, or psychology
10 diplomate; requiring the Board of Psychology to approve
11 certifying bodies; providing a condition for approval of
12 the certifying bodies; requiring the Board of Psychology
13 to establish an application and approval process by rule;
14 specifying that a person licensed under ch. 490, F.S., may
15 specify the types of services he or she provides;
16 providing an effective date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19
20 Section 1. Section 490.0149, Florida Statutes, is created
21 to read:
22 490.0149 Specialties.--

23 (1) As used in this section, the term "certified
24 psychology specialist," "board-certified psychology specialist,"
25 or "psychology diplomate" means a psychologist with special
26 competency that is acquired through an organized sequence of
27 formal education, training, experience, and professional
28 standing and is recognized by a certifying body approved under
29 subsection (3).
30 (2) A person licensed as a psychologist may not hold
31 himself or herself out as a certified psychology specialist,
32 board-certified psychology specialist, or psychology diplomate
33 unless the person has received formal recognition as a certified
34 psychology specialist, board-certified psychology specialist, or
35 psychology diplomate from a certifying body approved under
36 subsection (3).
37 (3)(a) The board shall be responsible for approving the
38 certifying bodies that recognize certified psychology
39 specialists, board-certified psychology specialists, or
40 psychology diplomates. The certifying body shall require, as a
41 condition of recognition, the following criteria in order to be
42 approved by the board:
43 1. A minimum of 3 years of experience as a psychologist.
44 2. Peer review of applicants.
45 3. Additional education which may include self-study.
46 4. Adherence to standards established by the certifying
47 body.
48 (b) The board shall adopt, by rule under ss. 120.536(1)
49 and 120.54, an application and a process for the approval of
50 certifying bodies.

51 (4) A person licensed under this chapter may indicate the
52 services he or she offers and may indicate that his or her
53 practice is limited to one or more types of services when this
54 accurately reflects his or her scope of practice.
55 Section 2. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 819 CS Radiologist Assistants
SPONSOR(S): Grant
TIED BILLS: **IDEN./SIM. BILLS:** SB 1366

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	10 Y, 0 N, w/CS	Hamrick	Mitchell
2) Health Care Appropriations Committee	11 Y, 1 N	Money	Massengale
3) Health & Families Council		Hamrick	Moore
4)			
5)			

SUMMARY ANALYSIS

Section 11.62, F.S., the Sunrise Act that establishes criteria for new regulation of professions, states that it is the intent of the Legislature that no profession or occupation be subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage; and no profession or occupation be regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation.

House Bill 819 CS provides for the certification of a relatively new profession called a radiologist assistant. The radiologist assistant functions as a physician extender for a radiologist. Currently only three states regulate radiologist assistants: Montana, Tennessee and Mississippi. The bill incorporates radiologist assistants into the "Radiology Technologist Certification Act' (chapter 468, part VI, F.S.). The bill renames the act as the "Radiological Personnel Certification Act."

A "radiologist assistant" is a person, other than a licensed practitioner, who is qualified by education and certification as an advanced-level radiologic technologist, who works under the supervision of a radiologist to enhance patient care by assisting the radiologist in the medical imaging environment. A radiologist assistant may perform, under the supervision of a radiologist (who is a medical doctor), certain procedures such as arthograms, upper and lower gastrointestinal tract examinations, placements of feeding tubes, and central venous catheters.

The bill specifies that the scope of practice for a radiologist assistant must be adopted by rule and be consistent with the national scope of practice adopted by the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the American Registry of Radiologic Technologists (ARRT). The bill restricts the scope of practice of radiologist assistants such that they may not interpret images, make a diagnosis, or prescribe medications. A radiologist assistant must be under the "direct" supervision of a radiologist who must be present in the office suite and immediately available to furnish assistance and direction throughout a medical procedure. The bill provides for fees and educational requirements to include a clinical preceptorship. The bill adds a radiologist assistant to the Advisory Council on Radiation Protection.

According to the Department of Health, the fiscal impact to the department will be minimal since the fees to regulate the profession would cover their administrative costs.

The bill takes effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited government and safeguard individual liberty—The bill will allow a radiologist (who is a medical doctor) to use a radiologist assistant as a physician extender, which may allow increased access to radiologic services by consumers.

B. EFFECT OF PROPOSED CHANGES:

Current Situation
The State of Florida currently regulates several general types of individuals who use radiological techniques in health care: basic x-ray machine operators, general radiographers, radiologic technologists and radiologists. Current statute recognizes specializations within each of these categories. For example, a basic x-ray machine operator may specialize in podiatric medicine or a certified radiologic technologist may specialize in nuclear medicine.[1] These professions are not regulated by a board, but an advisory council makes recommendations to the Division of Medical Quality Assurance within the Department of Health concerning the requirements and qualifications for all the professions in the field of radiology.

A person may not use radiation or otherwise practice radiologic technology on a human being unless he or she possesses a license or is certified by the Department of Health. The term "radiation" encompasses x-rays and gamma rays, alpha and beta particles, high-speed electrons, neutrons, and other nuclear particles. If an individual uses radiation on another person and is not in compliance with s. 468.302, F.S., they may be charged with a second degree misdemeanor pursuant to s. 468.311, F.S.

The bill provides for the certification of radiologist assistants (RA). A radiologist assistant will act as a radiologist extender. The proponents for the legislation provided examples of other physician extenders such as anesthesiologist and nurse anesthetists. According to the proponents of the bill, only three states—Montana, Tennessee and Mississippi—have passed laws regulating RAs, while others are seeking legislation.

Sunrise Act
The proponents of this legislation did not submit a sunrise questionnaire for staff to review.

According to s. 11.62(3), F.S., of the Florida Sunrise Act, the Legislature is required to consider the following factors when determining whether to regulate a profession:

- **The unregulated practice of the profession will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote.**

  Currently, an individual who is not certified or licensed by the Department of Health may not use radiation on a human being. A prerequisite for national certification as a radiologist assistant is that the individual be certified as a general radiographer (or radiologic technologist). Currently, if an individual performed the duties of a radiologist assistant in Florida they would be practicing out of the scope of their profession and subject to disciplinary charges. Since this is a new profession, not just to Florida, but across the nation, the potential harm or danger to the public is unknown. The duties outlined in the scope of practice of a radiologic assistant in the bill are currently performed by a licensed medical doctor.

[1] See s. 468.302, F.S.

- **The practice of the profession requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements reasonably assure initial and continuing professional ability.**

  Based on the information gathered by staff, the role of a radiologist assistant will require specialized skill and training. According to the American Society of Radiologic Technologists (ASRT) and the American Registry of Radiologic Technologists (ARRT) their training will be readily measurable or quantifiable.

- **The regulation will not unreasonably affect job creation or retention in the state, or place unreasonable restrictions on finding employment by individuals who practice or seek to practice the profession.**

  Since this is a new profession and limited schools in the United States offer the program, the impact on other professions such as the radiologic technologist or basic x-ray machine operator is difficult to project. However, the educational backgrounds for both of these professions is substantially different from the radiologist assistant who is required to have at least a bachelors degree. Radiologic technologists and x-ray operators may only have an associates degree or certificate of completion. If passed, this legislation may provide an avenue for individuals in the field to advance their knowledge and skill in the field if they return to school.

- **Whether the public is not, or can not, be effectively protected by other means.**

  Currently, the public is receiving the services of a radiologic assistant by a radiologist, who is a licensed medical doctor. Because of workforce shortages in the field of radiology, the provisions of the bill may increase assess to radiologic services.

- **Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, is favorable.**

  The bill creates another tier of practitioner in the field of radiology. The services that are currently provided to consumers are performed by a medical doctor (a radiologist) or a technician (radiologic technologist or x-ray operator) who may have an associate's degree. The radiologist assistant (RA) must have at least a bachelor's degree. For this reason, a radiologist assistant may want to be paid at a higher rate than a radiologic technologist.

The Effects of the Bill

The bill provides for the certification of a new profession called a radiologist assistant. The radiologist assistant will function as a physician extender for a radiologist. A "radiologist assistant" is defined as a person, other than a licensed practitioner, who is qualified by education and certification as an advanced-level radiologic technologist who works under the supervision of a radiologist to enhance patient care by assisting the radiologist in the medical imaging environment.

The bill incorporates the radiologist assistant to the entire section that is called the "Radiology Technologist Certification Act' (chapter 468, part VI, F.S.). The bill renames the act as the "Radiological Personnel Certification Act." The bill provides a definition of "certificate holder" to mean any person who holds a certificate and is authorized to use radiation on human beings. This term is used throughout the act in a manner that allows for the incorporation of radiologist assistants.

The bill provides that the scope of practice for a radiologist assistant must be adopted by rule and be consistent with the national scope of practice adopted by the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the American Registry of Radiologic Technologists (ARRT). The bill restricts the scope of practice of radiologist assistants such that they

may not interpret images, make a diagnosis, or prescribe medications or therapies. A radiologist assistant may not perform nuclear medicine or radiation therapy procedures unless they are certified and trained in those areas.

The bill provides that a radiologist assistant is supervised such that the radiologist (who is a medical doctor) must be present in the office suite and immediately available to furnish assistance and direction throughout a medical procedure. This does not require the radiologist to be in the room while the procedure is performed. The bill provides for fees and educational requirements to include a clinical preceptorship. The bill adds a radiologist assistant to the Advisory Council on Radiation Protection.

BACKGROUND

American Society of Radiologic Technologists (ASRT) Radiologist Assistant Certification Program

The concept of a radiologist extender was first explored in the early 1970s and revived in the mid-1990s. In early 2002, the American Society of Radiologic Technologists (ASRT) convened a panel to explore the concept of a physician extender in radiology. Representatives from the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT, or the Society), the American Registry of Radiologic Technologists (ARRT, or the Registry), state licensing agencies, the National Society of Radiology Practitioner Assistants, and the industry produced a consensus document proposing the positions title and definition and addressing educational preparation, roles and responsibilities, level of supervision, and regulatory issues. Building on the panel's concept and consensus, the Registry developed certification standards. The radiologist assistant program incorporates educational, ethical and exam standards.

According to the Society, educational standards for a radiologist assistant are designed to address the didactic and clinical components of the field, as well as a national certification and registration in radiography. Clinical education is provided through a preceptorship with a radiologist. Radiologist assistant programs provide a baccalaureate degree or higher. In 2005, six universities offered radiologist assistant educational programs. An individual must be certified as a radiographer by the registry, as a prerequisite to enrollment in a radiologist assistant program. Graduates of a radiologist assistant program may sit for the radiologist assistant certification examination administered by the Registry.

The Radiologist Assistant and National Scope of Practice Outlined by the ACR, ASRT and ARRT

A radiologist assistant works under the supervision of a radiologist to provide patient care as a radiologist extender in the diagnostic imaging environment. Radiologist assistants (RAs) have three major areas of responsibility.

First, they have a leading role in patient management and assessment. Duties in this area may include determining whether a patient has been appropriately prepared for a procedure, obtaining patient consent prior to beginning the procedure, answering questions from the patient and his or her family, and adapting exam protocols to improve diagnostic quality. The radiologist assistant is expected to serve as a patient advocate, ensuring that each patient receives quality care while in the radiology department or clinic.[2]

Second, the radiologist assistant performs selected radiology examinations and procedures under the supervision of a radiologist. A RA's responsibilities may include assisting radiologists with invasive procedures such as arthograms, upper and lower gastrointestinal tract examinations, urinary tract examinations, lymphanogiograms, performing fluoroscopy for noninvasive procedures under direct supervision of the radiologist, placement of nasoenteric and oroenteric feeding tubes, and performing

[2] American Society of Radiologic Technologists. The Radiologist Assistant. http://www.asrt.org/content/RTs/SpecialtySpecific/RadiologistAssistant/Radiologist_Assistant.aspx (March 25, 2006).

selected peripheral venous diagnostic procedures such as venograms, paracentesis, thoracentesis or the insertion of central venus catheters.[3]

Third, the radiologist assistant may be responsible for evaluating image quality, making initial image observations and forwarding those observations to the supervising radiologist. The supervising radiologist remains responsible for providing a final written report, an interpretation or a diagnosis.[4]

Current Professions in the Field of Radiology that are Regulated in Florida

Basic X-ray Machine Operator is Certified

A basic x-ray machine operator may perform general diagnostic radiographic and general fluoroscopic procedures under the direct supervision of a licensed practitioner (doctor, podiatrist, or chiropractor), excluding radiation therapy and nuclear medicine. They are limited to the locations they may work such that they are not allowed to work in a hospital with less than 150 beds or a walk-in emergency center.[5]

Radiologic Technologist is trained to Operate Equipment and is Certified

A radiologic technologist is trained to operate radiographic equipment to produce images. The radiologic technologist may explain the imaging procedure to the patient and assist in positioning the patient for imaging specific areas of the patient's body as prescribed by the referring physician.[6] A radiologic technologist may use radiation on human beings under the specific direction and general supervision of a licensed practitioner as defined in s. 468.301(14), F.S.

A Radiologist is a Licensed Medical Doctor

A radiologist is a licensed medical or osteopathic physician trained to diagnose diseases by obtaining and interpreting medical images through the use of imaging techniques such as X-rays, ultrasound, computed tomography, and magnetic resonance imaging. A radiologist must have graduated from an accredited medical school, passed a national licensing examination, and completed a residency of at least four years. Such health care practitioners are usually board-certified to practice in the field of radiology by the American Board of Radiology or the American Osteopathic Board of Radiology.

Advisory Council on Radiation Protection

In Florida, there is an Advisory Council on Radiation Protection, not a board, that oversees the practice of radiology. The council consists of 15 specified professionals and consumers appointed by the Secretary of Health:

- Certified radiologic technologist-radiographer.
- Certified radiologic technologist-nuclear medicine.
- Certified radiologic technologist-therapy.
- Basic X-ray machine operator or a licensed practitioner who employs such an operator.
- Board-certified radiologist.
- Board-certified nuclear medicine physician.
- Certified health physicist.
- Representative from the administration of a hospital affiliated with a radiologic technology educational program.
- An expert in environmental radiation matters.
- Chiropractic radiologist, a board-certified podiatric physician.
- Board-certified radiological physicist.
- Board-certified therapeutic radiologist or board-certified radiation oncologist.
- Two persons, neither of whom has ever been certified as a radiologic technologist or been a member of any closely related profession.

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[3] Ibid.
[4] Ibid.
[5] See s. 468.302(3), F.S.
[6] Ibid.

C. SECTION DIRECTORY:

Section 1. Amends s. 468.3001, F.S., redesignating part IV of chapter 468 as the "Radiological Personnel Certification Act."

Section 2. Amends s. 468.301, F.S., providing a definition for certificate holder, radiologist and radiologist assistant.

Section 3. Amends s. 468.302, F.S., providing identification and duties of a certified radiologist assistant; rulemaking authority to the Department of Health; and specifying limitation on the duties of a radiologist assistant.

Section 4. Amends s. 468.304, F.S., providing certification criteria for an applicant seeking a radiologist assistant certificate.

Section 5. Amends s. 468.306, F.S., exempting radiologist assistants from examination requirements as long as they possess a current certification granted by the American Registry of Radiologic Technologists.

Section 6. Amends s. 468.3065, F.S., extending licensure by endorsement provisions to radiologist assistants if they remit a fee and possess a current certification granted by the American Registry of Radiologic Technologists.

Sections 7 through 12 Amend ss. 468.307, 468.309, 468.3095, 468.3101, 468.311, and 468.3115 F.S., including radiologist assistants in provisions that deal with certificate display, certificate renewal, change of certificate status, grounds for disciplinary action, violations, penalties, and injunctive relief.

Section 13. Amends s. 468.314, F.S., providing for an additional member to the Advisory Council on Radiation Protection.

Section 14. Provides that the bill will take effect on July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Radiologist assistant applicants for certification by endorsement must pay a nonrefundable application fee no greater than $50.

D. FISCAL COMMENTS:

According to the Department of Health, the fiscal impact to the department to enforce regulatory provisions relating to the certification of radiologist assistants will be minimal since the fees to regulate the profession will cover their administrative costs. According to the Bureau of Radiation Control within DOH, only about 10 radiologist assistants become certified in the nation on an annual basis. This number may increase to 20 if the exam is offered biannually.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides the Department of Health with adequate rule-making authority to implement the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 28, 2006, the Health Care Regulation Committee adopted a strike-all amendment offered by the bill's sponsor. The Committee Substitute differs from the original bill as filed in that it:

- Incorporates the radiologist assistant in the entire section of statute that is called the "Radiology Technologist Certification Act' (chapter 468, part VI, F.S.).
- Renames the act as the "Radiological Personnel Certification Act."
- Provides a definition of "certificateholder" to mean any person who holds a certificate and is authorized to use radiation on human beings.
- Uses the term "certificateholder" and "radiologist assistant" throughout the act to incorporate radiologist assistants into all of the provisions within the practice act.

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

CHAMBER ACTION

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1 The Health Care Regulation Committee recommends the following:
2
3 **Council/Committee Substitute**
4 Remove the entire bill and insert:
5 A bill to be entitled
6 An act relating to radiologist assistants; amending s.
7 468.3001, F.S.; redesignating part IV of ch. 468, F.S., as
8 the "Radiological Personnel Certification Act"; amending
9 s. 468.301, F.S.; providing definitions; amending s.
10 468.302, F.S.; providing for identification and duties of
11 a radiologist assistant; providing for rulemaking by the
12 Department of Health; providing limitations on duties a
13 radiologist assistant may perform; amending s. 468.304,
14 F.S.; providing conditions for qualification for a
15 radiologist assistant's certificate; amending s. 468.306,
16 F.S.; specifying the applicants required to pass a
17 certification examination; requiring the department to
18 accept certain demonstrations by an applicant for a
19 certification to practice as a radiologist assistant in
20 lieu of any examination requirement; amending s. 468.3065,
21 F.S.; authorizing the Department of Health to issue
22 certificates by endorsement to certain radiologist
23 assistants; providing for a fee; amending ss. 468.307,

24 468.309, 468.3095, 468.3101, 468.311, and 468.3115, F.S.;
25 including radiologist assistants in provisions applicable
26 to radiologic technologists with respect to requirements
27 for certificate display, certificate renewal, change of
28 certificate status, grounds for disciplinary action,
29 violations, penalties, and injunctive relief; amending s.
30 468.314, F.S.; adding a certified radiologist assistant to
31 the membership of the Advisory Council on Radiation
32 Protection; providing an effective date.
33
34 Be It Enacted by the Legislature of the State of Florida:
35
36 Section 1. Section 468.3001, Florida Statutes, is amended
37 to read:
38 468.3001 Short title.--This part ~~shall be known and~~ may be
39 cited as the "Radiological Personnel ~~Radiologic Technologist~~
40 Certification Act."
41 Section 2. Present subsections (4) through (14) of section
42 468.301, Florida Statutes, are renumbered as subsections (5)
43 through (15), respectively, present subsection (15) is
44 renumbered as subsection (18), new subsections (4), (16), and
45 (17) are added to that section, and present subsection (14) of
46 that section is amended, to read:
47 468.301 Definitions.--As used in this part, the term:
48 (4) "Certificateholder" means any person who holds a
49 certificate under this part that authorizes that person to use
50 radiation on human beings.

51 (15) ~~(14)~~ "Radiologic technologist" means a person, other
52 than a licensed practitioner, who is qualified by education,
53 training, or experience, as more specifically defined in s.
54 468.302(3)(d)-(g) ~~s. 468.302~~, to use radiation on human beings
55 under the specific direction and general supervision of a
56 licensed practitioner in each particular case.
57 (16) "Radiologist" means a physician specializing in
58 radiology certified by or eligible for certification by the
59 American Board of Radiology or the American Osteopathic Board of
60 Radiology, the British Royal College of Radiology, or the
61 Canadian College of Physicians and Surgeons.
62 (17) "Radiologist assistant" means a person, other than a
63 licensed practitioner, who is qualified by education and
64 certification, as set forth in s. 468.304, as an advanced-level
65 radiologic technologist who works under the supervision of a
66 radiologist to enhance patient care by assisting the radiologist
67 in the medical imaging environment.
68 Section 3. Subsections (1), (5), and (6) of section
69 468.302, Florida Statutes, are amended, paragraph (g) is added
70 to subsection (2) of that section, and paragraph (h) is added to
71 subsection (3) of that section, to read:
72 468.302 Use of radiation; identification of certified
73 persons; limitations; exceptions.--
74 (1) Except as provided in this section, a person may not
75 use radiation or otherwise practice radiologic technology or any
76 of the duties of a radiologist assistant on a human being unless
77 he or she:
78 (a) Is a licensed practitioner; ~~or~~

79 (b) Is the holder of a certificate, as provided in this
80 part, and is operating under the direct supervision or general
81 supervision of a licensed practitioner in each particular case;
82 or~~.~~
83 (c) Is the holder of a radiologist assistant certificate,
84 as provided in this part, and is operating under the supervision
85 of a radiologist, as specified in paragraph (3)(h).
86 (2)
87 (g) A person holding a certificate as a radiologist
88 assistant may use the title "Certified Radiologist Assistant" or
89 the letters "CRA" after his or her name.
90
91 No other person is entitled to so use a title or letters
92 contained in this subsection or to hold himself or herself out
93 in any way, whether orally or in writing, expressly or by
94 implication, as being so certified.
95 (3)
96 (h) A person holding a certificate as a radiologist
97 assistant may:
98 1. Perform specific duties allowed for a radiologist
99 assistant as defined by the department by rule. The rule must be
100 consistent with guidelines adopted by the American College of
101 Radiology, the American Society of Radiologic Technologists, and
102 the American Registry of Radiologic Technologists, with the
103 level of supervision required by such guidelines.
104 2. Not perform nuclear medicine or radiation therapy
105 procedures unless currently certified and trained to perform
106 those duties under the person's nuclear medicine technologist or

107 radiation therapy technologist certificate, interpret images,
108 make diagnoses, or prescribe medications or therapies.
109 (5) Nothing contained in this part relating to radiologic
110 technology or a radiologist assistant shall be construed to
111 limit, enlarge, or affect in any respect the practice by duly
112 licensed practitioners of their respective professions.
113 (6) Requirement for certification does not apply to:
114 (a) A hospital resident who is not a licensed practitioner
115 in this state or a student enrolled in and attending a school or
116 college of medicine, osteopathic medicine, chiropody, podiatric
117 medicine, or chiropractic medicine or a radiologic technology
118 educational program or radiologist assistant educational program
119 and who applies radiation to a human being while under the
120 direct supervision of a licensed practitioner.
121 (b) A person who is engaged in performing the duties of a
122 radiologic technologist or of a radiologist assistant in his or
123 her employment by a governmental agency of the United States.
124 (c) A person who is trained and skilled in cardiopulmonary
125 technology and who provides cardiopulmonary technology services
126 at the direction, and under the direct supervision, of a
127 licensed practitioner.
128 Section 4. Paragraph (e) of subsection (3) of section
129 468.304, Florida Statutes, is amended to read:
130 468.304 Certification.--The department shall certify any
131 applicant who meets the following criteria:
132 (3) Submits satisfactory evidence, verified by oath or
133 affirmation, that she or he:

134 (e)1. Has successfully completed an educational program,
135 which program may be established in a hospital licensed pursuant
136 to chapter 395 or in an accredited postsecondary academic
137 institution which is subject to approval by the department as
138 maintaining a satisfactory standard; or
139 2.a. With respect to an applicant for a basic X-ray
140 machine operator's certificate, has completed a course of study
141 approved by the department with appropriate study material
142 provided the applicant by the department;
143 b. With respect to an applicant for a basic X-ray machine
144 operator-podiatric medicine certificate, has completed a course
145 of study approved by the department, provided that such course
146 of study shall be limited to that information necessary to
147 perform radiographic procedures within the scope of practice of
148 a podiatric physician licensed pursuant to chapter 461;
149 c. With respect only to an applicant for a general
150 radiographer's certificate who is a basic X-ray machine operator
151 certificateholder, has completed an educational program or a 2-
152 year training program that takes into account the types of
153 procedures and level of supervision usually and customarily
154 practiced in a hospital, which educational or training program
155 complies with the rules of the department; ~~or~~
156 d. With respect only to an applicant for a nuclear
157 medicine technologist's certificate who is a general
158 radiographer certificateholder, has completed an educational
159 program or a 2-year training program that takes into account the
160 types of procedures and level of supervision usually and

161 customarily practiced in a hospital, which educational or
162 training program complies with the rules of the department; or~~.~~
163 e. With respect to an applicant for a radiologist
164 assistant's certificate who demonstrates to the department that
165 he or she holds a current certificate or registration as a
166 radiologist assistant granted by the American Registry of
167 Radiologic Technologists.
168
169 The department may not certify any applicant who has committed
170 an offense that would constitute a violation of any of the
171 provisions of s. 468.3101 or the rules adopted thereunder if the
172 applicant had been certified by the department at the time of
173 the offense. No application for a limited computed tomography
174 certificate shall be accepted. All persons holding valid
175 computed tomography certificates as of October 1, 1984, are
176 subject to the provisions of s. 468.309.
177 Section 5. Section 468.306, Florida Statutes, is amended
178 to read:
179 468.306 Examinations.--All applicants for certification as
180 a radiologic technologist, basic X-ray machine operator, or
181 basic X-ray machine operator-podiatric medicine, except those
182 certified pursuant to s. 468.3065, shall be required to pass an
183 examination. In lieu of an examination for a radiologist
184 assistant certificate, the department shall accept a
185 demonstration by the applicant for such a certificate that he or
186 she holds a current certificate or registration as a radiologist
187 assistant granted by the American Registry of Radiologic
188 Technologists. The department may ~~is authorized to~~ develop or

189 use examinations for each type of certificate. The department
190 may require an applicant who does not pass an examination after
191 five attempts to complete additional remedial education, as
192 specified by rule of the department, before admitting the
193 applicant to subsequent examinations.
194 (1) The department may ~~shall have the authority to~~
195 contract with organizations that develop such test examinations.
196 Examinations may be administered by the department or the
197 contracting organization.
198 (2) Examinations shall be given for each type of
199 certificate at least twice a year at such times and places as
200 the department may determine to be advantageous for applicants.
201 (3) All examinations shall be written and include
202 positioning, technique, and radiation protection. The department
203 shall either pass or fail each applicant on the basis of his or
204 her final grade. The examination for a basic X-ray machine
205 operator shall include basic positioning and basic techniques
206 directly related to the skills necessary to safely operate
207 radiographic equipment.
208 (4) A nonrefundable fee not to exceed $75 plus the actual
209 per-applicant cost for purchasing the examination from a
210 national organization shall be charged for any subsequent
211 examination.
212 Section 6. Section 468.3065, Florida Statutes, is amended
213 to read:
214 468.3065 Certification by endorsement.--
215 (1) The department may issue a certificate by endorsement
216 to practice as a radiologist assistant to an applicant who, upon

217 applying to the department and remitting a nonrefundable fee not
218 to exceed $50, demonstrates to the department that he or she
219 holds a current certificate or registration as a radiologist
220 assistant granted by the American Registry of Radiologic
221 Technologists.
222 (2) The department may issue a certificate by endorsement
223 to practice radiologic technology to an applicant who, upon
224 applying to the department and remitting a nonrefundable fee not
225 to exceed $50, demonstrates to the department that he or she
226 holds a current certificate, license, or registration to
227 practice radiologic technology, provided that the requirements
228 for such certificate, license, or registration are deemed by the
229 department to be substantially equivalent to those established
230 under this part and rules adopted under this part.
231 Section 7. Subsection (3) of section 468.307, Florida
232 Statutes, is amended to read:
233 468.307 Certificate; issuance; display.--
234 (3) Every employer of certificateholders ~~radiologic~~
235 ~~technologists~~ shall display the certificates of all of such
236 employees in a place accessible to view.
237 Section 8. Paragraph (a) of subsection (1) and subsections
238 (4), (5), (6), and (7) of section 468.309, Florida Statutes, are
239 amended to read:
240 468.309 Certificate; duration; renewal; reversion to
241 inactive status; members of Armed Forces and spouses.--
242 (1)(a) A ~~radiologic technologist's~~ certificate issued in
243 accordance with this part expires as specified in rules adopted
244 by the department which establish a procedure for the biennial

245 renewal of certificates. A certificate shall be renewed by the
246 department for a period of 2 years upon payment of a renewal fee
247 in an amount not to exceed $75 and upon submission of a renewal
248 application containing such information as the department deems
249 necessary to show that the applicant for renewal is a
250 certificateholder ~~radiologic technologist~~ in good standing and
251 has completed any continuing education requirements that the
252 department establishes.
253 (4) Any certificate that is not renewed by its expiration
254 date shall automatically be placed in an expired status, and the
255 certificateholder may not practice radiologic technology or
256 perform the duties of a radiologist assistant until the
257 certificate has been reactivated.
258 (5) A certificateholder in good standing remains in good
259 standing when he or she becomes a member of the Armed Forces of
260 the United States on active duty without paying renewal fees or
261 accruing continuing education credits as long as he or she is a
262 member of the Armed Forces on active duty and for a period of 6
263 months after discharge from active duty, if he or she is not
264 engaged in practicing radiologic technology or performing the
265 duties of a radiologist assistant in the private sector for
266 profit. The certificateholder must pay a renewal fee and
267 complete continuing education not to exceed 12 classroom hours
268 to renew the certificate.
269 (6) A certificateholder who is in good standing remains in
270 good standing if he or she is absent from the state because of
271 his or her spouse's active duty with the Armed Forces of the
272 United States. The certificateholder remains in good standing

273 without paying renewal fees or completing continuing education
274 as long as his or her spouse is a member of the Armed Forces on
275 active duty and for a period of 6 months after the spouse's
276 discharge from active duty, if the certificateholder is not
277 engaged in practicing radiologic technology or performing the
278 duties of a radiologist assistant in the private sector for
279 profit. The certificateholder must pay a renewal fee and
280 complete continuing education not to exceed 12 classroom hours
281 to renew the certificate.
282 (7) A certificateholder may resign his or her
283 certification by submitting to the department a written,
284 notarized resignation on a form specified by the department. The
285 resignation automatically becomes effective upon the
286 department's receipt of the resignation form, at which time the
287 certificateholder's certification automatically becomes null and
288 void and may not be reactivated or renewed or used to practice
289 radiologic technology or to perform the duties of a radiologist
290 assistant. A certificateholder who has resigned may become
291 certified again only by reapplying to the department for
292 certification as a new applicant and meeting the certification
293 requirements pursuant to s. 468.304 or s. 468.3065. Any
294 disciplinary action that had been imposed on the
295 certificateholder prior to his or her resignation shall be
296 tolled until he or she again becomes certified. Any disciplinary
297 action proposed at the time of the certificateholder's
298 resignation shall be tolled until he or she again becomes
299 certified.

300 Section 9. Paragraphs (a) and (c) of subsection (2) of
301 section 468.3095, Florida Statutes, are amended to read:
302 468.3095 Inactive status; reactivation; automatic
303 suspension; reinstatement.--
304 (2)(a) A certificate that has been expired for less than
305 10 years may be reactivated upon payment of the biennial renewal
306 fee and a late renewal fee, not to exceed $100, and submission
307 of a reactivation application containing any information that
308 the department deems necessary to show that the applicant is a
309 certificateholder ~~radiologic technologist~~ in good standing and
310 has met the requirements for continuing education. The
311 department shall prescribe, by rule, continuing education
312 requirements as a condition of reactivating a certificate. The
313 continuing education requirements for reactivating a certificate
314 may not exceed 10 classroom hours for each year the certificate
315 was expired and may not exceed 100 classroom hours for all years
316 in which the certificate was expired.
317 (c) A certificate that has been inactive or expired for 10
318 years or more automatically becomes null and void and may not be
319 reactivated, renewed, or used to practice radiologic technology
320 or to perform the duties of a radiologist assistant. A
321 certificateholder whose certificate has become null and void may
322 become certified again only by reapplying to the department as a
323 new applicant and meeting the requirements of s. 468.304 or s.
324 468.3065.
325 Section 10. Subsections (1), (2), (3), and (5) of section
326 468.3101, Florida Statutes, are amended to read:
327 468.3101 Disciplinary grounds and actions.--

328 (1) The department may make or require to be made any
329 investigations, inspections, evaluations, and tests, and require
330 the submission of any documents and statements, which it
331 considers necessary to determine whether a violation of this
332 part has occurred. The following acts shall be grounds for
333 disciplinary action as set forth in this section:
334 (a) Procuring, attempting to procure, or renewing a
335 certificate ~~to practice radiologic technology~~ by bribery, by
336 fraudulent misrepresentation, or through an error of the
337 department.
338 (b) Having a voluntary or mandatory certificate to
339 practice radiologic technology <u>or to perform the duties of a</u>
340 <u>radiologist assistant</u> revoked, suspended, or otherwise acted
341 against, including being denied certification, by a national
342 organization; by a specialty board recognized by the department;
343 or by a certification authority of another state, territory, or
344 country.
345 (c) Being convicted or found guilty, regardless of
346 adjudication, in any jurisdiction of a crime that directly
347 relates to the practice of radiologic technology <u>or to the</u>
348 <u>performance of the duties of a radiologist assistant,</u> or to the
349 ability to practice radiologic technology <u>or the ability to</u>
350 <u>perform the duties of a radiologist assistant</u>. Pleading nolo
351 contendere shall be considered a conviction for the purpose of
352 this provision.
353 (d) Being convicted or found guilty, regardless of
354 adjudication, in any jurisdiction of a crime against a person.

355 Pleading nolo contendere shall be considered a conviction for
356 the purposes of this provision.
357 (e) Making or filing a false report or record that the
358 certificateholder knows to be false, intentionally or
359 negligently failing to file a report or record required by state
360 or federal law, or willfully impeding or obstructing such filing
361 or inducing another to do so. Such reports or records include
362 only those reports or records which are signed in the capacity
363 of the certificateholder ~~as a radiologic technologist~~.
364 (f) Engaging in unprofessional conduct, which includes,
365 but is not limited to, any departure from, or the failure to
366 conform to, the standards of practice of radiologic technology
367 or the standards of practice for radiologist assistants as
368 established by the department, in which case actual injury need
369 not be established.
370 (g) Being unable to practice radiologic technology or to
371 perform the duties of a radiologist assistant with reasonable
372 skill and safety to patients by reason of illness or use of
373 alcohol, drugs, narcotics, chemicals, or other materials or as a
374 result of any mental or physical condition. A certificateholder
375 ~~radiologic technologist~~ affected under this paragraph shall, at
376 reasonable intervals, be afforded an opportunity to demonstrate
377 that he or she can resume the competent practice of his or her
378 certified profession ~~radiologic technology~~ with reasonable skill
379 and safety.
380 (h) Failing to report to the department any person who the
381 certificateholder knows is in violation of this part or of the
382 rules of the department.

383 (i) Violating any provision of this part, any rule of the
384 department, or any lawful order of the department previously
385 entered in a disciplinary proceeding or failing to comply with a
386 lawfully issued subpoena of the department.
387 (j) Employing, for the purpose of applying ionizing
388 radiation or otherwise practicing radiologic technology or
389 performing the duties of a radiologist assistant on a human
390 being, any individual who is not certified under the provisions
391 of this part.
392 (k) Testing positive for any drug, as defined in s.
393 112.0455, on any confirmed preemployment or employer-required
394 drug screening when the certificateholder ~~radiologic~~
395 ~~technologist~~ does not have a lawful prescription and legitimate
396 medical reason for using such drug.
397 (l) Failing to report to the department in writing within
398 30 days after the certificateholder has had a voluntary or
399 mandatory certificate to practice radiologic technology or to
400 perform the duties of a radiologist assistant revoked,
401 suspended, or otherwise acted against, including being denied
402 certification, by a national organization, by a specialty board
403 recognized by the department, or by a certification authority of
404 another state, territory, or country.
405 (m) Having been found guilty of, regardless of
406 adjudication, or pleading guilty or nolo contendere to, any
407 offense prohibited under s. 435.03 or under any similar statute
408 of another jurisdiction.
409 (n) Failing to comply with the recommendations of the
410 department's impaired practitioner program for treatment,

411 evaluation, or monitoring. A letter from the director of the
412 impaired practitioner program that the certificateholder is not
413 in compliance shall be considered conclusive proof under this
414 part.
415 (2) If the department finds any person or firm guilty of
416 any of the grounds set forth in subsection (1), it may enter an
417 order imposing one or more of the following penalties:
418 (a) Refusal to approve an application for certification.
419 (b) Revocation or suspension of a certificate.
420 (c) Imposition of an administrative fine not to exceed
421 $1,000 for each count or separate offense.
422 (d) Issuance of a reprimand.
423 (e) Placement of the certificateholder ~~radiologic~~
424 ~~technologist~~ on probation for such period of time and subject to
425 such conditions as the department may specify, including
426 requiring the certificateholder ~~radiologic technologist~~ to
427 submit to treatment, to undertake further relevant education or
428 training, to take an examination, or to work under the
429 supervision of a licensed practitioner.
430 (3) The department shall not reinstate a person's ~~the~~
431 certificate ~~of a radiologic technologist~~, or cause a certificate
432 to be issued to a person it has deemed unqualified, until such
433 time as the department is satisfied that such person has
434 complied with all the terms and conditions set forth in the
435 final order and is capable of safely engaging in the practice of
436 his or her certified profession ~~radiologic technology~~.
437 (5) A final disciplinary action taken against a
438 certificateholder ~~radiologic technologist~~ in another

439 jurisdiction, whether voluntary or mandatory, shall be
440 considered conclusive proof of grounds for a disciplinary
441 proceeding under this part.
442 Section 11. Section 468.311, Florida Statutes, is amended
443 to read:
444 468.311 Violations; penalties.--Each of the following acts
445 constitutes a misdemeanor of the second degree, punishable as
446 provided in s. 775.082 or s. 775.083:
447 (1) Practicing radiologic technology or performing the
448 duties of a radiologist assistant without holding an active
449 certificate to do so.
450 (2) Using or attempting to use a certificate which has
451 been suspended or revoked.
452 (3) The willful practice of radiologic technology or the
453 willful performance of the duties of a radiologist assistant by
454 a student ~~radiologic technologist~~ without a direct supervisor
455 being present.
456 (4) Knowingly allowing a student ~~radiologic technologist~~
457 to practice radiologic technology or perform the duties of a
458 radiologist assistant without a direct supervisor being present.
459 (5) Obtaining or attempting to obtain a certificate under
460 this part through bribery or fraudulent misrepresentation.
461 (6) Using any ~~the~~ name or title specified in s. 468.302(2)
462 ~~"Certified Radiologic Technologist"~~ or any other name or title
463 which implies that a person is certified to practice radiologic
464 technology or to perform the duties of a radiologist assistant,
465 unless such person is duly certified as provided in this part.

466 (7) Knowingly concealing information relating to the
467 enforcement of this part or rules adopted pursuant to this part.
468 (8) Employing, for the purpose of applying ionizing
469 radiation to, or otherwise practicing radiologic technology or
470 any of the duties of a radiologist assistant on, any human
471 being, any individual who is not certified under the provisions
472 of this part.
473 Section 12. Section 468.3115, Florida Statutes, is amended
474 to read:
475 468.3115 Injunctive relief.--The practice of radiologic
476 technology or the performance of the duties of a radiologist
477 assistant in violation of this part, or the performance of any
478 act prohibited in this part, is declared a nuisance inimical to
479 the public health, safety, and welfare of this state. In
480 addition to other remedies provided in this part, the
481 department, or any state attorney in the name of the people of
482 this state, may bring an action for an injunction to restrain
483 such violation until compliance with the provisions of this part
484 and the rules adopted pursuant to this part has been
485 demonstrated to the satisfaction of the department.
486 Section 13. Subsections (1), (2), and (5) of section
487 468.314, Florida Statutes, are amended to read:
488 468.314 Advisory Council on Radiation Protection;
489 appointment; terms; powers; duties.--
490 (1) The Advisory Council on Radiation Protection is
491 created within the Department of Health and shall consist of 16
492 ~~15~~ persons to be appointed by the secretary for 3-year terms.
493 (2) The council shall be comprised of:

494 (a) A certified radiologic technologist-radiographer.
495 (b) A certified radiologic technologist-nuclear medicine.
496 (c) A certified radiologic technologist-therapy.
497 (d) A basic X-ray machine operator or a licensed
498 practitioner who employs such an operator.
499 (e) A board-certified radiologist.
500 (f) A board-certified nuclear medicine physician.
501 (g) A certified health physicist.
502 (h) A certified radiologist assistant.
503 (i) ~~(h)~~ A representative from the administration of a
504 hospital affiliated with a radiologic technology educational
505 program.
506 (j) ~~(i)~~ An expert in environmental radiation matters.
507 (k) ~~(j)~~ A chiropractic radiologist.
508 (l) ~~(k)~~ A board-certified podiatric physician.
509 (m) ~~(l)~~ A board-certified radiological physicist.
510 (n) ~~(m)~~ A board-certified therapeutic radiologist or board-
511 certified radiation oncologist.
512 (o) ~~(n)~~ Two persons, neither of whom has ever been
513 certified pursuant to this part ~~as a radiologic technologist~~ or
514 been a member of any closely related profession.
515 (5)(a) The council may recommend to the department
516 examination procedures for applicants and minimum requirements
517 for qualification of applicants.
518 (b) The council shall:
519 1. Recommend to the department a code of ethics for the
520 certificateholder's practice of his or her certified profession
521 ~~radiologic technology~~.

522 2. Make recommendations for the improvement of continuing
523 education courses.
524 3. Make recommendations to the department on matters
525 relating to the practice of radiologic technology, the
526 performance of the duties of a radiologist assistant, and
527 radiation protection.
528 4. Study the utilization of medical imaging and
529 nonionizing radiation, such as nuclear magnetic resonance or
530 similarly related technology, and make recommendations to the
531 department on the personnel appropriate to conduct such
532 procedures and the minimum qualifications for such personnel.
533 Section 14. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1033 CS Child Abuse
SPONSOR(S): Vana
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 2360

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families Committee	6 Y, 0 N, w/CS	Davis	Collins
2) Health Care Appropriations Committee	14 Y, 0 N	Ekholm	Massengale
3) Health & Families Council		Preston	Moore
4)			
5)			

SUMMARY ANALYSIS

The bill requires that all employees of the Department of Children and Family Services (DCF or the department) who are assigned to report, manage or supervise cases of child abuse, abandonment, and neglect complete a 1-hour continuing education course on child abuse each year.

The bill also requires that reporters of child abuse who are licensed or regulated by the state and their employees who are mandatory reporters complete a 1-hour continuing education course on child abuse each year. An exception to this requirement is granted to individuals in certain specified occupational categories, primarily medical and mental health personnel.

There is no significant fiscal impact on state government; the fiscal impact on the private sector depends on whether this course would be subsumed by current continuing education requirements.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill requires DCF employees and mandatory reporters to complete a 1-hour continuing education course on child abuse each year.

B. EFFECT OF PROPOSED CHANGES:

Mandatory Reporting of Child Abuse

Florida law requires **any** person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare to report such knowledge or suspicion to the Department of Children and Family Services' hotline as prescribed by law.[1] This means that **every** individual, **regardless of his or her occupation**, is required to report known or suspected child abuse, neglect, or abandonment. Logically, then, this requirement applies to all 14,665 employees of the department, not just the 2,899 who have responsibility for providing child welfare services.[2]

Florida law also provides that **reporters in the following occupation categories** are required to **provide their names** to the hotline staff when reporting:

- Physicians, osteopathic physicians, medical examiners, chiropractic physicians, nurses, or hospital personnel engaged in the admission, examination, care, or treatment of persons;
- Health or mental health professionals other than those listed above;
- Practitioners who rely solely on spiritual means for healing;
- School teachers or other school officials or personnel;
- Social workers, day care center workers, or other professional child care, foster care, residential, or institutional workers;
- Law enforcement officers; and
- Judges.[3]

Current Training Requirements

Currently, the department, in collaboration with the Department of Education and the Division of Children's Medical Services Prevention and Intervention of the Department of Health, is required to develop a state plan for the prevention of abuse, abandonment, and neglect of children. In addition, appropriate local agencies and organizations shall be provided an opportunity to participate in the development of the state plan at the local level. Appropriate local groups and organizations shall include, but not be limited to, community mental health centers, guardian ad litem programs under the circuit court; the school boards of the local school districts, private or public organizations or programs with recognized expertise in working with children who are abused, abandoned, or neglected and with expertise in working with the families of such children, private or public programs or organizations with expertise in maternal and infant health care, multidisciplinary child protection teams, child day care centers, and law enforcement agencies.[4]

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[1] See s. 39.201, Florida Statutes.
[2] The department is responsible not just for child welfare, but for economic assistance, adult protective services, mental health and substance abuse programs, refugee services, homelessness services, child care regulation, and domestic violence services, s. 20.19, F.S.
[3] See s. 39.201, Florida Statutes.
[4] See s. 39.001(7), Florida Statutes.

As a part of the plan development process:

- The department, the Department of Education, and the Department of Health shall work together in developing ways to inform and instruct parents of school children and **appropriate district school personnel** in all school districts in the detection of child abuse, abandonment, and neglect and in the proper action that should be taken in a suspected case of child abuse, abandonment, or neglect, and in caring for a child's needs after a report is made.

- The department, the Department of Law Enforcement, and the Department of Health shall work together in developing ways to inform and instruct appropriate **local law enforcement personnel** in the detection of child abuse, abandonment, and neglect and in the proper action that should be taken in a suspected case of child abuse, abandonment, or neglect.

- Within existing appropriations, the department shall work with other appropriate public and private agencies to emphasize efforts to educate the **general public** about the problem of and ways to detect child abuse, abandonment, and neglect and in the proper action that should be taken in a suspected case of child abuse, abandonment, or neglect.

- The department, the Department of Education, and the Department of Health shall work together on the enhancement or adaptation of curriculum materials to assist **instructional personnel** in providing instruction through a multidisciplinary approach on the identification, intervention, and prevention of child abuse, abandonment, and neglect.[5]

According to the Department of Children and Family Services, employees of the department and of community-based care providers and their subcontractors who provide child welfare services [6] are already required to complete continuing education requirements which exceed the requirements in the bill. However, the Child Care Program Office of DCF, which oversees licensing of child care providers, reports that the current training for their staff and the licensees they oversee does not include this training. Nonetheless, minimum personnel standards for child care personnel in licensed child care facilities include training on identifying and reporting child abuse and neglect.[7]

According to the Florida Department of Law Enforcement (FDLE), the Criminal Justice Standards and Training Commission within FDLE is authorized by s. 943.15, Florida Statutes, to establish uniform minimum training standards for the training of all criminal justice officers in the state and is responsible for the certification and revocation of certification of all officers and instructors. The basic recruit training now in effect, according to FDLE, touches on child abuse investigation, but there is not a module devoted specifically to this topic. When the curriculum is revised, FDLE expects that this issue will receive additional attention. In addition, criminal justice training schools work with local criminal justice agencies to develop specialized continuing education courses to fulfill each agency's needs. Categories for such courses include health and investigations. In order to be approved, a specialized course must include four hours of instruction.

According the Florida Nurses' Association, continuing education courses for licensed medical professionals are regulated by the Department of Health. The Florida Hospital Association reports that hospitals are required by law [8] to adopt a policy that provides that all employees have an affirmative duty to report child abuse. Employees are informed of this requirement during orientation. Hospitals provide further training for clinicians who may come in contact with children. Not all hospital employees, nor all medical personnel, have any occasion to come in contact with children in a professional capacity, since some hospitals and some medical professionals limit their practice to adults.

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[5] See s. 39.001(7), Florida Statutes.
[6] "A person providing child welfare services" is defined in s. 402.40, Florida Statutes, as "a person who has a responsibility for supervisory, legal, direct care or support related work in the provision of child welfare services pursuant to chapter 39."
[7] See s. 402.305, Florida Statutes.
[8] See s. 395.1023, Florida Statutes.

Judges are required to take 30 hours of continuing judicial education every three years. The topic of child abuse is covered as one of many topics in the New Judges' College. Advanced education courses for judges to meet the 30 hours requirement are selected by each judge from a curriculum in which not all courses are offered every year. The Office of State Courts Administrator reports that requiring all judges to take a particular course every year would require significant revamping of the current system of judicial education.

The Department of Education reports that teachers no longer receive continuing education units at all but, instead, adhere to Florida's standards for professional development. These standards do not award professional development credit for informational meetings but award credit for competency. It is not clear that the 1-hour continuing education course on child abuse will be recognized as a credit under the standards for professional development. However, current law provides that it is the intent of the Legislature that primary child abuse prevention training for all children in kindergarten through grade 12 be encouraged in the district school system through the training of school teachers, guidance counselors, parents, and children.

A training program shall include, among other things, information related to recognizing physical and behavioral indicators of abuse, to rights and responsibilities related to reporting, school procedures related to reporting, and caring for a child's needs after a report is made.[9]

The Department of Children and Family Services reports that most, if not all, of the reporters who are required to identify themselves when making hotline calls are required to have continuing education courses as a condition of maintaining their professional licenses. The department does not track whether these education requirements include courses on child abuse issues.

Provisions of the bill

The bill requires that all employees of the Department of Children and Family Services (DCF or the department) who are assigned to report, manage or supervise cases of child abuse, abandonment, and neglect complete a 1-hour continuing education course on child abuse each year.

The bill also requires that reporters of child abuse who are licensed or regulated by the state and their employees who are mandatory reporters complete a 1-hour continuing education course on child abuse each year. An exception to this requirement is granted to individuals in certain specified occupational categories.

C. SECTION DIRECTORY:

Section 1. Amends s. 39.001, F.S., relating to personnel standards and screening.

Section 2. Amends s. 39.201, F.S., relating to mandatory reporting of child abuse, neglect, and abandonment.

Section 3. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

[9] See s. 30.0015, Florida Statutes.

2. Expenditures:

Current ongoing continuing education requirements already exceed guidelines proposed by the bill and training costs are covered for caseworkers and supervisors through Child Welfare Training Trust Funds (IV-E). Community-based care personnel training costs for child abuse professionals are currently also funded through the Child Welfare Training Trust Funds (IV-E).

If the bill is intended to require all employees of the Department of Children and Family Services to receive the training, rather than only the child protection professionals (who already receive training on this issue in excess of that required by the bill), there will be costs associated in expanding the training to cover these additional employees. The Child Care Program Office of the department predicts a cost in the range of $40,000 to $60,000 to develop the web-based training and tracking program that will be needed to train and track the training of child care providers and DCF staff regulating child care.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

There may be the potential for a fiscal impact on local governments if local government employees are required to take the course.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There will be a significant but indeterminate cost if existing continuing education requirements for the various professionals required to provide their names to hotline staff have to be reconfigured to ensure that an hour of child abuse education is included in the curricula. If tracking of compliance is contemplated, additional costs will be incurred.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Administrative Rule and operating procedures are currently being developed with the anticipation that the child welfare certification process will far exceed this bill's requirement for continuing education courses by professionals in this field. Whereas, this bill proposes one hour per year, the standard expected to be set will more likely require 15 hours of continuing education courses per year. Current ongoing continuing education requirements already exceed guidelines proposed by current bill and training costs are covered for caseworkers and supervisors through Child Welfare Training Trust Funds (Title IV-E).

Most, if not all, of the occupational categories of individuals who are required to provide their name when reporting to the abuse hotline also have continuing education requirements as part of their re-licensure process. What is not known is if any of these occupational categories presently require a course on child abuse issues. This means many of these professionals may already be meeting or exceeding the standards proposed by this bill. The bill does not describe a "tracking mechanism" relating to compliance with the new requirement. It is unclear if the department is expected to provide this oversight and/or develop a 1-hour continuing education course to help satisfy this requirement.

The addition of "reporters of child abuse who are licensed or regulated by the state and their employees who are mandatory reporters" to the continuing education requirement, would appear to have the potential to have a substantial impact on the general public. Since every individual in the state is required to report known or suspected child abuse, neglect, or abandonment, the bill provides that every member of a subset of that population, which would be anyone who is licensed or regulated by the state, and a sub-subset which includes the employees of those licensed or regulated would be required to complete the 1-hour continuing education requirement. This would mean, for example, that a plumbing contractor and all of his or her employees would be required to complete the education requirement proposed by the bill.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 4, 2006, the Future of Florida's Families Committee adopted a Committee Substitute to HB 1033. The amendment requires that reporters of child abuse who are licensed or regulated by the state and their employees who are mandatory reporters complete a 1-hour continuing education course on child abuse each year. An exception to this requirement is granted to individuals in certain specified occupational categories, primarily medical and mental health personnel.

The bill analysis reflects this change.

CHAMBER ACTION

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1 The Future of Florida's Families Committee recommends the
2 following:
3
4 **Council/Committee Substitute**
5 Remove the entire bill and insert:
6 A bill to be entitled
7 An act relating to child abuse; amending ss. 39.001 and
8 39.201, F.S.; requiring Department of Children and Family
9 Services employees and persons in specified occupation
10 categories assigned to report, manage, or supervise cases
11 of child abuse, abandonment, and neglect to annually
12 complete a continuing education course; providing
13 exceptions; providing an effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Paragraph (e) of subsection (2) of section
18 39.001, Florida Statutes, is amended to read:
19 39.001 Purposes and intent; personnel standards and
20 screening.--
21 (2) DEPARTMENT CONTRACTS.--The department may contract
22 with the Federal Government, other state departments and
23 agencies, county and municipal governments and agencies, public

24 and private agencies, and private individuals and corporations
25 in carrying out the purposes of, and the responsibilities
26 established in, this chapter.
27 (e) The department shall develop and implement a written
28 and performance-based testing and evaluation program to ensure
29 measurable competencies of all employees assigned to report,
30 manage, or supervise cases of child abuse, abandonment, and
31 neglect. All employees assigned to report, manage, or supervise
32 cases of child abuse, abandonment, and neglect shall complete a
33 1-hour continuing education course on child abuse each year.
34 Section 2. Paragraph (b) of subsection (1) of section
35 39.201, Florida Statutes, is amended to read:
36 39.201 Mandatory reports of child abuse, abandonment, or
37 neglect; mandatory reports of death; central abuse hotline.--
38 (1)
39 (b) Reporters licensed or regulated by the state and their
40 employees who are mandatory reporters are required to complete a
41 1-hour continuing education course on child abuse each year,
42 except for reporters in subparagraphs 1. and 2. Reporters in the
43 following occupation categories are required to provide their
44 names to the hotline staff:
45 1. Physician, osteopathic physician, medical examiner,
46 chiropractic physician, nurse, or hospital personnel engaged in
47 the admission, examination, care, or treatment of persons;
48 2. Health or mental health professional other than one
49 listed in subparagraph 1.;
50 3. Practitioner who relies solely on spiritual means for
51 healing;

52 4. School teacher or other school official or personnel;
53 5. Social worker, day care center worker, or other
54 professional child care, foster care, residential, or
55 institutional worker;
56 6. Law enforcement officer; or
57 7. Judge.
58
59 The names of reporters shall be entered into the record of the
60 report, but shall be held confidential and exempt as provided in
61 s. 39.202.
62 Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1093 CS Physicians
SPONSOR(S): Altman and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1410

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	8 Y, 0 N, w/CS	Hamrick	Mitchell
2) Health Care Appropriations Committee	14 Y, 0 N, w/CS	Money	Massengale
3) Health & Families Council		Hamrick	Moore
4)			
5)			

SUMMARY ANALYSIS

House Bill 1093 CS requires the Division of Health Access and Tobacco within the Department of Health to monitor, evaluate and report on the supply, distribution and specialty of allopathic and osteopathic physicians in Florida. The bill requires the division to use data that is available from public and private sources.

The bill provides an option for physicians seeking licensure to:

- Submit their core credentials to the Federation Credentials Verifications Services of the Federation of State Medical Boards and submit their Physician Information Profile originating from the Federation to the Department of Health or
- Submit their core credentials directly to the Department of Health.

The federation verifies the submitted information and certifies it as a life-long primary source document from which a physician profile may be created and sent to employers, hospitals and the Board of Medicine, which then may evaluate an individual's eligibility for licensure.

The bill also requires the Division of Health Access and Tobacco within the Department of Health to analyze the supply and distribution of Florida-licensed dentists in Medicaid Services Areas one and two of the Agency of Health Care Administration.

The bill provides an appropriation of one full-time equivalent position, salary rate of 36,245, and $161,148 from the Medical Quality Assurance Trust Fund for the first year and $110,771 each succeeding year.

The bill takes effect on October 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provides limited government—The bill requires the Division of Health Access and Tobacco to monitor, evaluate and report on the supply and demand of physicians in the state. The bill also requires the Division of Health Access and Tobacco within the Department of Health to analyze the supply and distribution of Florida-licensed dentists in Medicaid Services Areas one and two of the Agency of Health Care Administration. The bill provides an option to physicians to submit their core credentialing information to specified entities.

B. EFFECT OF PROPOSED CHANGES:

The bill requires the Division of Health Access and Tobacco within the Department of Health to monitor, evaluate and report on the supply and distribution of physicians in the state. The division is required to develop a strategy to track and analyze, on an ongoing basis, the distribution of licensed physicians by specialty and geographic location. The division must use public and private resources for available data. A report must be submitted to the Governor, the President of the Senate, and the Speaker of the House each year starting March 1, 2008.

The bill adds a requirement to the licensure by endorsement and licensure by examination provisions, which require physicians who are seeking licensure to submit their core credentials to either the Federation Credentials Verification Services of the Federation of State Medical Boards or the Department of Health. If they opt to send their credentials to the federation, they must submit a copy of the Physician Information Profile created by the federation to the Department of Health.

The bill requires the Division of Health Access and Tobacco within the Department of Health to analyze the supply and distribution of Florida-licensed dentists in Medicaid Services Areas one and two of the Agency of Health Care Administration, and a preliminary report shall be submitted on March 1, 2007 with the final report due March 1, 2008.

The bill provides an appropriation from the Medical Quality Assurance Trust Fund to the Department of Health to implement the provisions of this bill for Fiscal Year 2006-2007.

PRESENT SITUATION

Physician Workforce Data

Recently, the Council on Graduate Medical Education, a national advisory organization that makes recommendations on the adequacy of the supply and distribution of physicians, predicted that the demand for physicians, nationally, would significantly outpace the supply. In Florida, the costs of medical malpractice insurance, the recent adoption of a constitutional amendment that prohibits licensure or continued licensure of physicians who have committed three or more incidents of medical malpractice, and other variables have affected the number of students applying to medical schools in Florida. The number of allopathic and osteopathic physicians applying for licensure and practicing in Florida has also been impacted.

The statewide collection of physician data and its analysis is fragmented in Florida and under the purview of different agencies. Currently, there is no centralized physician workforce database that is available to provide objective statewide information on physician practice and manpower needs.

Under s. 408.05, F.S., the State Center for Health Statistics within the Agency for Health Care Administration (AHCA) must collect data on health resources, including physicians, dentists, nurses,

and other health care professionals. The Division of Health Access and Tobacco within DOH administers several programs that relate to physician access. The Florida Medicaid program in AHCA has claims data for physicians participating in the Medicaid program. Although several entities collect information on Florida physicians, there is no centralized responsibility for statewide collection and analysis of health workforce data, including physician data.

2003 Surgeon General Report on America's Oral Health

According to the Surgeon General's Report, oral diseases are progressive and cumulative and become more complex over time. Health disparities exist across the population groups at all ages.[1] Health disparities are commonly associated with populations whose access to health care services is comprised by poverty, limited education or language skills, geographic isolation, age, gender, disability, or an existing medical problem. While Medicaid, State Children's Health Insurance Programs (SCHIP), and private organizations have expanded outreach efforts to identify and enroll eligible persons and simplify the enrollment process, they have not completely closed the gap. Some 25 million Americans live in dental care shortage areas, as defined by Health Professional Shortage Area criteria (HPSA).[2]

A geographic area will be designated as having a dental professional shortage if the following three criteria are met:

- The area is a rational area for the delivery of dental services.
- One of the following conditions prevails in the area:
  - The area has a population to full-time-equivalent dentist ratio of at least 5,000:1, or
  - The area has a population to full-time-equivalent dentist ratio of less than 5,000:1 but greater than 4,000:1 and has unusually high needs for dental services or insufficient capacity of existing dental providers.
- Dental professionals in contiguous areas are over utilized, excessively distant, or inaccessible to the population of the area under consideration.

Over 108 million children and adults lack dental insurance, which is over 2.5 times the number of individuals who lack medical insurance.[3] Uninsured children are 2.5 times less likely than insured children to receive dental care.[4]

The report also states that Medicaid is not able to fill the gap in dental care for poor children. Less than one in five Medicaid-covered children received a single dental visit during a year-long study. Programs such as the State Children's Health Insurance Program (SCHIP) may increase the number of insured children; many still are left without effective dental coverage.

Further, the report provides that for every adult 19 years or older who has medical insurance coverage; there are three adults who lack dental insurance. Less than two thirds of adults report having visited a dentist in the past 12 months.

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[1] U.S. Department of Health and Human Services. A National Call to Action to Promote Oral Health. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, and the National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, May 2003.

[2] See 42 USC 216 sec. 332 and 42 USC 254e

[3] Ibid.

[4] Ibid.

Dental Workforce Data and Medicaid

Currently, there are 10,728 actively licensed dentists and 191 dentists who have received a retired license in Florida. Currently, the Department of Health does not track whether dentists practice full or part-time. The COMPAS data system, which is utilized by the Department of Health, tracks address of licensed dentists in Florida. Licensed dentists are required to keep the Board of Dentistry informed of their address changes. According to data provided by the Department of Health the following numbers of licensed dentists are located in Medicaid areas one and two, which is primarily the panhandle area from Pensacola to Tallahassee:

COUNTY/ SERVICE AREA	# OF CLEAR, ACTIVE, LICENSED DENTISTS	# OF CLEAR, INACTIVE LICENSED DENTISTS	# OF RETIRED DENTISTS
Bay	69	1	1
Calhoun	4		
Escambia	146		2
Franklin	2		
Gadsden	10		1
Gulf	4		
Holmes	3		
Jackson	14		
Jefferson	2		
Leon	109	1	2
Liberty	1		
Madison	2		
Okaloosa	94		
Santa Rosa	35		
Taylor	2		
Wakulla	3		
Walton	15		
Washington	6		

According to the Agency for Health Care Administration (AHCA), there are 6,059 Medicaid enrolled dental providers in Florida. This number includes providers in Georgia and Alabama who may treat Florida Medicaid recipients. According to AHCA, there are 387 Medicaid enrolled dental providers in Medicaid areas one and two.

As of April 2006, AHCA estimated there were 1.2 million children eligible for Medicaid dental services. The children's dental program provides full dental services for all Medicaid eligible children less than 21 years of age. The adult dental program provides emergencies and dentures or denture related emergencies.

Current Statutory Licensure Requirements

Chapter 458, F.S., governs the practice of allopathic medicine. Currently, an applicant seeking licensure to practice medicine in Florida must submit specified information regarding education, training and discipline to the Board of Medicine, and must submit an application fee not to exceed $500. The bill amends language into s. 458.311, F.S., that relates to licensure by examination and s. 458.313, F.S., that relates to licensure by endorsement. Both of these sections provide a pathway to licensure.

Credentialing Process by the Board of Medicine

As part of the initial licensure process, the staff of the Board of Medicine verifies an applicant's core credentials. The core credentials include medical education, all postgraduate medical training, national licensure examination history, Educational Commission for Foreign Medical Graduates (ECFMG) certification, any current staff privileges, and any physician licenses held in other states, disciplinary history, and medical malpractice claims. Primary source verification of a physician licensure applicant's

credentials can be a laborious process, which results in substantial delay in a board's evaluation of an applicant's credentials.

The Florida Board of Medicine encourages, but does not require, licensure applicants to use the Federation Credentials Verification Service (FCVS) to have the applicant's core credentials verified. A one-time fee of approximately $275 is assessed by the federation for this service. Additional fees or surcharges may be assessed depending upon what additional information is needed.

Federation Credentials Verification Service offered by the Federation of State Medical Boards

Federation Credentials Verification Service (FCVS) was established in September 1996 to provide a centralized, uniform process for state medical boards to obtain a verified, primary source record of a physician's core medical credentials. The FCVS acts as a repository of information for physicians and establishes a confidential, lifetime professional portfolio with FCVS which can be forwarded, at the physician's request, to any state medical board that has established an agreement with FCVS, hospital, health care or any other entity. FCVS obtains primary source verification of medical education, postgraduate training, examination history, board action history, board certification and identity.

This service is designed to lighten the workload of credentialing staff and reduce duplication of effort by gathering, verifying and permanently storing the physician's and/or physician assistant's credentials in a central repository at the federation.

Currently, 38 states *accept* a physician's credentials that are verified by the federation, including Florida. Nine states currently *require* verification by the federation.

Hospital Credentialing and Federation Credentials Verification Service

Currently, hospitals are not required to recognize the Federation Credentials Verification Service (FCVS). According to information received from the FCVS, limited numbers of hospitals have accepted credentialing from the federation. Since 2001, only 69 medical groups or health care facilities in the state accepted FCVS physician profiles. In comparison, (as of 2005) there were 264 licensed hospitals in the state.

Hospitals and other health care entities are required to meet certain accreditation standards that are set by such entities as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the National Committee for Quality Assurance (NCQA) and they are ultimately responsible for the accuracy of employee's credentials. For this reason, a physician could submit their credentials to the FCVS and still be responsible for submitting the identical information to a hospital.

C. SECTION DIRECTORY:

Section 1. Creates s. 381.0304, F.S., requiring the Division of Health Access and Tobacco within the Department of Health to monitor, evaluate, and report on the supply and distribution of allopathic and osteopathic physicians in the state, the report shall be submitted annually starting on March 1, 2008.
Section 2. Amends s. 458.311, F.S., providing an option for submitting core credentials for licensure by examination.
Section 3. Amends s. 458.313, F.S., providing an option for submitting core credentials for licensure by endorsement.
Sections 4 through 6 amend ss. 458.316, 458.3165, and 458.317, F.S., conforming cross-references.
Section 7. Requires that the Division of Health Access and Tobacco within the Department of Health shall analyze the supply and distribution of Florida-licensed dentists in Medicaid Services Areas one and two of the Agency of Health Care Administration, and a preliminary report shall be submitted on March 1, 2007 with the final report due March 1, 2008.

Section 8. Provides an appropriation.
Section 9. Provides that the bill will take effect on October 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

According to the Department of Health the fiscal impact reflects costs for compiling and evaluating reports of physician licensure data by specialty and location.

1. Revenues:

   No dedicated source of revenue.

2. Expenditures:

Estimated Expenditures	1st Year	2nd Year (Annualized/Recurr.)
Salaries		
1 FTE Research Associate (no lapse, base + 10% w/28% fringe) – DHAT	$50,340	$50,340
1 part time OPS Admin. Support staff at 25 hours/week @$10.00 hour – DHAT	$13,995	$13,995
1 part time OPS Operations Management Consultant at 25 hours/week @$17.00 hour -to support desk audit functions – DHAT	$23,791	$23,791
Expense		
DOH Professional Package 1 FTE with limited travel and 1 OPS – DHAT	$23,479	$16,793
DOH Support Staff Package – DHAT	$7,986	$5,195
GIS Mapping Software – DHAT	$10,000	
HR Services (1FTE and 2 part-time OPS) – DHAT	$657	$657
OCO		
Standard OCO professional packages for 1 FTE and 1 OPS – DHAT	$3,800	0
Standard OCO package for 1 support staff – DHAT	$2,100	0
Other		
Software costs (MQA)	$25,000	0
Total Estimated Expenditures	$161,148	$110,771

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Physicians may opt to incur the cost of having their core credentials verified by the Federation of State Medical Boards (FSMB). A one-time fee is assessed for this service of approximately $275. Additional fees may be assessed to collect such items as examination transcripts and Educational Commission for Foreign Medical Graduates (ECFMG) Program certification.[5] Physicians, who complete the verification process conducted by the federation, establish a life-long file of their credentials, which can be easily accessed throughout their career by potential employers, state licensure, hospital privileges, and professional memberships. This may also be beneficial for foreign trained physicians who may have difficulty accessing or gathering core credentialing information from the medical school they attended in another country.

D. FISCAL COMMENTS:

According to the Department of Health, the cost to implement the provisions of the bill will be $161,148 for the first year and $110,771 each succeeding year.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

3. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

According to the Department of Health, current data sources, particularly the department's MQA licensure data, are not sufficient to prepare a report on the geographic distribution of physicians by specialty. To prepare an annual report to meet the needs of the Graduate Medical Education Committee and the Community Hospital Education Council, the collection of data on physicians in the DOH licensing process must be expanded.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 22, 2006, the Health Care Regulation Committee adopted four amendments offered by the bill's sponsor. The Committee Substitute differs from the original bill as filed in that it:

- Removes s. 458.347(7)(b), F.S., which was re-enacted to incorporate the language requiring physicians to submit their core credentials to the Federation Credentials Verification Services. This section was included in the bill as a technicality to ensure that the amendment to s. 458.311(1)(g), F.S., dealing with the credentialing by the federation was applied.

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[5] The Educational Commission for Foreign Medical Graduates (ECFMG) assesses whether international medical graduates met minimum standards of eligibility to include the verification of education. In order for international medical graduates to receive licensure to practice medicine in Florida, applicants must have ECFMG certification.

- Specifies that workforce data will be collected on allopathic physicians licensed under chapter 458, F.S., and osteopathic physicians licensed under chapter 459, F.S.
- Moves the workforce data reporting date from January 1 to March 1.
- Removes the requirement that physicians must submit their core credentials to the Federation Credentials Verification Services of the Federation of State Medical Boards and makes it optional. A physician may submit their core credentials to the Federation or the Department of Health. If they opt to submit the information to the federation, they must submit to the department the Physician Information Profile that is created by the federation.

The bill, as amended, was reported favorably as a committee substitute.

On April 11, 2006, the Health Care Appropriations Committee adopted one amendment offered by the bill's sponsor. The amendment:

- Requires that the Division of Health Access and Tobacco within the Department of Health analyze the supply and distribution of Florida-licensed dentists in Medicaid Services Areas one and two of the Agency of Health Care Administration, and a preliminary report shall be submitted on March 1, 2007 with the final report due March 1, 2008.
- Provides an appropriation of one full-time equivalent position, salary rate of 36,245, and $161,148 from the Medical Quality Assurance Trust Fund for the first year and $110,771 each succeeding year.

This analysis is drafted to the committee substitute.

CHAMBER ACTION

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1 The Health Care Appropriations Committee recommends the
2 following:
3
4 **Council/Committee Substitute**
5 Remove the entire bill and insert:
6 A bill to be entitled
7 An act relating to physicians; creating s. 381.0304, F.S.;
8 requiring the Division of Health Access and Tobacco of the
9 Department of Health to monitor, evaluate, and report on
10 the supply and distribution of allopathic physicians and
11 osteopathic physicians in the state; amending ss. 458.311
12 and 458.313, F.S.; requiring applicants for physician
13 licensure to submit core credentials to specified
14 entities; amending ss. 458.316, 458.3165, and 458.317,
15 F.S.; conforming cross-references; requiring the division
16 to report on the supply and distribution of dentists in
17 specified Agency for Health Care Administration Medicaid
18 service areas; providing an appropriation; providing an
19 effective date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22

23 Section 1. Section 381.0304, Florida Statutes, is created
24 to read:
25 381.0304 Supply and distribution of physicians;
26 reports.--The Division of Health Access and Tobacco of the
27 department shall monitor, evaluate, and report on the supply and
28 distribution of allopathic physicians licensed under chapter 458
29 and osteopathic physicians licensed under chapter 459 in this
30 state. The division shall develop a strategy to track and
31 analyze, on an ongoing basis, the distribution of state-licensed
32 physicians by specialty and geographic location using data that
33 are available from public and private sources. The division
34 shall submit a report to the Governor, the President of the
35 Senate, and the Speaker of the House of Representatives by March
36 1, 2008, and annually thereafter.
37 Section 2. Subsection (1) of section 458.311, Florida
38 Statutes, is amended to read:
39 458.311 Licensure by examination; requirements; fees.--
40 (1) Any person desiring to be licensed as a physician, who
41 does not hold a valid license in any state, shall apply to the
42 department on forms furnished by the department. The department
43 shall license each applicant who the board certifies:
44 (a) Has completed the application form and remitted a
45 nonrefundable application fee not to exceed $500.
46 (b) Is at least 21 years of age.
47 (c) Is of good moral character.
48 (d) Has not committed any act or offense in this or any
49 other jurisdiction which would constitute the basis for
50 disciplining a physician pursuant to s. 458.331.

51 (e) For any applicant who has graduated from medical
52 school after October 1, 1992, has completed the equivalent of 2
53 academic years of preprofessional, postsecondary education, as
54 determined by rule of the board, which shall include, at a
55 minimum, courses in such fields as anatomy, biology, and
56 chemistry prior to entering medical school.
57 (f) Meets one of the following medical education and
58 postgraduate training requirements:
59 1.a. Is a graduate of an allopathic medical school or
60 allopathic college recognized and approved by an accrediting
61 agency recognized by the United States Office of Education or is
62 a graduate of an allopathic medical school or allopathic college
63 within a territorial jurisdiction of the United States
64 recognized by the accrediting agency of the governmental body of
65 that jurisdiction;
66 b. If the language of instruction of the medical school is
67 other than English, has demonstrated competency in English
68 through presentation of a satisfactory grade on the Test of
69 Spoken English of the Educational Testing Service or a similar
70 test approved by rule of the board; and
71 c. Has completed an approved residency of at least 1 year.
72 2.a. Is a graduate of an allopathic foreign medical school
73 registered with the World Health Organization and certified
74 pursuant to s. 458.314 as having met the standards required to
75 accredit medical schools in the United States or reasonably
76 comparable standards;
77 b. If the language of instruction of the foreign medical
78 school is other than English, has demonstrated competency in

79 English through presentation of the Educational Commission for
80 Foreign Medical Graduates English proficiency certificate or by
81 a satisfactory grade on the Test of Spoken English of the
82 Educational Testing Service or a similar test approved by rule
83 of the board; and
84 c. Has completed an approved residency of at least 1 year.
85 3.a. Is a graduate of an allopathic foreign medical school
86 which has not been certified pursuant to s. 458.314;
87 b. Has had his or her medical credentials evaluated by the
88 Educational Commission for Foreign Medical Graduates, holds an
89 active, valid certificate issued by that commission, and has
90 passed the examination utilized by that commission; and
91 c. Has completed an approved residency of at least 1 year;
92 however, after October 1, 1992, the applicant shall have
93 completed an approved residency or fellowship of at least 2
94 years in one specialty area. However, to be acceptable, the
95 fellowship experience and training must be counted toward
96 regular or subspecialty certification by a board recognized and
97 certified by the American Board of Medical Specialties.
98 (g) Has either submitted core credentials to the
99 Federation Credentials Verification Services of the Federation
100 of State Medical Boards and submitted the Physician Information
101 Profile originating from the Federation Credentials Verification
102 Service to the department or has submitted core credentials
103 directly to the department.
104 (h) ~~(g)~~ Has submitted to the department a set of
105 fingerprints on a form and under procedures specified by the
106 department, along with a payment in an amount equal to the costs

107 incurred by the Department of Health for the criminal background
108 check of the applicant.
109 (i) ~~(h)~~ Has obtained a passing score, as established by
110 rule of the board, on the licensure examination of the United
111 States Medical Licensing Examination (USMLE); or a combination
112 of the United States Medical Licensing Examination (USMLE), the
113 examination of the Federation of State Medical Boards of the
114 United States, Inc. (FLEX), or the examination of the National
115 Board of Medical Examiners up to the year 2000; or for the
116 purpose of examination of any applicant who was licensed on the
117 basis of a state board examination and who is currently licensed
118 in at least one other jurisdiction of the United States or
119 Canada, and who has practiced pursuant to such licensure for a
120 period of at least 10 years, use of the Special Purpose
121 Examination of the Federation of State Medical Boards of the
122 United States (SPEX) upon receipt of a passing score as
123 established by rule of the board. However, for the purpose of
124 examination of any applicant who was licensed on the basis of a
125 state board examination prior to 1974, who is currently licensed
126 in at least three other jurisdictions of the United States or
127 Canada, and who has practiced pursuant to such licensure for a
128 period of at least 20 years, this paragraph does not apply.
129 Section 3. Paragraph (a) of subsection (1) of section
130 458.313, Florida Statutes, is amended to read:
131 458.313 Licensure by endorsement; requirements; fees.--
132 (1) The department shall issue a license by endorsement to
133 any applicant who, upon applying to the department on forms

134 furnished by the department and remitting a fee set by the board
135 not to exceed $500, the board certifies:
136 (a) Has met the qualifications for licensure in s.
137 458.311(1)(b)-(h) ~~s. 458.311(1)(b)-(g)~~ or in s. 458.311(1)(b)-
138 (e) and (h) ~~(g)~~ and (3);
139 Section 4. Subsection (1) of section 458.316, Florida
140 Statutes, is amended to read:
141 458.316 Public health certificate.--
142 (1) Any person desiring to obtain a public health
143 certificate shall submit an application fee not to exceed $300
144 and shall demonstrate to the board that he or she is a graduate
145 of an accredited medical school and holds a master of public
146 health degree or is board eligible or certified in public health
147 or preventive medicine, or is licensed to practice medicine
148 without restriction in another jurisdiction in the United States
149 and holds a master of public health degree or is board eligible
150 or certified in public health or preventive medicine, and shall
151 meet the requirements in s. 458.311(1)(a)-(f) and (h) ~~s.~~
152 ~~458.311(1)(a)-(g)~~ and (5).
153 Section 5. Section 458.3165, Florida Statutes, is amended
154 to read:
155 458.3165 Public psychiatry certificate.--The board shall
156 issue a public psychiatry certificate to an individual who
157 remits an application fee not to exceed $300, as set by the
158 board, who is a board-certified psychiatrist, who is licensed to
159 practice medicine without restriction in another state, and who
160 meets the requirements in s. 458.311(1)(a)-(f) and (h) ~~s.~~
161 ~~458.311(1)(a)-(g)~~ and (5). A recipient of a public psychiatry

162 certificate may use the certificate to work at any public mental
163 health facility or program funded in part or entirely by state
164 funds.
165 (1) Such certificate shall:
166 (a) Authorize the holder to practice only in a public
167 mental health facility or program funded in part or entirely by
168 state funds.
169 (b) Be issued and renewable biennially if the secretary of
170 the Department of Health and the chair of the department of
171 psychiatry at one of the public medical schools or the chair of
172 the department of psychiatry at the accredited medical school at
173 the University of Miami recommend in writing that the
174 certificate be issued or renewed.
175 (c) Automatically expire if the holder's relationship with
176 a public mental health facility or program expires.
177 (d) Not be issued to a person who has been adjudged
178 unqualified or guilty of any of the prohibited acts in this
179 chapter.
180 (2) The board may take disciplinary action against a
181 certificateholder for noncompliance with any part of this
182 section or for any reason for which a regular licensee may be
183 subject to discipline.
184 Section 6. Paragraph (a) of subsection (1) of section
185 458.317, Florida Statutes, is amended to read:
186 458.317 Limited licenses.--
187 (1)(a) Any person desiring to obtain a limited license
188 shall:

189 1. Submit to the board, with an application and fee not to
190 exceed $300, an affidavit stating that he or she has been
191 licensed to practice medicine in any jurisdiction in the United
192 States for at least 10 years and intends to practice only
193 pursuant to the restrictions of a limited license granted
194 pursuant to this section. However, a physician who is not fully
195 retired in all jurisdictions may use a limited license only for
196 noncompensated practice. If the person applying for a limited
197 license submits a notarized statement from the employing agency
198 or institution stating that he or she will not receive
199 compensation for any service involving the practice of medicine,
200 the application fee and all licensure fees shall be waived.
201 However, any person who receives a waiver of fees for a limited
202 license shall pay such fees if the person receives compensation
203 for the practice of medicine.
204 2. Meet the requirements in s. 458.311(1)(b)-(f) and (h)
205 ~~s. 458.311(1)(b)-(g)~~ and (5). If the applicant graduated from
206 medical school prior to 1946, the board or its appropriate
207 committee may accept military medical training or medical
208 experience as a substitute for the approved 1-year residency
209 requirement in s. 458.311(1)(f).
210
211 Nothing herein limits in any way any policy by the board,
212 otherwise authorized by law, to grant licenses to physicians
213 duly licensed in other states under conditions less restrictive
214 than the requirements of this section. Notwithstanding the other
215 provisions of this section, the board may refuse to authorize a
216 physician otherwise qualified to practice in the employ of any

217 agency or institution otherwise qualified if the agency or
218 institution has caused or permitted violations of the provisions
219 of this chapter which it knew or should have known were
220 occurring.
221 Section 7. The Division of Health Access and Tobacco of
222 the Department of Health shall analyze the supply and
223 distribution of state-licensed dentists in the Agency for Health
224 Care Administration's Areas One and Two using data that are
225 available from public and private sources. The division shall
226 determine whether such dentists are retired or working full
227 time. The division shall submit a preliminary report to the
228 Governor, the President of the Senate, and the Speaker of the
229 House of Representatives by March 1, 2007, that identifies the
230 supply and distribution of state-licensed dentists in the Agency
231 for Health Care Administration's Areas One and Two, indicates
232 whether state-licensed dentists in such areas are retired or
233 working full time, and recommends strategies to improve a
234 broader distribution of dentists in such areas if a shortage or
235 maldistribution is determined to exist. The division shall
236 submit a final report to the Governor, the President of the
237 Senate, and the Speaker of the House of Representatives by March
238 1, 2008.
239 Section 8. The sum of $161,148, of which $110,771 is
240 recurring, is appropriated from the Medical Quality Assurance
241 Trust Fund to the Department of Health, and one full-time
242 equivalent position at 36,245 in salary rate is authorized, to
243 implement this act for fiscal year 2006-2007.
244 Section 9. This act shall take effect October 1, 2006.

HB 1231 CS

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1231 CS Child Care
SPONSOR(S): Ausley
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 270 and SB 1510

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families Committee	7 Y, 0 N, w/CS	Davis	Collins
2) Health Care Appropriations Committee	12 Y, 0 N	Ekholm	Massengale
3) Health & Families Council		Davis	Moore
4)			
5)			

SUMMARY ANALYSIS

House Bill 1231 CS amends existing statutory provisions relating to chapter 402, F.S., pertaining to the Teacher Education and Compensation Helps scholarship program, the Gold Seal Quality Care designation, revising the definition of the term "screening", expanding the Department of Children and Family Services (DCF's) licensing authority, revising disciplinary actions and fines, and requiring minimum safety standards for family day care homes.

Specifically, this bill:

- Transfers authority for the administration of the Teacher Education and Compensation Helps (T.E.A.C.H.) scholarship program from the Department of Children and Family Services to the Agency for Workforce Innovation.
- Revises provisions relating to the background screening of volunteers in child care settings regulated by the Department of Children and Family Services to remove conflicting language.
- Revises provisions relating to the department's enforcement authority in registered family day care homes to provide the same escalating enforcement options available in other child care settings.
- Provides the department with specific rulemaking authority relating to safety standards in licensed family day care homes.
- Revises the Gold Seal Quality Care program to require a child care provider to maintain a certain compliance history in order to maintain their Gold Seal status.

This bill substantially amends, creates, or repeals the following sections of the Florida Statutes: 402.3017, 402.281, 402.302, 402.309, 402.310, 402.313, 402.3131.

According to the Department and Children and Family Services, this bill has a potential fiscal impact. SEE FISCAL COMMENTS section of bill analysis.

This bill shall take effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—This bill increases the responsibility and the authority of the Department of Children and Families in the licensure and registration of certain child care facilities.

Safeguard Individual Liberty—This bill decreases an individual's or private organization's options regarding the conduct of their own affairs because licensed family day care homes potentially could face larger administrative fines.

B. EFFECT OF PROPOSED CHANGES:

Present Situation:

Health and Safety

According to DCF, the provisions of this bill are intended to better ensure the safety of children in child care through the establishment of consistent safety standards and enforcement measures and were developed with the input of the following organizations:

Florida Family Child Care Homes Association
Florida Association of Child Care Management
National Association of Child Development Education
Florida Children's Forum
Florida Partnership for School Readiness
Early Childhood Association of Florida

T.E.A.C.H. Program

In 2000, the Legislature authorized the Department of Children and Family Services (DCF) to contract for the administration of the Teacher Education and Compensation Helps (T.E.A.C.H.) Early Childhood Scholarship program, which provides educational scholarships to caregivers and administrators of early childhood programs, family day care homes, and large family child care homes (s. 15, ch. 2000-253, L.O.F.; s. 402.3017(2), F.S.).

The T.E.A.C.H. program addresses the issues of poor education, low compensation, and high turnover in the child care sector by providing early childhood professional development opportunities for teachers, directors, and family child care providers. The T.E.A.C.H. program provides scholarships for child care personnel to pursue a Child Development Associate (CDA) credential or equivalency, an A.S. degree in Child Development and Education, or a Director's Credential. The Florida Children's Forum is the authorized agent for the T.E.A.C.H. Early Childhood Scholarship program in Florida. Although s. 402.3017, F.S., directs/authorizes the Department of Children and Family Services to administer the program, the Agency for Workforce Innovation (AWI) has actually been responsible for administering the program since 2002, pursuant to the implementing bill of each year's General Appropriations Act.[1]

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[1] (s. 55, ch. 2002-402, L.O.F.; s. 15, ch. 2000-253, L.O.F.; ss. 55, 79, ch. 2002-402, L.O.F.; s. 73, ch. 2003-399 L.O.F.; s. 55, ch. 2004-269, L.O.F.; and s. 40, ch. 2005-71, L.O.F.).

Gold Seal Quality Care Program

In 1996, the Florida Legislature established the Gold Seal Quality Care program to recognize those child care facilities and homes that are accredited by nationally recognized associations whose standards reflect a level of quality of child care that exceeds minimum licensing standards. A private pre-kindergarten provider must be Gold Seal or otherwise accredited to participate in the Voluntary Universal Pre-kindergarten program in s. 1002.55(3), F.S. This has resulted in heightened awareness of Gold Seal and its correlation to quality child care.

According to DCF, a disconnect currently exists between the level of quality implied by Gold Seal Quality Care status and the licensure compliance history of a child care program. Gold Seal status is conferred at the request of the provider upon becoming accredited by an accrediting agency that has been recognized by the Department of Children and Family Services as having accreditation standards that substantially meet or exceed the National Association for the Education of Young Children (NAEYC), the National Association of Family Child Care, or the National Early Childhood Program Accreditation Commission. The accrediting standards of an approved accrediting agency may or may not address a provider's regulatory compliance history. Current law, s. 402.281, F.S., does not provide the Department of Children and Family Services with the authority to "revoke" a provider's Gold Seal status based on non-compliance with state child care standards, nor does it provide the department with the authority to require the accrediting agency to revoke the provider's accreditation for the same.

Background Screening of Volunteers

Current law contains the following conflicting language relating to the background screening of volunteers in a child care setting:

> Pursuant to s. 402.302(3), F.S., volunteers who work more than 40 hours per month are considered "child care personnel" for purposes of background screening. Pursuant to s. 402.305(2), F.S., "child care personnel" are subject to a Level 2 background screening. However, s. 402.302(13), F.S., states that screening for volunteers that meet the definition of child care personnel only includes a local criminal records check and a statewide criminal records correspondence check (not an employment history check and federal criminal records check).

Enforcement Authority in Registered Family Day Care Homes

Although statute provides a series of enforcement options for non-compliance with uniform child care standards in licensed child care facilities, licensed family day care homes, and large family child care homes, the department currently has very limited enforcement authority with regard to *registered* family day care homes. Section 402.310, F.S., relating to escalating administrative actions, fines, suspension, and revocation applies specifically to *licensed* child care providers.

According to DCF, the lack of enforcement authority relating to registered family day care homes limits the ability of child care licensing staff to timely assure the safety of children in registered care and leaves the department with little recourse in the event of non-compliance by a registered provider. As a result, the department's ability to timely and consistently assure the safety of children in care in registered family day care homes is more limited than in other child care settings. This has been a long-standing problem identified by district legal offices, the General Counsel of the department, the child care program office, and child care field staff.

Pursuant to s. 402.309(1), F.S., a local licensing agency or the department may issue a provisional license to applicants for a license or to licensees who are unable to conform to child care standards, provided adequate provisions have been made for the health and safety of children in care. Provisional licenses are typically issued when background screening or fire inspection backlogs

prevent the timely receipt of required documentation, provided the background screening or fire inspection requests were timely submitted. Because the term "child care facility" is used, these provisions apply only to licensed centers, not licensed family day care homes. Current statute does not provide for provisional registration of family day care homes.

Administrative Fines

Statute currently includes the following provisions relating to fines for non-compliance with child care standards:

- Licensed facilities and licensed family day care homes—Denial, suspension or revocation of a license or imposition of an administrative fine not to exceed $100 per violation, per day, for the violation of any provision of ss. 402.301-402.319, F.S., or rules adopted thereunder (s. 402.310(1)(a), F.S.). In addition, "where the violation could or does cause death or serious harm, the department or local licensing agency may impose an administrative fine, not to exceed $500 per violation per day." (s. 402.310(1)(a), F.S.)

- Licensed or registered family day care homes—Section 402.313(1)(b), F.S., authorizes the department or local licensing agency to "impose an administrative fine, not to exceed $100, for failure to comply with licensure or registration requirements."

- Large family child care homes—Paragraph 402.3131(1)(a), F.S., authorizes the department or local licensing agency to "impose an administrative fine, not to exceed $1,000, for failure to comply with licensure requirements."

Safety Standards in Licensed Family Day Care Homes

DCF currently has the authority to adopt rules relating to minimum safety standards for licensed child care facilities, but not licensed family day care homes. The department's rule authority relating to family day care homes is currently limited to "minimum health standards" rather than "health *and* safety standards." This inconsistency leaves children in family day care homes more vulnerable to the risk (or the potential risk) of harm than children being cared for in other licensed child care settings.

Effect of Proposed Changes

T.E.A.C.H. Program

The bill amends s. 402.3017, F.S., relating to the Teacher Education and Compensation Helps (T.E.A.C.H.) scholarship program to transfer authority for administration of the program from the Department of Children and Family Services (DCF) to the Agency for Workforce Innovation (AWI). This makes the substantive statute consistent with directives included in the implementing bill since 2002.

House Bill 1231 CS permanently transfers the T.E.A.C.H. scholarship program from DCF to AWI, thereby eliminating the need for the appropriations implementing act to annually reflect the transfer for the fiscal year. Although current law authorizes, but does not require DCF to contract for the T.E.A.C.H. scholarship program, the bill would require AWI to contract for the program and adopt rules to administer the program.

Gold Seal Quality Care Program

This bill revises s. 402.281, F.S., relating to the Gold Seal Quality Care program to require a child care provider to maintain the following compliance history to achieve and maintain Gold Seal status:

- The child care provider must not have had any Class I deficiencies (as defined by rule) within the two years preceding application for Gold Seal Quality Care status. Commission of a Class 1 violation shall be grounds for termination of Gold Seal status until such time as the provider has established a two-year period with no Class 1 violations.

- The child care provider must not have had three or more Class 2 deficiencies (as defined by rule) within the two years preceding application for Gold Seal Quality Care status. Commission of three or more Class 2 violations within a two-year period shall be grounds for termination of Gold Seal status until such time as the provider has established a one-year period with no Class 2 violations.

- The child care provider must not have been cited for the same Class 3 violation (as defined by rule) three or more times within the two years preceding application for Gold Seal Quality Care status. Commission of the same Class 3 violation three or more times during a two-year period shall be grounds for termination of Gold Seal status until such time as the provider has established a one-year period with none of the same type of violation.

According to DCF, these proposed changes are consistent with department and program goals, and are important for the continued protection of children in child care. The bill provides consistent enforcement measures and safety standards for all child care arrangements to protect the health and safety of all children in care, regardless of the type of setting.

Background Screening of Volunteers

The bill revises s. 402.302(13), F.S., relating to the screening of volunteers, to remove conflicting language. The bill provides for volunteers who meet the definition of "child care personnel" to be subject to the same level of screening as other child care personnel.

Enforcement Authority in Registered Family Day Care Homes

The bill amends s. 402.309, F.S., relating to provisional child care licenses in the following ways:

- Renames the existing "provisional license" as a "probation-status license."
- Specifies that a probation status license may be issued to any licensed child care arrangement (licensed center, licensed family day care homes, or licensed large family child care home).
- Authorizes the issuance of a probation status *registration* to a family day care home that is unable to meet child care standards.
- Expands provisions to enable the department to revoke a probation status license (the department already has the authority to *suspend* a provisional license), and to revoke or suspend a probation registration, if periodic inspection or review indicates that insufficient progress has been made toward compliance with licensing or registration standards.
- Requires the department to adopt administrative rules specifying the conditions and procedures under which a probation status license or registration may be issued, suspended, or revoked.

In addition, the bill revises s. 402.310, F.S., relating to disciplinary actions; hearings upon denial, suspension, or revocation of a license; and administrative fines in the following ways:

- Expands enforcement provisions that currently apply to licensed facilities, licensed family day care homes, and large family child care homes to include *registered* family day care homes—providing the same series of enforcement options for all child care providers.
- Provides for the administrative fine imposed "where the violation could or does cause death or serious harm" [s. 402.310(1)(a), F.S.] to be imposed in addition to, or in lieu of, any other disciplinary action imposed.

According to the Department of Children and Family Services, the bill provides the department the authority necessary to enforce (through consistent fines and the ability to revoke or suspend registration) the minimal standards for registered family day care homes and ensure greater protection for children in care.

Administrative Fines

The bill revises current statutory language relating to the maximum amount of administrative fines included in ss. 402.313 and 402.3131, F.S., to provide consistent fines for all provider types. The proposed revision provides for the imposition of a maximum of $100 per violation, per day, regardless of the type of child care setting, which is consistent with guidelines for fines currently imposed upon licensed child care centers.

Safety Standards in Licensed Family Day Care Homes

The bill revises current statutory language regarding licensed family day care homes to provide rulemaking authority regarding minimum safety standards. This will provide safety standards for all child care arrangements to protect the health and safety of all children in care, regardless of the type of setting.

Prolonged Child Care

The bill allows parents to have their children in a secure, safe, licensed day care when they have to work a 24-hour shift. The bill provides for written certification from the employer that the parent is working a 24-hour shift. It also specifies clearly that the time a child remains in child care may not exceed 72 hours in a 7 day period.

C. SECTION DIRECTORY:

Section 1: Renumbers and amends s. 402.3017, F.S., transferring the Teacher Education and Compensation Helps scholarship program from DCF to the Agency for Workforce Innovation.

Section 2: Amends s. 402.281, F.S., adding two subsections of law relating to the Gold Seal Quality Care program.

Section 3: Amends s. 402.302, F.S., changing the definition of the term "screening."

Section 4: Amends s.402.309, F.S., adding licensure or registration responsibilities to DCF for child care facilities.

Section 5: Amends s. 402.310, F.S., adding disciplinary sanctions.

Section 6: Amends s. 402.313, F.S., deleting administrative fine requirements related to family day care homes.

Section 7: Amends s. 402.3131, F.S., deleting administrative fine requirements related to large family child care homes.

Section 8: Creates s. 402.317, F.S., adding prolonged child care guidelines.

Section 9: Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See Fiscal Comments.

D. FISCAL COMMENTS:

DCF offered the following fiscal analysis of House Bill 1231 CS. This proposal would revise the fee/fine structure relating to non-compliance with child care standards. As a result, licensed and registered family day care homes would be potentially subject to an increased administrative fine ($100 *per violation, per day*—consistent with guidelines for fines imposed upon licensed facilities and family day care homes—rather than the $100 limit established by current statute). Large family child care homes would be potentially subject to either a reduced or increased administrative fine, depending on the length of the violation ($100 *per violation, per day*—consistent with guidelines for fines imposed upon licensed family day care homes—rather than the $1,000 limit established by current statute).

In addition, Gold Seal child care providers that participate in the school readiness program (i.e., subsidized child care) are eligible for a higher reimbursement rate than those who have not achieved Gold Seal status. If Gold Seal status is "revoked" due to a negative compliance history, that provider would no longer be eligible for the higher reimbursement rate. However, this proposal will not prohibit such a provider from continuing to participate in the subsidy program at the regular reimbursement rate.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill authorizes the Department and Children and Family Services to adopt rules under ss. 120.536(1) and 120.54, F.S., that provide criteria and procedures for reviewing and approving accrediting agencies for participation in the Gold Seal Quality Care program.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 15, 2006, the Future of Florida's Families Committee adopted a committee substitute to House Bill 1231 CS. The original bill differs from the committee substitute in the following areas:

- The term "may" was deleted and "shall" was inserted to require DCF to adopt rules.
- The term "provisional license" was renamed to "probation-status license" at the request of DCF.
- Allows parents to have their children in a secure, safe, licensed day care when they have to work a 24-hour shift. The change provides for written certification from the employer that the parent is working a 24-hour shift. It also specifies that the time a child remains in child care may not exceed 72 hours in a seven day period.

This analysis was written to reflect the committee substitute.

CHAMBER ACTION

1 The Future of Florida's Families Committee recommends the
2 following:
3
4 **Council/Committee Substitute**
5 Remove the entire bill and insert:
6 A bill to be entitled
7 An act relating to child care; renumbering and amending s.
8 402.3017, F.S.; transferring authority for administration
9 of the Teacher Education and Compensation Helps (TEACH)
10 scholarship program from the Department of Children and
11 Family Services to the Agency for Workforce Innovation;
12 amending s. 402.281, F.S.; providing additional criteria
13 for a child care provider to obtain and maintain Gold Seal
14 Quality Care designation; requiring the Department of
15 Children and Family Services to adopt rules; amending s.
16 402.302, F.S.; revising the definition of the term
17 "screening" to broaden the requirements for the screening
18 of volunteers in child care facilities; amending s.
19 402.309, F.S.; authorizing the local licensing agency or
20 the Department of Children and Family Services to issue a
21 provisional license or registration to a child care
22 facility, family day care home, or large family child care
23 home; providing that a provisional license or registration

24 may not be issued unless child care personnel are screened
25 according to law; requiring the department to adopt rules
26 for issuing, suspending, and revoking provisional licenses
27 and registrations; amending s. 402.310, F.S.; providing
28 that an increased administrative fine may be imposed in
29 addition to or in lieu of other disciplinary actions;
30 authorizing the department or local licensing agencies to
31 convert a license or registration to probation status for
32 a violation of certain laws and rules; authorizing the
33 department or local licensing agencies to apply
34 disciplinary actions to licensed child care facilities,
35 licensed large family child care homes, and licensed or
36 registered family day care homes; directing the department
37 to adopt rules establishing grounds for imposing
38 disciplinary actions for violations of certain laws and
39 rules; directing the department to adopt rules to create a
40 uniform system of procedures to use for disciplinary
41 actions; amending s. 402.313, F.S.; removing a provision
42 relating to a fine to conform to changes made by the act;
43 requiring minimum safety standards for family day care
44 homes; amending s. 402.3131, F.S.; removing a provision
45 relating to a fine to conform to changes made by the act;
46 creating s. 402.317, F.S.; authorizing the provision of
47 child care for a period longer than otherwise authorized
48 if a parent or legal guardian works a shift of 24 hours or
49 more or during a declared state of emergency; providing an
50 effective date.
51

52 Be It Enacted by the Legislature of the State of Florida:
53
54 Section 1. Section 402.3017, Florida Statutes, is
55 renumbered as section 411.0103, Florida Statutes, and amended to
56 read:
57 411.0103 ~~402.3017~~ Teacher Education and Compensation Helps
58 (TEACH) scholarship program.--
59 (1) The Legislature finds that the level of early child
60 care teacher education and training is a key predictor for
61 determining program quality. The Legislature also finds that low
62 wages for child care workers prevent many from obtaining
63 increased training and education and contribute to high turnover
64 rates. The Legislature therefore intends to help fund a program
65 which links teacher training and education to compensation and
66 commitment to the field of early childhood education.
67 (2) The Agency for Workforce Innovation shall ~~Department~~
68 ~~of Children and Family Services is authorized to~~ contract for
69 the administration of the Teacher Education and Compensation
70 Helps (TEACH) scholarship program, which provides educational
71 scholarships to caregivers and administrators of early childhood
72 programs, family day care homes, and large family child care
73 homes.
74 (3) The Agency for Workforce Innovation ~~department~~ shall
75 adopt rules under ss. 120.536(1) and 120.54 as necessary to
76 administer ~~implement~~ this section.
77 ~~(4) For the 2005-2006 fiscal year only, the Agency for~~
78 ~~Workforce Innovation shall administer this section. This~~
79 ~~subsection expires July 1, 2006.~~

80 Section 2. Subsections (3) and (4) are added to section
81 402.281, Florida Statutes, to read:
82 402.281 Gold Seal Quality Care program.--
83 (3) In order for a child care provider to obtain and
84 maintain Gold Seal Quality Care designation, a child care
85 facility, large family child care home, or family day care home
86 must meet the following additional criteria:
87 (a) A child care provider must not have had any Class 1
88 deficiencies, as defined by rule, within the 2 years preceding
89 application for Gold Seal Quality Care designation. The
90 commission of a Class 1 violation is grounds for the termination
91 of Gold Seal Quality Care designation. Gold Seal Quality Care
92 designation may not be restored until the provider has had no
93 Class 1 violations for 2 consecutive years.
94 (b) A child care provider must not have had three or more
95 Class 2 deficiencies, as defined by rule, within the 2 years
96 preceding application for Gold Seal Quality Care designation.
97 The commission of three or more Class 2 violations within a 2-
98 year period shall be grounds for termination of Gold Seal
99 Quality Care designation. Gold Seal Quality Care designation may
100 not be restored until the provider has had no Class 2 violations
101 for 1 year.
102 (c) A child care provider must not have been cited for the
103 same Class 3 violation, as defined by rule, three or more times
104 within the 2 consecutive years preceding application for Gold
105 Seal Quality Care designation. The commission of the same Class
106 3 violation three or more times during a 2-year period is
107 grounds for termination of Gold Seal Quality Care designation.

108 Gold Seal Quality Care designation may not be restored until the
109 provider has not committed the same Class 3 violation for 1
110 year.
111 (4) The Department of Children and Family Services shall
112 adopt rules under ss. 120.536(1) and 120.54 that provide
113 criteria and procedures for reviewing and approving accrediting
114 agencies for participation in the Gold Seal Quality Care
115 program, conferring and revoking Gold Seal Quality Care
116 designation, and classifying violations.
117 Section 3. Subsection (13) of section 402.302, Florida
118 Statutes, is amended to read:
119 402.302 Definitions.--
120 (13) "Screening" means the act of assessing the background
121 of child care personnel and volunteers and includes, but is not
122 limited to, employment history checks, local criminal records
123 checks through local law enforcement agencies, fingerprinting
124 for all purposes and checks in this subsection, statewide
125 criminal records checks through the Department of Law
126 Enforcement, and federal criminal records checks through the
127 Federal Bureau of Investigation~~; except that screening for~~
128 ~~volunteers included under the definition of personnel includes~~
129 ~~only local criminal records checks through local law enforcement~~
130 ~~agencies for current residence and residence immediately prior~~
131 ~~to employment as a volunteer, if different, and statewide~~
132 ~~criminal records correspondence checks through the Department of~~
133 ~~Law Enforcement~~.
134 Section 4. Section 402.309, Florida Statutes, is amended
135 to read:

136 402.309 Provisional license or registration.--
137 (1) The local licensing agency or the department,
138 whichever is authorized to license child care facilities in a
139 county, may issue a provisional license for child care
140 facilities, family day care homes, or large family child care
141 homes, or a provisional registration for family day care homes
142 to applicants for an initial ~~a~~ license or registration or to
143 licensees or registrants seeking a renewal who are unable to
144 meet ~~conform to~~ all the standards provided for in ss. 402.301-
145 402.319.
146 (2) A ~~No~~ provisional license or registration may not be
147 issued unless the operator or owner makes adequate provisions
148 for the health and safety of the child. A provisional license
149 may be issued for a child care facility if all of the screening
150 materials have been timely submitted.~~; however,~~ A provisional
151 license or registration may not be issued unless the child care
152 facility, family day care home, or large family child care home
153 is in compliance with the requirements for screening of child
154 care personnel in ss. 402.305, ~~and~~ 402.3055, 402.313, and
155 402.3131, respectively.
156 (3) The provisional license or registration may not ~~shall~~
157 ~~in no event~~ be issued for a period that exceeds ~~in excess of~~ 6
158 months; however, it may be renewed one time for a period that
159 may not exceed ~~in excess of~~ 6 months under unusual circumstances
160 beyond the control of the applicant.
161 (4) The provisional license or registration may be
162 suspended or revoked if periodic inspection or review ~~made~~ by

163 the local licensing agency or the department indicates that
164 insufficient progress has been made toward compliance.
165 (5) The department shall adopt rules specifying the
166 conditions and procedures under which a provisional license or
167 registration may be issued, suspended, or revoked.
168 Section 5. Section 402.310, Florida Statutes, is amended
169 to read:
170 402.310 Disciplinary actions; hearings upon denial,
171 suspension, or revocation of license or registration;
172 administrative fines.--
173 (1)(a) The department or local licensing agency may
174 administer any of the following disciplinary sanctions for a
175 violation of any provision of ss. 402.301-402.319 or rules
176 adopted thereunder: ~~deny, suspend, or revoke a license or~~
177 1. Impose an administrative fine not to exceed $100 per
178 violation~~,~~ per day~~, for the violation of any provision of ss.~~
179 ~~402.301-402.319 or rules adopted thereunder~~. However, if ~~where~~
180 the violation could or does cause death or serious harm, the
181 department or local licensing agency may impose an
182 administrative fine~~,~~ not to exceed $500 per violation per day in
183 addition to or in lieu of any other disciplinary action imposed
184 pursuant to this section.
185 2. Convert a license or registration to probation status
186 and require the licensee or registrant to comply with the terms
187 of probation. A probation-status license or registration may not
188 be issued for a period that exceeds 6 months and the probation-
189 status license or registration may not be renewed. A probation-
190 status license or registration may be suspended or revoked if

191 periodic inspection by the department or local licensing agency
192 finds that the probation-status licensee or registrant is not in
193 compliance with the terms of probation or that the probation-
194 status licensee or registrant is not making sufficient progress
195 towards compliance with ss. 402.301-402.319.
196 3. Deny, suspend, or revoke a license or registration.
197 (b) In determining the appropriate disciplinary action to
198 be taken for a violation as provided in paragraph (a), the
199 following factors shall be considered:
200 1. The severity of the violation, including the
201 probability that death or serious harm to the health or safety
202 of any person will result or has resulted, the severity of the
203 actual or potential harm, and the extent to which the provisions
204 of ss. 402.301-402.319 have been violated.
205 2. Actions taken by the licensee or registrant to correct
206 the violation or to remedy complaints.
207 3. Any previous violations of the licensee or registrant.
208 (c) The department shall adopt rules to:
209 1. Establish the grounds under which the department may
210 deny, suspend, or revoke a license or registration or place a
211 licensee or registrant on probation status for violations of ss.
212 402.301-402.319.
213 2. Establish a uniform system of procedures to impose
214 disciplinary sanctions for violations of ss. 402.301-402-319.
215 The uniform system of procedures must provide for the consistent
216 application of disciplinary actions across districts and a
217 progressively increasing level of penalties from predisciplinary
218 actions, such as efforts to assist licensees or registrants to

219 correct the statutory or regulatory violations, to severe
220 disciplinary sanctions for actions that jeopardize the health
221 and safety of children, such as for the deliberate misuse of
222 medications. The department shall implement this subparagraph on
223 January 1, 2007, and the implementation is not contingent upon a
224 specific appropriation.
225 (d) The disciplinary sanctions set forth in this section
226 apply to licensed child care facilities, licensed large family
227 child care homes, and licensed or registered family day care
228 homes.
229 (2) When the department has reasonable cause to believe
230 that grounds exist for the denial, suspension, or revocation of
231 a license or registration, the conversion of a license or
232 registration to probation status, or the imposition of an
233 administrative fine ~~exist~~, it shall determine the matter in
234 accordance with procedures prescribed in chapter 120. When the
235 local licensing agency has reasonable cause to believe that
236 grounds exist for the denial, suspension, or revocation of a
237 license or registration, the conversion of a license or
238 registration to probation status, or the imposition of an
239 administrative fine ~~exist~~, it shall notify the applicant,
240 registrant, or licensee in writing, stating the grounds upon
241 which the license or registration is being denied, suspended, or
242 revoked, the license or registration is being converted to
243 probation status, or an administrative fine is being imposed. If
244 the applicant, registrant, or licensee makes no written request
245 for a hearing to the local licensing agency within 15 days after
246 ~~from~~ receipt of the ~~such~~ notice, the license or registration

247 shall be deemed denied, suspended, or revoked, the license or
248 registration shall be converted to probation status, or an
249 administrative fine shall be imposed.
250 (3) If a request for a hearing is made to the local
251 licensing agency, a hearing shall be held within 30 days and
252 shall be conducted by an individual designated by the county
253 commission.
254 (4) An applicant, registrant, or licensee has ~~shall have~~
255 the right to appeal a decision of the local licensing agency to
256 a representative of the department. Any required hearing shall
257 be held in the county in which the child care facility, family
258 day care home, or large family child care home is being operated
259 or is to be established. The hearing shall be conducted in
260 accordance with ~~the provisions of~~ chapter 120.
261 Section 6. Paragraphs (b), (c), and (d) of subsection (1)
262 and subsection (13) of section 402.313, Florida Statutes, are
263 amended to read:
264 402.313 Family day care homes.--
265 (1) Family day care homes shall be licensed under this act
266 if they are presently being licensed under an existing county
267 licensing ordinance, if they are participating in the subsidized
268 child care program, or if the board of county commissioners
269 passes a resolution that family day care homes be licensed. If
270 no county authority exists for the licensing of a family day
271 care home, the department shall have the authority to license
272 family day care homes under contract for the purchase-of-service
273 system in the subsidized child care program.

274 ~~(b) The department or local licensing agency may impose an~~
275 ~~administrative fine, not to exceed $100, for failure to comply~~
276 ~~with licensure or registration requirements.~~
277 (b) ~~(c)~~ A family day care home not participating in the
278 subsidized child care program may volunteer to be licensed under
279 the provisions of this act.
280 (c) ~~(d)~~ The department may provide technical assistance to
281 counties and family day care home providers to enable counties
282 and family day care providers to achieve compliance with family
283 day care homes standards.
284 (13) The department shall, by rule, establish minimum
285 standards for family day care homes that are required to be
286 licensed by county licensing ordinance or county licensing
287 resolution or that voluntarily choose to be licensed. The
288 standards should include requirements for staffing, training,
289 maintenance of immunization records, minimum health and safety
290 standards, reduced standards for the regulation of child care
291 during evening hours by municipalities and counties, and
292 enforcement of standards.
293 Section 7. Subsection (1) of section 402.3131, Florida
294 Statutes, is amended to read:
295 402.3131 Large family child care homes.--
296 (1) Large family child care homes shall be licensed under
297 this section.
298 ~~(a) The department or local licensing agency may impose an~~
299 ~~administrative fine, not to exceed $1,000, for failure to comply~~
300 ~~with licensure requirements.~~

301 (a) ~~(b)~~ A licensed family day care home must first have
302 operated for a minimum of 2 consecutive years, with an operator
303 who has had a child development associate credential or its
304 equivalent for 1 year, before seeking licensure as a large
305 family child care home.
306 (b) ~~(c)~~ The department may provide technical assistance to
307 counties and family day care home providers to enable the
308 counties and providers to achieve compliance with minimum
309 standards for large family child care homes.
310 Section 8. Section 402.317, Florida Statutes, is created
311 to read:
312 402.317 Prolonged child care.--Notwithstanding the time
313 restriction specified in s. 402.302(1), child care may be
314 provided for 24 hours or longer for a child whose parent or
315 legal guardian works a shift of 24 hours or more. The
316 requirement that a parent or legal guardian work a shift of 24
317 hours or more must be certified in writing by the employer, and
318 the written certification shall be maintained in the facility by
319 the child care provider and made available to the licensing
320 agency. The time that a child remains in child care, however,
321 may not exceed 72 consecutive hours in any 7-day period. During
322 a declared state of emergency, the child care licensing agency
323 may temporarily waive the time limitations provided in this
324 section.
325 Section 9. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1247 CS Developmental Disabilities
SPONSOR(S): Kravitz
TIED BILLS: **IDEN./SIM. BILLS:** SB 2226

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee	6 Y, 0 N, w/CS	DePalma	Walsh
2) Health Care Appropriations Committee	12 Y, 0 N, w/CS	Speir	Massengale
3) Health & Families Council		DePalma	Moore
4)			
5)			

SUMMARY ANALYSIS

HB 1247 CS amends s. 409.912, F.S., and requires the Agency for Health Care Administration to work with the Agency for Persons with Disabilities to develop and seek federal approval to expand the statutorily-required home and community-based waiver serving children who are diagnosed with Familial Dysautonomia to include adults. The bill also amends the nature of this waiver by deleting a requirement that the agencies seek approval for a "model" waiver.

The bill does not have a fiscal impact, and provides that the act is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government and Empower Families—The bill creates Medicaid eligibility for a new group of individuals.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

Familial Dysautonomia Syndrome

Familial Dysautonomia (FD)—or Riley-Day Syndrome—is an example of a group of disorders known as "hereditary sensory and autonomic neuropathies" (HSAN) characterized by widespread sensory dysfunction resulting from incomplete development of sensory and autonomic neurons.[1] First identified in a report by Drs. Conrad Riley and Richard Day in 1949, FD is a debilitating disease that is present from birth, and results in lifelong progressive neuronal degeneration.[2]

Prior to 1960, approximately 50 percent of patients suffering from FD died before reaching the age of five.[3] However, recent advances in supportive treatment approaches have extended the life expectancy of individuals with FD, and the probability of reaching age 20 has now increased to 60 percent,[4] and roughly half of patients diagnosed with FD live to the age of 30.

Transmission

Unlike other HSAN, Familial Dysautonomia has been observed only in individuals of Eastern European Jewish Ancestry (Ashkenazi Jewish extraction), and it is estimated that one in 27 individuals of Eastern European Jewish origin are carriers of the FD gene.[5] The Dysautonomia Foundation, Inc., in New York reports that, based on information available from the FD world-wide registry, as of January 2004 there were more than 340 people worldwide living with FD. One-third of these individuals live in the metropolitan New York City area, one-third reside in Israel, and the remaining third live elsewhere in the United States and worldwide.[6] It has been reported by the Agency for Health Care Administration (AHCA) that 18 persons with FD (**10 children and 8 adults**) are residents of Florida.

Familial Dysautonomia is an autosomal recessive disorder[7], meaning that a child must inherit a copy of the FD gene from each of their birth parents. All parents of children with Familial Dysautonomia are

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[1] *More About FD*, 2005, the NYU School of Medicine Department of Pediatrics Dysautonomia Treatment & Evaluation Center, available at: http://www.med.nyu.edu/fd/fdcenter.html.
[2] *Familial Dysautonomia*, January 10, 2005, report by GeneTest (funded by the National Institutes of Health), available at: http://www.genetests.org/profiles/fd.
[3] *Familial Dysautonomia (FD)*, accessed March 9, 2006, Jewish Genetic Diseases: A Mazornet Guide, available at: http://www.mazornet.com/genetics/familial_dysautonomia.asp.
[4] *Ibid.*
[5] *FD 101: What is FD?*, accessed March 6, 2006, Familial Dysautonomia Hope Foundation, available at: http://www.fdhope.org/FamilialDysautonomia/AboutFD/FD101.htm.
[6] *FD History and Statistics*, accessed March 6, 2006, the Dysautonomia Foundation, Inc., available at: http://www.familialdysautonomia.org/history.htm.
[7] *About Familial Dysautonomia: Genetics*, accessed March 6, 2006, Familial Dysautonomia Hope Foundation, available at: http://www.fdhope.org/FamilialDysautonomia/AboutFD/genetics.htm.

carriers of the recessive gene that transmits the disease, although a parent or carrier of the gene has no symptoms or warning signs of being a carrier until a child's birth.[8]

Symptoms

Familial Dysautonomia primarily affects the body's autonomic nervous system (responsible for the subconscious regulation of bodily functions and the activities of specific organs) and its sensory nervous system (which controls the body's perceptions of hot/cold and taste, and regulates its protective reactions to pain and other external stimuli).[9]

Although symptoms vary with age, the hallmark clinical feature of Familial Dysautonomia is the absence of overflow tears typically associated with emotional crying.[10] Corneal sensitivity and various other severe eye problems occur frequently in FD patients as a result.

Feeding difficultly is observed in 60 percent of infants with FD in the neonatal period, and poor suck and misdirected swallows often persist and put the patient at risk for aspiration pneumonia (a major cause of lung infections). Other clinical manifestations of the disorder include decreased responsiveness to pain and temperature, extreme fluctuations in blood pressure, red blotching of the skin, and increased sweating. Additionally, individuals suffering from Familial Dysautonomia often have delayed acquisition of speech and walking abilities, unsteady gait, breath-holding episodes and poor growth patterns. By age 13, 90 percent of FD patients experience some spinal curvature.[11]

Familial Dysautonomia patients can be expected to function independently if treatment is begun early and major disabilities are avoided. Affected individuals typically are of normal intelligence.

Dysautonomia Crisis

Roughly 40 percent of individuals with FD will react to stressors or stress events (frequently caused by physical infection or emotional events) with what is termed a "dysautonomia crisis." In addition to vomiting, an individual having a dysautonomia crisis experiences elevated heart rate and blood pressure, irritability and insomnia, severe dysphagia and drooling, and excessive sweating and blotching of the face and trunk.[12]

Treatment

As there is still no cure for Familial Dysautonomia, treatment approaches remain preventative, supportive and largely symptomatic. These include:[13]

- artificial tears;
- special feeding techniques;
- special occupational, physical and speech therapies;
- special drug management of autonomic manifestations;
- respite care;
- orthopedic treatment (for complications from tibial torsion and spinal curvature); and
- compensation for labile blood pressures.

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[8] *More About FD*, the NYU School of Medicine Department of Pediatrics Dysautonomia Treatment & Evaluation, *supra*.
[9] What is Familial Dysautonomia?, accessed March 6, 2006, the Dysautonomia Foundation, Inc., available at: http://www.familialdysautonomia.org/whatisfd.htm.
[10] *More About FD*, the NYU School of Medicine Department of Pediatrics Dysautonomia Treatment & Evaluation, *supra*, noting that, although the absence of overflow tears is the most distinctive feature of Familial Dysautonomia, it is typical for a child not to have tears until reaching 7 months of age.
[11] *Ibid.*
[12] *Ibid.*
[13] *Familial Dysautonomia (FD)*, Jewish Genetic Diseases: A Mazornet Guide, *supra*.

Funding for Familial Dysautonomia Services

The Department of Health, Children's Medical Services (CMS), currently provides services to children diagnosed with FD whose families meet certain income limitations. Under certain federal requirements of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) specifying that Medicaid programs meet children's medical needs, CMS is able to provide care coordination for a range of needed services and therapies. However, CMS does not have funding to provide families of FD children with respite or behavioral services. Persons with FD are not served by the Agency for Persons with Disabilities (APD).[14]

Medicaid Home and Community-based Waivers

In 1981, Congress authorized the waiver of certain federal requirements to enable a state to provide home and community-based services (other than room and board) to individuals who would otherwise require institutional care reimbursed by Medicaid. The waiver programs are called "1915(c) waivers." Under 1915(c) waiver authority, states can provide services not traditionally covered by the Medicaid program, as long as these services are integral to preventing an individual's institutionalization. A 1915(c) waiver may include a waiver of the requirements of the following sections of the Social Security Act:[15]

- 1902(a)(1), relating to statewideness. This allows states to target waivers to particular areas of the state where the need is greatest, or perhaps where certain types of providers are available;
- 1902(a)(10)(B), relating to comparability of services. This allows states to make waiver services available to the Medicaid population at large. States use this authority to target services to particular groups, such as elderly individuals, technology-dependent children, or persons with mental retardation or developmental disabilities; and
- 1902(a)(10)(c)(i)(III), relating to community income and resource rules for the medically needy. This allows states to provide Medicaid to individuals who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent. States may also use spousal impoverishment rules to determine financial eligibility or waiver services.

A 1915(c) waiver is initially authorized for three years, and renewals are required every five years thereafter. Within the parameters of broad federal guidelines, 1915(c) waiver authority provides states with flexibility in structuring home and community-based waiver programs designed to meet the specific needs of targeted populations. Federal requirements for states choosing to implement a home and community-based waiver program include:

- demonstrating that provision of waiver services to a target population is no more costly than the cost of services such individuals would receive in an institutional setting;
- ensuring that measures will be taken to protect the health and welfare of consumers;
- assuring financial accountability for funds expended under the waiver authority;
- providing adequate and reasonable provider standards intended to meet the needs of the target population; and
- ensuring that services are provided in accordance with a plan of care.

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[14] The Agency for Persons with Disabilities was formerly the Development Disabilities Program of the Department of Children and Families. Pursuant to s. 20.197(2), APD is charged with administering waivers established to provide services to persons with developmental disabilities. Familial Dysautonomia is not a "developmental disability" pursuant to s. 393.063(10), F.S."

[15] HCBS Waivers Section 1915(c), accessed March 29, 2006, U.S. Department of Health and Human Services Center for Medicare and Medicaid Services, available at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp#TopOfPage.

Previous Legislation

Chapter 2005-115, L.O.F., enacting House Bill 17, directed the Agency for Health Care Administration (AHCA) to work with APD in developing a model home and community-based waiver to serve children diagnosed with FD. The legislation required AHCA to seek federal waiver approval and implement the approved waiver, subject to the availability of funds and any limitations provided in the General Appropriations Act. The act also appropriated $171,840 from the General Revenue Fund and $246,160 from the Medical Care Trust Fund for Fiscal Year 2005-2006.

On March 20, 2006, AHCA submitted an application for a section 1915(c) home and community-based waiver to authorize operation of a Familial Dysautonomia Model Home and Community-Based Services Waiver. By electing to structure the waiver as a "Model" waiver,[16] federal regulations require that no more than 200 individuals are to be served by the waiver at any one time.[17]

The Department of Children and Family Services (DCF) reports that, for purposes of establishing Medicaid eligibility under the waiver, children and single adults are considered a "family of one", and only the income and assets of the child or single adult individually are considered by the department when assessing eligibility.

PROPOSED CHANGES

HB 1247 CS amends s. 409.912(51), F.S., to add adults as participants in the Familial Dysautonomia home and community-based waiver.

Moreover, by deleting the reference to a "model" home and community-based waiver in s. 409.912(51), F.S., the CS requires that the waiver be structured as a regular home and community-based waiver pursuant to 42 C.F.R. s. 441.305(a). Therefore, the bill makes the 200-participant limited enrollment provision for "model" waivers[18] inapplicable.

The bill is effective upon becoming law.

C. SECTION DIRECTORY:

Section 1: Amends s. 409.912, F.S., adding adults diagnosed with Familial Dysautonomia to the home and community-based waiver developed by AHCA and APD.

Section 2: Provides that the bill is effective upon becoming a law.

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[16] The "Model" waiver submitted by AHCA is different from the model waiver authorized under section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA 134), commonly referred to as the "Katie Beckett" waiver. A waiver under this provision in TEFRA allows a state to make the full array of Medicaid services available to a disabled child irrespective of the income and assets of the child's parents. Such children are "deemed" eligible. A Katie Beckett waiver is not a means of providing Medicaid funds or services to adults.

[17] 42 C.F.R. s. 441.305(b).

[18] *Ibid.*

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA advises that no additional funding is necessary to administer this legislation.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

AHCA reports that the bill creates no direct economic impact on the private sector.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Should this legislation be enacted, it would require AHCA to amend its pending application to reflect "regular" waiver status, rather than "model."

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At its April 4, 2006 meeting the Elder and Long-Term Care Committee adopted an amendment to HB 1247, removing the appropriations made to AHCA for the purpose of implementing this act during FY 2006-07. Appropriations staff reports that the funds appropriated from the General Revenue and Medical Care Trust

Funds for the purpose of implementing the 2005 legislation are recurring and, therefore, no additional appropriations are necessary.

The committee favorably reported a committee substitute.

At its April 11, 2006 meeting the Health Care Appropriations Committee adopted a strike-all amendment to House Bill 1247 CS to retain the statutory requirement that the Familial Dysautonomia home and community-based waiver is subject to the availability of funds and any limitations provided in the General Appropriations Act.

The committee favorably reported a committee substitute, and this analysis is drafted to the committee substitute.

CHAMBER ACTION

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1 The Health Care Appropriations Committee recommends the
2 following:
3
4 **Council/Committee Substitute**
5 Remove the entire bill and insert:
6 A bill to be entitled
7 An act relating to developmental disabilities; amending s.
8 409.912, F.S.; requiring the Agency for Health Care
9 Administration to develop a waiver program to serve
10 children and adults with specified disorders; requiring
11 the agency to seek federal approval and implement the
12 approved waiver in the General Appropriations Act, subject
13 to certain limitations; providing an effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Subsection (51) of section 409.912, Florida
18 Statutes, is amended to read:
19 409.912 Cost-effective purchasing of health care.--The
20 agency shall purchase goods and services for Medicaid recipients
21 in the most cost-effective manner consistent with the delivery
22 of quality medical care. To ensure that medical services are
23 effectively utilized, the agency may, in any case, require a

24 confirmation or second physician's opinion of the correct
25 diagnosis for purposes of authorizing future services under the
26 Medicaid program. This section does not restrict access to
27 emergency services or poststabilization care services as defined
28 in 42 C.F.R. part 438.114. Such confirmation or second opinion
29 shall be rendered in a manner approved by the agency. The agency
30 shall maximize the use of prepaid per capita and prepaid
31 aggregate fixed-sum basis services when appropriate and other
32 alternative service delivery and reimbursement methodologies,
33 including competitive bidding pursuant to s. 287.057, designed
34 to facilitate the cost-effective purchase of a case-managed
35 continuum of care. The agency shall also require providers to
36 minimize the exposure of recipients to the need for acute
37 inpatient, custodial, and other institutional care and the
38 inappropriate or unnecessary use of high-cost services. The
39 agency shall contract with a vendor to monitor and evaluate the
40 clinical practice patterns of providers in order to identify
41 trends that are outside the normal practice patterns of a
42 provider's professional peers or the national guidelines of a
43 provider's professional association. The vendor must be able to
44 provide information and counseling to a provider whose practice
45 patterns are outside the norms, in consultation with the agency,
46 to improve patient care and reduce inappropriate utilization.
47 The agency may mandate prior authorization, drug therapy
48 management, or disease management participation for certain
49 populations of Medicaid beneficiaries, certain drug classes, or
50 particular drugs to prevent fraud, abuse, overuse, and possible
51 dangerous drug interactions. The Pharmaceutical and Therapeutics

52 Committee shall make recommendations to the agency on drugs for
53 which prior authorization is required. The agency shall inform
54 the Pharmaceutical and Therapeutics Committee of its decisions
55 regarding drugs subject to prior authorization. The agency is
56 authorized to limit the entities it contracts with or enrolls as
57 Medicaid providers by developing a provider network through
58 provider credentialing. The agency may competitively bid single-
59 source-provider contracts if procurement of goods or services
60 results in demonstrated cost savings to the state without
61 limiting access to care. The agency may limit its network based
62 on the assessment of beneficiary access to care, provider
63 availability, provider quality standards, time and distance
64 standards for access to care, the cultural competence of the
65 provider network, demographic characteristics of Medicaid
66 beneficiaries, practice and provider-to-beneficiary standards,
67 appointment wait times, beneficiary use of services, provider
68 turnover, provider profiling, provider licensure history,
69 previous program integrity investigations and findings, peer
70 review, provider Medicaid policy and billing compliance records,
71 clinical and medical record audits, and other factors. Providers
72 shall not be entitled to enrollment in the Medicaid provider
73 network. The agency shall determine instances in which allowing
74 Medicaid beneficiaries to purchase durable medical equipment and
75 other goods is less expensive to the Medicaid program than long-
76 term rental of the equipment or goods. The agency may establish
77 rules to facilitate purchases in lieu of long-term rentals in
78 order to protect against fraud and abuse in the Medicaid program

79 as defined in s. 409.913. The agency may seek federal waivers
80 necessary to administer these policies.
81 (51) The agency shall work with the Agency for Persons
82 with Disabilities to develop a ~~model~~ home and community-based
83 waiver to serve children and adults who are diagnosed with
84 familial dysautonomia or Riley-Day syndrome caused by a mutation
85 of the IKBKAP gene on chromosome 9. The agency shall seek
86 federal waiver approval and implement the approved waiver
87 subject to the availability of funds and any limitations
88 provided in the General Appropriations Act. The agency may adopt
89 rules to implement this waiver program.
90 Section 2. This act shall take effect upon becoming a law.

HB 1319 CS

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1319 CS Certification of Swimming Instructors
SPONSOR(S): Goldstein
TIED BILLS: **IDEN./SIM. BILLS:** SB 2426

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N, w/CS	Halperin	Mitchell
2) Business Regulation Committee	17 Y, 0 N	Watson	Liepshutz
3) Health Care Appropriations Committee	12 Y, 1 N, w/CS	Ekholm	Massengale
4) Health & Families Council		Halperin	Moore
5)			

SUMMARY ANALYSIS

This bill authorizes additional certification of swimming instructors at swimming pools who hold themselves out as specializing in training people with developmental disabilities. It allows the certification to be obtained from the Dan Marino Foundation, based in Weston, Florida. The bill further requires the Dan Marino Foundation to develop certification requirements and training curriculum for review by the Department of Health.

The bill specifies that the act shall take effect on July 1, 2006 only if a specific appropriation to the Department of Health to fund the Dan Marino Foundation, Inc., is made in the General Appropriations Act for Fiscal Year 2006-2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—The bill authorizes a new certification option to the practice of swimming instruction in Florida.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

Section 514.071, F.S. requires that any person working as a swimming instructor or lifeguard at a public swimming pool must be certified by the American Red Cross, the Y.M.C.A., or another nationally recognized aquatic training program.[1] Swimming instructors are to be certified in swimming instruction, first aid, and cardiopulmonary resuscitation. Rule 64E-9.008, F.A.C., further requires that swimming instructors be certified in child and infant cardiopulmonary resuscitation through the American Red Cross, or the American Heart Association or the National Safety Council. In terms of enforcement, the Department of Health may currently sue to enjoin the operation of any public swimming pool that uses any swimming instructor or lifeguard in violation of this section, in addition to any other remedies available to the department.

Current Swimming Instruction Provided to Developmentally Disabled Children

Broward County has a unique program for serving developmentally disabled individuals, and currently provides instruction to between 4,000 and 5,000 special needs children each year in their regular swim instruction program.

Developmental Disabilities in Florida

Section 393.063(10), F.S., defines a developmental disability as a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely. Developmental disabilities begin anytime during development up to 22 years of age and usually last throughout a person's lifetime.[2] As of 2003, there were 7,151 children with autism in Florida. This represents a 690 percent cumulative growth rate of autism from 1992 to 2003, or an average annual growth rate of 19 percent. The increase in autism prevalence is systemic across the United States with rates having grown from 1 in 10,000 births in the 1980s to 1 in 166 births today.[3]

Proponents of the bill claim that many developmentally disabled children are not being taught to swim properly because instructors lack expertise in training special needs students. While teachers in

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[1] Pursuant to Rule 64E-9.008, "nationally recognized aquatic training programs" adopt as reference the standards found in the 2000 edition of the American Red Cross Lifeguarding Instructors Manual, the 1995 edition of the American Red Cross Water Safety Guide for Training Instructors, the On the Guard II, The YMCA Lifeguard Manual, Fourth Edition, (YMCA) The Youth and Adult Aquatic Program Manual (1999), and (YMCA) The Parent/Child and Preschool Aquatic Program Manual (1999).

[2] U.S. Centers for Disease Control. http://www.cdc.gov/ncbddd/dd/default.htm.

[3] Public Schools Autism Prevalence Report Series, 1992-2003, www.fightingautism.org. Data Note: The Individuals with Disabilities Education Act (IDEA) requires each state's Department of Education and the U.S. Department of Education to record specific childhood disabilities, including autism, for each school year. This means that in order for a child to be recorded in the autism disability category the student must require special academic support for the disability; and means that some children with autism who attend private school or other facilities are not included in these counts. Data sources include www.ideadata.org and www.cdc.gov.nchs/.

classrooms must receive additional certification to instruct special needs children, swimming instructors are not required to have additional training.

Florida Geography

Florida has 11,761 square miles covered by water, making it the third wettest state behind Alaska and Michigan.[4] Florida also has the second longest coastline of 1,350 miles, and the second longest shoreline of 8,426 miles.[5] Approximately 80 percent of residents live by the coast, and no resident is more than 75 miles from water.[6]

Drowning Statistics

Drowning is the second leading cause of injury death of infants and children younger than 15 years of age in the United States, and children under the age of five have the highest drowning rates. For every child who drowns, four children are hospitalized for near-drowning. Of the estimated 5,000 children who are hospitalized annually for near-drowning, 15 percent die in the hospital and one-third suffer significant neurological damage. In Florida, drowning is the leading cause of death to children age 14 and younger[7], and the state has the highest number of drowning accidents in the nation.[8] Children younger than one year of age are most likely to drown in bathtubs and buckets, while children between the ages of 1 and 4 most frequently drown in residential swimming pools. Children usually enter pools through unprotected gates and are only out of eyesight for moments before immersing in the water. Children and adolescents between the ages of 5 and 19 most often drown in lakes, ponds, rivers and pools. The annual cost of care per year for an impaired survivor of a near-drowning is approximately $100,000.[9]

Factors That Increase the Risk of Drowning

Some underlying medical conditions are known to increase the risk of drowning. Persons with developmental disabilities are at higher risk of pedestrian accidents in general, including falls, fires, and drowning.[10] Children with epilepsy are estimated to be 4 to 14 times more at risk of submersion;[11] and two recent studies suggest that children with autism may also be at increased risk.[12] However, both studies are based on a small number of drowning deaths and more research is necessary to evaluate the relation between autism and drowning. For some parents of children with autism, fears about the child's wellbeing sometimes lead them entirely to avoid swimming lessons.[13] Minority and underprivileged children are also at increased risk of drowning. According to 2002 statistics, 40 percent

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[4] http://www.netstate.com/states/geography/fl_geography.htm.
[5] http://www.50states.com/florida.htm.
[6] Florida Department of Environmental Protection. http://www.floridadep.org/law/grants/cmp/.
[7] Orange County, CA, Fire Authority. http://www.poolalarms.com/pool_drowning_statistics.htm.
[8] http://www.poolalarms.com/statistics_florida_swimming_pool_accidents.htm.
[9] Statistics on Drowning. http://hsc.usf.edu/CLASS/JulieJ/Statistics.htm.
[10] Strauss, D., Shavelle, R., Anderson, T. and Baumeister, A. "External Causes of Death among Persons with Developmental Disability." *American Journal of Epidemiology.* 1998, Vol. 147, No. 9: 855-862. http://aje.oxfordjournals.org/cgi/content/abstract/147/9/855
[11] Smith GS, Brenner RA. The changing risks of drowning for adolescents in the US and effective control strategies. *Adolescent Medicine.* 1995; 6 :153 –170. See also footnotes 39-41 in Brenner, R.A. "Prevention of Drowning in Infants, Children, and Adolescents. *Pediatrics.* Vol. 112 No. 2 August 2003, pp. 440-445. Available at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/2/440.
[12] Sibert JR, Lyons RA, Smith BA, et al. Preventing deaths by drowning in children in the United Kingdom: have we made progress in 10 years? Population based incidence study. *British Journal of Medicine* .2002; 324 :1070–1071; and Shavelle RM, Strauss DJ, Pickett J. Causes of death in autism. *Journal of Autism and Developmental Disorders.* 2001; 31 :569 –576.
[13] Life Science Services Contract with NASA.http://fitness.ksc.nasa.gov/articles/autism.php.

of children who die from drowning are minority children. This is based on factors of race, class, privilege and poverty that limit a child's access to aquatic facilities and swimming lessons. [14]

Effect of Proposed Changes

This bill creates s. 514.072, F.S., authorizing additional certification of individuals working at pools who hold themselves out as specializing in training people with developmental disabilities, as defined in s. 393.063(10), F.S.

The bill provides that the "special needs" swimming instructor certification requirements will be developed by the Dan Marino Foundation, Inc., and instructors must meet these additional certification requirements to teach individuals with developmental disabilities. The bill requires the Dan Marino Foundation, Inc., to submit the certification requirements to the Department of Health for review and incorporation into rule by January 1, 2007.

Swimming instructors at public pools who are certified under s. 514.071, F.S. before July 1, 2007 must meet the additional requirements by January 1, 2008. Individuals certified under s. 514.071, F.S. on or after July 1, 2007 must meet the additional requirements within 6 months after receiving the original certification.

The effective date of the bill is July 1, 2006.

New Certification Requirements

The certification program required in the bill is being drafted by a workgroup organized by the Broward County Swim Central in conjunction with the Dan Marino Foundation. The new proposed certification requirements are not currently available for review. According to the Department of Health analysis on this bill, there are currently nationally recognized courses that are required for swimming instructors and lifeguards. It is not known how the certification requirements in the bill will integrate with the national requirements for certification. The department suggests that an alternative way of designing additional certification requirements is to submit the idea to the Red Cross, YMCA or other national swimming instruction program for incorporation into existing swimming courses for certification.

About the Dan Marino Foundation

The Dan Marino Foundation, Inc., is based in Weston, Florida, and was founded in 1992 as a non-profit organization supporting medical, emotional or behavioral programs that provide integrated intervention services for children with special needs. The foundation has distributed and pledged over $7 million dollars to provide research, programs, and services that have benefited more than 100,000 children. [15]

C. SECTION DIRECTORY:

Section 1. Creates s. 514.072, F.S., authorizing additional certification for swimming instructors who teach people who have developmental disabilities.

Section 2. Specifies that the bill shall only take effect if a specific appropriation is made in the General Appropriations Act.

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[14] Anderson, Kelli. "Just Add Water: A Complete Guide to Aquatic Centers." *Recreation Management.* http://www.recmanagement.com/feature_print.php?fid=200602fe01.

[15] Dan Marino Foundation, Inc. www.danmarinofoundation.org.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill specifies that the act shall take effect only if a specific appropriation to the Department of Health to fund the Dan Marino Foundation, Inc., is made in the General Appropriations Act for Fiscal Year 2006-2007.

   According to Department of Health analysis, staff time spent at public pools will need to be increased during the routine inspections, which will result in additional costs. Increased violations could also result in a significant increase in the workload of department legal staff. The amounts of these costs are both indeterminate at this time. The department is responsible for 34,000 public pools statewide. To the extent that the amendment to the bill adopted by the Health Care Appropriations Committee authorizes this new certification rather than requires it, the workload of the department may be less than originally anticipated.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See Fiscal Comments.

D. FISCAL COMMENTS:

According to Department of Health analysis, each city or county that operates a public pool and offers swimming instruction to developmentally disabled persons will incur a cost for each staff member certified under the requirements of bill. Travel costs may be also be incurred for instructors to go to Broward County to receive training and certification.[16] These costs would only be incurred to the extent that the respective cities or counties authorized their staff members to obtain this newly-authorized certification.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Although the bill requires counties and municipalities to spend funds or take an action requiring the expenditure of funds, the impact is less than $1.8 million and is insignificant. The bill is therefore exempt from the provisions of Article VII, Section 18(b), Florida Constitution.

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[16] Berrios, J. "Swimming teachers could get extra duties." *Miami Herald*. March 20, 2006. http://www.miami.com/mld/miamiherald/news/local/states/florida/counties/broward_county/13994776.htm.

This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None required.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The department suggests that the certification proposed in the bill be done initially in Broward County to ensure its effectiveness prior to implementation statewide.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 28, 2006, the Health Care Regulation Committee adopted a strike-all amendment to the bill and reported the bill favorably with a committee substitute. The amendment provided the following changes:

- Allocates entire appropriation of $535,000 to the Dan Marino Foundation, Inc., for the 2006-2007 fiscal year for purpose of implementing this act; rather than having funding go toward different entities.
- Requires the Dan Marino Foundation to develop certification requirements and training curriculum for swimming instructors of people who have developmental disabilities; and requires them to submit the certification requirements to the Department of Health for review and incorporation into rule by January 1, 2007.
- Changes the date by which swimming instructors must comply with new certification requirements, to account for the extra time in which curriculum and requirements are developed and put into Administrative Rule.
- As amended, the bill requires that a person certified under s. 514.071, F.S. before July 1, 2007, must meet the additional certification requirements of this section by January 1, 2008. A person certified under s. 514.071, F.S. on or after July 1, 2007, must meet the additional certification requirements of this section within 6 months after receiving certification under 514.071, F.S.

On April 5, 2006 the Business Regulation Committee adopted an amendment to the bill and reported it favorably with the committee substitute. The amendment made the following changes:

- Changed the certification requirement to apply only to swimming instructors who hold themselves out to specialize in training those with developmental disabilities.
- Applied the requirement to swim instructors regardless of whether they work at a public or private pool.

On April 17, 2006, the Health Care Appropriations Committee adopted three amendments, and favorably reported the committee substitute. The amendments provide the following:

- Authorizes but does not require a swimming instructor specializing in training people who have developmental disabilities to be certified by the Dan Marino Foundation, Inc.
- Deletes the authority of the department to sue to enjoin the operation of a public swimming pool that uses a swimming instructor in violation of subsection (1) of the bill.
- Specifies that the bill shall take effect only if a specific appropriation is provided in the General Appropriations Act.

This analysis is drafted to the committee substitute.

CHAMBER ACTION

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1 The Health Care Appropriations Committee recommends the
2 following:
3
4 **Council/Committee Substitute**
5 Remove the entire bill and insert:
6 A bill to be entitled
7 An act relating to certification of swimming instructors;
8 creating s. 514.072, F.S.; requiring additional
9 certification of swimming instructors specializing in
10 training people who have developmental disabilities;
11 requiring the Dan Marino Foundation, Inc., to develop
12 certification requirements and a training curriculum and
13 to submit the certification requirements to the Department
14 of Health for review; providing deadlines for
15 certification; providing a contingent effective date.
16
17 Be It Enacted by the Legislature of the State of Florida:
18
19 Section 1. Section 514.072, Florida Statutes, is created
20 to read:
21 514.072 Certification of swimming instructors for people
22 who have developmental disabilities required.--Any person
23 working at a swimming pool who holds himself or herself out as a

24 swimming instructor specializing in training people who have
25 developmental disabilities, as defined in s. 393.063(10), may be
26 certified by the Dan Marino Foundation, Inc., in addition to
27 being certified under s. 514.071. The Dan Marino Foundation,
28 Inc., must develop certification requirements and a training
29 curriculum for swimming instructors for people who have
30 developmental disabilities and must submit the certification
31 requirements to the Department of Health for review by January
32 1, 2007. A person certified under s. 514.071 before July 1,
33 2007, must meet the additional certification requirements of
34 this section before January 1, 2008. A person certified under s.
35 514.071 on or after July 1, 2007, must meet the additional
36 certification requirements of this section within 6 months after
37 receiving certification under s. 514.071.
38 Section 2. This act shall take effect July 1, 2006, only
39 if a specific appropriation to the Department of Health to fund
40 the Dan Marino Foundation, Inc., is made in the General
41 Appropriations Act for fiscal year 2006-2007.

HB 1327 CS

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1327 CS Transition Services for Adolescents and Young Adults with Disabilities
SPONSOR(S): Davis, D.
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 2288

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families Committee	6 Y, 0 N, w/CS	Preston	Collins
2) Health Care Appropriations Committee	13 Y, 0 N, w/CS	Money	Massengale
3) Health & Families Council		Preston	Moore
4)			
5)			

SUMMARY ANALYSIS

The bill establishes the Jacksonville Health and Transition Services Pilot Program for the purpose of assisting adolescents and young adults with special health care, educational, or vocational needs in transitioning into the adult health care system and employment. The pilot program is to serve persons in North Central Florida, which includes residents in Baker, Clay, Duval, Nassau, and St. Johns counties. The pilot program is to be located in Children's Medical Services in the Department of Health for administrative purposes.

Provisions of the bill address the following:

- Require participants in the pilot program to be offered an assessment of their developmental, educational, and vocational achievement.
- Require the pilot program to work with participants and their families to plan for transition to college or to programs for adult educational and vocational rehabilitation.
- Require the pilot program to work with local educational and vocational entities to provide vocational counseling and training.
- Specify that the pilot program should develop partnerships with community agencies to support comprehensive transition planning and educational and vocational counseling services.

The bill requires specific health services, social services, and administrative services to be provided to participants by the Department of Internal Medicine at the University of Florida-Jacksonville, the Department of Pediatrics at the University of Florida-Jacksonville, the Nemours Children's Clinic, the Institute for Health, Policy, and Evaluation Research within the Duval County Health Department, and other state and local entities. Participation in the pilot by these entities is voluntary, but such participation requires the program to comply with the requirements of the bill.

This act shall take effect July 1, 2006, only if a specific appropriation to the Department of Health to fund the provisions of this act is made in the General Appropriations Act for Fiscal Year 2006-2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – The bill provides an opportunity for many private entities to participate in the development and implementation of the pilot program, which results in additional responsibilities for those groups.

Safeguard individual liberty – If individuals are able to become more self-sufficient and productive as a result of participation in the pilot, then they will have an increased ability to conduct their own affairs.

Empower families – If participants of the program are able to become more self-sufficient and supporting as adults, then their reliance on assistance from family and other sources should decrease.

B. EFFECT OF PROPOSED CHANGES:

Transitioning from Childhood and Adolescent Services to Adult Services and Employment

Children with special health care or educational needs face significant obstacles as they age out of child health care and educational service programs. Many states, universities, organizations, and health care providers are developing plans to assist youth with special health care and educational needs to successfully transition into multiple aspects of adult life.

Transitioning into adulthood is a difficult process for all adolescents, but the transition presents additional challenges for young people with health care and educational disabilities. "Transition services" is the term used to describe a set of services and supports designed to assist adolescents in adjusting to the change from the home and school environment to independent living and meaningful employment. Students with health or educational disabilities often face this transition unprepared for further vocational training, post secondary education, gainful employment, or the ability to navigate the non-pediatric health care system. Some of the barriers to a successful transition include:

- Students leaving school are often placed on a waitlist for adult services and may not be able to keep a job they obtained in school because of a lack of transitional supports as adults. Medicaid waiver rules require students to return to school for services until age 22 if they have a special education diploma.
- Youth with disabilities and their families are often poorly prepared for the transition from an entitlement program (such as a free and appropriate education, Children's Medical Services (CMS), or Medicaid) to an adult service system.
- Priorities and expectations in the systems that serve children and youth with health and educational disabilities are very different than the structure of the service and support system for adults, which is focused on integration into the community rather than separate programs that are only for people with disabilities.
- Commitment to the philosophy of self-determination and choice varies across agencies;
- Eligibility for services and supports vary by agency and often support staff and families may be unaware of services for which they are eligible because planning processes are often not coordinated.
- Social Security benefits often create a disincentive to work. Individuals on Social Security Disability Income (SSDI) who require supports and health benefits to obtain a job lose eligibility for those services if they make over $850, thus losing the benefits that enable them to obtain and keep meaningful employment.
- Agencies may have different criteria for providers of the same service.

Although there are a variety of federal and state programs and agencies with some involvement in meeting the health care, educational and vocational needs of children and adolescents transitioning into adult programs, successfully integrating these efforts has proven difficult.

Health Care Transitioning

Persons with special health care needs or disabilities are more than twice as likely to postpone needed health care because they cannot afford it. Furthermore, people with disabilities are four times more likely to have special needs that are not covered by their health insurance. True independence requires accessible and affordable health care.

However, children and adolescents with special health care needs face significant challenges in transitioning into the adult health care system. Primarily, this is because of the complexity of their health care needs and their high utilization of medical services relative to other adults. For example, according to a survey by Brandeis University and Family Voices of parents of children with special health care needs, parents reported that in the preceding year, their child needed the following services:[1]

- 82 percent needed services from specialty medical doctors.
- 49 percent needed speech therapy.
- 48 percent needed physical therapy.
- 48 percent needed occupational therapy.
- 29 percent needed home health services.
- 20 percent needed mental health services.

Currently, in Florida, there are a number of initiatives that conduct research and provide information to patients and their families on how to transition children and adolescents into the non-pediatric health care system. These initiatives include the following:

- Health Care Transitions—The Promising Practices in Health Care Transition Project is a research and training initiative of the Institute for Child Health Policy at the University of Florida. The website includes tools, resources, and links that deal with transition issues and how other youth and families are meeting this goal. It is also the site of a Transition Listserv that provides international communication for youth, families and professionals who would like to communicate and share ideas and resources with each other.[2]

- The Transition Center—The Transition Center, located at the University of Florida in Gainesville, aims to enrich the lives of students through self-advocacy, access to contacts, proper resources, and by providing an opportunity for students to interact with one another as they make decisions and discover what they want out of life. They are also a resource for family members and professionals.[3]

- Adolescent Health Transition Project—This website was created by the University of Washington and is housed at the Center for Human Development and Disability. The Adolescent Health Transition Project is designed to help ease the transition from pediatric to adult health care for adolescents with special health care needs. This site is a resource for information, materials, and links to other people with an interest in health transition issues.[4]

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[1] The Consortium for Children and Youth with Disabilities and Special Health Care Needs, *Children with Special Health Care Needs and Access to Health and Rehabilitative Services: A Fact Sheet on Findings*, May 2002. Found at http://www3.georgetown.edu/research/gucchd/consortium/documents/brief1.pdf

[2] See http://hctransitions.ichp.edu/

[3] See http://www.thetransitioncenter.org/page.asp?page=content/about.html&pagetype=visitor

[4] See http://depts.washington.edu/healthtr/index.html

Educational and Vocational Transitioning

Advocates for persons with disabilities emphasize that education is the key to independence and future success, is critical to obtaining work, and affects how much money an individual can earn. Before the passage of the Individuals with Disabilities Education Act (IDEA) in 1975, which granted all children with disabilities a free, appropriate public education, many children with disabilities did not attend school because the buildings or class activities were inaccessible. Even now, 22 percent of Americans with disabilities fail to graduate high school, compared to 9 percent of those without disabilities. According to the National Organization on Disability's Harris Survey of Americans with Disabilities,[5]

- Young people with disabilities drop out of high school at twice the rate of their peers.
- As many as 90 percent of children with disabilities are living at the poverty level three years after graduation.
- Eighty percent of people with significant disabilities are not working.
- Currently, only one out of ten persons with a developmental disability will achieve integrated, competitive employment, and most will earn less than $2.40 an hour in a sheltered workshop.

Recently, there have been several statewide initiatives focused on helping to identify challenges faced by young adults with disabilities as they transition from high school to adult life and to develop strategies to create an effective transition system. The state agencies involved in these interagency activities include the Agency for Persons with Disabilities, the Department of Education, the Department of Children and Family Services, the Department of Health (DOH), the Agency for Health Care Administration, and the Department of Juvenile Justice.

A variety of private organizations and individuals have also been involved in these activities, including the Able Trust, the Advocacy Center for Persons with Disabilities, Inc., the ADA Working Group, Center for Autism and Related Disabilities at the University of South Florida, Family Network on Disabilities of Florida, Inc., the Florida Developmental Disabilities Council, Inc., the Florida Independent Living Council, Inc., the Florida Institute for Family Involvement, the Florida Recreation and Parks Association, the Florida Rehabilitation Council, the Florida Schools Health Association, the Transition Center at the University of Florida, the Transition to Independence Process Project, Workforce Florida, Inc., parents, self-advocates, and teachers from throughout the state.[6]

JaxHATS: Jacksonville Health and Transition Services

The Jacksonville Health and Transition Services (JaxHATS) pilot program was created in 2005 to establish a "medical home" for all youth and young adults with chronic medical or developmental problems in Northeast Florida (Duval, Baker, Clay, Nassau and St. Johns counties). The pilot program is based at the University of Florida Shands-Jacksonville campus and has collaborative agreements with other providers such as the Nemours Children's Clinic. For Fiscal Year 2005-06, the program is funded through CMS.

Some, of the diagnostic categories covered by the JaxHATS program include: Spina Bifida; Cerebral Palsy; Muscular Dystrophies and other neuromuscular diseases; Sickle Cell Anemia; Cystic Fibrosis and other chronic lung diseases; Down's Syndrome; autism and other developmental disabilities; diabetes and other chronic endocrine disorders; congenital heart disease or heart disease acquired during childhood; chronic gastro-intestinal (GI) disease, such as Crohn's Disease, Ulcerative Collitis, Short Gut Syndrome; and immunodeficiencies.

Estimates indicate that as many as 6,000 adolescents and young adults living in North Central Florida have chronic medical or developmental conditions, as well as special needs in education. As of March

[5] The 2004 National Organization on Disability/Harris Survey of Americans with Disabilities. Found at www.nod.org
[6] Florida Partners in Transition, http://partnersintransition.org/members.htm

2006, JaxHATS served approximately 40 individuals in its pilot program. JaxHATS has several future goals for the pilot program, including:

- The establishment of a medical home for all youth/young adults with chronic medical or developmental problems in North Central Florida.
- The development of a reliable referral network of adult medical and surgical specialists.
- The design and implementation of a comprehensive evaluation of the proposed pilot project.
- The development of a multidisciplinary research program to formulate and integrate research in the field of medical transition and conduct studies that will establish Standards of Excellence in the field of transition.

Effects of the Bill

The bill creates the Jacksonville Health and Transition Services Pilot Program, the purpose of which is to assist adolescents and young adults with special health care, educational, or vocational needs in transitioning into the adult health care system and employment. The pilot program is located in the CMS program in DOH for administrative purposes.

The bill requires the Department of Internal Medicine and the Department of Pediatrics at the University of Florida-Jacksonville Campus to develop the pilot program in collaboration with CMS and specified community partners, including, but not limited to, the Area Association for Retarded Citizens (ARC Jacksonville), Hope Haven Clinic, the Spina Bifida Association, and the Down Syndrome Association. The primary care clinic for the pilot program will be located in the Ambulatory Care Center on the Shands-Jacksonville Hospital campus. Participation in the pilot by these entities is voluntary, but such participation requires the program to comply with the requirements of the bill.

The target population for the pilot program includes disabled persons who are 14 through 25 years of age; reside in the North Central area of CMS; have chronic health-related or developmental conditions; and could benefit from the program. All children in the CMS State Child Health Insurance Program (SCHIP), Medicaid, and Safety Net (CMS), as well as referrals from the Nemours Children's Clinic, the Duval County School District, general pediatricians, and other health care providers, should be assessed for eligibility to enroll in the program.

Participants in the pilot program must be offered an assessment of their developmental, educational, and vocational achievement. The pilot program must work with participants and their families to plan for transition to college or to programs for adult educational and vocational rehabilitation. The pilot program must work with local educational and vocational entities to provide vocational counseling and training. The pilot program should develop partnerships with the community agencies listed above to support comprehensive transition planning and educational and vocational counseling services.

The pilot program shall include the following:

- A primary-care clinic in the University of Florida-Jacksonville Adult Ambulatory Care Center, which shall be staffed by a multidisciplinary team that includes a pediatrician and an internist, a nurse care coordinator, a transition specialist, and an insurance specialist.
- A network of adult medical and surgical specialists in the community and from the University of Florida-Jacksonville System who agree to treat the special needs of the program's participants.
- Comprehensive intake-evaluation and transition-planning services for participants which cover health care planning, assessment of educational needs, vocational preparation, referral to habilitative support services, assistance in securing insurance, and coordination of services across these areas.

- Coordination and collaboration with other agencies that are involved in providing services to adolescents and young adults who have special health care needs, including the ARC of Jacksonville, Hope Haven Clinic, Nemours Children's Clinic, the Duval County School District, the juvenile justice system, family support services, the foster care program of the Department of Children and Families Services, faith-based community programs, and the Duval County Health Department.
- Ongoing evaluation of patient satisfaction, disease self-management, and success in taking steps toward employment and health-related quality of life and other health-related outcomes.
- Services that support the intellectual development and educational and vocational preparation of program participants.

Specified health services, educational and vocational services, and administrative services must be provided to participants by the Department of Internal Medicine at the University of Florida-Jacksonville, the Department of Pediatrics at the University of Florida-Jacksonville, the Nemours Children's Clinic, the Institute for Health, Policy, and Evaluation Research within the Duval County Health Department, and other state and local entities.

C. SECTION DIRECTORY:

Section 1. Creates an unnumbered section of Florida Statute relating to the creation of the Jacksonville Health and Transition Services Pilot Program.

Section 2. Provides that this act shall take effect July 1, 2006, only if a specific appropriation to the Department of Health to fund the provisions of this act is made in the General Appropriations Act for Fiscal Year 2006-2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   This act shall take effect only if a specific appropriation to the Department of Health to fund the provisions of this act is made in the General Appropriations Act for Fiscal Year 2006-2007.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The pilot program creates a number of administrative and service requirements for non-profit agencies and health care providers who choose to participate. While CMS is provided an appropriation for initial start-up costs to administer the pilot program, there is no specific appropriation for the activities required in the bill for private and non-profit entities. Although the exact amount is indeterminate at this time, it is estimated that substantial resources would be necessary to implement the provisions of the bill in the private sector.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 4, 2006, the Future of Florida's Families Committee adopted one amendment to the bill that provides for the pilot to develop collaborative partnerships with the public and private entities specified in the bill to implement and administer the pilot. Any entity that participates in the pilot is voluntary, but any entity that participates must comply with the requirements of the bill.

On April 17, 2006, the Health Care Appropriations Committee adopted one amendment to the bill that provides that the act shall take effect only if a specific appropriation to the Department of Health to fund the provisions of this act is made in the General Appropriations Act for Fiscal Year 2006-2007.

The bill was reported favorably as committee substitute. The analysis reflects the committee substitute.

CHAMBER ACTION

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1 The Health Care Appropriations Committee recommends the
2 following:
3
4 **Council/Committee Substitute**
5 Remove the entire bill and insert:
6 A bill to be entitled
7 An act relating to transition services for adolescents and
8 young adults with disabilities; creating the Jacksonville
9 Health and Transition Services Pilot Program; assigning
10 the program for administrative purposes to the Children's
11 Medical Services program in the Department of Health;
12 providing purposes of the pilot program; providing for the
13 development of collaborative partnerships with certain
14 entities; delineating the target population; describing
15 participating service providers and the services that they
16 are to provide; providing for the design and
17 implementation of a comprehensive evaluation of the pilot
18 program; providing a contingent effective date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21

22 Section 1. Jacksonville Health and Transition Services
23 Pilot Program; creation; purposes; participating agencies and
24 services provided; evaluation.--
25 (1) The Jacksonville Health and Transition Services Pilot
26 Program is created for the purpose of assisting adolescents and
27 young adults who have special needs relating to health care and
28 educational and vocational services in making a smooth
29 transition from the child health care and educational system to
30 the adult health care system and to employment. For
31 administrative purposes, the pilot program is located in the
32 Children's Medical Services program in the Department of Health.
33 (2) The pilot program, in consultation with the Children's
34 Medical Services program in the Department of Health, shall
35 develop collaborative partnerships with the public and private
36 entities specified in this section to administer and implement
37 the pilot program. Participation in the program by such entities
38 is voluntary. However, an entity that participates in the
39 program must comply with the requirements of this section.
40 (3) The Department of Internal Medicine and the Department
41 of Pediatrics at the University of Florida Jacksonville, in
42 collaboration with Children's Medical Services and community
43 partners, including, but not limited to, ARC Jacksonville, Hope
44 Haven Children's Clinic and Family Center, the Spina Bifida
45 Association, and the Down Syndrome Association, shall develop
46 the pilot program. The primary care clinic for the program shall
47 be located in the Ambulatory Care Center on the University of
48 Florida/Shands Jacksonville campus.

49 (4) The target population for the pilot program comprises
50 adolescents and young adults with disabilities who are between
51 14 and 25 years of age, inclusive, reside in the North Central
52 area of Children's Medical Services of the Department of Health,
53 have chronic health-related or developmental conditions, and
54 could benefit from such a program. All children in the
55 Children's Medical Services State Child Health Insurance Program
56 (SCHIP), Medicaid, and Safety Net (Children's Medical Services),
57 as well as referrals from the Nemours Children's Clinic, the
58 Duval County School District, general pediatricians, and other
59 health care providers, shall be assessed for eligibility to
60 enroll in the program.
61 (5) Upon intake into the program, participants shall be
62 offered an assessment of their development and educational and
63 vocational achievement. The pilot program shall work with
64 participants and their families to plan for transition to
65 college or to programs for adult educational and vocational
66 rehabilitation. The program shall work with local school
67 systems, community colleges, technical centers, and community-
68 based agencies to provide vocational counseling and training.
69 The pilot program shall develop partnerships with community-
70 based agencies as listed in subsection (3) to support
71 comprehensive transition planning and educational and vocational
72 counseling services.
73 (6) The pilot program shall include:
74 (a) A primary-care clinic in the Ambulatory Care Center on
75 the University of Florida/Shands Jacksonville campus, which
76 shall be staffed by a multidisciplinary team that includes a

77 pediatrician and an internist, a nurse care coordinator, a
78 transition specialist, and insurance specialists.
79 (b) A network of adult medical and surgical specialists
80 from the community and from the University of Florida
81 Jacksonville Health Care System who agree to treat the special
82 needs of the adolescents and young adults who are being served
83 in the pilot program.
84 (c) Comprehensive intake-evaluation and transition-
85 planning services for adolescents and young adults and their
86 families that cover health care planning, assessment of
87 educational needs, vocational preparation, referral to
88 habilitative support services, assistance in securing insurance,
89 and coordination of services across these areas.
90 (d) Coordination and collaboration with other agencies
91 that are involved in providing services to adolescents and young
92 adults who have special health care needs, including ARC
93 Jacksonville, Hope Haven Children's Clinic and Family Center,
94 Nemours Children's Clinic, the Duval County School District, the
95 juvenile justice system, family support services, the foster
96 care program of the Department of Children and Family Services,
97 faith-based community programs, and the Duval County Health
98 Department.
99 (e) Ongoing evaluation of patient satisfaction, disease
100 self-management, and success in taking steps toward employment
101 and health-related quality of life and other health-related
102 outcomes.

103 (f) Services that support the intellectual development and
104 educational and vocational preparation of adolescents and young
105 adults with disabilities who are enrolled in the program.
106 (7) Participating agencies and the health and social
107 services that they shall provide include:
108 (a) The Department of Internal Medicine at the University
109 of Florida Jacksonville, which shall:
110 1. Provide a primary care physician who shall serve as the
111 co-medical director of the pilot program.
112 2. Work with both medical and surgical specialty services
113 to facilitate specialty referrals of patients.
114 3. Provide administrative support to the pilot program,
115 including, but not limited to, supervision of clinic staff,
116 scheduling, and billing.
117 4. Allot clinic space for a multidisciplinary transition
118 clinic, which shall initially operate at least once a week and
119 shall expand as the demand increases.
120 5. Assign nursing and support staff to the clinic,
121 including staff to implement an appointment system.
122 6. Maintain medical records and charts under the
123 University of Florida/Shands Health Care System.
124 7. Make efforts to ensure that adolescents and young
125 adults with disabilities participating in the pilot program,
126 regardless of their funding source, shall continue to receive
127 health care services, including primary and specialty outpatient
128 medical services, medications, and laboratory services, until
129 they reach their 26th birthday.

130 (b) The Department of Pediatrics at the University of
131 Florida Jacksonville, which shall:
132 1. Provide a primary care pediatrician who shall serve as
133 the co-medical director of the pilot program.
134 2. Work with pediatric specialty physicians to facilitate
135 the transfer of adolescents and young adults with disabilities
136 from pediatric health care specialists to adult health care
137 specialists. The Department of Pediatrics shall contact
138 pediatric specialists and determine what activities or supports
139 are needed to transfer patients from pediatric specialty care to
140 adult specialty care, such as the transfer of medical records
141 and the provision of educational programs for adult specialists.
142 3. Encourage participation by the subspecialty pediatric
143 physicians through the development of transition programs within
144 each specialty area to prepare patients and their families for
145 participation in the pilot program.
146 4. Identify and refer adolescents and young adults and
147 their families who are candidates for the pilot program.
148 (c) The Nemours Children's Clinic, which shall:
149 1. Encourage participation by the subspecialty pediatric
150 physicians through the development of transition programs within
151 each specialty area to prepare adolescents and young adults with
152 disabilities and their families for participation in the pilot
153 program.
154 2. Identify and refer adolescents and young adults and
155 their families who are candidates for the pilot program.
156 3. Provide in-kind support for care coordination and
157 specialized transitional services.

158 (d) The Institute for Health, Policy and Evaluation
159 Research within the Duval County Health Department, which shall
160 provide the design and implementation of a comprehensive
161 evaluation of the pilot program that includes an assessment of
162 the service-oriented process and patient and family-oriented
163 outcome measures. The Institute for Health, Policy and
164 Evaluation Research shall also conduct a longitudinal study to
165 determine whether the adolescents and young adults with
166 disabilities who participate in this pilot program are more
167 successful than the adolescents and young adults with
168 disabilities who are not associated with the program but receive
169 assistance with vocational rehabilitation only.
170 (e) Hope Haven Children's Clinic and Family Center,
171 Nemours Children's Clinic, ARC Jacksonville, the Duval County
172 School District, the Florida Community College of Jacksonville,
173 the Division of Vocational Rehabilitation of the Department of
174 Education, and other groups, which shall develop a comprehensive
175 educational and vocational transition program that shall be
176 offered to adolescents and young adults with disabilities in the
177 program. The transition specialists in these agencies shall
178 identify, to the greatest extent feasible, all adolescents and
179 young adults with disabilities in the district and refer them to
180 the program.
181 Section 2. This act shall take effect July 1, 2006, only
182 if a specific appropriation to the Department of Health to fund
183 the provisions of this act is made in the General Appropriations
184 Act for fiscal year 2006-2007.

HB 1365 CS

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1365 CS Florida Healthy Kids Corporation Act
SPONSOR(S): Davis, M. and others
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 2050

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Future of Florida's Families Committee	6 Y, 0 N, w/CS	Davis	Collins
2) Health Care Appropriations Committee	14 Y, 0 N, w/CS	Speir	Massengale
3) Health & Families Council		Davis	Moore
4)			
5)			

SUMMARY ANALYSIS

House Bill 1365 CS does the following:

- Allows children to have 12-months of continuous eligibility in the KidCare program even when switching from one component to another.
- Allows health and dental plans participating in the KidCare Program to market the program.
- Allows the Florida Healthy Kids Corporation to release certain information concerning a child's application to parents or legal guardians of the child.

This bill does not have a fiscal impact.

The bill shall take effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Empower Families — Allows 12-months of continuous eligibility in the KidCare program.

B. EFFECT OF PROPOSED CHANGES:

The Legislature created Florida's KidCare program during the 1998 Legislative Session, in response to passage of Title XXI of the Social Security Act, to make affordable health insurance available to previously uninsured, low-income children. The KidCare program components are Medicaid, Medikids, the Florida Healthy Kids program, and the Children's Medical Services (CMS) Network. Children will transfer between components as a result of changes in family income and age of the child.

Medicaid is governed pursuant to Title XIX of the Social Security Act. The Department of Children and Families (DCF) determines a child's eligibility for Medicaid using federal eligibility requirements. When a child applies for Medicaid, DCF does not require enrollees to provide the documents required by state law for eligibility in the KidCare program.

Medikids and the Florida Healthy Kids program are administered by the Florida Healthy Kids Corporation (FHKC). FHKC determines a child's eligibility for Medikids and the Florida Healthy Kids program using the eligibility requirements for KidCare found in s. 409.814, F.S.

Section 409.814, F.S., states that once a child is enrolled in the Florida KidCare program, the child is eligible for coverage under the program for 12 months without a redetermination or reverification of eligibility. However, despite this statutory direction, FHKC verifies a child's eligibility for Medikids or the Florida Healthy Kids program when a child switches to these programs from Medicaid even if the child is switching before the enrollment anniversary date.

FHKC does this because DCF has not collected the documentation required by s. 409.814, F.S. The documents are proof of family income and a statement from all family members concerning employer sponsored insurance. As a result, some children switching between components lose coverage when the documents are not provided to FHKC. This bill adds language to ensure that administrators allow 12-months of continuous eligibility in the KidCare program even when a child enters a new component.

Section 409.821, F.S., states that information regarding a child in the KidCare program is confidential and may be released only with the written consent of the program applicant. The applicant is either the guardian or the parent of the enrollee. As a result of this statute, FHKC is not releasing information concerning a child to non-custodial parents when they receive such a request. This bill amends the law to allow administrators to release information to an enrollee's parent or legal guardian that confirms coverage and dates of coverage.

Plans providing services to KidCare enrollees often market and promote the KidCare program. They do this with the approval of the KidCare administrators. Some plans are concerned that there could be problems with their activities since the KidCare statute does not address these activities. This bill creates s. 409.8125, F.S., to allow health and dental plans to market and promote the KidCare program.

C. SECTION DIRECTORY:

Section 1. Amends s. 409.814, F.S., ensuring that children receive 12-months of continuous eligibility in the KidCare program even when switching program components.

Section 2. Amends s. 409.821, F.S., allowing administrators to release certain information concerning a child's application to parents or legal guardians of the child.

Section 3. Creates s. 409.8215, F.S., allowing participating health and dental plans to market and promote the KidCare program.

Section 4. The bill takes effect July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

There is a conflict in the Florida Statutes governing continuous eligibility in Medicaid and KidCare. Section 409.813, F.S., states that Medicaid is a component of KidCare. Section 409.814 (6), F.S., states that children will have 12 months of continuous eligibility in the KidCare program. Section 409.904 (6), F.S., states that children enrolled in Medicaid will be continuously eligible for 12 months if they are under age 5, and for 6 months if they are age 5 and older.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 5, 2006, the Future of Florida's Families committee adopted a Committee Substitute to House Bill 1365. The substantive changes made in the committee substitute include changing provisions related to the maximum income threshold in the Florida KidCare program and revising provisions relating to the Florida Healthy Kids Corporation.

On April 17, 2006, the Health Care Appropriations Committee adopted a strike-all amendment to House Bill 1365 CS. The strike-all did the following:

- Allows that 12-months of continuous eligibility applies when switching KidCare components.
- Allows KidCare administrators to release certain information concerning a child's application to parents or legal guardians of the child.
- Allows participating health and dental plans to develop marketing and other promotional materials and participate in activities, such as health fairs and public events, as approved by the Agency for Health Care Administration.

The committee favorably reported a committee substitute, and this analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Appropriations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to the Florida KidCare program; amending s. 409.814, F.S.; specifying that 12 months of continuous eligibility includes changes between program components; amending s. 409.821, F.S., relating to a public records exemption; specifying that such provision does not prohibit an enrollee's parent or legal guardian from obtaining confirmation of coverage and dates of coverage; creating s. 409.8215, F.S.; authorizing participating health and dental plans to develop marketing and other promotional materials and to participate in activities to promote the Florida KidCare program; providing an effective date.

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

Section 1. Subsection (6) of section 409.814, Florida Statutes, is amended to read:

24 409.814 Eligibility.--A child who has not reached 19 years
25 of age whose family income is equal to or below 200 percent of
26 the federal poverty level is eligible for the Florida KidCare
27 program as provided in this section. For enrollment in the
28 Children's Medical Services Network, a complete application
29 includes the medical or behavioral health screening. If,
30 subsequently, an individual is determined to be ineligible for
31 coverage, he or she must immediately be disenrolled from the
32 respective Florida KidCare program component.
33 (6) Once a child is enrolled in the Florida KidCare
34 program, the child is eligible for coverage under the program
35 for 12 months without a redetermination or reverification of
36 eligibility <u>even when switching from one component of the</u>
37 <u>program to another</u>, if the family continues to pay the
38 applicable premium. Eligibility for program components funded
39 through Title XXI of the Social Security Act shall terminate
40 when a child attains the age of 19. Effective January 1, 1999, a
41 child who has not attained the age of 5 and who has been
42 determined eligible for the Medicaid program is eligible for
43 coverage for 12 months without a redetermination or
44 reverification of eligibility.
45 Section 2. Section 409.821, Florida Statutes, is amended
46 to read:
47 409.821 Florida KidCare program public records
48 exemption.--Notwithstanding any other law to the contrary, any
49 information identifying a Florida KidCare program applicant or
50 enrollee, as defined in s. 409.811, held by the Agency for
51 Health Care Administration, the Department of Children and

52 Family Services, the Department of Health, or the Florida
53 Healthy Kids Corporation is confidential and exempt from s.
54 119.07(1) and s. 24(a), Art. I of the State Constitution. Such
55 information may be disclosed to another governmental entity only
56 if disclosure is necessary for the entity to perform its duties
57 and responsibilities under the Florida KidCare program and shall
58 be disclosed to the Department of Revenue for purposes of
59 administering the state Title IV-D program. The receiving
60 governmental entity must maintain the confidential and exempt
61 status of such information. Furthermore, such information may
62 not be released to any person without the written consent of the
63 program applicant. This exemption applies to any information
64 identifying a Florida KidCare program applicant or enrollee held
65 by the Agency for Health Care Administration, the Department of
66 Children and Family Services, the Department of Health, or the
67 Florida Healthy Kids Corporation before, on, or after the
68 effective date of this exemption. A violation of this section is
69 a misdemeanor of the second degree, punishable as provided in s.
70 775.082 or s. 775.083. <u>This section does not prohibit an</u>
71 <u>enrollee's parent or legal guardian from obtaining confirmation</u>
72 <u>of coverage and dates of coverage.</u>
73 Section 3. Section 409.8215, Florida Statutes, is created
74 to read:
75 <u>409.8215 Marketing by service providers.--</u>
76 <u>(1) Participating health and dental plans may develop</u>
77 <u>marketing and other promotional materials and participate in</u>
78 <u>activities, such as health fairs and public events, as approved</u>
79 <u>by the Agency for Health Care Administration.</u>

80 (2) The health and dental plans may also contact their
81 enrollees and former enrollees to encourage continued
82 participation in the Florida KidCare program.
83 (3) The agency may adopt rules pursuant to ss. 120.536(1)
84 and 120.54 to implement the provisions of this section.
85 Section 4. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1409 CS Florida Health Information Network, Inc.
SPONSOR(S): Benson
TIED BILLS: HB 1411 **IDEN./SIM. BILLS:** SB 2786

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N	Bell	Mitchell
2) Health Care Appropriations Committee	13 Y, 0 N, w/CS	Speir	Massengale
3) Health & Families Council		Bell AJB	Moore MPh
4)			
5)			

SUMMARY ANALYSIS

House Bill 1409 creates the "Florida Health Information Network Act" as a public/private partnership that will implement a statewide electronic medical records network.

The bill establishes the Florida Health Information Network, Inc., as a not-for-profit corporation. The corporation will be managed by an uncompensated board of directors. The initial board will consist of the current Governor's Health Information Infrastructure Advisory Board (for 18 months).

The primary duties of the Florida Health Information Network, Inc., are to oversee, coordinate, and implement a statewide electronic medical records network. Among the many duties listed in the enabling legislation, the Florida Health Information Network, Inc., is charged with development of technical standards for electronic medical records and recruiting participants into the network.

The Agency for Health Care Administration (agency) will provide oversight of the Florida Health Information Network, Inc.

This bill will only take effect if a specific appropriation is made in the General Appropriation Act for Fiscal Year 2006-2007. If an appropriation is made, then the effective date will be July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government - The bill creates the Florida Health Information Network, Inc. as a not-for-profit corporation. The fiscal impact of the bill is $9,426,117 in year one.

Empower Families/Safeguard Individual Liberty - Full implementation of electronic medical records may increase individual's access to their own health care information, provide more transparency in the health care system, and increase the quality of care.

Maintain Public Security - Full implementation of electronic medical records would better prepare the state for natural or manmade disasters, such as hurricanes.

B. EFFECT OF PROPOSED CHANGES:

Executive Order Number 04-93 created the Governor's Health Information Infrastructure Advisory Board (board) on May 4, 2004. The Executive Order states that the board shall be "advisory in nature." The board is to advise the Agency for Health Care Administration (agency) in creating a health information infrastructure. The board is to continue in existence until June 30, 2007 or all of its objectives are achieved. The Executive Order named W. Michael Heekin as Chair of the Board.

In collaboration with the agency, the board established the Florida Health Information Network, Inc., as a Florida not-for-profit corporation. The Articles of Incorporation were filed on April 5, 2005, and named W. Michael Heekin as the initial director and officer. The Articles of Incorporation states that the directors are to appointed or elected "per executive order 04-93."

The 2005 Legislature appropriated $1.5 million to AHCA for the Florida Health Information Network subject to Legislative Budget Commission approval. The initial budget amendment request from AHCA sought $250,000 for start-up funds for the creation of the Florida Health Information Network, Inc. The amendment was changed to have all $1.5 million fund grants.

The budget amendment providing for the funding of grants for the Florida Health Information Network was approved by the Legislative Budget Commission on October 20, 2005. The grants program provides grants for the planning and implementation of local and regional health information exchange projects and for technical assistance programs to encourage the adoption of electronic health record systems by physicians and other practitioners. Nine (9) grant projects were awarded during the period January through June 30, 2006. These include five planning grants, three implementation grants and one technical assistance grant. Final reports on the projects are due to the agency July 10, 2006.

House Bill 1409 creates s. 408.064, F.S., establishing the "Florida Health Information Network Act" to promote statewide integration of electronic medical records. It creates the Florida Health Information Network, Inc., as a not-for-profit corporation that will be managed by an uncompensated board of directors. The initial board of directors will consist of the current Governor's Health Information Infrastructure Advisory Board for 18 months.

The primary duty of the Florida Health Information Network, Inc., is to develop a statewide health information network. To accomplish this end, the Florida Health Information Network, Inc., is directed in its enabling legislation to:

- Devise and implement a strategic plan for infrastructure development, and periodically evaluate and modify the plan.
- Develop, operate, and maintain the technical infrastructure necessary to perform the functions of the network consistent with the strategic plan.
- Promote an integrated approach to efforts to create a secure network for communication of electronic health information in the state.
- Market the network to promote widespread use.
- Assist in the development and expansion of existing local or regional health information networks and the creation of new networks.
- Develop annual budgets.
- Take commercially reasonable measures to protect its intellectual property, including obtaining patents, trademarks, and copyrights where appropriate.
- Make recommendations for reform of the state's laws regarding medical records.

The Florida Health Information Network, Inc., is also charged with developing and enforcing privacy, security, operational, and technical standards among regional and local health information networks.

The bill requires the Florida Health Information Network, Inc., to regularly assess the adoption of electronic records systems and utilization of the statewide network, and incorporate the results into its regular strategic planning process.

The Agency for Heath Care Administration (agency) is responsible for promoting the development of the health information network as a public-private partnership in the state. The agency is also responsible for developing and implementing a plan for the formation and operation of the health information network.

Pursuant to House Bill 1409, AHCA will contract with the Florida Health Information Network, Inc., to implement the plan, July 1, 2006, through June 30, 2008.

The effective date of the bill is July 1, 2006 only if an appropriation is provided in the General Appropriations Act.

C. SECTION DIRECTORY:

Section 1. - Creates s. 408.064, F.S., establishing the Florida Health Information Network, Inc., as a not-for-profit corporation.

Section 2. - Provides an effective date of July 1, 2006 if an appropriation is made.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

   Expenditures:

   See Fiscal Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

According to the Agency for Health Care Administration (agency), the fiscal impact of the bill is $9,426,117 for the first year. This amount includes $9,426,117 for the agency to contract with the Florida Health Information Network, Inc., to carry out the purposes of the act. The contract will provide $5,953,200 for the health information network technical infrastructure, $1,524,452 for technical staff and technical consulting, $1,052,446 for professional and administrative personnel and overhead, and $896,019 for practitioner outreach projects and a public education campaign. The agency anticipates the need for an additional $9,426,117 appropriation in year two.

The long-term impacts of electronic medical records are estimated to create more efficiency in the health care system and improve patient safety. Researchers estimate that nationwide implementation of electronic medical records could eventually save more than $81 billion annually.[1]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration has the necessary rulemaking authority to carry out the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At its April 17, 2006 meeting the Health Care Appropriations Committee adopted an amendment to House Bill 1409. The amendment made the act subject to a specific appropriation in the General Appropriation Act for Fiscal Year 2006-2007. The committee favorably reported a committee substitute.

The analysis is drafted to the committee substitute.

[1] Health Affairs, 24, no. 5 (2005): 1103-1117.

CHAMBER ACTION

The Health Care Appropriations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to the Florida Health Information Network, Inc.; creating s. 408.064, F.S.; providing a short title and purpose; requiring the Agency for Health Care Administration to develop and implement a plan for the formation and operation of a health information network; requiring the agency to enter into a contract to implement the plan; creating the Florida Health Information Network, Inc., as a not-for-profit corporation; providing for a board of directors and for terms thereof; providing duties and responsibilities of the corporation; requiring a report to the Governor and Legislature; providing a contingent effective date.

WHEREAS, the cost of health care in Florida has grown substantially while the demand for a more coordinated system of health care has increased, and

23 WHEREAS, with the benefit of an effective system for
24 sharing privacy-protected medical information among authorized
25 health care stakeholders, health care providers and consumers,
26 aided by computerized tools that automatically analyze available
27 health information and by combining that data with clinical
28 logic and practice guidelines based on current, sound medical
29 science, will have access to the medical information needed to
30 make sound decisions about health care, and
31 WHEREAS, the state's health care system would benefit from
32 a reduction in the time it takes to evaluate promising medical
33 techniques, devices, and drugs and to bring the products and
34 procedures that are proven safe and effective to the health care
35 marketplace more quickly, and
36 WHEREAS, the state's public health officers require
37 effective information systems to detect, monitor, and manage
38 emerging health threats most efficiently, and
39 WHEREAS, a successful medical response to large-scale
40 disasters such as hurricanes is enhanced by effective and timely
41 access to the medical records of those needing medical care, and
42 WHEREAS, providing consumers with effective access to their
43 personal health information and computerized tools that gather
44 data from their medical records and assist in interpreting and
45 monitoring the data in partnership with their health care
46 providers would permit consumers to become better informed and
47 more proactive in managing their health and wellness, thereby
48 reducing utilization of and adding efficiencies to the health
49 care system, and

50 WHEREAS, it is feasible and advisable for the state to
51 implement an effective integrated health information network
52 capable of drawing together critical health information from
53 multiple sources and presenting that information to authorized
54 parties in a usable format to support sound decisions about
55 health care by providers, consumers, public health officers, and
56 researchers while ensuring the privacy and security of personal
57 health information, and
58 WHEREAS, studies have shown that health information
59 networks are more likely to succeed if they are developed,
60 implemented, and operated by a neutral manager with broad
61 support among health care stakeholders, and
62 WHEREAS, the Legislature declares that an integrated health
63 information network is a necessary and important part of
64 effectively addressing the challenges and opportunities facing
65 the state's health care delivery system, and it is the policy of
66 the state to promote the development and implementation of an
67 integrated statewide health information network to be operated
68 by a neutral manager as a public-private partnership, with
69 reasonable oversight and regulation by the state to promote the
70 safety, security, and integrity of the health information
71 network, NOW, THEREFORE,
72
73 Be It Enacted by the Legislature of the State of Florida:
74
75 Section 1. Section 408.064, Florida Statutes, is created
76 to read:

77 408.064 Florida Health Information Network Act; purpose;
78 duties.--
79 (1) This section may be cited as the "Florida Health
80 Information Network Act."
81 (2) The purpose of this section is to promote the
82 establishment of a privacy-protected and secure integrated
83 statewide network for the communication of electronic health
84 information among authorized parties and to foster a coordinated
85 public-private initiative for the development and operation of
86 Florida's health information infrastructure.
87 (3) The agency is responsible for promoting the
88 development of a health information network as a public-private
89 partnership among the state's providers, payors, consumers,
90 employers, public health officials, medical researchers, and
91 other health care stakeholders. The agency shall develop and
92 implement a plan for the formation and operation of a health
93 information network and shall contract with the Florida Health
94 Information Network, Inc., for the purpose of implementing the
95 plan, in conformity with the legislative intent expressed in
96 this section, for the period July 1, 2006, through June 30,
97 2008.
98 (4) There is created a not-for-profit corporation, to be
99 known as the "Florida Health Information Network, Inc.," which
100 shall be registered, incorporated, organized, and operated in
101 compliance with chapter 617, and which shall not be a unit or
102 agency of state government. The affairs of the not-for-profit
103 corporation shall be managed by a board of directors who shall
104 serve without compensation. The initial board of directors shall

105 be the Governor's Health Information Infrastructure Advisory
106 Board which shall serve a term of 18 months. Upon expiration of
107 the terms of the initial members, members shall be appointed to
108 4-year staggered terms in accordance with s. 20.052 by majority
109 vote as provided in the bylaws of the corporation. Any vacancy
110 in office shall be filled for the remainder of the term by
111 majority vote of the members. Any member may be reappointed.
112 (5) The Florida Health Information Network, Inc., shall:
113 (a) Institute a statewide health information network in
114 the state by:
115 1. Devising and implementing a strategic plan for
116 infrastructure development and periodically evaluating and
117 modifying that plan.
118 2. Developing, operating, and maintaining the technical
119 infrastructure necessary to perform the functions of the network
120 consistent with the strategic plan.
121 3. Promoting an integrated approach to efforts to create a
122 secure network for communication of electronic health
123 information in the state.
124 4. Marketing the network to promote widespread use of the
125 network.
126 5. Assisting in the development and expansion of existing
127 local or regional health information networks and the creation
128 of new networks.
129 (b) Develop and implement specific programs or strategies
130 that address the creation, development, and expansion of
131 regional or local health information networks and the
132 recruitment of participants in the network.

133 (c) Specify standards among regional and local health
134 information networks and other participants in the Florida
135 Health Information Network, Inc., to promote effective statewide
136 and interstate interoperability.
137 (d) Regularly assess the adoption of electronic health
138 records systems and utilization of the statewide network by
139 providers, consumers, public health officers, and other health
140 care stakeholders to identify and regularly reevaluate the
141 state's health information infrastructure strengths and
142 weaknesses, assess opportunities to increase consumer access to
143 the consumer's health records, and incorporate such information
144 into its regular strategic planning process.
145 (e) Develop and enforce privacy, security, operational,
146 and technical standards among regional and local health
147 information networks to ensure effective statewide privacy, data
148 security, efficiency, and interoperability across the network.
149 The network's standards shall be guided by reference to widely
150 adopted standards or standards accepted by recognized national
151 standard-setting organizations.
152 (f) Develop annual budgets that include funding from
153 public and private entities, including user fees.
154 (g) Take commercially reasonable measures to protect its
155 intellectual property, including obtaining patents, trademarks,
156 and copyrights where appropriate.
157 (h) Make recommendations for reform of the state's laws
158 regarding medical records.
159 (6) The agency shall review the data gathered about the
160 Florida Health Information Network, Inc., pursuant to paragraph

161 (5)(d) and make recommendations for its continued development in
162 a report to be submitted to the Governor, the President of the
163 Senate, and the Speaker of the House of Representatives by June
164 1, 2007.
165 Section 2. This act shall take effect July 1, 2006 , only
166 if a specific appropriation to fund the Florida Health
167 Information Network Act is made in the General Appropriations
168 Act for fiscal year 2006-2007.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1451 CS Public Records
SPONSOR(S): Gannon
TIED BILLS: HB 1449 **IDEN./SIM. BILLS:** SB 2564

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee	9 Y, 0 N	Ciccone	Brown-Barrios
2) Governmental Operations Committee	6 Y, 0 N, w/CS	Williamson	Williamson
3) Health & Families Council		Ciccone	Moore
4)			
5)			

SUMMARY ANALYSIS

HB 1451 CS creates a public records exemption for the Florida Center for Brain Tumor Research. The following information is confidential and exempt from public records requirements: an individual's medical record and any information received from an individual from another state or nation or the Federal Government that is otherwise confidential or exempt. The committee substitute provides for future review and repeal of the exemption, provides a statement of public necessity, and provides a contingent effective date.

This committee substitute does not grant rule-making authority to any administrative agency.

This committee substitute requires a two-thirds vote of the members present and voting for passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – The committee substitute decreases access to public records.

B. EFFECT OF PROPOSED CHANGES:

Public Records Law

Article I, s. 24(a), Florida Constitution, sets forth the state's public policy regarding access to government records. The section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government. The Legislature, however, may provide by general law for the exemption of records from the requirements of Article I, s. 24(a), Florida Constitution. The general law must state with specificity the public necessity justifying the exemption (public necessity statement) and must be no broader than necessary to accomplish its purpose. Public policy regarding access to government records also is addressed in the Florida Statutes.

Chapter 119, F.S., more completely addresses the issue of public records. Section 119.07(1), F.S., also guarantees every person a right to inspect, examine, and copy any state, county, or municipal record.

Open Government Sunset Review Act

Section 119.15, F.S., the "Open Government Sunset Review Act," sets forth a legislative review process that requires newly created or expanded exemptions to include an automatic repeal of the exemption on October 2nd of the fifth year after enactment or substantial amendment, unless the Legislature reenacts the exemption. It provides that a public records or public meetings exemption may be created or maintained only if it serves an identifiable public purpose, and may be no broader than is necessary to meet one of the following public purposes:

- Allowing the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protecting sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety. However, only the identity of an individual may be exempted under this provision; or
- Protecting trade or business secrets.

Effect of Bill

This committee substitute creates a public records exemption for the Florida Center for Brain Tumor Research. The following information is confidential and exempt[1] from public records requirements:

- An individual's medical record.
- Information received from an individual from another state or nation or the Federal Government, which is confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

[1] There is a difference between information and records that the Legislature has designated exempt from public disclosure and those the Legislature has deemed confidential and exempt. Information and records classified exempt from public disclosure are permitted to be disclosed under certain circumstances. *See City of Riviera Beach v. Barfield*, 642 So. 2d 1135 (Fla. 4th DCA 1994); *Williams v. City of Minneola*, 575 So. 2d 687 (Fla. 5th DCA 1991). If the Legislature designates certain information and records confidential and exempt from public disclosure, such information and records may not be released by the records custodian to anyone other than the persons or entities specifically designated in the statutory exemption. *See Attorney General Opinion 85-62*, August 1, 1985.

The committee substitute provides for future review and repeal of the exemption on October 2, 2011. It also provides a statement of public necessity and a contingent effective date.

C. SECTION DIRECTORY:

Section 1. Creates s. 381.8531, F.S., to create a public records exemption for the Florida Center for Brain Tumor Research.

Section 2. Provides a public necessity statement.

Section 3. Provides a July 1, 2006 effective date that is contingent upon the passage of HB 1449 or similar legislation.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   This committee substitute does not create, modify, amend or eliminate a state revenue source.

2. Expenditures:

   This committee substitute does not create, modify, amend, or eliminate a state expenditure.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   This committee substitute does not create, modify, amend, or eliminate a local revenue source.

2. Expenditures:

   This committee substitute does not create, modify, amend, or eliminate a local expenditure.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

This committee substitute could create a fiscal impact on the Florida Center for Brain Tumor Research, because staff responsible for complying with public records requests will require training related to the newly created public records exemption. In addition, the center could incur costs associated with redacting the confidential and exempt information prior to releasing a record.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This committee substitute does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. The committee substitute does not reduce the percentage of a state tax shared with counties or municipalities. The committee substitute does not reduce the authority that municipalities have to raise revenue.

2. Other:

Vote Requirement

Article I, s. 24(c) of the Florida Constitution, requires a two-thirds vote of the members present and voting for passage of a newly created public records or public meetings exemption. The committee substitute creates a public records exemption. Thus, it requires a two-thirds vote for passage.

Public Necessity Statement

Article I, s. 24 (c) of the Florida Constitution, requires a statement of public necessity (public necessity statement) for a newly created public records or public meetings exemption. The committee substitute creates a public records exemption. Thus, it includes a public necessity statement.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 17, 2006, the Governmental Operations Committee adopted an amendment and reported the committee substitute favorably with committee substitute. The amendment corrected an error in the title of the committee substitute.

CHAMBER ACTION

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1 The Governmental Operations Committee recommends the following:
2
3 **Council/Committee Substitute**
4 Remove the entire bill and insert:
5 A bill to be entitled
6 An act relating to public records; creating s. 381.8531,
7 F.S.; providing an exemption from public records
8 requirements for an individual's medical record or
9 information received from an individual from another state
10 or nation or the Federal Government that is otherwise
11 confidential or exempt that is held by the Florida Center
12 for Brain Tumor Research; providing for future review and
13 repeal; providing a finding of public necessity; providing
14 a contingent effective date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Section 381.8531, Florida Statutes, is created
19 to read:
20 381.8531 Florida Center for Brain Tumor Research; public
21 records exemption.--

22 (1) The following information held by the Florida Center
23 for Brain Tumor Research is confidential and exempt from s.
24 119.07(1) and s. 24, Art. I of the State Constitution:
25 (a) An individual's medical record.
26 (b) Any information received from an individual from
27 another state or nation or the Federal Government that is
28 otherwise confidential or exempt pursuant to the laws of that
29 state or nation or pursuant to federal law.
30 (2) This section is subject to the Open Government Sunset
31 Review Act in accordance with s. 119.15 and shall stand repealed
32 on October 2, 2011, unless reviewed and saved from repeal
33 through reenactment by the Legislature.
34 Section 2. The Legislature finds that it is a public
35 necessity that an individual's medical record held by the brain
36 tumor registry developed pursuant to s. 381.853(3), Florida
37 Statutes, be made confidential and exempt from public records
38 requirements. Matters of personal health are traditionally
39 private and confidential concerns between the patient and the
40 health care provider. The private and confidential nature of
41 personal health matters pervades both the public and private
42 health care sectors. For these reasons, the individual's
43 expectation of and right to privacy in all matters regarding his
44 or her personal health necessitates this exemption. The
45 Legislature further finds that it is a public necessity to
46 protect a patient's medical record because the release of such
47 record could be defamatory to the patient or could cause
48 unwarranted damage to the name or reputation of that patient.
49 Finally, the Legislature finds that it is a public necessity to

50 protect information received by the brain tumor registry from an
51 individual from another state or nation or the Federal
52 Government that is otherwise exempt or confidential pursuant to
53 the laws of that state or nation or pursuant to federal law.
54 Without this protection, another state or nation or the Federal
55 Government might be less likely to provide information to the
56 registry in the furtherance of its duties and responsibilities.
57 Section 3. This act shall take effect July 1, 2006, if
58 House Bill 1449 or similar legislation is adopted in the same
59 legislative session or an extension thereof and becomes law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7139 CS PCB HCG 06-01 Emergency Management
SPONSOR(S): Health Care General Committee; Harrell and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/CS/CS/CS/SB 1058

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health Care General Committee	10 Y, 0 N	Ciccone	Brown-Barrios
1) Health Care Appropriations Committee	13 Y, 0 N, w/CS	Massengale	Massengale
2) Health & Families Council		Ciccone	Moore
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 7139 CS amends various sections of Florida Statutes relating to the planning and operation of special needs emergency shelters in Florida. Specifically, the committee substitute addresses emergency planning and management to enhance the safety and well-being of persons with special needs before, during and after a disaster. The committee substitute assigns lead responsibility regarding special needs shelter maintenance and operation to certain state agencies, establishes the multi-agency special needs shelter discharge planning team and encourages coordination of emergency services among national, state and local agencies and volunteer organizations.

The committee substitute assigns lead agency education, communication and outreach responsibilities to the Department of Community Affairs, expands special needs registration efforts, revises the membership and role of the Special Needs Interagency Committee and amplifies the Department of Health's role in establishing a more coordinated comprehensive emergency plan review of certain facilities and providers with the Department of Elder Affairs and the Agency for Health Care Administration.

The committee substitute provides procedures to address the needs of families of special needs shelter residents, provides facility and provider reimbursement when rendering services during a disaster, authorizes certain facilities to exceed their licensed capacity during an evacuation situation, and requires the Agency for Health Care Administration to monitor and assist nursing homes during a disaster and to publish an emergency phone number for nursing homes requesting assistance.

The committee substitute makes the reimbursement to health care practitioners and facilities subject to the availability of both state and federal funds. The committee substitute also provides appropriations for permanent emergency power for special needs shelters based on a competitive award process ($21.5 million federal funds, which requires 25 percent local participation), retrofitting public hurricane evacuation shelters based on a competitive award process ($9 million federal funds), and 20 positions and $1,000,955 from the General Revenue Fund to the Department of Health for emergency management plan reviews of home health agencies and nurse registry, hospice and home medical equipment providers.

The committee substitute provides for an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—The committee substitute adds responsibilities to the Department of Health's role in establishing a more coordinated comprehensive emergency plan review of certain facilities and providers with the Department of Elder Affairs and the Agency for Health Care Administration.

Promote Personal Responsibility and **Empower Families**—Providing time and appropriate pre- and post-disaster information and improving the availability of services should enable the state's residents to make choices that will enhance the safety and well-being of themselves and their families.

B. EFFECT OF PROPOSED CHANGES:

Proposed Changes

The committee substitute amends certain sections of chapter 252, F. S., and other chapters addressing pre- and post-disaster planning to address services to persons with special needs before, during and after disasters. The committee substitute assigns lead responsibility for certain functions to specific state agencies and establishes a multi-agency emergency special needs shelter discharge planning team to assist local areas impacted by natural or manmade disasters that require the use of special needs shelters. The committee substitute also provides certain pre- and post-disaster facility use and licensure flexibility. The effect of these provisions should be to provide increased coordination among federal, state and local entities and to facilitate the timely and appropriate use of facilities to serve the special needs population.

The committee substitute provides the following:

- Includes individuals with cognitive impairments among persons considered to have special needs.
- Expands the communication and outreach efforts regarding special needs registration.
- Requires year-round maintenance of the special needs registry.
- Provides local law enforcement agencies with access to shelter registration information.
- Designates the Department of Community Affairs as the lead agency responsible for community education and outreach and requires the department to coordinate with certain other entities in those efforts.
- Provides that a special needs shelter is considered a public facility when activated for a disaster and as such must allow people with disabilities to bring their service animals into the facility.
- Authorizes the Department of Agriculture and Consumer Services to serve as the lead agency responsible for pet and animal sheltering during a disaster.
- Designates Children's Medical Services as the lead agency for coordinating local medical and health care providers for the staffing and management of pediatric special needs shelters.
- Authorizes the Agency for Health Care Administration to monitor nursing homes during emergencies to determine if assistance is needed and requires that the agency publishes an emergency telephone number for nursing homes to use.
- Specifies that the Division of Emergency Management include special needs shelter assessment, location, estimated need, and other information in its statewide emergency shelter plan.
- Requires the Department of Health to assist the Division of Emergency Management in determining the estimated need for special needs shelter space and the adequacy of the facility to meet the needs of those seeking shelter.
- Requires the Division of Emergency Management to include information regarding the availability of pet friendly shelters in the statewide emergency shelter plan.

- Requires the local emergency management agency to inspect a facility to determine its readiness prior to activating such facility.
- Assigns the county health departments, in conjunction with the local emergency management agencies, the lead responsibility to coordinate and recruit health care practitioners to staff local special needs shelters, and encourages coordination of non-medical staffing and operating of special needs shelters.
- Requires local emergency management agencies to be responsible for the designation and operation and closure of facilities and that these services and activities are coordinated with county health departments.
- Establishes state employee roles under certain circumstances in a disaster response.
- Establishes a multi-agency emergency special needs shelter discharge planning team.
- Directs the Department of Elder Affairs to convene the multi-agency special needs shelter discharge planning team as necessary to assist local areas impacted by emergency or disaster.
- Allows certain practitioners, hospitals, nursing homes or receiving facilities to request reimbursement for sheltering persons with special needs.
- Provides protections against duplication of reimbursements to receiving facilities.
- Revises the duties and membership of the Special Needs Shelter Interagency Committee and expands the committee to include the Florida Association of Aging Services Providers, the Florida Renal Coalition and AARP.
- Requires the Department of Health to adopt rules.
- Authorizes the Department of Health to solicit pre-planning event participation.
- Requires emergency management plans to address home health agency, nurse registry, hospice, and home medical equipment provider's functional staffing plan for shelters to ensure continuity of care and services for clients.
- Provides that home health agencies, nurse registries, hospice and home medical equipment providers include a continuity of care component in their respective comprehensive emergency management plans, encourages these entities to establish links to emergency operations centers to determine a mechanism to approach disaster areas to reach clients, provides for a more coordinated review of such plans by the county health departments and allows sanctioning capability by the Agency for Health Care Administration under certain circumstances.
- Provides licensure and use flexibility to allow nursing homes, assisted living facilities, and other residential care facilities to exceed their licensed bed capacity to act as a receiving facility in accordance with emergency operations plans.
- The committee substitute makes the reimbursement to health care practitioners and facilities subject to the availability of both state and federal funds. The committee substitute also provides appropriations for permanent emergency power for special needs shelters based on a competitive award ($21.5 million federal funds, which requires 25 percent local participation), retrofitting public hurricane evacuation shelters based on a competitive award ($9 million federal funds), and 20 positions and $1,000,995 from the General Revenue Fund to the Department of Health for emergency management plan reviews of home health agencies and nurse registry, hospice and home medical equipment providers.

Current Situation

Florida's geographical location makes this state vulnerable to a variety of natural disasters. Various state agencies coordinate with local and federal governments, interstate organizations, and the private sector to prepare residents and visitors before disasters to help protect them during such events and assist with recovery afterward.

Florida's regulatory guidelines regarding disaster response are outlined in several documents. Chapter 252, F.S., mandates the development of the Florida Comprehensive Emergency Management Plan. The plan establishes the framework to ensure that Florida is prepared to deal with the aftermath of any one of several hazards that threaten our communities, businesses, and the environment. The plan coordinates response and recovery activities with federal, state, local, and volunteer entities and

organizations to unify the efforts of these groups to ensure a comprehensive approach to reducing and mitigating the effects of an emergency or disaster.

Additionally, laws relating to health care providers, including ancillary services, provide that certain rules be developed and enforced to establish reasonable and consistent quality of care to persons prior to, during and after a disaster.

A significant number of Florida's citizens are considered vulnerable in the event of natural disasters such as hurricanes:

- More than 76 percent of Florida's total population (12,816,041 persons) resides in the 35 coastal counties.
- Eight percent of the state's total population (1,333,969 persons) resides in mobile homes.
- More than 18 percent of the state's total population (3,051,453 persons) is 65 years of age or older, with the highest number in Miami-Dade (314,497), Palm Beach (278,868), Broward (315,470), Pinellas (229,763) and Hillsborough (139,341) counties.[1]
- Florida has made significant strides in reducing the deficit of safe hurricane shelter space in the past five years. Approximately 50 percent of the deficit has been eliminated. Between 2004 and 2009, however, the vulnerable population in Florida is projected to increase by nearly 900,000 with as many as 16 percent possibly seeking safety in public shelters.[2]
- There are 746 nursing homes with 81,986 licensed beds in the state.
- There are an estimated 333,492 citizens that may be considered "frail elderly" (about 2 percent of the Florida's population).

Special needs shelters provide refuge to persons who because of a health or medical condition require the supervision of a health care professional during a disaster or emergency. These shelters operate and coordinate services with state, local agency and volunteer organizations. The Department of Health is the primary agency under the Emergency Support Function-8 operations to maintain and staff special needs shelters.[3] On September 1, 2004, the Governor issued Executive Order Number 04-192, authorizing the Department of Health to assume responsibility for special needs shelter operations if specifically requested by any county director of emergency management. This order, incorporated in subsequent hurricane executive orders, was prompted by, "(T)he recognition that the system was overwhelmed and that the department was in the best position, under the circumstances to assume expedient responsibility for SpNs operations..."

The Department of Health, in its 2004 Hurricane Season *AFTER ACTION REPORT*, documents that changing demographics have resulted in increasing numbers of elderly and disabled individuals receiving in-home services. The reports states, "(D)uring these storms, Florida, with its high proportion of elderly, experienced the effects of these combinations of factors like never before. Individuals, who functioned well in their homes during normal times, many with support services from home health care agencies, were unable to maintain that level of functionality during and after the storms. Storm-related disruptions to communications, transportation, power supplies, and lack of continuity of in-home support services as well as structural damage to their homes, forced many seniors out of their independent living status and into SpNS, at least temporarily. In some areas, those who had not evacuated prior to the storm found they could not safely remain in their homes after the storm due to these disruptions resulting in a 'second wave' of evacuees entering special needs shelters."[4]

The department's report underscored a number of issues and lessons learned including:

- County health departments were not always involved with other government entities in selecting SpNS.

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[1] *Comprehensive Emergency Management Plan 2004*, February 1, 2004
[2] *State of Florida 2004 Statewide Emergency Shelter Plan*, February 2004.
[3] The Florida House of Representatives, Interim Project Report, Health Care General Committee, November 2005
[4] Florida Department of Health, 2004 Hurricane Season *AFTER ACTION REPORT*, March 4, 2005.

- Many eligible persons were not aware of the Special Needs Registry and many of those registered did not actually choose to shelter in SpNS.
- Many eligible persons asked to be added to the registry just prior to storm landfall and many registry lists were not updated.
- Better asset assignment was needed, including staff with current specialty skill sets and specialized equipment such as heavy patient lift devices or able-bodied staff, respiratory therapists, oxygen concentrators and other medical support equipment.
- Lack of air conditioning and marginal food and water supplies created stressful shelter conditions.
- More coordinated discharge planning was needed.

Further, during the 2005 hurricane season, additional analysis revealed that physically impaired individuals who decided to shelter at home in multi-story buildings became "trapped" when elevators were rendered inoperable due to power outages. These individuals represent a substantial group that may also seek SpNS services in the future.

C. SECTION DIRECTORY:

Section 1. Amends s. 252.355, F.S., regarding public shelter space and special needs registration.

Section 2. Creates s. 252.3568, F.S., regarding emergency pet sheltering.

Section 3. Creates s. 252.357, F.S., regarding monitoring of nursing homes during a disaster.

Section 4. Amends s. 252.385, F.S., regarding public shelter space, statewide shelter survey and need information included in the statewide emergency shelter plan, space allocation within a shelter, shelter location, adequacy of facilities, pet friendly shelters, inspection, shelter readiness and coordination of shelter services.

Section 5. Amends s. 381.0303, F.S., regarding operation, maintenance and closure of special needs shelters; assignment and coordination of local and state agency lead responsibilities; coordination of medical and non-medical staffing in special needs shelters; designation, operation and infrastructure of special needs shelters; state employees' disaster response roles; the Department of Elder Affairs' convening of the multi-agency special needs shelter discharge planning team; health care practitioner and other emergency personnel reimbursement; hospitals, nursing and other facilities reimbursement for disaster-incurred expenses; special needs shelter interagency committee membership and responsibilities; the Department of Health's rule-making authority; pre-event planning activities, and home health agency, nurse registry, hospice and home medical equipment provider emergency management plan review.

Section 6. Amends, s. 400.492, F.S., regarding home health agencies and the provision of services during an emergency; provides that home health agencies may establish links to local emergency operations centers and provides sanctioning ability by the Agency for Health Care Administration.

Section 7. Amends s. 400.497, F.S., regarding rules establishing minimum standards; establishes county health department procedures regarding the review of home health agencies comprehensive emergency plans, provides for notification of plan approval or deficiency, and provides that the Agency for Health Care Administration may impose a fine under certain circumstances.

Section 8. Amends s. 400.506, F.S., regarding nurse registries and the provision of services during an emergency; provides that nurse registries may establish links to local emergency operations centers; establishes county health department procedures regarding review of nurse registries' comprehensive emergency plans, provides for notification of plan approval or deficiency; and provides that the Agency for Health Care Administration may impose a fine under certain circumstances.

Section 9. Amends s. 400.610, F.S, regarding hospice facilities and the provision of services during an emergency; provides that hospice facilities may establish links to local emergency operations centers; establishes county health department procedures regarding the review of hospice facilities comprehensive emergency plans; provides for notification of plan approval or deficiency; and provides sanctioning ability by Agency for Health Care Administration.

Section 10. Amends s. 400.925, F.S., providing the definition of life-supporting or life-sustaining equipment.

Section 11. Amends s. 400.934, F.S., regarding home medical equipment providers and the provision of services during an emergency; provides that home medical equipments providers may establish links to local emergency operations centers; establishes county health department procedures regarding review of home medical equipment providers comprehensive emergency plans; provides for notification of plan approval or deficiency; and provides that the Agency for Health Care Administration may impose a fine under certain circumstances.

Section 12. Amends s. 400.935, F.S., providing rules establishing minimum standards.

Section 13. Amends s. 408.831, F.S., regarding facility licensure and the provision of certain licensure and facility use pre-and post-disaster.

Section 14. Provides an appropriation based on a competitive award process to special needs shelters for permanent power generating capacity based on a competitive award process; requires 25 percent local match.

Section 15. Provides an appropriation for retrofitting public hurricane evacuation shelters based on a competitive award process.

Section 16. Provides an appropriation to the Department of Health for home health agencies' and nurse registry, hospice and home medical equipment providers' emergency management plan reviews.

Section 17. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   The committee substitute provides appropriations for permanent emergency power for special needs shelters based on a competitive award process ($21.5 million federal funds, which requires 25 percent local participation), retrofitting public hurricane evacuation shelters based on a competitive award process ($9 million federal funds), and 20 positions and $1,000,955 from the General Revenue Fund to the Department of Health for emergency management plan reviews of home health agencies and nurse registry, hospice and home medical equipment providers.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

The grant awards for permanent emergency power for special needs shelters require a 25 percent local cash match.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Reimbursement of health care practitioners and facilities is subject to the availability of state and federal funds.

D. FISCAL COMMENTS:

The Department of Community Affairs, the Department of Elder Affairs, and the Agency for Health Care Administration, should be able to carry out the provisions of the committee substitute within existing resources.

The Department of Health recommended 30 positions and $1.5 million for the 2006-2007 fiscal year, and $2.5 million (annualized) for the 2007-2008 fiscal year to conduct reviews of emergency management plans for home health agencies and nurse registry, hospice and home medical equipment providers. Based on a subsequent conversation with department staff, 20 positions and $1 million would be sufficient as long as there were no due dates for the completion of the initial plan reviews.

	2006-2007	2007-2008
Salaries		
4 Hlth Svcs & Fac Consult @ $44,330 (pg 024)	226,970	226,970
14 Hlth Svcs & Fac Consult w/ 50% lapse	397,197	794,394
2 Admin. Asst. III @ $37,352 (pg 021) w/ 25% lapse	72,276	96,368
Subtotal Salaries	696,443	1,117,732
Expense		
18 FTE @ professional w/ travel @ $10,177	182,106	182,106
18 FTE @$3,343 NR	60,174	
2 FTE support @ $5,195	10,390	10,390
2 FTE support @ $2,791 NR	5,582	
Subtotal Expense	258,252	192,496
OCO		
18 FTE @ professional $1,900	34,200	
2 FTE @ support $2,100	4,200	
Subtotal OCO	38,400	
Human Resources Services		
20 FTE @ $393	7,860	7,860
Total Recurring	896,799	1,318,088
Total Nonrecurring	104,156	
General Revenue Fund Total	1,000,955	1,318,088

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Although the grant awards for permanent emergency power for special needs shelters require a 25 percent local cash match, the grants are awarded on a competitive basis. Local governments are not required to apply for the grants.

2. Other:

None

B. RULE-MAKING AUTHORITY:

The Department of Health is required to promulgate rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On February 22, 2006, the House Health Care General Committee passed Proposed Committee Bill HCG 06-01 and adopted two amendments:

Amendment #1: A strike-all amendment which included the provisions contained within the PCB and the following revisions:

- Increase special needs registration notification requirements;
- Require the Division of Emergency Management to address evacuation of persons with pets in the shelter component of the state emergency management plan;
- Require the Department of Agriculture and Consumer Services to assist the Division of Emergency Management in determining strategies regarding persons evacuating with pets;
- Require the Division of Emergency Management to inspect facilities to determine availability, readiness and adequacy of facilities;
- Assign responsibility for the designation, operation and infrastructure of special needs shelters and requires local health departments to coordinate efforts regarding same;
- Add the Florida Renal Coalition to the membership of the Special Needs Interagency Committee;
- Increase coordination among entities regarding home health agency, nurse registry, hospice and home medical equipment comprehensive plan reviews by local health departments.

Amendment #2:

- Provide access to special needs registration information to local law enforcement agencies.

On April 17, 2006, the Health Care Appropriations Committee adopted two amendments, and favorably reported the committee substitute. The two amendments add the following:

- Restores the subject to the availability of both state and federal funds language for the reimbursement to health care practitioners and facilities.
- Provides appropriations for permanent emergency power for special needs shelters based on a competitive award process ($21.5 million federal funds, which requires 25 percent local participation), retrofitting public hurricane evacuation shelters based on a competitive award process ($9 million federal funds), and 20 positions and $1,000,955 from the General Revenue Fund to the Department of Health for emergency management plan reviews of home health agencies and nurse registry, hospice and home medical equipment providers.

The analysis reflects the committee substitute as amended.

CHAMBER ACTION

1 The Health Care Appropriations Committee recommends the
2 following:
3
4 **Council/Committee Substitute**
5 Remove the entire bill and insert:
6 A bill to be entitled
7 An act relating to emergency management; amending s.
8 252.355, F.S.; specifying additional entities and agencies
9 that are required to provide registration information to
10 persons with disabilities or special needs for purposes of
11 inclusion within the registry of persons with special
12 needs maintained by local emergency management agencies;
13 providing that the Department of Community Affairs shall
14 be the designated lead agency responsible for community
15 education and outreach to the general public, including
16 persons with special needs, regarding registration as a
17 person with special needs, special needs shelters, and
18 general information regarding shelter stays; requiring the
19 department to disseminate educational and outreach
20 information through local emergency management offices;
21 requiring the department to coordinate community education
22 and outreach related to special needs shelters with
23 specified agencies and entities; providing that special

24 needs shelters must allow persons with special needs to
25 bring service animals into special needs shelters;
26 revising provisions with respect to the required
27 notification of residential utility customers of the
28 availability of the special needs registration program;
29 providing that specified confidential and exempt
30 information relating to registration of persons with
31 special needs be provided to the Department of Health and
32 local law enforcement agencies; creating s. 252.3568,
33 F.S.; requiring the Division of Emergency Management to
34 address evacuation of persons with pets in the shelter
35 component of the state comprehensive emergency management
36 plan; creating s. 252.357, F.S., requiring the Florida
37 Comprehensive Emergency Management Plan to permit the
38 Agency for Health Care Administration to make initial
39 contact with each nursing home in a disaster area;
40 requiring the agency to annually publish an emergency
41 telephone number that may be used by nursing homes to
42 contact the agency; amending s. 252.385, F.S., relating to
43 public shelter space; requiring the Division of Emergency
44 Management of the Department of Community Affairs to
45 biennially prepare and submit a statewide emergency
46 shelter plan to the Governor and the Cabinet for approval;
47 providing plan requirements; requiring the Department of
48 Health to provide specified assistance to the division;
49 revising those facilities which are excluded as being
50 suitable for use as public hurricane evacuation shelters;
51 requiring local emergency management agencies to inspect a

52 designated facility prior to activation to determine its
53 readiness; amending s. 381.0303, F.S.; providing for the
54 operation, maintenance, and closure of special needs
55 shelters; providing that local Children's Medical Services
56 offices shall assume lead responsibility for specified
57 coordination with respect to the development of a plan for
58 the staffing and medical management of pediatric special
59 needs shelters; requiring such plans to conform to the
60 local comprehensive emergency management plan; requiring
61 county governments to assist the Department of Health with
62 nonmedical staffing and operation of special needs
63 shelters; requiring local health departments and emergency
64 management agencies to coordinate such efforts to ensure
65 appropriate staffing; providing that the appropriate
66 county health department, Children's Medical Services
67 office, and local emergency management agency shall
68 jointly determine the responsibility for medical
69 supervision in a special needs shelter; providing
70 notification requirements; requiring local emergency
71 management agencies to be responsible for the
72 infrastructure and closure of special needs shelters;
73 requiring the emergency management agency and the local
74 health department to coordinate efforts to ensure
75 appropriate designation, operation, and infrastructure in
76 special needs shelters; providing that a county health
77 department is not prohibited from entering into an
78 alternative agreement with a local emergency management
79 agency to assume the lead responsibility for special needs

80 shelter supplies and equipment; providing that state
81 employees with a preestablished role in disaster response
82 are subject to serve in times of disaster in specified
83 capacities; requiring the Secretary of Elderly Affairs to
84 convene multiagency special needs shelter discharge
85 planning teams to assist local areas that are severely
86 impacted by a natural or manmade disaster that requires
87 the use of special needs shelters; providing duties and
88 responsibilities of such discharge planning teams;
89 providing for the inclusion of specified state agency
90 representatives on each discharge planning team; revising
91 provisions relating to reimbursement of health care
92 practitioners; providing for eligibility of specified
93 health care facilities for reimbursement when a
94 multiagency special needs shelter discharge planning team
95 discharges persons with special needs to such receiving
96 facilities; providing procedures and requirements with
97 respect to such reimbursement; requiring the department to
98 specify by rule expenses that are reimbursable and the
99 rate of reimbursement for services; revising provisions
100 which prescribe means of and procedures for reimbursement;
101 disallowing specified reimbursements; revising provisions
102 with respect to the organization, role, duties, and
103 composition of the special needs shelter interagency
104 committee; requiring the department to adopt specified
105 rules with respect to special needs shelters; providing
106 requirements with respect to emergency management plans
107 submitted to a county health department by a home health

108 agency, nurse registry, hospice, or home medical equipment
109 provider; amending ss. 400.492, 400.497, 400.506, 400.610,
110 and 400.934, F.S.; revising requirements with respect to
111 the comprehensive emergency management plans of home
112 health agencies, nurse registries, and hospices, and
113 providing such requirements with respect to home medical
114 equipment providers, to include the means by which
115 continuing services will be provided to patients who
116 evacuate to special needs shelters; authorizing the
117 establishment of links to local emergency operations
118 centers for specified purposes; providing actions that
119 constitute abandonment of a patient; providing sanctions
120 for abandonment; revising requirements of a county health
121 department with respect to review of a comprehensive
122 emergency management plan submitted by a home health
123 agency, nurse registry, or hospice, and providing such
124 requirements with respect to a home medical equipment
125 provider; providing requirements upon failure to submit a
126 plan or requested information to the department; providing
127 for imposition of a fine; revising requirements of the
128 Department of Health with respect to review of the plan of
129 a home health agency, nurse registry, or hospice that
130 operates in more than one county, and providing such
131 requirements with respect to a home medical equipment
132 provider that operates in more than one county; providing
133 that the preparation and maintenance of a comprehensive
134 emergency management plan by a home medical equipment
135 provider is a requirement for licensure and must meet

136 minimum criteria established by the Agency for Health Care
137 Administration; providing plan requirements; providing
138 that the plan is subject to review and approval by the
139 county health department; requiring each home medical
140 equipment provider to maintain a current prioritized list
141 of patients who need continued services during an
142 emergency; amending s. 400.925, F.S.; defining "life-
143 supporting or life-sustaining equipment" for purposes of
144 pt. X of ch. 400, F.S., relating to home medical equipment
145 providers; amending s. 400.935, F.S.; requiring the Agency
146 for Health Care Administration to adopt rules with respect
147 to the comprehensive emergency management plan prepared by
148 a home medical equipment services provider; amending s.
149 408.831, F.S.; providing that entities regulated or
150 licensed by the Agency for Health Care Administration may
151 exceed their licensed capacity to act as a receiving
152 facility under specified circumstances; providing
153 requirements while such entities are in an overcapacity
154 status; providing for issuance of an inactive license to
155 such licensees under specified conditions; providing
156 requirements and procedures with respect to the issuance
157 and reactivation of an inactive license; providing fees;
158 providing legislative findings with respect to the
159 equipping of all designated public special needs hurricane
160 evacuation shelters with permanent emergency power
161 generating capacity by a specified date; requiring the
162 Department of Community Affairs to work with local
163 communities to ensure a sufficient number of public

164 special needs shelters designated to meet anticipated
165 demand; specifying the percentage of local match for such
166 projects; providing an appropriation to the Department of
167 Community Affairs to establish a competitive award
168 process; specifying a limit with respect to administration
169 of the funding; providing legislative findings with
170 respect to retrofitting public hurricane evacuation
171 shelters; providing criteria for the retrofitting of a
172 public hurricane evacuation shelter; providing an
173 appropriation to the Department of Community Affairs to
174 establish a competitive award process; specifying a limit
175 with respect to administration of the funding; providing
176 an appropriation to implement the provisions of emergency
177 management plan reviews for home health agencies and nurse
178 registry, hospice, and home medical equipment providers;
179 providing an effective date.
180
181 Be It Enacted by the Legislature of the State of Florida:
182
183 Section 1. Section 252.355, Florida Statutes, is amended
184 to read:
185 252.355 Registry of persons with special needs; notice.--
186 (1) In order to meet the special needs of persons who
187 would need assistance during evacuations and sheltering because
188 of physical, mental, <u>cognitive impairment,</u> or sensory
189 disabilities, each local emergency management agency in the
190 state shall maintain a registry of persons with special needs
191 located within the jurisdiction of the local agency. The

192 registration shall identify those persons in need of assistance
193 and plan for resource allocation to meet those identified needs.
194 To assist the local emergency management agency in identifying
195 such persons, home health agencies, hospices, nurse registries,
196 home medical equipment providers, the Department of Children and
197 Family Services, the Department of Health, the Agency for Health
198 Care Administration, the Department of Education, Agency for
199 Persons with Disabilities, ~~Department of Labor and Employment~~
200 ~~Security,~~ and the Department of Elderly Affairs shall provide
201 registration information to all of their special needs clients
202 and to all people with disabilities or special needs who receive
203 services ~~incoming clients as a part of the intake process~~. The
204 registry shall be continuously maintained ~~updated annually~~. The
205 registration program shall give persons with special needs the
206 option of preauthorizing emergency response personnel to enter
207 their homes during search and rescue operations if necessary to
208 assure their safety and welfare following disasters.
209 (2) The Department of Community Affairs shall be the
210 designated lead agency responsible for community education and
211 outreach to the general public, including special needs clients,
212 regarding registration and special needs shelters and general
213 information regarding shelter stays. The Department of Community
214 Affairs shall disseminate such educational and outreach
215 information through the local emergency management offices. The
216 department shall coordinate the development of curriculum and
217 dissemination of all community education and outreach related to
218 special needs shelters with the Clearinghouse on Disability
219 Information of the Governor's Working Group on the Americans

220 with Disabilities Act, the Department of Children and Family
221 Services, the Department of Health, the Agency for Health Care
222 Administration, the Department of Education, the Agency for
223 Persons with Disabilities, and the Department of Elderly
224 Affairs.
225 (3) A person with special needs shall be allowed to bring
226 his or her service animal into a special needs shelter in
227 compliance with the Americans with Disabilities Act of 1990,
228 Pub. L. No. 101-336. Because a special needs shelter is
229 considered a public facility when it is activated for a
230 disaster, persons with disabilities must be allowed access to
231 special needs shelters when accompanied by a service animal in
232 compliance with the Americans with Disabilities Act, which
233 provides that businesses and organizations that serve the public
234 must allow people with disabilities to bring their service
235 animals into all areas of a facility where customers are
236 normally allowed to go.
237 (4) ~~(2)~~ ~~On or before May 1 of each year~~ Each electric
238 utility in the state shall ~~annually~~ notify residential customers
239 in its service area of the availability of the registration
240 program available through their local emergency management
241 agency with either: ~~.~~
242 (a) An initial notification upon the activation of new
243 residential service with the electric utility followed by one
244 annual notification between January 1 and May 31; or
245 (b) Two separate annual notifications between January 1
246 and May 31.
247

248 The notification required under this subsection may be made by
249 any available means, including, but not limited to, written,
250 electronic, or verbal notification, and may be made concurrently
251 with any other notification to residential customers required by
252 law or rule.
253 (5) ~~(3)~~ All records, data, information, correspondence, and
254 communications relating to the registration of persons with
255 special needs as provided in subsection (1) are confidential and
256 exempt from the provisions of s. 119.07(1), except that such
257 information shall be available to other emergency response
258 agencies, as determined by the local emergency management
259 director, and to the Department of Health in the furtherance of
260 its duties and responsibilities. Local law enforcement agencies
261 shall be provided complete shelter registration information upon
262 request.
263 (6) ~~(4)~~ All appropriate agencies and community-based
264 service providers, including home health care providers,
265 hospices, nurse registries, and home medical equipment
266 providers, shall assist emergency management agencies by
267 collecting registration information for persons with special
268 needs as part of program intake processes, establishing programs
269 to increase the awareness of the registration process, and
270 educating clients about the procedures that may be necessary for
271 their safety during disasters. Clients of state or federally
272 funded service programs with physical, mental, cognitive
273 impairment, or sensory disabilities who need assistance in
274 evacuating, or when in shelters, must register as persons with
275 special needs.

276 Section 2. Section 252.3568, Florida Statutes, is created
277 to read:
278 252.3568 Emergency sheltering of persons with pets.--In
279 accordance with the provisions of s. 252.35, the division shall
280 address the evacuation of persons with pets in the shelter
281 component of the state comprehensive emergency management plan.
282 The Department of Agriculture and Consumer Services shall assist
283 the division in determining strategies regarding this activity.
284 Section 3. Section 252.357, Florida Statutes, is created
285 to read:
286 252.357 Monitoring of nursing homes during disaster.--The
287 Florida Comprehensive Emergency Management Plan shall permit the
288 Agency for Health Care Administration, working from the agency's
289 offices or in the Emergency Operations Center, ESF-8, to make
290 initial contact with each nursing home in the disaster area. The
291 agency, by July 15, 2006, and annually thereafter, shall publish
292 on the Internet an emergency telephone number that may be used
293 by nursing homes to contact the agency on a schedule established
294 by the agency to report requests for assistance. The agency may
295 also provide the telephone number to each facility when it makes
296 the initial facility call.
297 Section 4. Subsection (2) and paragraphs (a) and (b) of
298 subsection (4) of section 252.385, Florida Statutes, are amended
299 to read:
300 252.385 Public shelter space.--
301 (2)(a) The division shall administer a program to survey
302 existing schools, universities, community colleges, and other
303 state-owned, municipally owned, and county-owned public

304 buildings and any private facility that the owner, in writing,
305 agrees to provide for use as a public hurricane evacuation
306 shelter to identify those that are appropriately designed and
307 located to serve as such shelters. The owners of the facilities
308 must be given the opportunity to participate in the surveys. The
309 Board of Regents, district school boards, community college
310 boards of trustees, and the Department of Education are
311 responsible for coordinating and implementing the survey of
312 public schools, universities, and community colleges with the
313 division or the local emergency management agency.
314 (b) By January 31 of each even-numbered year, the division
315 shall prepare and submit a statewide emergency shelter plan to
316 the Governor and the Cabinet for approval, subject to the
317 requirements for approval provided in s. 1013.37(2). The plan
318 shall identify the general location and square footage of
319 special needs shelters, by regional planning council region,
320 during the next 5 years. The plan shall also include information
321 on the availability of shelters that accept pets. The Department
322 of Health shall assist the division in determining the estimated
323 need for special needs shelter space and the adequacy of
324 facilities to meet the needs of persons with special needs based
325 on information from the registries of persons with special needs
326 and other information.
327 (4)(a) Public facilities, including schools, postsecondary
328 education facilities, and other facilities owned or leased by
329 the state or local governments, but excluding hospitals, hospice
330 care facilities, assisted living facilities, or nursing homes,
331 which are suitable for use as public hurricane evacuation

332 shelters shall be made available at the request of the local
333 emergency management agencies. The local emergency management
334 agency shall inspect a designated facility to determine its
335 readiness prior to activating the facility for a specific
336 hurricane or disaster. Such agencies shall coordinate with the
337 appropriate school board, university, community college, or
338 local governing board when requesting the use of such facilities
339 as public hurricane evacuation shelters.
340 (b) The Department of Management Services shall
341 incorporate provisions for the use of suitable leased public
342 facilities as public hurricane evacuation shelters into lease
343 agreements for state agencies. Suitable leased public facilities
344 include leased public facilities that are solely occupied by
345 state agencies and have at least 2,000 square feet of net floor
346 area in a single room or in a combination of rooms having a
347 minimum of 400 square feet in each room. The net square footage
348 of floor area shall ~~must~~ be determined by subtracting from the
349 gross square footage the square footage of spaces such as
350 mechanical and electrical rooms, storage rooms, open corridors,
351 restrooms, kitchens, science or computer laboratories, shop or
352 mechanical areas, administrative offices, records vaults, and
353 crawl spaces.
354 Section 5. Section 381.0303, Florida Statutes, is amended
355 to read:
356 381.0303 ~~Health practitioner recruitment for~~ Special needs
357 shelters.--
358 (1) PURPOSE.--The purpose of this section is to provide
359 for the operation, maintenance, and closure of special needs

360 shelters and to designate the Department of Health, through its
361 county health departments, as the lead agency for coordination
362 of the recruitment of health care practitioners, as defined in
363 s. 456.001(4), to staff special needs shelters in times of
364 emergency or disaster and to provide resources to the department
365 to carry out this responsibility. However, nothing in this
366 section prohibits a county health department from entering into
367 an agreement with a local emergency management agency to assume
368 the lead responsibility for recruiting health care
369 practitioners.
370 (2) SPECIAL NEEDS SHELTER PLAN; STAFFING; CLOSURE; STATE
371 AGENCY ASSISTANCE ~~AND STAFFING~~.--Provided funds have been
372 appropriated to support ~~medical services~~ disaster coordinator
373 positions in county health departments:~~,~~
374 (a) The department shall assume lead responsibility for
375 the ~~local~~ coordination of local medical and health care
376 providers, the American Red Cross, and other interested parties
377 in developing a plan for the staffing and medical management of
378 special needs shelters. The local Children's Medical Services
379 offices shall assume lead responsibility for the coordination of
380 local medical and health care providers, the American Red Cross,
381 and other interested parties in developing a plan for the
382 staffing and medical management of pediatric special needs
383 shelters. Plans shall conform to ~~The plan shall be in~~
384 ~~conformance with~~ the local comprehensive emergency management
385 plan.
386 (b) ~~(a)~~ County health departments shall, in conjunction
387 with the local emergency management agencies, have the lead

388 responsibility for coordination of the recruitment of health
389 care practitioners to staff local special needs shelters. County
390 health departments shall assign their employees to work in
391 special needs shelters when those employees are needed to
392 protect the health and safety of persons with special needs ~~of~~
393 ~~patients~~. County governments shall assist the Department of
394 Health with nonmedical staffing and the operation of special
395 needs shelters. The local health department and emergency
396 management agency shall coordinate these efforts to ensure
397 appropriate staffing in special needs shelters.
398 (c) ~~(b)~~ The appropriate county health department,
399 Children's Medical Services office, and local emergency
400 management agency shall jointly decide ~~determine~~ who has
401 responsibility for medical supervision in each ~~a~~ special needs
402 shelter and shall notify the Division of Emergency Management
403 and the Department of Health of their decision.
404 (d) ~~(c)~~ Local emergency management agencies shall be
405 responsible for the designation, ~~and~~ operation, and
406 infrastructure of special needs shelters during times of
407 emergency or disaster and the closure of the facilities
408 following an emergency or disaster. The emergency management
409 agency and the local health department shall coordinate these
410 efforts to ensure appropriate designation, operation, and
411 infrastructure in special needs shelters. County health
412 departments shall assist the local emergency management agency
413 with regard to the management of medical services in special
414 needs shelters. However, nothing in this section prohibits a
415 county health department from entering into an alternative

416 agreement with a local emergency management agency to assume the
417 lead responsibility for special needs shelter supplies and
418 equipment.
419 (e) Any state employee with a preestablished role in
420 disaster response that has been designated by the employing
421 agency is subject to serve in times of disaster in a capacity
422 that is commensurate with the employee's knowledge, skills, and
423 abilities and to participate in any needed activities related to
424 the disaster unless the employee has other mandated response
425 activities that preclude participation.
426 (f) The Secretary of Elderly Affairs, or his or her
427 designee, shall convene, at any time that he or she deems
428 appropriate and necessary, a multiagency special needs shelter
429 discharge planning team or teams to assist local areas that are
430 severely impacted by a natural or manmade disaster that requires
431 the use of special needs shelters. Multiagency special needs
432 shelter discharge planning teams shall provide assistance to
433 local emergency management agencies with the continued operation
434 or closure of the shelters, as well as with the discharge of
435 special needs clients to alternate facilities if necessary.
436 Local emergency management agencies may request the assistance
437 of a multiagency special needs shelter discharge planning team
438 by alerting statewide emergency management officials of the
439 necessity for additional assistance in their area. The Secretary
440 of Elderly Affairs is encouraged to proactively work with other
441 state agencies prior to any natural disasters for which warnings
442 are provided to ensure that multiagency special needs shelter
443 discharge planning teams are ready to assemble and deploy

444 rapidly upon a determination by state emergency management
445 officials that a disaster area requires additional assistance.
446 The Secretary of Elderly Affairs may call upon any state agency
447 or office to provide staff to assist a multiagency special needs
448 shelter discharge planning team or teams. Unless the secretary
449 determines that the nature or circumstances surrounding the
450 disaster do not warrant participation from a particular agency's
451 staff, each multiagency special needs shelter discharge planning
452 team shall include at least one representative from each of the
453 following state agencies:
454 1. Department of Elderly Affairs.
455 2. Department of Health.
456 3. Department of Children and Family Services.
457 4. Department of Veterans' Affairs.
458 5. Department of Community Affairs.
459 6. Agency for Health Care Administration.
460 7. Agency for Persons with Disabilities.
461 (3) REIMBURSEMENT TO HEALTH CARE PRACTITIONERS AND
462 FACILITIES.--
463 (a) The Department of Health shall upon request reimburse,
464 subject to the availability of funds for this purpose, health
465 care practitioners, as defined in s. 456.001, provided the
466 practitioner is not providing care to a patient under an
467 existing contract, and emergency medical technicians and
468 paramedics licensed under ~~pursuant to~~ chapter 401 for medical
469 care provided at the request of the department in special needs
470 shelters or at other locations during times of emergency or a
471 declared ~~major~~ disaster. Reimbursement for health care

472 practitioners, except for physicians licensed under ~~pursuant to~~
473 chapter 458 or chapter 459, shall be based on the average hourly
474 rate that such practitioners were paid according to the most
475 recent survey of Florida hospitals conducted by the Florida
476 Hospital Association or other nationally or state recognized
477 data source. Reimbursement shall be requested on forms prepared
478 by the Department of Health and shall be paid as specified in
479 paragraph (c).
480 (b) If, upon closure of a special needs shelter, a
481 multiagency special needs shelter discharge planning team
482 determines that it is necessary to discharge persons with
483 special needs to other health care facilities, such as
484 hospitals, nursing homes, assisted living facilities, and
485 community residential homes, the receiving facilities shall be
486 eligible for reimbursement for services provided to the
487 individuals for up to 90 days. Any facility eligible for
488 reimbursement under this paragraph shall submit invoices for
489 reimbursement on forms developed by the department. A facility
490 must show proof of a written request from a representative of an
491 agency serving on the multiagency special needs shelter
492 discharge planning team that the individual for whom the
493 facility is seeking reimbursement for services rendered was
494 referred to that facility from a special needs shelter. The
495 department shall specify by rule which expenses are reimbursable
496 and the rate of reimbursement for each service. Reimbursement
497 for the services described in this paragraph shall be paid as
498 specified in paragraph (c).

499 (c) If a Presidential Disaster Declaration has been issued
500 ~~made~~, and the Federal Government makes funds available, the
501 department shall request federal ~~use such funds for~~
502 reimbursement of eligible expenditures. In other situations, or
503 if federal funds do not fully compensate the department for
504 reimbursements permissible under ~~reimbursement made pursuant to~~
505 this section, the department shall process a budget amendment to
506 obtain reimbursement from unobligated, unappropriated moneys in
507 the General Revenue Fund. The department shall not provide
508 reimbursement to facilities under this subsection for services
509 provided to a person with special needs if, during the period of
510 time in which the services were provided, the individual was
511 enrolled in another state-funded program, such as Medicaid or
512 another similar program, was covered under a policy of health
513 insurance as defined in s. 624.603, or was a member of a health
514 maintenance organization or prepaid health clinic as defined in
515 chapter 641, which would otherwise pay for the same services.
516 Travel expense and per diem costs shall be reimbursed pursuant
517 to s. 112.061.
518 (4) HEALTH CARE PRACTITIONER REGISTRY.--The department may
519 use the registries established in ss. 401.273 and 456.38 when
520 health care practitioners are needed to staff special needs
521 shelters or to assist with other disaster-related activities
522 ~~staff disaster medical assistance teams~~.
523 (5) SPECIAL NEEDS SHELTER INTERAGENCY COMMITTEE.--The
524 Secretary ~~Department~~ of Health may establish a special needs
525 shelter interagency committee and serve as or appoint a designee
526 to serve as the committee's chair. The department shall provide

527 any necessary staff and resources to support the committee in
528 the performance of its duties~~, to be chaired and staffed by the~~
529 ~~department~~. The committee shall address and resolve problems
530 related to special needs shelters not addressed in the state
531 comprehensive emergency medical plan and shall consult on ~~serve~~
532 ~~as an oversight committee to monitor~~ the planning and operation
533 of special needs shelters.
534 (a) The committee shall ~~may~~:
535 1. Develop, ~~and~~ negotiate, and regularly review any
536 necessary interagency agreements.
537 2. Undertake other such activities as the department deems
538 necessary to facilitate the implementation of this section.
539 3. Submit recommendations to the Legislature as necessary.
540 (b) The special needs shelter interagency committee shall
541 be composed of representatives of emergency management, health,
542 medical, and social services organizations. Membership shall
543 include, but shall not be limited to, representatives of the
544 Departments of Health, Community Affairs, Children and Family
545 Services, Elderly Affairs, ~~Labor and Employment Security,~~ and
546 Education; the Agency for Health Care Administration; the
547 Florida Medical Association; the Florida Osteopathic Medical
548 Association; Associated Home Health Industries of Florida, Inc.;
549 the Florida Nurses Association; the Florida Health Care
550 Association; the Florida Assisted Living Affiliation
551 ~~Association~~; the Florida Hospital Association; the Florida
552 Statutory Teaching Hospital Council; the Florida Association of
553 Homes for the Aging; the Florida Emergency Preparedness
554 Association; the American Red Cross; Florida Hospices and

555 Palliative Care, Inc.; the Association of Community Hospitals
556 and Health Systems; the Florida Association of Health
557 Maintenance Organizations; the Florida League of Health Systems;
558 Private Care Association; ~~and~~ the Salvation Army; the Florida
559 Association of Aging Services Providers; AARP; and the Florida
560 Renal Coalition.
561 (c) Meetings of the committee shall be held in
562 Tallahassee, and members of the committee shall serve at the
563 expense of the agencies or organizations they represent. The
564 committee shall make every effort to use teleconference or video
565 conference capabilities in order to ensure statewide input and
566 participation.
567 (6) RULES.--The department has the authority to adopt
568 rules necessary to implement this section. Rules shall ~~may~~
569 include:
570 (a) The ~~a~~ definition of a "person with special needs",
571 including eligibility criteria for individuals with physical,
572 mental, cognitive impairment, or sensory disabilities and the
573 services a person with special needs can expect to receive in a
574 special needs shelter ~~patient, specify physician reimbursement,~~
575 ~~and designate which county health departments will have~~
576 ~~responsibility for implementation of subsections (2) and (3)~~.
577 (b) The process for special needs shelter health care
578 practitioners and facility reimbursement for services provided
579 in a disaster.
580 (c) Guidelines for special needs shelter staffing levels
581 to provide services.

582 (d) The definition of and standards for special needs
583 shelter supplies and equipment, including durable medical
584 equipment.
585 (e) Compliance with applicable laws relating to service
586 animals.
587 (f) Standards for the special needs shelter registration
588 process, including guidelines for addressing the needs of
589 unregistered persons in need of a special needs shelter.
590 (g) Standards for addressing the needs of families where
591 only one dependent is eligible for admission to a special needs
592 shelter and the needs of adults with special needs who are
593 caregivers for individuals without special needs.
594 (h) The requirement of the county health departments to
595 seek the participation of hospitals, nursing homes, assisted
596 living facilities, home health agencies, hospice providers,
597 nurse registries, home medical equipment providers, dialysis
598 centers, and other health and medical emergency preparedness
599 stakeholders in preevent planning activities.
600 (7) ~~REVIEW OF~~ EMERGENCY MANAGEMENT PLANS; CONTINUITY OF
601 CARE.--Each emergency management plan submitted to a county
602 health department by a home health agency under s. 400.492, by a
603 nurse registry pursuant to s. 400.506(16)(e), by a hospice
604 pursuant to s. 400.610(1)(b), or by a home medical equipment
605 provider pursuant to s. 400.934(20)(a) shall specify the means
606 by which the home health agency, nurse registry, hospice, or
607 home medical equipment provider will continue to provide staff
608 and equipment to perform the same type and quantity of services
609 for their patients who evacuate to special needs shelters that

610 were being provided to those patients prior to evacuation. The
611 submission of emergency management plans to county health
612 departments by home health agencies, ~~pursuant to s.~~
613 ~~400.497(8)(c) and (d) and by~~ nurse registries, ~~pursuant to s.~~
614 ~~400.506(16)(e) and by~~ hospice programs, ~~pursuant to s.~~
615 ~~400.610(1)(b)~~ and home medical equipment providers is
616 conditional upon the receipt of an appropriation by the
617 department to establish ~~medical services~~ disaster coordinator
618 positions in county health departments unless the secretary of
619 the department and a local county commission jointly determine
620 to require such plans to be submitted based on a determination
621 that there is a special need to protect public health in the
622 local area during an emergency.
623 Section 6. Section 400.492, Florida Statutes, is amended
624 to read:
625 400.492 Provision of services during an emergency.--Each
626 home health agency shall prepare and maintain a comprehensive
627 emergency management plan that is consistent with the standards
628 adopted by national or state accreditation organizations and
629 consistent with the local special needs plan. The plan shall be
630 updated annually and shall provide for continuing home health
631 services during an emergency that interrupts patient care or
632 services in the patient's home. The plan shall include the means
633 by which the home health agency will continue to provide staff
634 to perform the same type and quantity of services to their
635 patients who evacuate to special needs shelters that were being
636 provided to those patients prior to evacuation. The plan shall
637 describe how the home health agency establishes and maintains an

638 effective response to emergencies and disasters, including:
639 notifying staff when emergency response measures are initiated;
640 providing for communication between staff members, county health
641 departments, and local emergency management agencies, including
642 a backup system; identifying resources necessary to continue
643 essential care or services or referrals to other organizations
644 subject to written agreement; and prioritizing and contacting
645 patients who need continued care or services.
646 (1) Each patient record for patients who are listed in the
647 registry established pursuant to s. 252.355 shall include a
648 description of how care or services will be continued in the
649 event of an emergency or disaster. The home health agency shall
650 discuss the emergency provisions with the patient and the
651 patient's caregivers, including where and how the patient is to
652 evacuate, procedures for notifying the home health agency in the
653 event that the patient evacuates to a location other than the
654 shelter identified in the patient record, and a list of
655 medications and equipment which must either accompany the
656 patient or will be needed by the patient in the event of an
657 evacuation.
658 (2) Each home health agency shall maintain a current
659 prioritized list of patients who need continued services during
660 an emergency. The list shall indicate how services shall be
661 continued in the event of an emergency or disaster for each
662 patient and if the patient is to be transported to a special
663 needs shelter, and shall indicate if the patient is receiving
664 skilled nursing services and the patient's medication and
665 equipment needs. The list shall be furnished to county health

666 departments and to local emergency management agencies, upon
667 request.
668 (3) Home health agencies shall not be required to continue
669 to provide care to patients in emergency situations that are
670 beyond their control and that make it impossible to provide
671 services, such as when roads are impassable or when patients do
672 not go to the location specified in their patient records. Home
673 health agencies may establish links to local emergency
674 operations centers to determine a mechanism to approach specific
675 areas within a disaster area in order for the agency to reach
676 its clients. The presentation of a home health agency client to
677 a special needs shelter without the home health agency making a
678 good faith effort to provide services in the shelter setting
679 shall be considered abandonment of the client and constitutes a
680 class II deficiency, subject to sanctions provided in s.
681 400.484(2)(b). For purposes of this section, "good faith effort"
682 may be demonstrated by documented attempts of staff to follow
683 procedures as outlined in the home health agency's comprehensive
684 emergency management plan, and by the patient's record, which
685 support a finding that continuing care has been provided for
686 those patients who have been identified as needing care by the
687 home health agency in the event of an emergency or disaster
688 under subsection (1).
689 (4) Notwithstanding the provisions of s. 400.464(2) or any
690 other provision of law to the contrary, a home health agency may
691 provide services in a special needs shelter located in any
692 county.

693 Section 7. Paragraphs (c) and (d) of subsection (8) of
694 section 400.497, Florida Statutes, are amended to read:
695 400.497 Rules establishing minimum standards.--The agency
696 shall adopt, publish, and enforce rules to implement this part,
697 including, as applicable, ss. 400.506 and 400.509, which must
698 provide reasonable and fair minimum standards relating to:
699 (8) Preparation of a comprehensive emergency management
700 plan pursuant to s. 400.492.
701 (c) The plan is subject to review and approval by the
702 county health department. During its review, the county health
703 department shall contact state and local health and medical
704 stakeholders during its review when necessary. ~~ensure that the~~
705 ~~following agencies, at a minimum, are given the opportunity to~~
706 ~~review the plan:~~
707 ~~1. The local emergency management agency.~~
708 ~~2. The Agency for Health Care Administration.~~
709 ~~3. The local chapter of the American Red Cross or other~~
710 ~~lead sheltering agency.~~
711 ~~4. The district office of the Department of Children and~~
712 ~~Family Services.~~
713
714 The county health department shall complete its review to ensure
715 that the plan is in accordance with the criteria set forth in
716 the rules of the Agency for Health Care Administration within 90
717 ~~60~~ days after receipt of the plan and shall either approve the
718 plan or advise the home health agency of necessary revisions. If
719 the home health agency fails to submit a plan or fails to submit
720 the requested information or revisions to the county health

721 department within 30 days after written notification from the
722 county health department, the county health department shall
723 notify the Agency for Health Care Administration. The agency
724 shall notify the home health agency that such failure
725 constitutes a deficiency, subject to a fine of $5,000 per
726 occurrence. If the plan is not submitted, information is not
727 provided, or revisions are not made as requested, the agency may
728 impose the fine.
729 (d) For any home health agency that operates in more than
730 one county, the Department of Health shall review the plan,
731 after consulting with state and local health and medical
732 stakeholders, when necessary ~~all of the county health~~
733 ~~departments, the agency, and all the local chapters of the~~
734 ~~American Red Cross or other lead sheltering agencies in the~~
735 ~~areas of operation for that particular home health agency~~. The
736 department ~~of Health~~ shall complete its review within 90 days
737 after receipt of the plan and shall either approve the plan or
738 advise the home health agency of necessary revisions. The
739 department ~~of Health~~ shall make every effort to avoid imposing
740 differing requirements on a home health agency that operates in
741 more than one county as a result of differing or conflicting
742 comprehensive plan requirements of the ~~based on differences~~
743 ~~between~~ counties in which ~~on~~ the home health agency operates.
744 Section 8. Subsection (16) of section 400.506, Florida
745 Statutes, is amended to read:
746 400.506 Licensure of nurse registries; requirements;
747 penalties.--

748 (16) Each nurse registry shall prepare and maintain a
749 comprehensive emergency management plan that is consistent with
750 the criteria in this subsection and with the local special needs
751 plan. The plan shall be updated annually. The plan shall include
752 the means by which the nurse registry will continue to provide
753 staff to perform the same type and quantity of services to their
754 patients who evacuate to special needs shelters that were being
755 provided to those patients prior to evacuation. The plan shall
756 specify how the nurse registry shall facilitate the provision of
757 continuous care by persons referred for contract to persons who
758 are registered pursuant to s. 252.355 during an emergency that
759 interrupts the provision of care or services in private
760 residencies. Nurse registries may establish links to local
761 emergency operations centers to determine a mechanism to
762 approach specific areas within a disaster area in order for a
763 provider to reach its clients. The presentation of nurse
764 registry clients to a special needs shelter without the nurse
765 registry provider making a good faith effort to provide services
766 in the shelter setting shall be considered abandonment of the
767 patient and constitutes a class II deficiency, subject to
768 sanctions provided in s. 400.484(2)(b). For purposes of this
769 section, "good faith effort" may be demonstrated by documented
770 attempts of staff to follow procedures as outlined in the nurse
771 registry's comprehensive emergency management plan which support
772 a finding that continuing care has been provided for those
773 patients who have been identified as needing care by the nurse
774 registry in the event of an emergency under s. 400.506(1).

775 (a) All persons referred for contract who care for persons
776 registered pursuant to s. 252.355 must include in the patient
777 record a description of how care will be continued during a
778 disaster or emergency that interrupts the provision of care in
779 the patient's home. It shall be the responsibility of the person
780 referred for contract to ensure that continuous care is
781 provided.
782 (b) Each nurse registry shall maintain a current
783 prioritized list of patients in private residences who are
784 registered pursuant to s. 252.355 and are under the care of
785 persons referred for contract and who need continued services
786 during an emergency. This list shall indicate, for each patient,
787 if the client is to be transported to a special needs shelter
788 and if the patient is receiving skilled nursing services. Nurse
789 registries shall make this list available to county health
790 departments and to local emergency management agencies upon
791 request.
792 (c) Each person referred for contract who is caring for a
793 patient who is registered pursuant to s. 252.355 shall provide a
794 list of the patient's medication and equipment needs to the
795 nurse registry. Each person referred for contract shall make
796 this information available to county health departments and to
797 local emergency management agencies upon request.
798 (d) Each person referred for contract shall not be
799 required to continue to provide care to patients in emergency
800 situations that are beyond the person's control and that make it
801 impossible to provide services, such as when roads are

802 impassable or when patients do not go to the location specified
803 in their patient records.
804 (e) The comprehensive emergency management plan required
805 by this subsection is subject to review and approval by the
806 county health department. During its review, the county health
807 department shall contact state and local health and medical
808 stakeholders, when necessary ~~ensure that, at a minimum, the~~
809 ~~local emergency management agency, the Agency for Health Care~~
810 ~~Administration, and the local chapter of the American Red Cross~~
811 ~~or other lead sheltering agency are given the opportunity to~~
812 ~~review the plan~~. The county health department shall complete its
813 review to ensure that the plan is in accordance with the
814 criteria set forth in the rules of the Agency for Health Care
815 Administration within 90 ~~60~~ days after receipt of the plan and
816 shall either approve the plan or advise the nurse registry of
817 necessary revisions. If a nurse registry fails to submit a plan
818 or fails to submit requested information or revisions to the
819 county health department within 30 days after written
820 notification from the county health department, the county
821 health department shall notify the Agency for Health Care
822 Administration. The agency shall notify the nurse registry that
823 such failure constitutes a deficiency, subject to a fine of
824 $5,000 per occurrence. If the plan is not submitted, information
825 is not provided, or revisions are not made as requested, the
826 agency may impose the fine.
827 (f) The Department of Health shall review the
828 comprehensive emergency management plan of any nurse registry
829 that operates in more than one county. The department shall

830 complete its review within 90 days after receipt of the plan and
831 shall either approve the plan or advise the nurse registry of
832 necessary revisions. The department shall make every effort to
833 avoid imposing differing requirements on nurse registries that
834 operate in more than one county as a result of differing or
835 conflicting comprehensive plan requirements of the counties in
836 which the nurse registry operates.
837 (g) ~~(f)~~ The Agency for Health Care Administration shall
838 adopt rules establishing minimum criteria for the comprehensive
839 emergency management plan and plan updates required by this
840 subsection, with the concurrence of the Department of Health and
841 in consultation with the Department of Community Affairs.
842 Section 9. Paragraph (b) of subsection (1) of section
843 400.610, Florida Statutes, is amended to read:
844 400.610 Administration and management of a hospice.--
845 (1) A hospice shall have a clearly defined organized
846 governing body, consisting of a minimum of seven persons who are
847 representative of the general population of the community
848 served. The governing body shall have autonomous authority and
849 responsibility for the operation of the hospice and shall meet
850 at least quarterly. The governing body shall:
851 (b)1. Prepare and maintain a comprehensive emergency
852 management plan that provides for continuing hospice services in
853 the event of an emergency that is consistent with local special
854 needs plans. The plan shall include provisions for ensuring
855 continuing care to hospice patients who go to special needs
856 shelters. The plan shall include the means by which the hospice
857 provider will continue to provide staff to perform the same type

858 and quantity of services to their patients who evacuate to
859 special needs shelters that were being provided to those
860 patients prior to evacuation. The plan is subject to review and
861 approval by the county health department, except as provided in
862 subparagraph 2. During its review, the county health department
863 shall contact state and local health and medical stakeholders,
864 when necessary ~~ensure that the department, the agency, and the~~
865 ~~local chapter of the American Red Cross or other lead sheltering~~
866 ~~agency have an opportunity to review and comment on the plan~~.
867 The county health department shall complete its review to ensure
868 that the plan is in accordance with the criteria set forth in
869 the rules of the Department of Elderly Affairs within 90 ~~60~~ days
870 after receipt of the plan and shall either approve the plan or
871 advise the hospice of necessary revisions. Hospice providers may
872 establish links to local emergency operations centers to
873 determine a mechanism to approach specific areas within a
874 disaster area in order for the provider to reach its clients.
875 The presentation of hospice clients to a special needs shelter
876 without the hospice provider making a good faith effort to
877 provide services in the shelter setting shall be considered
878 abandonment of the client subject to sanction as provided by law
879 or rule. For the purposes of this section, "good faith effort"
880 may be demonstrated by documented attempts of staff to follow
881 procedures as outlined in the hospice's comprehensive emergency
882 management plan and to provide continuing care for those hospice
883 clients who have been identified as needing alternative
884 caregiver services in the event of an emergency.

885 2. For any hospice that operates in more than one county,
886 the Department of Health during its review shall contact state
887 and local health and medical stakeholders, when necessary ~~review~~
888 ~~the plan, after consulting with all of the county health~~
889 ~~departments, the agency, and all the local chapters of the~~
890 ~~American Red Cross or other lead sheltering agency in the areas~~
891 ~~of operation for that particular hospice~~. The Department of
892 Health shall complete its review to ensure that the plan is in
893 accordance with the criteria set forth in the rules of the
894 Department of Elderly Affairs within 90 days after receipt of
895 the plan and shall either approve the plan or advise the hospice
896 of necessary revisions. The Department of Health shall make
897 every effort to avoid imposing ~~on the hospice~~ differing
898 requirements on a hospice that operates in more than one county
899 as a result of differing or conflicting comprehensive plan
900 requirements of the ~~based on differences between~~ counties in
901 which the hospice operates.
902 Section 10. Subsections (13) through (16) of section
903 400.925, Florida Statutes, are renumbered as subsections (14)
904 through (17), respectively, and a new subsection (13) is added
905 to that section to read:
906 400.925 Definitions.--As used in this part, the term:
907 (13) "Life-supporting or life-sustaining equipment" means
908 a device that is essential to, or that yields information that
909 is essential to, the restoration or continuation of a bodily
910 function important to the continuation of human life. Life-
911 supporting or life-sustaining equipment includes apnea monitors,
912 enteral feeding pumps, infusion pumps, portable home dialysis

913 equipment, and ventilator equipment and supplies for all related
914 equipment, including oxygen equipment and related respiratory
915 equipment.
916 Section 11. Subsections (20), (21), and (22) are added to
917 section 400.934, Florida Statutes, to read:
918 400.934 Minimum standards.--As a requirement of licensure,
919 home medical equipment providers shall:
920 (20)(a) Prepare and maintain a comprehensive emergency
921 management plan that meets minimum criteria established by the
922 agency in rule under s. 400.935. The plan shall be updated
923 annually and shall provide for continuing home medical equipment
924 services for life-supporting or life-sustaining equipment, as
925 defined in 400.925, during an emergency that interrupts home
926 medical equipment services in a patient's home. The plan shall
927 include:
928 1. The means by which the home medical equipment provider
929 will continue to provide equipment to perform the same type and
930 quantity of services to its patients who evacuate to special
931 needs shelters that were being provided to those patients prior
932 to evacuation.
933 2. The means by which the home medical equipment provider
934 establishes and maintains an effective response to emergencies
935 and disasters, including plans for:
936 a. Notification of staff when emergency response measures
937 are initiated.
938 b. Communication between staff members, county health
939 departments, and local emergency management agencies, which
940 shall include provisions for a backup communications system.

941 c. Identification of resources necessary to continue
942 essential care or services or referrals to other organizations
943 subject to written agreement.
944 d. Contacting and prioritizing patients in need of
945 continued medical equipment services and supplies.
946 (b) The plan is subject to review and approval by the
947 county health department. During its review, the county health
948 department shall contact state and local health and medical
949 stakeholders, when necessary. The county health department shall
950 complete its review to ensure that the plan is in accordance
951 with the criteria set forth in the rules of the Agency for
952 Health Care Administration within 90 days after receipt of the
953 plan. If a home medical equipment provider fails to submit a
954 plan or fails to submit requested information or revisions to
955 the county health department within 30 days after written
956 notification from the county health department, the county
957 health department shall notify the Agency for Health Care
958 Administration. The agency shall notify the home medical
959 equipment provider that such failure constitutes a deficiency,
960 subject to a fine of $5,000 per occurrence. If the plan is not
961 submitted, information is not provided, or revisions are not
962 made as requested, the agency may impose the fine.
963 (c) The Department of Health shall review the
964 comprehensive emergency management plan of any home medical
965 equipment provider that operates in more than one county. The
966 department shall complete its review within 90 days after
967 receipt of the plan and shall either approve the plan or advise
968 the home medical equipment provider of necessary revisions. The

969 department shall make every effort to avoid imposing differing
970 requirements on home medical equipment providers that operate in
971 more than one county as a result of differing or conflicting
972 comprehensive plan requirements of the counties in which the
973 home medical equipment provider operates.
974 (21) Each home medical equipment provider shall maintain a
975 current prioritized list of patients who need continued services
976 during an emergency. The list shall indicate the means by which
977 services shall be continued for each patient in the event of an
978 emergency or disaster, whether the patient is to be transported
979 to a special needs shelter, and whether the patient has life-
980 supporting or life-sustaining equipment, including the specific
981 type of equipment and related supplies. The list shall be
982 furnished to county health departments and local emergency
983 management agencies, upon request.
984 (22) Home medical equipment providers may establish links
985 to local emergency operations centers to determine a mechanism
986 to approach specific areas within a disaster area in order for
987 the provider to reach its patients.
988 Section 12. Subsection (11) is added to section 400.935,
989 Florida Statutes, to read:
990 400.935 Rules establishing minimum standards.--The agency
991 shall adopt, publish, and enforce rules to implement this part,
992 which must provide reasonable and fair minimum standards
993 relating to:
994 (11) Preparation of the comprehensive emergency management
995 plan under s. 400.934 and the establishment of minimum criteria
996 for the plan, including the maintenance of patient equipment and

997 supply lists that can accompany patients who are transported
998 from their homes. Such rules shall be formulated in consultation
999 with the Department of Health and the Department of Community
1000 Affairs.
1001 Section 13. Section 408.831, Florida Statutes, is amended
1002 to read:
1003 408.831 Denial, suspension, or revocation of a license,
1004 registration, certificate, or application.--
1005 (1) In addition to any other remedies provided by law, the
1006 agency may deny each application or suspend or revoke each
1007 license, registration, or certificate of entities regulated or
1008 licensed by it:
1009 (a) If the applicant, licensee, registrant, or
1010 certificateholder, or, in the case of a corporation,
1011 partnership, or other business entity, if any officer, director,
1012 agent, or managing employee of that business entity or any
1013 affiliated person, partner, or shareholder having an ownership
1014 interest equal to 5 percent or greater in that business entity,
1015 has failed to pay all outstanding fines, liens, or overpayments
1016 assessed by final order of the agency or final order of the
1017 Centers for Medicare and Medicaid Services, not subject to
1018 further appeal, unless a repayment plan is approved by the
1019 agency; or
1020 (b) For failure to comply with any repayment plan.
1021 (2) In reviewing any application requesting a change of
1022 ownership or change of the licensee, registrant, or
1023 certificateholder, the transferor shall, prior to agency
1024 approval of the change, repay or make arrangements to repay any

1025 amounts owed to the agency. Should the transferor fail to repay
1026 or make arrangements to repay the amounts owed to the agency,
1027 the issuance of a license, registration, or certificate to the
1028 transferee shall be delayed until repayment or until
1029 arrangements for repayment are made.
1030 (3) Entities subject to this section may exceed their
1031 licensed capacity to act as a receiving facility in accordance
1032 with an emergency operations plan for clients of evacuating
1033 providers from a geographic area where an evacuation order has
1034 been issued by a local authority having jurisdiction. While in
1035 an overcapacity status, each provider must furnish or arrange
1036 for appropriate care and services to all clients. In addition,
1037 the agency may approve requests for overcapacity beyond 15 days,
1038 which approvals may be based upon satisfactory justification and
1039 need as provided by the receiving and sending facility.
1040 (4) An inactive license may be issued to a licensee
1041 subject to this section when the provider is located in a
1042 geographic area where a state of emergency was declared by the
1043 Governor if the provider:
1044 (a) Suffered damage to the provider's operation during
1045 that state of emergency.
1046 (b) Is currently licensed.
1047 (c) Does not have a provisional license.
1048 (d) Will be temporarily unable to provide services but is
1049 reasonably expected to resume services within 12 months.
1050
1051 An inactive license may be issued for a period not to exceed 12
1052 months but may be renewed by the agency for up to 6 additional

1053 months upon demonstration to the agency of progress toward
1054 reopening. A request by a licensee for an inactive license or to
1055 extend the previously approved inactive period must be submitted
1056 in writing to the agency, accompanied by written justification
1057 for the inactive license which states the beginning and ending
1058 dates of inactivity and includes a plan for the transfer of any
1059 clients to other providers and appropriate licensure fees. Upon
1060 agency approval, the licensee shall notify clients of any
1061 necessary discharge or transfer as required by authorizing
1062 statutes or applicable rules. The beginning of the inactive
1063 licensure period shall be the date the provider ceases
1064 operations. The end of the inactive period shall become the
1065 licensee expiration date, and all licensure fees must be
1066 current, paid in full, and may be prorated. Reactivation of an
1067 inactive license requires the prior approval by the agency of a
1068 renewal application, including payment of licensure fees and
1069 agency inspections indicating compliance with all requirements
1070 of this part and applicable rules and statutes.
1071 (5) ~~(3)~~ This section provides standards of enforcement
1072 applicable to all entities licensed or regulated by the Agency
1073 for Health Care Administration. This section controls over any
1074 conflicting provisions of chapters 39, 381, 383, 390, 391, 393,
1075 394, 395, 400, 408, 468, 483, and 641 or rules adopted pursuant
1076 to those chapters.
1077 Section 14. The Legislature finds that all designated
1078 public special needs hurricane evacuation shelters should be
1079 equipped with permanent emergency power generating capacity to
1080 provide the necessary equipment, heating, ventilation, and air-

1081 conditioning to meet the medical needs of patients by June 1,
1082 2007. The Department of Community Affairs shall work with local
1083 communities to ensure that there is a sufficient number of
1084 public special needs shelters designated to meet the anticipated
1085 demand based on best available data as determined by the
1086 department and the Department of Health. Local match for these
1087 projects shall be no less than 25 percent of project cost. There
1088 is hereby appropriated $21.5 million from the U.S. Contributions
1089 Trust Fund in fixed capital outlay to the Department of
1090 Community Affairs to establish a competitive award process to
1091 implement this section. No more than 5 percent of the funds
1092 provided under this section may be used by the department for
1093 administration of the funding.
1094 Section 15. The Legislature finds that retrofitting public
1095 hurricane evacuation shelters is an efficient and economical
1096 method of accelerating the state and local efforts to reduce the
1097 shelter deficit. Criteria for the retrofitting of a public
1098 hurricane evacuation shelter shall include, but not be limited
1099 to, the project's ability to meet the structural and siting
1100 requirements of American Red Cross Standard ARC 4496,
1101 "Guidelines for Hurricane Evacuation Shelter Selection," once
1102 completed; the shelter needs for the local government, as well
1103 as the overall needs of the hurricane evacuation planning
1104 region; the cost-effectiveness of the project in terms of the
1105 number of public hurricane evacuation spaces; and the priority
1106 ranking of the proposed project in the applicable local
1107 mitigation strategy. There is hereby appropriated $9 million
1108 from the U.S. Contributions Trust Fund in fixed capital outlay

1109 to the Department of Community Affairs to establish a
1110 competitive award process to implement this section. No more
1111 than 5 percent of the funds provided under this section may be
1112 used by the department for administration of this funding.
1113 Section 16. For the 2006-2007 fiscal year, the sums of
1114 $896,799 from recurring general revenue funds and $104,156 from
1115 nonrecurring general revenue funds are appropriated, and 20
1116 full-time equivalent positions are authorized at 872,644 salary
1117 rate, to implement the provisions of emergency management plan
1118 reviews for home health agencies and nurse registry, hospice,
1119 and home medical equipment providers.
1120 Section 17. This act shall take effect July 1, 2006.

HB 7203

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7203 CS PCB HCR 06-07 Obesity
SPONSOR(S): Health Care Regulation Committee
TIED BILLS: **IDEN./SIM. BILLS:** 1324

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health Care Regulation Committee	9 Y, 0 N	Bell	Mitchell
1) PreK-12 Committee	11 Y, 0 N, w/CS	Mizereck	Mizereck
2) Health Care Appropriations Committee	12 Y, 0 N, w/CS	Money	Massengale
3) Health & Families Council		Bell AJB	Moore MM
4)			
5)			

SUMMARY ANALYSIS

House Bill 7203 CS addresses the issue of obesity in Florida. In 2000, more than six and a half million Florida adults were overweight or obese based on self-reported height and weight; and of those, approximately 2.5 million adults were obese. Its implications include serious health consequences such as diabetes, coronary heart disease, high blood pressure, high cholesterol, osteoarthritis, sleep disturbances and breathing problems, and certain cancers.

The bill requires the Department of Health (DOH or department), in addition to its current health promotion and prevention activities, to:

- Collaborate with other state agencies to develop policies and strategies for preventing obesity, which must be incorporated into programs administered by each agency and which must include promoting healthy lifestyles of employees of each agency.
- Advise Florida-licensed health care practitioners regarding the morbidity, mortality, and costs associated with the conditions of being overweight or obese, inform such practitioners of clinical best practices for preventing obesity, and encourage practitioners to counsel their patients regarding the adoption of healthy lifestyles.

According to the Department of Health, the bill will have no significant fiscal impact on state government.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote Limited Government - The bill directs the Department of Health to work with all the state agencies to offer wellness programming to employees and advise health care practitioners to provide healthy lifestyle recommendations to their patients.

Empower Families - Obesity is a serious risk factor for diabetes, heart disease, stroke, asthma, and many other chronic diseases. Early obesity interventions improve quality and quantity of life.

B. EFFECT OF PROPOSED CHANGES:

CURRENT SITUATION

The Prevalence of Obesity

The prevalence of obesity doubled in the past few decades. Today, approximately 129 million U.S. adults are considered obese. The number of overweight and obese persons in the country surpasses the number of people who smoke, live in poverty, or drink heavily. The U.S. Surgeon General recognized in 2001 that overweight and obesity have reached epidemic proportions in America.[1] An "epidemic" is defined as any disease occurring at a greater frequency than usually expected. Although historically the term "epidemic" referred to occurrences of infectious diseases, the definition has evolved to include chronic diseases and conditions such as obesity.

Defining & Measuring Overweight and Obesity

Overweight and obesity are both labels for ranges of weight that are greater than what is generally considered healthy for a given height. For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the "body mass index" (BMI). The BMI is calculated by dividing weight in pounds by height in inches squared, then multiplying the quotient by 703. An adult who has a BMI between 24 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. For children and teens, BMI ranges above a normal weight have different labels (at risk of overweight and overweight). Additionally, BMI ranges for children and teens are defined so that they take into account normal differences in body fat between boys and girls and differences in body fat at various ages.

Florida Statistics on Obesity and Overweight

In 2000, more than six and a half million Florida adults[2] were overweight or obese based on self-reported height and weight; and of those, approximately 2.5 million adults were obese. Since 1986, when height and weight were first monitored in Florida's adult population, overweight increased from 35.3 percent of the adult population in 1986 to 57.4 percent in 2002 to 60 percent in 2004.[3] The

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[1] U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001].

[2] Most of Florida data comes from the Behavioral Risk Factor Surveillance System (BRFSS). This is an on-going, state-based, random-digit dialed telephone survey of the general civilian population aged 18 and older. Youth Physical Activity and Nutrition Survey (YPANS) are used for data on physical activity, nutrition, and sedentary lifestyles among public middle school students, and the Florida Youth Behavior Survey (YRBS) is used to collect similar data among high school students.

[3] CDC BRFSS 2004 data. http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/florida.htm

prevalence of obesity has increased dramatically among both men and women between 1990 and 2002; for men the prevalence of obesity has increased 61 percent, and among women, the prevalence has increased 27 percent.

The BMI is also used to identify children who are overweight or who are at risk of becoming overweight.[4] In 2004, approximately 12.4 percent of Florida's high school students were considered overweight, with the rates for boys (16.5 percent) nearly doubling that of girls (8.1 percent). An additional 14 percent of Florida's high school students were considered at risk of overweight, with similar trends between boys (14.6 percent) and girls (13.4 percent). In 2002, nearly one-third of students in kindergarten, third, sixth, and ninth grades were significantly above their ideal weights.

Health Costs of Obesity & Overweight

Obesity is second only to tobacco use as a threat to public health. Its implications include serious health consequences such as diabetes, coronary heart disease, high blood pressure, high cholesterol, osteoarthritis, sleep disturbances and breathing problems, and certain cancers. Further studies conclude that obesity is linked to higher rates of chronic health conditions than smoking, drinking or poverty.[5] The U.S. Surgeon General reports that 300,000 deaths per year are attributed to obesity. The problem of obesity is especially dangerous for children. The adverse health conditions that typically occur in adults are becoming more prevalent in adolescents, and these conditions in childhood lead to chronic illness. One out of four children, who are overweight, show early signs of type 2 diabetes.[6] Overweight children are far more likely to become overweight adults than children who maintain normal weight through adolescence.[7]

Economic Cost of Obesity & Overweight

The U.S. Surgeon General announced that obesity and overweight cost U.S. taxpayers $117 billion per year in direct health care costs and indirect costs such as lost wages. Of this, the Centers for Disease Control (CDC) estimates that direct health care costs alone reached $75 billion in 2003. In Florida, obesity-related medical expenditures for adults total more than $3.9 billion in that year, with more than half of the costs financed by Medicare and Medicaid. Because of this, Florida's Agency for Health Care Administration (AHCA) reported that obesity and overweight have caused increased statewide healthcare expenditures for hospitalizations and treatments, including disability costs, related to chronic conditions.

Numerous studies have found a correlation between obesity and increased claims costs on insurance. A Kaiser-Oakland study found that individuals with a BMI of 30-30.49 had increased claims 25 percent; those with a BMI of more than 35 percent increased claims 44 percent. A Medstat Group study found that claims from individuals with a BMI of more than 27.5 percent cost 25 percent more than claims from those with an ideal body weight. Finally, a Bank One Study found that 24 percent of health care costs were because of overweight.

Causes of the Obesity Epidemic

In simple terms, obesity has reached epidemic proportions because our energy input through food exceeds our energy output through physical activity. Some contributors to this include larger meal portions, diets higher in fat, frequency of meals away from home, higher calorie and high fat drinks, and

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[4] These terms are defined based on a comparison of BMI to all other youth of the same age and sex. A child is considered at risk for overweight if his or her BMI is higher than the 85th percentile, and lower than the 95 percent percentile, of his or her peers. A child is considered overweight if his or her BMI is greater than or equal to the BMI of the 95th percentile of peers.
[5] RAND Corporation
[6] NEJM.
[7] National Library of Medicine

sedentary lifestyles. According to a recent study by the National Center for Health Statistics (NCHS), less than a third of U.S. adults engage in regular leisure-time physical activity. One study looked at adults who were trying to lose or not gain weight and found that less than 20 percent of them were following recommendations about increasing physical activity and reducing calories.[8] Another notable finding is that only 42.8 percent of obese people, who had routine checkups in past months, had been urged during those visits to lose weight.[9]

In 2002, only 25.7 percent of Floridian adults consumed five or more servings of fruit and vegetables a day. Also in this year, 26.4 percent of Floridian adults were physically inactive, with women and Hispanics the most likely to be sedentary. Even among those who reported being physically active, the level of intensity of physical activity has decreased since 1992.

Solutions for Handling the Obesity Epidemic

Changing people's habits related to physical activity is challenging. Individuals who want to be more active often find it difficult to do so because of daily demands and other constraints associated with work and family. The U.S. Surgeon General reported, in his 2001 "Call to Action to Prevent and Decrease Overweight and Obesity," that individual behavior can only change in a supportive environment, by giving people access to affordable and healthy food choices, and by giving people the opportunity for regular physical activity. A number of initiatives have been developed in both the private and public sectors to encourage individuals to adopt healthy nutrition and fitness behaviors.

Obesity Prevention in Florida

In October 2003, the Governor of Florida created a task force to address the rising rates of overweight and obesity among adults and youth in Florida, to evaluate data and testimony to determine the extent of the problem in Florida, and to make recommendations on how to address obesity in Florida.[10] The Governor's Task Force on the Obesity Epidemic issued a final report in February 2004, with 22 comprehensive recommendations.[11]

Section 381.0054, F.S., requires the Department of Health (DOH) to promote healthy lifestyles to reduce the prevalence of overweight and obesity in Florida by implementing appropriate physical activity and nutrition programs that target all Floridians. These activities include:

- Using all appropriate media to promote maximum public awareness of the latest research on healthy lifestyles and chronic diseases and disseminating relevant information through a statewide clearinghouse relating to wellness, physical activity, and nutrition and their impact on chronic diseases and disabling conditions.
- Providing technical assistance, training, and resources on healthy lifestyles and chronic diseases to the public, county health departments, health care providers, school districts, and other persons or entities, including faith-based organizations, that request such assistance to promote physical activity, nutrition, and healthy lifestyle programs.
- Developing, implementing, and using all available research methods to collect data, including, but not limited to, population-specific data, and track the incidence and effects of weight gain, obesity, and related chronic diseases. The department must include an evaluation and data collection component in all programs as appropriate.
- Partnering with the Department of Education, local communities, school districts, and other entities to encourage Florida schools to promote activities during and after school to help students meet a minimum goal of 60 minutes of activity per day.

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[8] Mokdad AH, Bowman, BA, Ford ES, Vinicor F, Marks JS, Koplan JP. The continuing epidemics of obesity and diabetes in the United States. *JAMA* 2001; 286(10): 1195-1200.
[9] Ibid.
[10] See Executive Order No. 2003-196.
[11] See http://www.doh.state.fl.us/Family/GTFOE/report.pdf (last visited on March 10, 2006).

- Partnering with the Department of Education, school districts, and the Florida Sports Foundation to develop a program that recognizes schools whose students demonstrate excellent physical fitness or fitness improvement.
- Maximizing all local, state, and federal funding sources, including grants, public-private partnerships, and other mechanisms, to strengthen the department's current physical activity and nutrition programs and to enhance similar county health department programs.

The Obesity Prevention Program within DOH is funded through a cooperative agreement with a planning grant of $450,000 from the United States Centers for Disease Control and Prevention (CDC). This funding must be used to develop infrastructure within the program in an effort to reduce the burden of obesity among adults and youth in Florida, develop partnerships to combat obesity, and develop a five-year work plan that focuses on increased physical activity, healthy nutrition, initiation and duration of breastfeeding, and decreased TV, video, or computer screen time.

During Fiscal Year 2004-05, DOH used media for public awareness through limited partner funds to conduct a direct-hit marketing campaign to affect physical activity in an identified five-county area, and a billboard campaign and bus placard campaign in Miami-Dade County to affect fruit and vegetable consumption. Because of the lack of funding, DOH has no plans for a public awareness media campaign for Fiscal Year 2005-06.

The department has launched an obesity prevention website that serves as a clearinghouse where limited resources can be downloaded and weblinks are available to other resources that may be purchased by the public. Limited resources are provided by DOH to county health departments, public or private agencies, schools, and community groups, as funding allows. Local media events are conducted by the Bureau of Chronic Disease Prevention and Health Promotion that cover all 67 Florida counties.

The Bureau of Chronic Disease Prevention and Health Promotion provides technical assistance to the public, county health departments, health care providers, school districts, and others who request assistance to promote physical activity, nutrition, and healthy lifestyle programs. The department uses the Behavior Risk Factor Surveillance System developed by CDC for state surveillance and data collection to assess overweight, obesity, physical activity levels, and fruit and vegetable consumption for adults. The department also surveys middle and high school students and conducts body-mass-index surveys on all full service school students enrolled in kindergarten, third, sixth, and ninth grades.

The department collaborates with the Department of Education through the school health program to promote the CDC School Health Index Assessment and conduct seven regional trainings for the school health advisory committee regarding the development of school wellness policies, which include increased opportunities for physical activity during and after school and the Step Up Florida physical activity campaign. On the local level, education coordinators for the Bureau of Chronic Disease Prevention and Health Promotion work with local schools to implement policy and environmental changes, as well as programs for during- and after-school physical activity. According to DOH staff, no state standards have been developed for measuring school physical fitness levels or methods to assess physical fitness or fitness improvement among students.

The department collaborates with several state agencies on specific projects and programs to address increasing physical activity and healthy nutrition, such as the school health program with the Department of Education and the safe ways to schools program with the Department of Transportation. The department maximizes local, state and federal funding to strengthen the Obesity Prevention

Program and other chronic disease prevention programs, through partnerships with state, local and federal organizations related to obesity prevention and related chronic diseases.

At the local level, the Bureau of Chronic Disease Prevention and Health Promotion emphasizes community-specific needs and planning, and establishes partnerships with local businesses, health care organizations, community organizations, schools, and faith-based organizations, requiring a 25 percent match in local resources, to address the leading preventable risk factors for all chronic diseases through community-based programs.

EFFECTS OF THE BILL

The bill amends s. 381.0054, F.S., requiring DOH, in addition to its current health promotion and prevention activities aimed at reducing the prevalence of excess weight gain and obesity, to:

- Collaborate with other state agencies to develop policies and strategies for preventing obesity, which must be incorporated into programs administered by each agency and which must include promoting healthy lifestyles of employees of each agency.
- Advise, in accordance with s. 456.081, F.S., Florida-licensed health care practitioners regarding the morbidity, mortality, and costs associated with the conditions of being overweight or obese, inform such practitioners of clinical best practices for preventing obesity, and encourage practitioners to counsel their patients regarding the adoption of healthy lifestyles.

The effective date of the bill is July 1, 2006.

BACKGROUND

Wellness Initiatives for State Employees

State governments have been increasingly active in encouraging healthy habits. A sample of programs is highlighted below.

Oklahoma: State employees are eligible to receive two wellness incentives in the OK Health Program. The first incentive offers employees an initial visit to a primary care physician along with lab work at no out-of-pocket cost. The second incentive is a discount at a participating fitness center. Agency directors are also given the authority to offer financial incentives to their employees who participate in the OK Health Program. The pay incentive program consist of three separate lump sums payable to an employee upon completion of specified steps and is available during the first year participation. The three levels of pay incentive are: $100 (Bronze), for enrolling in the program and completing the initial visit; $300 (Silver) for completing a twelve-week follow up visit; and $500 (Gold) for achieving goals at the twelve-month follow up.[12]

Arkansas: Offers nutrition counseling and smoking cessation aids, including the nicotine patch, to Medicaid recipients and state employees. Workers in the governor's office are offered "walking breaks" instead of smoking breaks.[13]

Wisconsin: The governor created, through an executive order, the Wisconsin Encourages Healthy Lifestyles (WEHL) initiative and council to promote healthy lifestyles for state employees. The WEHL Council encourages each state agency to create its own council; designs a plan to promote the overall health and well-being of state employees; and is to identify incentives to promote participation by state

[12] Oklahoma's OK Health Program: http://www.ebc.state.ok.us/en/OkHealth/Finance_Incentives/FinancialIncentives.htm
[13] Kiely, Kathy. "Governor's healthy state." *USA Today.* July 7, 2004. http://www.usatoday.com/news/health/2004-07-11-arkansas-governor_x.htm

employees in WEHL activities. The goals of WELH are to encourage physical activity for at least 30 minutes per day and to encourage healthy eating habits among state employees.[14]

Licensed Health Care Practitioners

Chapter 456, F.S., specifies the general provisions for licensed health care practitioners in DOH's Division of Medical Quality Assurance. In addition to chapter 456, F.S., each health care profession has its own practice act with specific regulatory provisions. Section 456.081, F.S., grants authority to DOH and the boards to advise licensees periodically, through the publication of a newsletter on the department's website, about information that the department or the board determines is of interest to the industry.

C. SECTION DIRECTORY:

Section 1. - Amends s. 381.0054, F.S., directing the Department of Health to collaborate with other state agencies to develop workplace wellness programs and advise health care practitioners of the morbidity, mortality, and costs associated with obesity or overweight.

Section 2. - Provides the bill will take effect July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Department of Health Fiscal Impact

Estimated Expenditures	**1st Year**	**2nd Year** (Annualized/Recurr.)
Salaries and Fringe	**0**	**0**
Expense		
State Agency Obesity Prevention Workgroup	*$ 1,800*	*$ 800*
Funding for DCF, DOEA, ADP, AHCA, DJJ, DOA to Implement Obesity Prevention in current programs @ $5,000 each	*$ 30,000*	*$ 30,000*
Compliance with s.456.081 – Providing information to Healthcare Practitioners	*0*	*0*
Total:	**$31,800**	**$30,800**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

[14] State of Wisconsin, Executive Order on WEHL Council. http://oci.wi.gov/special/wehlcoun.htm

2. Expenditures:

According to the Department of Health, the changes made in the bill to s. 381.0054, F.S., will have an insignificant fiscal impact on state government.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

Section 381.0054, F.S., Healthy Lifestyle Promotion, is not currently funded. The Obesity Prevention program is funded by the Centers for Disease Control (CDC) and can only be used on CDC-approved projects.

Full implementation of s. 381.0054, F.S., is estimated by the Department of Health to cost $3,310,674 in year one and $2,341,319 in year two.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health has the necessary rulemaking authority to carry out the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 4, the PreK-12 Committee adopted two amendments to the bill. Amendment one removed the "Whereas" clauses. Amendment two removed the school district pilot program.

On April 17, 2006 the Health Care Appropriations Committee adopted one amendment to the bill. The amendment removed the undesignated appropriation in Section 2 of the bill.

This staff analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Appropriations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to the prevention of obesity; amending s. 381.0054, F.S.; requiring the Department of Health to collaborate with other state agencies in developing policies and strategies to prevent obesity which shall be incorporated into agency programs; requiring the department to advise health care practitioners regarding morbidity, mortality, and costs associated with the condition of being overweight or obese; requiring the department to inform health care practitioners about clinical best practices for obesity prevention and to encourage practitioners to counsel their patients regarding the adoption of healthy lifestyles; providing an effective date.

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

23 Section 1. Subsection (1) of section 381.0054, Florida
24 Statutes, is amended to read:
25 381.0054 Healthy lifestyles promotion.--
26 (1) The Department of Health shall promote healthy
27 lifestyles to reduce the prevalence of excess weight gain
28 ~~overweight~~ and obesity in Florida by implementing appropriate
29 physical activity and nutrition programs that are directed
30 towards ~~target~~ all Floridians by:
31 (a) Using all appropriate media to promote maximum public
32 awareness of the latest research on healthy lifestyles and
33 chronic diseases and disseminating relevant information through
34 a statewide clearinghouse relating to wellness, physical
35 activity, and nutrition and their impact on chronic diseases and
36 disabling conditions.
37 (b) Providing technical assistance, training, and
38 resources on healthy lifestyles and chronic diseases to the
39 public, county health departments, health care providers, school
40 districts, and other persons or entities, including faith-based
41 organizations, that request such assistance to promote physical
42 activity, nutrition, and healthy lifestyle programs.
43 (c) Developing, implementing, and using all available
44 research methods to collect data, including, but not limited to,
45 population-specific data, and track the incidence and effects of
46 weight gain, obesity, and related chronic diseases. The
47 department shall include an evaluation and data collection
48 component in all programs as appropriate.
49 (d) Partnering with the Department of Education, local
50 communities, school districts, and other entities to encourage

51 Florida schools to promote activities during and after school to
52 help students meet a minimum goal of 60 minutes of activity per
53 day.
54 (e) Partnering with the Department of Education, school
55 districts, and the Florida Sports Foundation to develop a
56 program that recognizes schools whose students demonstrate
57 excellent physical fitness or fitness improvement.
58 (f) Collaborating with other state agencies to develop
59 policies and strategies for preventing obesity, which shall be
60 incorporated into programs administered by each agency and shall
61 include promoting healthy lifestyles of employees of each
62 agency.
63 (g) Advising, in accordance with s. 456.081, health care
64 practitioners licensed in this state regarding the morbidity,
65 mortality, and costs associated with the condition of being
66 overweight or obese, informing such practitioners of clinical
67 best practices for preventing obesity, and encouraging
68 practitioners to counsel their patients regarding the adoption
69 of healthy lifestyles.
70 (h) ~~(f)~~ Maximizing all local, state, and federal funding
71 sources, including grants, public-private partnerships, and
72 other mechanisms, to strengthen the department's current
73 physical activity and nutrition programs and to enhance similar
74 county health department programs.
75 Section 2. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7217 (PCB FFF 06-02) Child Support
SPONSOR(S): Future of Florida's Families Committee; Galvano
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 1700

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Future of Florida's Families Committee	7 Y, 0 N	Preston	Collins
1) Civil Justice Committee	(W/D)		
2) Health & Families Council		Preston	Moore
3)			
4)			
5)			

SUMMARY ANALYSIS

The bill amends the current statutes relating to child support guidelines. Provisions of the bill include:

- New provisions relating to the imputation of income for purposes of determining the amount of a child support award;
- Elimination of an automatic reduction in child care costs related to the 25% federal child care credit;
- Reduction of the 40% threshold in shared parenting time for a setoff in the amount of a child support award to 20%;
- An explanation of the term "split parenting arrangement" and direction for calculating child support awards when those arrangements exist; and
- Requirement of a study by Office of Program Policy Analysis and Governmental Accountability to evaluate the current process for reviewing and revising Florida's child support guidelines. A required report must contain recommendations for improving the existing process or implementing a new one.

The bill amends the current statutes relating to actions for support, to reduce the arrearage threshold for denial of a passport.

The bill also amends the current statutes relating to automated administrative enforcement in interstate cases, to provide states with the option of establishing a corresponding case based on another state's administrative enforcement of an interstate case request.

There is no anticipated fiscal impact on either state or local government.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility – The bill lowers the threshold for the amount of arrearage owed by a child support obligor for purposes of passport denial.

Empower families – If child support award amounts better reflect shared parenting arrangements, collections may increase and noncustodial parents may spend more time with their children.

B. EFFECT OF PROPOSED CHANGES:

Background

In 1984, Congress recognized the potential value in requiring states to implement guidelines to be used in the determination of the amount of the child support obligation. The federal Child Support Amendments of 1984 required states to establish non-binding child support guidelines either by law, or judicial or administrative action no later than October 1, 1987.[1] The Family Support Act of 1988 made state child support guidelines presumptive with four primary objectives:

- To enhance the adequacy of child support orders;
- To improve the equity of orders by assuring more comparable treatment for cases with similar circumstances;
- To increase compliance as a result of the perceived fairness of child support awards; and
- To improve the efficiency of adjudicating child support orders.

The Family Support Act also required states to review their child support guidelines at least once every four years in order to ensure that their application results in child support award amounts that are appropriate. As a part of the review process, states must analyze case data related to the application of, and deviations from, the guidelines and they must also consider economic data related to the cost of raising children. With the exception of these two requirements, states have broad discretion and latitude in conducting guideline reviews.

The Florida House of Representatives has traditionally taken the lead in completing the reviews to meet the federal mandate. In spite of timely guideline reviews and some statutory changes, the Florida Legislature has not adjusted the guidelines schedule since 1993. Since the underlying data for the current schedule enacted in 1993 is the 1972-1973 Consumer Expenditure Survey, the schedule is considerably out of date. In addition, other provisions of the guidelines may no longer adequately reflect the needs and circumstances of Florida families.

In preparation for the current review, the Legislature allocated funds for an economic review of the state's child support guidelines.[2] In February 2003, the Legislature contracted with the Department of Economics at Florida State University (FSU). The analysis undertaken by the researchers consisted of three tasks:

- To update the existing Florida schedule of child support obligations based on the most recent data available on expenditures on children;

[1] Child Support Enforcement Amendments of 1984, 42 U.S.C. ss. 657-662 (1984).
[2] See SB 2000 (2001) and HB 27E (2002).

- To review three special issues relating to child support guidelines and to make recommendations for changes in Florida's treatment of these issues. The three issues are the treatment of low-income parents, provisions for, and the treatment of prior and subsequent children; and
- To review alternative models for the development of child support guidelines and possibly recommend a different model for use in Florida.

In addition, two issues that were not a part of the original scope of work were addressed in the report. Those include the treatment of the tax benefits associated with children and the treatment of child care related expenses.[3]

The final report was delivered to the Legislature in March 2004, and presentations were made on findings and recommendations to the Future of Florida's Families Committee during the 2004 and 2005 legislative sessions. Work continued during the interims in preparation for the development of proposed legislation for possible introduction during the 2006 legislative session. Findings in the report centered around three major issues: the support schedule; the treatment of low income obligors; and the treatment of various shared parenting arrangements.

Updating Florida's Child Support Guidelines Schedule

Florida's current schedule of child support guidelines is based on the income shares model. The income shares model determines the amount of child support obligations from estimated average expenditures on children in an intact family as a function of the combined income of the parents. The model was developed by Robert Williams from an analysis of expenditures on children by Thomas Espenshade.[4] Espenshade based his analysis on Ernst Engel's [5] approach to comparing living standards among families.

In the schedule proposed in the FSU report, the basic support obligations are lower at most income levels than those in the current schedule, with differences being relatively small except at the higher income levels. However, the amounts in the proposed guidelines are greater than those in the existing guidelines for families with low incomes and multiple children.

Using a representative sample of Florida child support cases, it was determined that for approximately 60% of the Title IV-D cases in the sample the average child support payment changes very little from the current schedule. Only for the 20% of cases in the IV-D sample with the highest incomes would the average payment change substantially. Similarly, in 40% of the private cases there is almost no change in the average child support payment. For the top 20% the average payment decreases substantially, and the average payment for the middle 40% decreases slightly. Applying the proposed schedule of basic child support obligations to the actual distribution of the child support cases in Florida indicates that the effect of the proposed schedule would be minimal for most cases. Only the top 20% of cases ranked by income would see a significant change in the amount of child support payments. In those cases, payments would decrease substantially.

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[3] *See* Updating Florida's Schedule of Child Support Obligations, Final Report to the Florida Legislature, Department of Economics, Florida State University, March 5, 2004.

[4] *See* Espenshade, T. J. (1973). The Cost of Children in Urban United States. Westport, Connecticut: Greenwood Press and Espenshade, T. J. (1984). Investing in Children: New Estimates of Parental Expenditures. Washington, D.C.: The Urban Institute Press.

[5] The underlying assumption of the Engel approach is that families of a different size that spend equal proportions of their incomes on food are equally well-off. The Engel approach assumes that as total spending increases, the budget share or percent devoted to food should decrease, freeing up expenditures for other goods, and that as family size increases, the food share of the budget should also increase.

Low-Income Parents

Child support obligations that are derived from the income shares methodology typically include an adjustment for low-income parents to ensure that parents owing child support are not living in poverty due to the obligation to provide support. The low-income adjustment in Florida's current guidelines applies to only about 1% of cases and is therefore ineffective at preventing or mitigating poverty among low-income parents. This ineffectiveness is primarily a result of four features of the current guidelines:

- The use of combined income of both parents with the single person poverty threshold;
- The application of the low-income provisions to the basic obligation rather than to the total obligation;
- The failure to update the child support schedule on a regular basis to reflect increases in the poverty guideline; and
- The imputation of income.

In addition, Florida's current schedule of child support obligations is regressive, which penalizes noncustodial parents who earn additional income and, therefore, serves as a disincentive to work. By imposing a very high marginal rate on additional earnings, it also discourages compliance. In fact, the compliance rate among low-income noncustodial parents is very low, which in turn presents a barrier to the involvement of the noncustodial parent with the children.

Shared Parenting Arrangements

Florida law currently provides that in shared parenting arrangements where a child spends less than 40 percent of overnights per year with the noncustodial parent, the court may use that arrangement as grounds for an adjustment in the amount of the child support obligation. A shared parenting arrangement where the number of overnights spent with the noncustodial parent exceeds 40 percent requires the court to adjust the noncustodial parent's support obligation to reflect the additional costs of maintaining two households for the child.

Failure to provide any adjustment where time spent with the noncustodial parent does not equal or exceed 40 percent may act as a disincentive for regular visitation with the noncustodial parent. Further, setting a threshold results in very large changes in the noncustodial parent's child support obligation in response to very small changes in the amount of visitation. For this reason, the existence of a threshold can be a source of excessive dispute and litigation between parents.

Currently, Florida's child support guidelines are silent regarding split parenting arrangements. As a result, determination of the amount of the basic support obligation in such cases is left to the discretion of the courts without any statutory guidance on dealing with this type of living arrangement. This gives rise to disparate treatment of these cases in different judicial districts, and can also be a source of dispute and litigation over living arrangements. Failure to provide explicitly for split parenting may discourage parents from adopting this arrangement even when it is in the best interests of the child.

The Bill

With regard to the three major sets of findings resulting from the FSU study, the bill retains the existing child support guidelines schedule, continues the current treatment of low income families, reduces the 40% threshold for shared parenting arrangements to 20%, and defines split parenting arrangements and provides direction for calculating the amount of an award in such circumstances.

The bill also contains the following provisions related to the child support guidelines:

- New provisions relating to the imputation of income for purposes of determining the amount of a child support award;
- Elimination of an automatic reduction in child care costs related to the 25% federal child care credit; and
- Requirement of a study by the Office of Program Policy Analysis and Governmental Accountability ("OPPAGA") to evaluate the current process for reviewing and revising Florida's child support guidelines. A required report must contain recommendations for improving the existing process or implementing a new one.

In addition, the bill contains two provisions related to the enforcement of child support orders:

- Reduction of the arrearage threshold for denial of a passport; and
- Providing the Department of Revenue the option of establishing a corresponding case based on another state's administrative enforcement of an interstate case request.

C. SECTION DIRECTORY:

Section 1. Amends s. 61.13, F.S., relating to custody and support of children, visitation rights, and the powers of the court in making orders.

Section 2. Amends s. 61.30, F.S., relating to the child support guidelines and retroactive support.

Section 3. Amends s. 409.2564, F.S., relating to actions for support.

Section 4. Amends s. 409.25641, F.S., relating to procedures for processing automated administrative enforcement requests.

Section 5. Requires an evaluation and a report by OPPAGA related to the 4 year guideline review.

Section 6. Provides an effective date of October 1, 2006, unless otherwise provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

None.

1 A bill to be entitled
2 An act relating to child support; amending s. 61.13, F.S.;
3 requiring either or both parents who owe support to secure
4 a child support award; amending s. 61.30, F.S.; providing
5 conditions for the imputation of income by the court under
6 certain circumstances; providing for the determination of
7 net income; providing the child support guidelines
8 schedule; revising amount of child care costs to be added
9 to the basic child support obligation; revising method for
10 calculating each parent's percentage share of the child
11 support need; revising method of calculating the total
12 minimum child support need; revising factors to be
13 considered by the court in adjusting child support awards;
14 providing for calculation of child support orders in cases
15 of split parenting arrangements; specifying the method for
16 determining a child support order amount; amending s.
17 409.2564, F.S.; providing a threshold for arrearages
18 before passport restrictions apply; amending s. 409.25641,
19 F.S.; requiring the Department of Revenue to employ
20 automated administrative enforcement of support orders in
21 interstate cases; authorizing the department to establish
22 a corresponding case under certain circumstances;
23 requiring the Office of Program Policy Analysis and
24 Government Accountability to evaluate state compliance
25 with federally required review of child support guidelines
26 and provide a report to the Governor and Legislature;
27 providing an effective date.
28

29 Be It Enacted by the Legislature of the State of Florida:
30
31 Section 1. Paragraphs (a) and (c) of subsection (1) of
32 section 61.13, Florida Statutes, are amended to read:
33 61.13 Custody and support of children; visitation rights;
34 power of court in making orders.--
35 (1)(a) In a proceeding under this chapter, the court may
36 at any time order either or both parents who owe a duty of
37 support to a child to pay support in accordance with the child
38 support guidelines in s. 61.30. The court initially entering an
39 order requiring one or both parents to make child support
40 payments shall have continuing jurisdiction after the entry of
41 the initial order to modify the amount and terms and conditions
42 of the child support payments when the modification is found
43 necessary by the court in the best interests of the child, when
44 the child reaches majority, or when there is a substantial
45 change in the circumstances of the parties. The court initially
46 entering a child support order shall also have continuing
47 jurisdiction to require the obligee to report to the court on
48 terms prescribed by the court regarding the disposition of the
49 child support payments.
50 (c) To the extent necessary to protect an award of child
51 support, the court may order either or both parents who owe a
52 duty of support to a child ~~the obligor~~ to purchase or maintain a
53 life insurance policy or a bond~~,~~ or to otherwise secure the
54 child support award with any other assets which may be suitable
55 for that purpose, depending upon the equities of the cause.

56 Section 2. Section 61.30, Florida Statutes, is amended to
57 read:
58 61.30 Child support guidelines; guidelines schedule;
59 retroactive child support.--
60 (1)(a) The child support guideline amount as determined by
61 this section presumptively establishes the amount the trier of
62 fact shall order as child support in an initial proceeding for
63 such support or in a proceeding for modification of an existing
64 order for such support, whether the proceeding arises under this
65 or another chapter. The trier of fact may order payment of child
66 support which varies, plus or minus 5 percent, from the
67 guideline amount, after considering all relevant factors,
68 including the needs of the child or children, age, station in
69 life, standard of living, and the financial status and ability
70 of each parent. The trier of fact may order payment of child
71 support in an amount which varies more than 5 percent from such
72 guideline amount only upon a written finding explaining why
73 ordering payment of such guideline amount would be unjust or
74 inappropriate. Notwithstanding the variance limitations of this
75 section, the trier of fact shall order payment of child support
76 which varies from the guideline amount as provided in paragraph
77 (11)(b) whenever any of the children are required by court order
78 or mediation agreement to spend a substantial amount of time
79 with the primary and secondary residential parents. This
80 requirement applies to any living arrangement, whether temporary
81 or permanent.
82 (b) The guidelines may provide the basis for proving a
83 substantial change in circumstances upon which a modification of

84 an existing order may be granted. However, the difference
85 between the existing monthly obligation and the amount provided
86 for under the guidelines shall be at least 15 percent or $50,
87 whichever amount is greater, before the court may find that the
88 guidelines provide a substantial change in circumstances.
89 (c) For each support order reviewed by the department as
90 required by s. 409.2564(11), if the amount of the child support
91 award under the order differs by at least 10 percent but not
92 less than $25 from the amount that would be awarded under s.
93 61.30, the department shall seek to have the order modified and
94 any modification shall be made without a requirement for proof
95 or showing of a change in circumstances.
96 (2) Income shall be determined on a monthly basis for <u>each</u>
97 <u>parent</u> ~~the obligor and for the obligee~~ as follows:
98 (a) Gross income shall include, but is not limited to, the
99 following ~~items~~:
100 1. Salary or wages.
101 2. Bonuses, commissions, allowances, overtime, tips, and
102 other similar payments.
103 3. Business income from sources such as self-employment,
104 partnership, close corporations, and independent contracts.
105 "Business income" means gross receipts minus ordinary and
106 necessary expenses required to produce income.
107 4. Disability benefits.
108 5. All workers' compensation benefits and settlements.
109 6. Unemployment compensation.
110 7. Pension, retirement, or annuity payments.
111 8. Social security benefits.

112 9. Spousal support received from a previous marriage or
113 court ordered in the marriage before the court.
114 10. Interest and dividends.
115 11. Rental income, which is gross receipts minus ordinary
116 and necessary expenses required to produce the income.
117 12. Income from royalties, trusts, or estates.
118 13. Reimbursed expenses or in kind payments to the extent
119 that they reduce living expenses.
120 14. Gains derived from dealings in property, unless the
121 gain is nonrecurring.
122 (b)1. Income on a monthly basis shall be imputed to an
123 unemployed or underemployed parent when such employment or
124 underemployment is found by the court to be voluntary on that
125 parent's part, absent a finding of fact by the court of physical
126 or mental incapacity or other circumstances over which the
127 parent has no control. In the event of such voluntary
128 unemployment or underemployment, the employment potential and
129 probable earnings level of the parent shall be determined based
130 upon his or her recent work history, occupational
131 qualifications, and prevailing earnings level in the community
132 as provided in this paragraph; however, the court may refuse to
133 impute income to a primary residential parent if the court finds
134 it necessary for the parent to stay home with the child who is
135 the subject of the child support calculation to care for that
136 child.
137 2. In order for the court to impute income under
138 subparagraph 1., the court must make specific findings of fact
139 consistent with the requirements of this paragraph. The party

140 seeking to impute income has the burden to present competent,
141 substantial evidence:
142 a. That the unemployment or underemployment is voluntary;
143 and
144 b. That identifies the amount and source of the imputed
145 income, through evidence of available income from employment for
146 which the party is suitably qualified by education, experience,
147 current licensure, or geographic location, with due
148 consideration being given to the parties' current existing
149 parental obligations and time-sharing plan and their historical
150 compliance with the plan.
151 3. A rebuttable presumption shall exist, which entitles
152 the court to impute Florida minimum wage to a parent if no other
153 evidentiary basis or mechanism for establishing a parent's gross
154 income is available, absent a finding by the court that:
155 a. The parent has a physical or mental incapacity that
156 renders the parent unemployable or underemployed;
157 b. The parent needs to stay home with a child who is the
158 subject of the child support calculation proceedings and care
159 for that child, thereby preventing the parent's employment or
160 rendering the parent underemployed; or
161 c. There are other circumstances over which the parent has
162 no control, except for penal incarceration, which prevents the
163 parent from earning an income.
164
165 If evidence is produced that demonstrates that the parent is a
166 resident of another state, the state minimum wage applicable to
167 the parent's state of residence shall apply if it is greater

168 than the Florida minimum wage. In the absence of a state minimum
169 wage or if the other state's minimum wage is lower than the
170 Florida minimum wage, the federal minimum wage as determined by
171 the United States Department of Labor shall apply.
172 4. Income may not be imputed beyond minimum wage
173 requirements in subparagraph 3. based upon:
174 a. Income records that are more than 5 years old at the
175 time of the hearing or trial at which imputation is sought.
176 b. Income at a level that a party has not previously ever
177 earned in the past, unless recently degreed, licensed,
178 certified, relicensed, or recertified and thus qualified for,
179 subject to geographic location, with due consideration being
180 given to the parties' current existing parental obligations and
181 time-sharing plan and their historical compliance with the plan.
182 (c) Public assistance as defined in s. 409.2554 shall be
183 excluded from gross income.
184 (3) Net income is obtained by subtracting allowable
185 deductions from gross income. Allowable deductions shall
186 include:
187 (a) Federal, state, and local income tax deductions,
188 adjusted for actual filing status and allowable dependents and
189 income tax liabilities.
190 (b) Federal insurance contributions or self-employment
191 tax.
192 (c) Mandatory union dues.
193 (d) Mandatory retirement payments.
194 (e) Health insurance payments, excluding payments for
195 coverage of the minor child.

196 (f) Court-ordered support for other children which is
197 actually paid.
198 (g) Spousal support paid pursuant to a court order from a
199 previous marriage or the marriage before the court.
200 (4) Net income for each parent ~~the obligor and net income~~
201 ~~for the obligee~~ shall be computed by subtracting allowable
202 deductions from gross income.
203 (5) Net income for each parent ~~the obligor and net income~~
204 ~~for the obligee~~ shall be added together for a combined net
205 income.
206 (6) The following guidelines schedules shall be applied to
207 the combined net income to determine the minimum child support
208 need:
209

Combined Monthly Net ~~Available~~ Income	Child or Children					
	One	Two	Three	Four	Five	Six
650.00	74	75	75	76	77	78
700.00	119	120	121	123	124	125
750.00	164	166	167	169	171	173
800.00	190	211	213	216	218	220
850.00	202	257	259	262	265	268
900.00	213	302	305	309	312	315

217 950.00	224	347	351	355	359	363
218 1000.00	235	365	397	402	406	410
219 1050.00	246	382	443	448	453	458
220 1100.00	258	400	489	495	500	505
221 1150.00	269	417	522	541	547	553
222 1200.00	280	435	544	588	594	600
223 1250.00	290	451	565	634	641	648
224 1300.00	300	467	584	659	688	695
225 1350.00	310	482	603	681	735	743
226 1400.00	320	498	623	702	765	790
227 1450.00	330	513	642	724	789	838
228 1500.00	340	529	662	746	813	869
229 1550.00	350	544	681	768	836	895
230 1600.00	360	560	701	790	860	920
231 1650.00	370	575	720	812	884	945
232 1700.00	380	591	740	833	907	971
233						

1750.00	390	606	759	855	931	996
1800.00	400	622	779	877	955	1022
1850.00	410	638	798	900	979	1048
1900.00	421	654	818	923	1004	1074
1950.00	431	670	839	946	1029	1101
2000.00	442	686	859	968	1054	1128
2050.00	452	702	879	991	1079	1154
2100.00	463	718	899	1014	1104	1181
2150.00	473	734	919	1037	1129	1207
2200.00	484	751	940	1060	1154	1234
2250.00	494	767	960	1082	1179	1261
2300.00	505	783	980	1105	1204	1287
2350.00	515	799	1000	1128	1229	1314
2400.00	526	815	1020	1151	1254	1340
2450.00	536	831	1041	1174	1279	1367
2500.00	547	847	1061	1196	1304	1394
2550.00	557	864	1081	1219	1329	1420

250 2600.00	568	880	1101	1242	1354	1447
251 2650.00	578	896	1121	1265	1379	1473
252 2700.00	588	912	1141	1287	1403	1500
253 2750.00	597	927	1160	1308	1426	1524
254 2800.00	607	941	1178	1328	1448	1549
255 2850.00	616	956	1197	1349	1471	1573
256 2900.00	626	971	1215	1370	1494	1598
257 2950.00	635	986	1234	1391	1517	1622
258 3000.00	644	1001	1252	1412	1540	1647
259 3050.00	654	1016	1271	1433	1563	1671
260 3100.00	663	1031	1289	1453	1586	1695
261 3150.00	673	1045	1308	1474	1608	1720
262 3200.00	682	1060	1327	1495	1631	1744
263 3250.00	691	1075	1345	1516	1654	1769
264 3300.00	701	1090	1364	1537	1677	1793
265 3350.00	710	1105	1382	1558	1700	1818
266						

	3400.00	720	1120	1401	1579	1723	1842
267	3450.00	729	1135	1419	1599	1745	1867
268	3500.00	738	1149	1438	1620	1768	1891
269	3550.00	748	1164	1456	1641	1791	1915
270	3600.00	757	1179	1475	1662	1814	1940
271	3650.00	767	1194	1493	1683	1837	1964
272	3700.00	776	1208	1503	1702	1857	1987
273	3750.00	784	1221	1520	1721	1878	2009
274	3800.00	793	1234	1536	1740	1899	2031
275	3850.00	802	1248	1553	1759	1920	2053
276	3900.00	811	1261	1570	1778	1940	2075
277	3950.00	819	1275	1587	1797	1961	2097
278	4000.00	828	1288	1603	1816	1982	2119
279	4050.00	837	1302	1620	1835	2002	2141
280	4100.00	846	1315	1637	1854	2023	2163
281	4150.00	854	1329	1654	1873	2044	2185
282	4200.00	863	1342	1670	1892	2064	2207

283 4250.00	872	1355	1687	1911	2085	2229
284 4300.00	881	1369	1704	1930	2106	2251
285 4350.00	889	1382	1721	1949	2127	2273
286 4400.00	898	1396	1737	1968	2147	2295
287 4450.00	907	1409	1754	1987	2168	2317
288 4500.00	916	1423	1771	2006	2189	2339
289 4550.00	924	1436	1788	2024	2209	2361
290 4600.00	933	1450	1804	2043	2230	2384
291 4650.00	942	1463	1821	2062	2251	2406
292 4700.00	951	1477	1838	2081	2271	2428
293 4750.00	959	1490	1855	2100	2292	2450
294 4800.00	968	1503	1871	2119	2313	2472
295 4850.00	977	1517	1888	2138	2334	2494
296 4900.00	986	1530	1905	2157	2354	2516
297 4950.00	993	1542	1927	2174	2372	2535
298 5000.00	1000	1551	1939	2188	2387	2551
299						

	5050.00	1006	1561	1952	2202	2402	2567
300	5100.00	1013	1571	1964	2215	2417	2583
301	5150.00	1019	1580	1976	2229	2432	2599
302	5200.00	1025	1590	1988	2243	2447	2615
303	5250.00	1032	1599	2000	2256	2462	2631
304	5300.00	1038	1609	2012	2270	2477	2647
305	5350.00	1045	1619	2024	2283	2492	2663
306	5400.00	1051	1628	2037	2297	2507	2679
307	5450.00	1057	1638	2049	2311	2522	2695
308	5500.00	1064	1647	2061	2324	2537	2711
309	5550.00	1070	1657	2073	2338	2552	2727
310	5600.00	1077	1667	2085	2352	2567	2743
311	5650.00	1083	1676	2097	2365	2582	2759
312	5700.00	1089	1686	2109	2379	2597	2775
313	5750.00	1096	1695	2122	2393	2612	2791
314	5800.00	1102	1705	2134	2406	2627	2807
315	5850.00	1107	1713	2144	2418	2639	2820

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5900.00	1111	1721	2155	2429	2651	2833
5950.00	1116	1729	2165	2440	2663	2847
6000.00	1121	1737	2175	2451	2676	2860
6050.00	1126	1746	2185	2462	2688	2874
6100.00	1131	1754	2196	2473	2700	2887
6150.00	1136	1762	2206	2484	2712	2900
6200.00	1141	1770	2216	2495	2724	2914
6250.00	1145	1778	2227	2506	2737	2927
6300.00	1150	1786	2237	2517	2749	2941
6350.00	1155	1795	2247	2529	2761	2954
6400.00	1160	1803	2258	2540	2773	2967
6450.00	1165	1811	2268	2551	2785	2981
6500.00	1170	1819	2278	2562	2798	2994
6550.00	1175	1827	2288	2573	2810	3008
6600.00	1179	1835	2299	2584	2822	3021
6650.00	1184	1843	2309	2595	2834	3034

6700.00	1189	1850	2317	2604	2845	3045
6750.00	1193	1856	2325	2613	2854	3055
6800.00	1196	1862	2332	2621	2863	3064
6850.00	1200	1868	2340	2630	2872	3074
6900.00	1204	1873	2347	2639	2882	3084
6950.00	1208	1879	2355	2647	2891	3094
7000.00	1212	1885	2362	2656	2900	3103
7050.00	1216	1891	2370	2664	2909	3113
7100.00	1220	1897	2378	2673	2919	3123
7150.00	1224	1903	2385	2681	2928	3133
7200.00	1228	1909	2393	2690	2937	3142
7250.00	1232	1915	2400	2698	2946	3152
7300.00	1235	1921	2408	2707	2956	3162
7350.00	1239	1927	2415	2716	2965	3172
7400.00	1243	1933	2423	2724	2974	3181
7450.00	1247	1939	2430	2733	2983	3191
7500.00	1251	1945	2438	2741	2993	3201

349 7550.00	1255	1951	2446	2750	3002	3211
350 7600.00	1259	1957	2453	2758	3011	3220
351 7650.00	1263	1963	2461	2767	3020	3230
352 7700.00	1267	1969	2468	2775	3030	3240
353 7750.00	1271	1975	2476	2784	3039	3250
354 7800.00	1274	1981	2483	2792	3048	3259
355 7850.00	1278	1987	2491	2801	3057	3269
356 7900.00	1282	1992	2498	2810	3067	3279
357 7950.00	1286	1998	2506	2818	3076	3289
358 8000.00	1290	2004	2513	2827	3085	3298
359 8050.00	1294	2010	2521	2835	3094	3308
360 8100.00	1298	2016	2529	2844	3104	3318
361 8150.00	1302	2022	2536	2852	3113	3328
362 8200.00	1306	2028	2544	2861	3122	3337
363 8250.00	1310	2034	2551	2869	3131	3347
364 8300.00	1313	2040	2559	2878	3141	3357
365						

	8350.00	1317	2046	2566	2887	3150	3367
366	8400.00	1321	2052	2574	2895	3159	3376
367	8450.00	1325	2058	2581	2904	3168	3386
368	8500.00	1329	2064	2589	2912	3178	3396
369	8550.00	1333	2070	2597	2921	3187	3406
370	8600.00	1337	2076	2604	2929	3196	3415
371	8650.00	1341	2082	2612	2938	3205	3425
372	8700.00	1345	2088	2619	2946	3215	3435
373	8750.00	1349	2094	2627	2955	3224	3445
374	8800.00	1352	2100	2634	2963	3233	3454
375	8850.00	1356	2106	2642	2972	3242	3464
376	8900.00	1360	2111	2649	2981	3252	3474
377	8950.00	1364	2117	2657	2989	3261	3484
378	9000.00	1368	2123	2664	2998	3270	3493
379	9050.00	1372	2129	2672	3006	3279	3503
380	9100.00	1376	2135	2680	3015	3289	3513
381	9150.00	1380	2141	2687	3023	3298	3523

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9200.00 1384 2147 2695 3032 3307 3532
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9250.00 1388 2153 2702 3040 3316 3542
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9300.00 1391 2159 2710 3049 3326 3552
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9350.00 1395 2165 2717 3058 3335 3562
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9400.00 1399 2171 2725 3066 3344 3571
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9450.00 1403 2177 2732 3075 3353 3581
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9500.00 1407 2183 2740 3083 3363 3591
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9550.00 1411 2189 2748 3092 3372 3601
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9600.00 1415 2195 2755 3100 3381 3610
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9650.00 1419 2201 2763 3109 3390 3620
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9700.00 1422 2206 2767 3115 3396 3628
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9750.00 1425 2210 2772 3121 3402 3634
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9800.00 1427 2213 2776 3126 3408 3641
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9850.00 1430 2217 2781 3132 3414 3647
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9900.00 1432 2221 2786 3137 3420 3653
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9950.00 1435 2225 2791 3143 3426 3659
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10000.0	1437	2228	2795	3148	3432	3666
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399
400 For combined monthly available income less than the amount set
401 out on the above schedules, the parent should be ordered to pay
402 a child support amount, determined on a case-by-case basis, to
403 establish the principle of payment and lay the basis for
404 increased orders should the parent's income increase in the
405 future. For combined monthly available income greater than the
406 amount set out in the above schedules, the obligation shall be
407 the minimum amount of support provided by the guidelines
408 schedule plus the following percentages multiplied by the amount
409 of income over $10,000:
410

Child or Children					
One	Two	Three	Four	Five	Six
5.0%	7.5%	9.5%	11.0%	12.0%	12.5%

411
412
413
414 (7) Child care costs incurred on behalf of the children
415 due to employment, job search, or education calculated to result
416 in employment or to enhance income of current employment of
417 either parent shall be ~~reduced by 25 percent and then shall be~~
418 added to the basic obligation. After the ~~adjusted~~ child care
419 costs are added to the basic obligation, any moneys prepaid by
420 the noncustodial parent for child care costs for the child or
421 children of this action shall be deducted from that noncustodial

422 parent's child support obligation for that child or those
423 children. Child care costs shall not exceed the level required
424 to provide quality care from a licensed source for the children.
425 (8) Health insurance costs resulting from coverage ordered
426 pursuant to s. 61.13(1)(b), and any noncovered medical, dental,
427 and prescription medication expenses of the child, shall be
428 added to the basic obligation unless these expenses have been
429 ordered to be separately paid on a percentage basis. After the
430 health insurance costs are added to the basic obligation, any
431 moneys prepaid by the noncustodial parent for health-related
432 costs for the child or children of this action shall be deducted
433 from that noncustodial parent's child support obligation for
434 that child or those children.
435 (9) Each parent's percentage share of the child support
436 need shall be determined by dividing each parent's net monthly
437 income by the combined net monthly income.
438 (10) The total minimum child support need shall be
439 determined by adding child care costs and health insurance costs
440 to the minimum child support need. Each parent's actual dollar
441 share of the total minimum child support need shall be
442 determined by multiplying the minimum child support need by each
443 parent's percentage share of the combined monthly net income.
444 (11)(a) The court may adjust the total minimum child
445 support award, or either or both parents' share of the total
446 minimum child support award, based upon the following deviation
447 factors ~~considerations~~:
448 1. Extraordinary medical, psychological, educational, or
449 dental expenses.

450 2. Independent income of the child, not to include moneys
451 received by a child from supplemental security income.
452 3. The payment of support for a parent which regularly has
453 been paid and for which there is a demonstrated need.
454 4. Seasonal variations in one or both parents' incomes or
455 expenses.
456 5. The age of the child, taking into account the greater
457 needs of older children.
458 6. Special needs, such as costs that may be associated
459 with the disability of a child, that have traditionally been met
460 within the family budget even though the fulfilling of those
461 needs will cause the support to exceed the presumptive amount
462 established by the ~~proposed~~ guidelines.
463 7. Total available assets of the obligee, obligor, and the
464 child.
465 8. The impact of the Internal Revenue Service dependency
466 exemption and waiver of that exemption and the impact of any
467 federal child care tax credit. The court may order the primary
468 residential parent to execute a waiver of the Internal Revenue
469 Service dependency exemption if the noncustodial parent is
470 current in support payments.
471 9. When application of the child support guidelines
472 requires a person to pay another person more than 55 percent of
473 his or her gross income for a child support obligation for
474 current support resulting from a single support order.
475 10. The particular parenting ~~shared parental~~ arrangement,
476 such as where the child spends a significant amount of time, but
477 less than 20 ~~40~~ percent of the overnights, with the noncustodial

478 parent, thereby reducing the financial expenditures incurred by
479 the primary residential parent; or the refusal of the
480 noncustodial parent to become involved in the activities of the
481 child.
482 11. Any other adjustment which is needed to achieve an
483 equitable result which may include, but not be limited to, a
484 reasonable and necessary existing expense or debt. Such expense
485 or debt may include, but is not limited to, a reasonable and
486 necessary expense or debt which the parties jointly incurred
487 during the marriage.
488 (b) Whenever a particular parenting ~~shared parental~~
489 arrangement provides that each child spend a substantial amount
490 of time with each parent, the court shall adjust any award of
491 child support, as follows:
492 1. In accordance with subsections (9) and (10), calculate
493 the amount of support obligation apportioned to the noncustodial
494 parent without including day care and health insurance costs in
495 the calculation and multiply the amount by 1.5.
496 2. In accordance with subsections (9) and (10), calculate
497 the amount of support obligation apportioned to the custodial
498 parent without including day care and health insurance costs in
499 the calculation and multiply the amount by 1.5.
500 3. Calculate the percentage of overnight stays the child
501 spends with each parent.
502 4. Multiply the noncustodial parent's support obligation
503 as calculated in subparagraph 1. by the percentage of the
504 custodial parent's overnight stays with the child as calculated
505 in subparagraph 3.

506 5. Multiply the custodial parent's support obligation as
507 calculated in subparagraph 2. by the percentage of the
508 noncustodial parent's overnight stays with the child as
509 calculated in subparagraph 3.
510 6. The difference between the amounts calculated in
511 subparagraphs 4. and 5. shall be the monetary transfer necessary
512 between the custodial and noncustodial parents for the care of
513 the child, subject to an adjustment for day care and health
514 insurance expenses.
515 7. Pursuant to subsections (7) and (8), calculate the net
516 amounts owed by the custodial and noncustodial parents for the
517 expenses incurred for day care and health insurance coverage for
518 the child. ~~Day care shall be calculated without regard to the~~
519 ~~25-percent reduction applied by subsection (7).~~
520 8. Adjust the support obligation owed by the custodial or
521 noncustodial parent pursuant to subparagraph 6. by crediting or
522 debiting the amount calculated in subparagraph 7. This amount
523 represents the child support which must be exchanged between the
524 custodial and noncustodial parents.
525 9. The court may deviate from the child support amount
526 calculated pursuant to subparagraph 8. based upon the deviation
527 factors ~~considerations~~ set forth in paragraph (a), as well as
528 the ~~custodial parent's~~ low income of either parent or the
529 inability of either parent ~~and ability~~ to maintain the basic
530 necessities of the home for the child, the likelihood that the
531 noncustodial parent will actually exercise the visitation
532 granted by the court, and whether all of the children are
533 exercising the same parenting ~~shared parental~~ arrangement.

534 10. For purposes of adjusting any award of child support
535 under this paragraph, "substantial amount of time" means that
536 the noncustodial parent exercises visitation at least 20 ~~40~~
537 percent of the overnights of the year.
538 (c) A noncustodial parent's failure to regularly exercise
539 court-ordered or agreed visitation not caused by the custodial
540 parent which resulted in the adjustment of the amount of child
541 support pursuant to subparagraph (a)10. or paragraph (b) shall
542 be deemed a substantial change of circumstances for purposes of
543 modifying the child support award. A modification pursuant to
544 this paragraph shall be retroactive to the date the noncustodial
545 parent first failed to regularly exercise court-ordered or
546 agreed visitation.
547 (d) A split parenting arrangement exists when there is
548 more than one child in common and each parent has the majority
549 of the overnight timesharing for at least one of the children.
550 In cases involving split parenting arrangements, the court shall
551 calculate and issue a separate child support order for each
552 parent based on the number of children for which that parent has
553 the majority of the overnight timesharing, and the difference
554 between the two calculations is the amount to be paid by the
555 parent with the higher child support order amount.
556 (12)(a) A parent with a support obligation may have other
557 children living with him or her who were born or adopted after
558 the support obligation arose. If such subsequent children exist,
559 the court, when considering an upward modification of an
560 existing award, may disregard the income from secondary
561 employment obtained in addition to the parent's primary

562 employment if the court determines that the employment was
563 obtained primarily to support the subsequent children.
564 (b) Except as provided in paragraph (a), the existence of
565 such subsequent children should not as a general rule be
566 considered by the court as a basis for disregarding the amount
567 provided in the guidelines schedule. The parent with a support
568 obligation for subsequent children may raise the existence of
569 such subsequent children as a justification for deviation from
570 the guidelines schedule. However, if the existence of such
571 subsequent children is raised, the income of the other parent of
572 the subsequent children shall be considered by the court in
573 determining whether or not there is a basis for deviation from
574 the guideline amount.
575 (c) The issue of subsequent children under paragraph (a)
576 or paragraph (b) may only be raised in a proceeding for an
577 upward modification of an existing award and may not be applied
578 to justify a decrease in an existing award.
579 (13) If the recurring income is not sufficient to meet the
580 needs of the child, the court may order child support to be paid
581 from nonrecurring income or assets.
582 (14) Every petition for child support or for modification
583 of child support shall be accompanied by an affidavit which
584 shows the party's income, allowable deductions, and net income
585 computed in accordance with this section. The affidavit shall be
586 served at the same time that the petition is served. The
587 respondent, whether or not a stipulation is entered, shall make
588 an affidavit which shows the party's income, allowable
589 deductions, and net income computed in accordance with this

590 section. The respondent shall include his or her affidavit with
591 the answer to the petition or as soon thereafter as is
592 practicable, but in any case at least 72 hours prior to any
593 hearing on the finances of either party.
594 (15) For purposes of establishing an obligation for
595 support in accordance with this section, if a person who is
596 receiving public assistance is found to be noncooperative as
597 defined in s. 409.2572, the IV-D agency is authorized to submit
598 to the court an affidavit attesting to the income of the
599 custodial parent based upon information available to the IV-D
600 agency.
601 (16) The Legislature shall review the guidelines
602 established in this section at least every 4 years beginning in
603 1997.
604 (17) In an initial determination of child support, whether
605 in a paternity action, dissolution of marriage action, or
606 petition for support during the marriage, the court has
607 discretion to award child support retroactive to the date when
608 the parents did not reside together in the same household with
609 the child, not to exceed a period of 24 months preceding the
610 filing of the petition, regardless of whether that date precedes
611 the filing of the petition. In determining the retroactive award
612 in such cases, the court shall consider the following:
613 (a) The court shall apply the guidelines <u>schedule</u> in
614 effect at the time of the hearing subject to the obligor's
615 demonstration of his or her actual income, as defined by
616 subsection (2), during the retroactive period. Failure of the
617 obligor to so demonstrate shall result in the court using the

618 obligor's income at the time of the hearing in computing child
619 support for the retroactive period.
620 (b) All actual payments made by the noncustodial parent to
621 the custodial parent or the child or third parties for the
622 benefit of the child throughout the proposed retroactive period.
623 (c) The court should consider an installment payment plan
624 for the payment of retroactive child support.
625 Section 3. Subsection (10) of section 409.2564, Florida
626 Statutes, is amended to read:
627 409.2564 Actions for support.--
628 (10) For the purposes of denial, revocation, or limitation
629 of an individual's United States passport, consistent with 42
630 U.S.C. s. 652(k)(1), the Title IV-D agency shall have procedures
631 to certify to the Secretary of the United States Department of
632 Health and Human Services, in the format and accompanied by such
633 supporting documentation as the secretary may require, a
634 determination that an individual owes arrearages of support in
635 an amount exceeding $2,500 ~~$5,000~~. Said procedures shall provide
636 that the individual be given notice of the determination and of
637 the consequence thereof and that the individual shall be given
638 an opportunity to contest the accuracy of the determination.
639 Section 4. Section 409.25641, Florida Statutes, is amended
640 to read:
641 409.25641 Procedures for processing automated
642 administrative enforcement requests.--
643 (1) The department ~~Title IV-D agency~~ shall use automated
644 administrative enforcement, as defined in Title IV-D of the
645 Social Security Act, in response to a request from another state

646 to enforce a support order and shall promptly report the results
647 of enforcement action to the requesting state.
648 (2) This request:
649 (a) May be transmitted from the other state by electronic
650 or other means.~~;~~
651 (b) Shall contain sufficient identifying information to
652 allow comparison with the databases within the state which are
653 available to the department. ~~Title IV-D agency; and~~
654 (c) Shall constitute a certification by the requesting
655 state:
656 1. Of the amount of arrearage accrued under the order; and
657 2. That the requesting state has complied with all
658 procedural due process requirements applicable to the case.
659 (3) If assistance is provided by the department ~~Title IV-D~~
660 ~~agency~~ to another state as prescribed above, the department may
661 not ~~neither state shall~~ consider the case to be transferred from
662 the caseload of the other state to the caseload of the
663 department, but the department may establish a corresponding
664 case based on the other state's request for assistance ~~Title IV-~~
665 ~~D agency~~.
666 (4) The department ~~Title IV-D agency~~ shall maintain a
667 record of:
668 (a) The number of requests received;
669 (b) The number of cases for which the department ~~Title IV-~~
670 ~~D agency~~ collected support in response to such a request; and
671 (c) The amount of such collected support.
672 (5) The department shall have authority to adopt rules to
673 implement this section.

674 Section 5. Every 4 years, the Office of Program Policy
675 Analysis and Government Accountability shall evaluate the
676 effectiveness of the system currently used for complying with
677 the federally required review of the state's child support
678 guidelines. The evaluation shall include a comparison of all
679 available methodologies being utilized by other states in
680 conducting their reviews of their child support guidelines and
681 include recommendations for either maintaining the current
682 review process with the Legislature or transferring the
683 responsibility to another entity. A report shall be submitted to
684 the Governor, the President of the Senate, and the Speaker of
685 the House of Representatives by January 31, 2007.
686 Section 6. This act shall take effect July 1, 2006.