# FLORIDA 2019
# LEGISLATIVE SESSION REPORT

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Broad-based health care reform was a significant priority for Speaker Oliva and other key members of the Florida House of Representatives. Over 250 health care bills were filed to revamp Florida's health care delivery system within a variety of sectors, from practitioner scope of practice to eliminating certificate of need.

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## TABLE OF CONTENTS


**2 Significant Bills Adopted & Failed**

**5 Access to Care Bills**

*Medical Marijuana* (SB 182), *Patient Access to Primary Care & Specialist Providers* (HB 843), *Telehealth* (HB 23 & 7067)

**8 First Responder Bills**

*E911 Systems* (HB 441), *Firefighters* (SB 426), *Tactical Medical Professional* (HB 487), *Workers' Compensation for First Responders* (HB 983)

**11 Hospital & Office Policy Bills**

*Hospital Licensure* (HB 21), *Office Surgery* (SB 732), *Stroke Centers* (SB 1460)

**13 Insurance Bills**

*Direct Health Care Agreements* (HB 7), *Health Insurance* (HB 1113), *Health Plans* (SB 322), *Insurer Guaranty Associations* (HB 673)

**20 Prescription Drugs & Prescribing Bills**

*Controlled Substances* (HB 7107), *E-Prescribing* (HB 831), *Prescription Drug Importation* (HB 19 & HB 7073) & *Monitoring Program* (HB 375 & HB 1253)

**23 Public Safety & Welfare Bills**

*Alzheimer's Disease* (HB 449), *Child Welfare* (HB 7099), *Human Trafficking* (HB 851), *Immunization Registry* (HB 213), *Nonemergency Medical Transportation Services* (HB 411), *Vaping* (SB 7012), *Wireless Communications While Driving* (HB 107)

**28 Substance Abuse & Mental Health Bills**

*Alternative Treatment Options for Veterans* (HB 501), *Infectious Disease Elimination Programs* (SB 366), *Mental Health* (SB 1418), *Nonopioid Alternatives* (HB 451), *Public Records/Mental Health Treatment & Services* (SB 838), *Substance Abuse Services* (HB 369), *Treatment-Based Drug Court Programs* (HB 7025)

# Significant Bills ADOPTED by the 2019 Legislature:

## TELEHEALTH

After years of attempting to adopt legislation regulating **telehealth** in Florida, both chambers reconciled their differences during the last week of Session and passed **HB 21**, allowing out-of-state practitioners to provide care via telemedicine to Florida patients (Florida-based physicians can continue practicing telehealth). Irrespective of our best efforts to limit such practice to Florida-licensed health care practitioners, both chambers agreed to expand telehealth to out-of-state providers through a Department of Health (DOH) registration process (though registration is not required in response to an emergency medical condition or during consultations). The bill also does not require telehealth services to be reimbursed at the same rate as in-person services, and allows that rate to be voluntarily negotiated between the provider and insurer, but for a rate lower than in-person services in such contract, the rate must be initialed by the telehealth provider. The House of Medicine fought hard for physician payment parity, considering tax incentives included in the bill directed to insurers, stressing that the success of telehealth is contingent on such payment parity for the provider, but ultimately lost that fight as well.

## E-PRESCRIBING

Though we attempted to slow the technology train on mandatory **e-prescribing** for all physicians (similar to the mandate under the federal law in 2021 for Medicare controlled substance prescriptions), the Legislature, under **HB 831**, moved Florida closer to electronic prescribing for all physicians. Under the legislation, which was substantially amended from its original version that did away with all paper prescriptions in Florida, any physician with an electronic health record system is required to e-prescribe by their license renewal date OR by July 1, 2021, whichever occurs first. (*Note: for half of Florida's MDs, license renewal is January 31, 2020; all DOs renew on March 31, 2020; and all other physicians will be required to e-prescribe by July 1, 2021.*)

In our work to mitigate negative effects of this legislation on patients and physicians, exceptions to e-prescribing were included in the bill. Such exceptions include: the patient or physician requests a written prescription to facilitate price shopping; the physician determines e-prescribing would be impractical to the

patient in receiving the needed drug in a timely manner, causing adverse effects to the patient; and DOH is allowed to grant exemptions up to one year based on hardships or technology limitations of the physician practice.

## AMBULATORY SURGICAL CENTERS

The legislature passed **HB 843**, which contains a provision relating to **ambulatory surgical centers (ASC)**. Specifically, the bill expands a patient's stay at ASCs to 24 hours. This will provide patients and ASCs greater flexibility in scheduling surgeries and assisting patients who require more time for recovery. It also requires the Agency for Health Care Administration (AHCA) to adopt rules establishing minimum standards for pediatric patient care in ASCs.

## STEP-THERAPY

**HB 843** also contains language providing some meaningful insurance reforms concerning **step-therapy**. The bill prohibits insurance companies from requiring a step-therapy protocol for a covered prescription drug if the patient was approved previously to receive the drug through the completion of a step-therapy protocol required by a separate health plan, and the patient provides documentation that the plan paid for the drug on the patient's behalf 90 days before the request. Although this policy is less robust than our original language, it does represent a significant step forward to enhance the prior authorization/step-therapy process when a patient switches insurance plans.

## CERTIFICATE OF NEED

The House and Senate reached an eleventh-hour compromise to eliminate the **certificate of need (CON)** requirement for certain hospitals. The Senate amended **HB 21** to limit specialty hospitals that could bypass CON. As amended, the bill maintains the existing ban that a hospital may not receive a new license if it restricts its medical and surgical services primarily or exclusively to cardiac, orthopedic, surgical or oncology specialties. The CON process for general hospitals will be repealed July 1, 2019.

## OFFICE SURGERY

The legislature passed **HB 732** relating to **office surgery** in response to several cosmetic surgery deaths in South Florida. As amended, the bill focuses on clinic registration and enforcement, limiting the initial impact as originally proposed to physicians performing

procedures in an office setting. DOH will now have the authority to suspend or revoke an office surgery registration for failure of any of the surgery center's physicians, owners or operators in complying with the new legislation. The bill also gives emergency suspension powers to DOH if the clinic is an imminent danger to the public (surprisingly outside their previous ability), and even allows DOH to revoke these bad actors up to five years.

### NEEDLE & SYRINGE EXCHANGE PROGRAMS

Based on the success of the needle-exchange pilot program in Miami-Dade County, the legislature passed a measure allowing needle-exchange programs in other counties. **SB 366** establishes the **Infectious Disease Elimination Act (IDEA)**. The bill allows county commissions to establish **sterile needle and syringe exchange programs** through the adoption of a county ordinance and satisfaction of specified program requirements. Exchange programs must cooperate with DOH and the local county health department.

### DIRECT CARE AGREEMENTS

Also expanded with legislation was the Direct Primary Care model, allowing other physicians to provide coverage for specialty physician services under **Direct Care Agreements**. **HB 843** eliminates third party payers and allows patients to contract directly with physicians for enumerated physician services, not just primary care.

### HUMAN TRAFFICKING NEW CME REQUIREMENT

In addition, the legislature passed **HB 851** relating to **human trafficking**. Health care providers often witness the tragic consequences of this modern form of slavery on victims. To build awareness among health care providers, **the bill requires providers to compete 1-hour of CME as part of their existing hours**. The bill also includes new requirements for non-health care providers.

## Significant Bills that FAILED:

Despite the challenges of the session, we did ensure patients continue to receive the highest level of care by impeding the onslaught of bills adopted in the House to expand scope of practice. **HB 831 APRN and PA Independent Practice**, **HB 373 Psychologists Prescribing**, **HB 111 Pharmacists Testing for Influenza and Strep**,

and **HB 833 relating to Consultant Pharmacists Expansion** passed out of the House of Representatives but failed to gain traction in the Senate.

No bills relating to repealing **Florida's No-Fault System (PIP)** passed this session, despite efforts by both Houses. **HB 1317 and SB 1790**—establishing a uniform fee schedule—failed to gain traction and died in committee. The bills would have capped services provided in a hospital setting at 200% of the Medicare fee schedule. According to the sponsors, the provisions were only intended to be applied to PIP services. However, as drafted, such provisions would have applied to health care services across the board for all payers.

# BILL SUMMARIES

## Access to Care Bills

### MEDICAL USE OF MARIJUANA (SB 182)

- Eliminates the prohibition against the smoking of marijuana (cannabis) from the definition of the "medical use" of marijuana;
- Specifies that low-THC cannabis may not be smoked in public and prohibits the medical use of marijuana by smoking in an "enclosed indoor workplace," as defined in the Florida Clean Indoor Air Act;
- Permits a qualified patient and his or her caregiver to purchase and possess delivery devices for the medical use of marijuana by smoking from a vendor that is not a Medical Marijuana Treatment Center (MMTC);
- Prohibits the certification of marijuana for medical use by smoking to patients under the age of 18 unless such patient is diagnosed with a terminal condition; Terminal patients under the age of 18 require a qualified physician to certify that smoking is the most effective means and a second physician, who is a pediatrician, must concur with this determination;
- Requires that the risks specifically associated with smoking marijuana must be included in the informed consent each patient must sign prior to being certified to receive medical marijuana;
- Requires the Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) adopt practice standards in rule for the certification of the medical use of marijuana by smoking;
- Specifies that a physician may not certify more than six 35-day

supplies of marijuana in a form for smoking and that a 35-day supply may not exceed four ounces;

- Requires each MMTC to produce and sell at least one type of pre-rolled marijuana cigarette;
- Specifies packaging and warning label requirements for medical marijuana intended for smoking and also specifies labeling and production requirements for marijuana delivery devices sold from an MMTC;
- Provides that s. 381.986, F.S. does not impair the ability of a private party to restrict or limit smoking on his or her private property, and does not prohibit the medical use of marijuana in a nursing home, hospice or assisted living facility if the facility's policies do not prohibit the medical use of marijuana;
- Renames the "Coalition for Medical Marijuana Research and Education" as the "Consortium for Medical Marijuana Clinical Outcomes Research." The Consortium is housed under the bill in the H. Lee Moffitt Cancer Center and Research Institute, Inc. (Moffitt) and must organize a program of research that contributes to the body of scientific knowledge on the effects of the medical use of marijuana and informs both policy and medical practice related to the treatment of debilitating medical conditions with marijuana.

## PATIENT ACCESS TO PRIMARY CARE & SPECIALIST PROVIDERS (HB 843)

- Requires hospitals to provide a discharge summary and any related information and records to a patient's primary care provider within 14 days of the patient's discharge;
- Requires hospitals (within 24 hours of the patient being stabilized or at the time of discharge, whichever comes first) to provide written information (report card) concerning facility quality. Reported items include: rate of hospital-acquired infections, Hospital Consumer Assessment of Healthcare Providers and Systems survey, and 15-day readmission rate;
- Allows a patient to stay in an ASC for 24 hours;
- Modifies the composition and duties of the Pediatric Cardiac Technical Advisory Panel;
- Requires hospitals provide patients written notice of their observation status immediately when patients are placed upon observation status;
- Requires Medicare patients receive the notice through the Medicare Outpatient Observation Notice form and non-Medicare patients through a form adopted by rule of AHCA;

- Provides that a restrictive covenant entered into with a physician who practices a medical specialty (in a county where one entity employs or contracts with all physicians who practice that specialty in that county) is not supported by a legitimate business interest, and is void and unenforceable;
- Requires that a restrictive covenant remains void and unenforceable until 3 years after the date on which a second entity that employs or contracts with one or more physicians who practice that specialty begins serving patients in the county;
- Amends s. 624.27, F.S., which currently allows individuals to contract directly with certain health care providers outside the scope of insurance, but only for primary care services. The bill removes this limitation and expands the scope of these agreements to allow direct health care agreements;
- Provides that a health maintenance organization through an individual or group contract may not require a step-therapy protocol under the contract for a covered prescription drug requested by a subscriber if the subscriber has previously been approved through the completion of a step-therapy protocol required by a separate health coverage plan and the subscriber provides documentation;
- Clarifies step-therapy protocols such that an insurer or HMO is not required to add a drug to its prescription drug formulary or to cover a prescription drug that the insurer or HMO does not otherwise cover;
- Requires the Office of Program Policy Analysis and Government Accountability to perform a comparative analysis of the Interstate Medical License Compact and Florida law, and submit a report to the Governor and Legislature;
- Creates the Dental Student Loan Repayment Program and the Donated Dental Services Program within the DOH, and conditions the implementation of each program upon legislative appropriation.

## TELEHEALTH (HB 23)

This bill creates a definition of telehealth in Florida statute and stipulates which licensed professionals can provide telehealth services. It also creates practice standards for telehealth, stipulating a provider has the duty to practice in a manner consistent with his or her scope of practice and within the same prevailing professional standard as provided by in-person services.

The bill also authorizes out-of-state health care professionals to use

telehealth to deliver health care services to Florida patients if they register with DOH, meet certain eligibility requirements and pay a fee. A registered telehealth provider is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida. The registered out-of-state provider must have an active, unencumbered license issued in another state but substantially similar to a license issued in Florida. They also cannot be the subject of a disciplinary action during the 5-year period prior to registering. DOH has disclosure requirements under the bill for registered telehealth providers and the bill also contains medical malpractice requirements for out-of-state registrants. The bill provides an exception to registration requirements in response to an emergency medical condition as defined in 395.002, but the other provisions of the bill apply. The legislation also provides an exemption from registration in consultation with a health care professional licensed in this state who has the ultimate authority over the diagnosis and care of the patient.

The bill also establishes standards of practice for services provided using telehealth, including patient examination, record-keeping and a prohibition on prescribing controlled substances except in certain circumstances.

### REGISTRATION FEES (HB 7067)

HB 7067, which is linked to HB 23, provides that an applicant for registration as an out-of-state telehealth provider must pay an initial registration fee of $150, and that an out-of-state telehealth provider registrant must pay a biennial registration renewal fee of $150 with a completed application for renewal.

The Florida Constitution requires legislation that imposes or authorizes new state taxes or fees, or that raises existing ones, must be approved by two-thirds of the membership of each house of the Legislature, and the tax or fee provisions must be passed in a separate bill that contains no other subject. HB 7067 creates and imposes a new fee on out-of-state telehealth providers, as created by HB 23 or similar legislation.

## First Responder Bills

### E911 SYSTEMS (HB 441)

The bill requires the Technology Program (Office) within the Department of Management Services to develop a plan by February 1, 2020 to upgrade 911 PSAPs within the state to allow the transfer of

an emergency call from one local, multijurisdictional or regional E911 system to another local, multijurisdictional or regional E911 system in the state. The bill specifies that this transfer capability should include voice, text message, image, video, caller identification information, location information and additional standards-based 911 call information.

Separately, in response to the Commission's recommendations, the bill requires the development and implementation of communications systems that allow direct radio communication between each PSAP and first responders outside the PSAP's normal service area. This should allow for more efficient dispatch of first responders in response to 911 communications.

Finally, the bill requires each county to develop a plan to implement countywide text-to-911 service and, by January 1, 2022, to enact a system that allows for text-to-911 service.

## FIREFIGHTER BENEFITS (SB 426)

SB 426 makes firefighters who are diagnosed with certain cancers eligible to receive certain disability or death benefits. Specifically, in lieu of pursuing workers' compensation coverage, a firefighter is entitled to cancer treatment and a one-time cash payout of $25,000, upon the firefighter's initial diagnosis of cancer.

In order to be entitled to such benefits, the firefighter must:

- Be employed full-time as a firefighter;
- Be employed by the state, university, city, county, port authority, special district, or fire control district;
- Have been employed by his or her employer for at least five continuous years;
- Not have used tobacco products for at least the preceding five years; and
- Have not been employed in any other position that is proven to create a higher risk for cancer in the preceding five years.

The term "cancer" includes bladder cancer, brain cancer, breast cancer, cervical cancer, colon cancer, esophageal cancer, invasive skin cancer, kidney cancer, large intestinal cancer, lung cancer, malignant melanoma, mesothelioma, multiple myeloma, non-Hodgkin's lymphoma, oral cavity and pharynx cancer, ovarian cancer, prostate cancer, rectal cancer, stomach cancer, testicular cancer and thyroid cancer.

In addition, the employer must provide coverage within an employer-sponsored health plan or through a group health insurance trust fund. The employer must timely reimburse the firefighter for any out-of-pocket deductible, co-payment or coinsurance costs incurred due to the treatment of cancer.

For disability and death benefits, the employer must consider a firefighter permanently and totally disabled if diagnosed with one of the 21 enumerated cancers and meets the retirement's plan definition of totally and permanently disabled due to the diagnosis of cancer or circumstances that arise out of the treatment of cancer. Moreover, the cancer or the treatment of cancer must be deemed to have occurred in the line of duty, resulting in higher disability and death benefits.

## TACTICAL MEDICAL PROFESSIONAL (HB 487)

HB 487 defines a tactical medical professional (TMP) as a paramedic, physician or osteopathic physician who has been appointed to provide medical services to a tactical law enforcement unit.

To be qualified as a TMP, a medical professional must:

- Be lawfully able to carry a firearm and have a concealed weapons permit;
- Be appointed to the tactical law enforcement unit;
- Be trained and deployed pursuant to established law enforcement agency policies;
- Complete a firearm and tactical training course; and
- Participate in annual firearm training provided by the law enforcement agency.

The bill allows a TMP to carry a firearm in the same manner and in the same location as a law enforcement officer while the TMP is actively operating in direct support of a law enforcement operation. A TMP has no duty to retreat and may only use force for self-defense or in the defense of others. The bill grants a TMP the same criminal and civil immunity as a law enforcement officer when the TMP is acting in the scope of his or her official duties.

The bill was amended in the Senate to clarify that a TMP may not carry, transport or store any firearm or ammunition on any fire apparatus or EMS vehicle, and the House concurred. The firearms authorization only applies to TMPs deployed with a tactical law enforcement unit.

## WORKERS' COMPENSATION FOR FIRST RESPONDERS (HB 983)

Effective October 1, 2018, workers' compensation wage replacement benefits are provided in specified circumstances for post-traumatic stress disorder (PTSD) suffered by a first responder, i.e., law enforcement officer, firefighter, emergency medical technician or paramedic, regardless of whether the individual's PTSD is accompanied by a physical injury requiring medical treatment.

First responder PTSD-related wage replacement benefits, in addition to currently available medical benefits, must be paid if the first responder is diagnosed by a psychiatrist with PTSD following certain specified death-related events that were experienced while acting in the course and scope of his or her employment. These death-related events include working a call involving the death of a child, a homicide, or of a person who suffered grievous bodily harm of a nature that shocks the conscience, including suicides. The circumstances include seeing the decedent, seeing or hearing the injury or death, and participating in the treatment or transport of those who die in these events.

The Department of Financial Services (DFS) adopted a rule, as required by law, to specify the types of third-party injuries qualifying as grievous bodily harm of a nature that shocks the conscience for the purposes of allowing wage replacement benefits for first responder PTSD. A statement of estimated regulatory costs (SERC) must be prepared if a proposed rule will have an adverse impact on small business or is likely to directly or indirectly increase regulatory costs in excess of $200,000 aggregated within one year after implementation. If the SERC shows that the adverse impact or regulatory costs of the proposed rule exceeds $1 million in the aggregate within five years after implementation, then the proposed rule must be submitted to the Legislature for ratification. The DFS SERC indicates that the rule will exceed $1 million within five years after implementation. Accordingly, the rule must be ratified by the Legislature to become effective. As such, r. 69L-3.009, F.A.C., was submitted to the Legislature for ratification.

# Hospital & Office Policies

## HOSPITAL LICENSURE (HB 21)

- Repeals certificate-of-need (CON) for general hospitals and tertiary hospital services effective July 1, 2019;
- Maintains existing ban that a hospital may not be licensed if

it restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical or oncology specialties;

- Maintains CON review for hospices, nursing homes and intermediate care facilities for the developmentally disabled;
- Requires the Office of Program Policy Analysis and Government Accountability to review federal requirements and other states' licensure statutes and rules governing the provision of tertiary health services.

## OFFICE SURGERY (SB 732)

The bill regulates office surgery procedures performed by physicians in an office setting. It requires an office in which a physician performs a liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is removed, a Level II office surgery, or a Level III office surgery to register with DOH.

Specifically, the bill:

- Provides clinic registration process with DOH and establishes clinic financial responsibilities;
- Provides that DOH may suspend or revoke the registration of an office in which certain procedures or surgeries are performed for failure of any of its physicians, owners, or operators to comply with this statute and rules;
- Mandates that DOH revoke the registration if the noncompliance constitutes an immediate or imminent danger to the health or safety of the public;
- Requires the Board of Medicine (BOM) and Board of Osteopathic Medicine (BOOM) to adopt rules relating to standards of practice for physicians who perform the following procedures or office surgeries: liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is removed; a Level II office surgery or a Level III office surgery;
- Provides the BOM and BOOM may adopt rules to administer the registration, inspection, and safety of offices in which a physician conducts certain procedures or office surgeries;
- Requires the BOM and BOOM to impose a fine of $5,000 per day on a physician who performs a procedure or surgery in an office that is not registered with the DOH;
- Requires DOH to conduct announced and unannounced inspections of such clinics;
- Requires clinics to designate a physician who is responsible for the office's compliance with the office health and safety

requirements. A designated physician must have a full, active and unencumbered license under chapter 458 or chapter 459 and shall practice at the office for which he or she has assumed responsibility.

### STROKE CENTERS (SB 1460)

SB 1460 revises the criteria under which a hospital qualifies as a stroke center and adds a new class of stroke centers to the current-law list of stroke centers that AHCA is required to maintain and make available on its website and to the DOH.

The bill directs AHCA to include thrombectomy-capable stroke centers (TSC) in its list of stroke centers, in addition to acute stroke-ready centers (ASRC), primary stroke centers (PSC) and comprehensive stroke centers (CSC) that current law requires AHCA to include in the list.

The bill eliminates a hospital's ability to be included in AHCA's list of stroke centers by attesting with an affidavit that it meets the criteria for qualifying as a stroke center or that it has been certified as a stroke center by a nationally-recognized accrediting organization. Under the bill, in order to be included in AHCA's list, a hospital must submit documentation verifying its certification as a stroke center, which may include offering and performing endovascular therapy consistent with standards identified by a nationally-recognized, guidelines-based organization approved by AHCA.

The bill also prohibits a hospital from advertising that it is a state-listed stroke center unless the hospital has submitted verifying documentation to AHCA, as opposed to merely notifying AHCA as under current law.

The bill directs the DOH to include data from TSCs in its annual list of licensed emergency medical service (EMS) providers to medical directors.

## Insurance Bills

### DIRECT HEALTH CARE AGREEMENTS (HB 7)

HB 7 expands the existing direct primary care model, authorizing direct care agreements to all specialty providers for any health care service within their competency and training, not just primary care. Direct primary care (DPC) is a primary care medical practice model that eliminates third-party payers from the primary care

provider-patient relationship. Until the passage of this bill, such care agreements were limited to primary care services offered by primary care providers licensed under chapter 458 and 459.

Direct Health Care Agreement must:

- Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice;
- Describe the scope of health care services covered;
- Specify the monthly fee and any fees for health care services not covered by the monthly fee;
- Specify the duration of the agreement and any automatic renewal provisions;
- Offer a refund to the patient, the patient's legal representative, or the patient's employer of monthly fees paid in advance if the health care provider ceases to offer health care services for any reason;
- Contain, in contrasting color and in at least 12-point type, the following statement on the signature page: "This agreement is not health insurance and the health care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any health care services covered by the agreement. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and Affordable Care Act, U.S.C. s. 5000A. This agreement is not workers' compensation insurance and does not replace an employer's obligations under chapter 440."

## HEALTH INSURANCE (HB 1113)

- Authorizes the creation of shared savings incentive programs, which are voluntary programs for insurers, health maintenance organizations, insureds and subscribers that are designed to provide financial incentives for insureds and subscribers to obtain high quality and cost-effective health care services;
- Authorizes the Department of Management Services (DMS), as the administrator of the Division of State Group Insurance, to contract with entities that provide optional participation in a Medicare Advantage Prescription Drug Plan;
- Requires DMS to offer, as a voluntary supplemental benefit option, international prescription services that offer maintenance medications at a reduced cost;
- Requires DSGI to implement formulary management for

prescription drugs and supplies beginning with the 2020 plan year. However, the formulary may not restrict an enrollee's access to the most clinically appropriate, effective and lowest cost net-cost drugs. An excluded drug must be available for inclusion if a prescribing provider indicates on the prescription that the drug is medically necessary. Provides reporting requirements;

- Requires the DSGI to provide coverage of medically necessary prescription and nonprescription enteral formula and amino-acid-based elemental formulas for home use, regardless of the method of delivery or intake, which is prescribed by a physician. The term "medically necessary" is defined. The annual coverage limit is $20,000 per insured or subscriber;
- Repeals section 8 of chapter 99-255, L.O.F., relating to DMS and management of prescription drugs;
- Requires DMS to adopt a rule establishing health maintenance organization regions for purposes of procuring HMO health care services throughout the state and submit the rule to the President of the Senate and the Speaker of the House of Representatives for ratification. The rule may not take effect until it is ratified by the Legislature;
- Requires DMS to enter into and maintain one or more contracts with benefits consulting companies.

## HEALTH PLANS (SB 322)

In part, the bill requires the Office of Insurance Regulation (OIR) to conduct a study to evaluate Florida's essential health benefits (EHB) benchmark plan and submit a report to the Governor, the President of the Senate, and the Speaker of the House.

The study must:

- Consider EHB-benchmark plans and benefits under the 10 essential health benefits categories established under 45 C.F.R. s. 156.110(a), which are used by the other 49 states;
- Compare the costs of benefits within categories and overall costs of EHB-benchmark plans used by other states with the costs of benefits within the categories and overall costs of the current EHB-benchmark plan of this state;
- Solicit and consider proposed individual and group health plans from health insurers and health maintenance organizations in developing recommendations for changes to the current EHB-benchmark plan.

Starting in plan year 2020, the federal government is providing each state with greater flexibility in the selection of its EHB-benchmark plan. This flexibility may foster innovation in plan design and greater access to affordable coverage in the states.

The bill includes the following options:

- Selecting an EHB-benchmark plan that another state used for the 2017 plan year;
- Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another state used for the 2017 plan year; or
- Selecting a set of benefits that would become the state's EHB-benchmark plan.

The bill also stipulates that short-term limited duration insurance is an individual or group health insurance coverage provided pursuant to a contract with an issuer. The contract must have an expiration date that is less than 12 months after the original effective date of the contract and has a duration of no longer than 36 months in total.

Short-term limited duration insurance was designed primarily to fill temporary gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another plan or coverage. Currently, a short-term limited duration insurance policy must expire within 12 months of the date of the contract, taking into account any extensions. The bill requires disclosure in the short-term limited duration insurance contract regarding the scope of the coverage.

Specifically, the bill:

- Creates new sections of statute (627.6426 and 627.6525) to allow for short-term health insurance policies;
- Defines "short-term health insurance" as: health insurance coverage provided by an issuer with an expiration date that is less than 12 months after the contract effective date, not to exceed 32 months in duration;
- Requires contracts to contain the following disclosure: "This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Patient Protection and Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting

conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage."

The bill revises regulatory provisions relating to association health plans (AHPs). An AHP is a type of multiple employer welfare association, which constitutes a legal arrangement that allows business associations or unrelated employer groups to offer jointly health insurance and other fringe benefits to their members or employees.

Changes in federal rules allow small employers, through associations, to gain regulatory and economic advantages that were previously only available to large employers. As a result of the federal regulatory changes, small employers, including working owners without employees, can form an AHP that would be treated as a large group rather than a small group for insurance purposes, which would lower insurance costs and regulatory burdens. In addition, the federal rule allows an AHP to form based on a geographic test, such as a common state, city, county or a metropolitan area across state lines. The regulations also allow working owners without employees, including sole proprietors, to join.

Specifically, the bill amends s. 627.654 F.S. as follows:

- Expands association health plans to include bona fide group or association of employers, as defined in 29 C.F.R. part 2510.3-5;
- Removes the association member threshold requirement. Prior to passage, such plans were required to have a minimum of 25 members;
- Removes the requirement that the small employer health alliance must be organized as a not-for-profit corporation;
- Removes the requirement for a small employer health alliance to establish conditions of participation in the alliance by a small employer, including but not limited to: assurance that the small employer is not formed for the purpose of securing health benefit coverage; and assurance that the employees of a small employer have not been added for the purpose of securing health benefit coverage.

The following provisions of SB 322 are contingent upon the enactment of a federal law that expressly repeals the Patient Protection and Affordable Care Act (PPACA) or if PPACA is invalidated by the U.S. Supreme Court:

- Require insurers issuing or delivering individual health insurance policies, group health insurance policies or HMO in Florida to offer at least one comprehensive major medical health insurance policy that does not exclude or delay coverage under the policy or contract due to one or more preexisting medical conditions;
- Provides that the comprehensive major medical health insurance policy offer must be a policy that had been actively marketed in this state during the year immediately preceding the repeal of PPACA;
- Provides the insurer may not limit or exclude benefits under such policy, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial;
- Defines "preexisting medical condition" as: a condition that was present before the effective date of coverage under a policy, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the effective date of coverage; and a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

## INSURER GUARANTY ASSOCIATIONS (HB 673)

An insurance guaranty association ensures that policyholders' paid insurance premiums are protected and outstanding claims are settled up to limits provided by law if their insurer is liquidated. In response to recent long-term care insurer insolvencies, the bill incorporates some recent changes made to the Life and Health Insurance Guaranty Association Model Act and additional recommendations of stakeholders by making changes to the Florida Life and Health Insurance Guaranty Association (FLAHIGA) and the Florida Health Maintenance Organization Consumer Assistance Plan (HMOCAP).

The bill:

- Expands the assessment base of the FLAHIGA to include life insurers, annuity insurers, and most HMOs in order to fund long-term care insurer impairments and insolvencies. Currently,

only health insurers are assessed. Any assessments related to a long-term care insurer would be allocated 50% to health insurers and HMOs and the remaining 50% to life and annuity member insurers;

- Exempts certain HMOs from assessments that result from long-term care insurer impairments and insolvencies. The exemption would apply to an HMO that is a nonprofit, operates only in this state, and has statutory capital and surplus less than $200 million as of December 31 of the year preceding the year in which the assessment is made;
- Caps a FLAHIGA member's or HMO's assessment relating to long-term care insurer impairments and insolvencies at 0.5% of the sum of its premiums written in Florida for the preceding calendar year;
- Removes the interest rate cap on the FLAHIGA's coverage for long-term care or any other health insurance benefit, as many long-term care insurance policies contain inflation protection benefits that exceed the current interest rate cap;
- Clarifies that Medicare, Medicaid, and the Children's Health Insurance Program are excluded from the FLAHIGA's coverage and assessments;
- Adds an exclusion for structured settlement annuity benefits to which a payee, or a beneficiary if the payee is deceased, has transferred his or her rights in a structured settlement factoring transaction;
- Adds two director positions to the FLAHIGA's board, one of which must be a director of the HMOCAP board of directors;
- Amends the FLAHIGA's powers and duties by allowing the FLAHIGA to reissue policies or contracts rather than simply continue policies that have proven unsustainable, removing the need for the FLAHIGA to seek approval from a receivership court to issue substitute coverage or an alternative policy, requiring such approval to be given by the Department of Financial Services (DFS), and allowing the FLAHIGA to directly file for rate or premium increases that are actuarially justified;
- Expands the HMOCAP's powers and duties in the event of a long-term care insurer impairment or insolvency.

# Prescription Drugs & Prescribing Bills

## CONTROLLED SUBSTANCES (HB 7107)

HB 7107 classifies Epidiolex as a Schedule V controlled substance, mirroring federal law. The Schedule V classification reflects the substance's newly approved medical use. Rescheduling Epidiolex in Schedule V will prevent an interruption in the supply of the drug to Florida patients.

## ELECTRONIC PRESCRIBING (HB 831)

HB 831 requires health care practitioners who maintain an electronic health records (EHR) system to electronically transmit prescriptions. The bill has an effective date of January 1, 2020, and the practitioner requirement become effective at renewal of the health care practitioner's license or by July 1, 2021, whichever is earlier. The system may not influence prescribing decision. In addition, the bill provides the prescribing practitioner's agent the ability for electronic prescribing software to display information regarding a payer's formulary, if designed in a manner as to not make the selection process more difficult.

The e-prescribing requirement DOES NOT APPLY IF:

- The practitioner determines that it is impractical for a patient to obtain in a timely manner a drug electronically prescribed and that the delay would adversely impact the patient's medical condition;
- The practitioner has been issued a waiver by the DOH, not to exceed one year, due to demonstrated economic hardship or technological limitations not reasonably within the practitioner's control, or other exceptional circumstances;
- The practitioner or patient determine that it is in the best interest of the patient to compare prescription drug prices among area pharmacies, and such determination is documented in the patient's medical record;
- The practitioner and the dispenser are the same entity;
- The prescription cannot be transmitted electronically under the most recently implemented version of the NCPDP SCRIPT program;
- The prescription is for a drug for which the federal FDA requires the prescription to contain elements that may not be included in electronic prescribing;
- The prescription is issued to an individual receiving hospice care

or who is a resident of a nursing home facility; or

- The practitioner is prescribing a drug under a research protocol;
- Prescribing practitioners who do not have access to an EHR system may provide written prescriptions to their patients for medicinal drugs. The DOH, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, may adopt rules to implement these provisions.

## PRESCRIPTION DRUG IMPORTATION PROGRAMS (HB 19)

HB 19 establishes two programs to import federal FDA-approved prescription drugs into the state: the Canadian Prescription-Drug Importation Program (CPDI Program) and the International Prescription Drug Importation Program (IPDI Program). AHCA is directed to establish the CPDI Program for the importation of safe and effective prescription drugs from Canada, which have the highest potential for cost savings to the state. The Department of Business and Professional Regulation is directed to establish the IPDI Program for the safe and effective importation of prescription drugs from foreign nations. Such nations must have current mutual recognition agreements, cooperation agreements, memoranda of understanding, or other federal mechanisms recognizing adherence to current, good manufacturing practices for pharmaceutical products with the U.S.

Both programs establish eligibility criteria for the types of prescription drugs that may be imported and the entities that may export or import prescription drugs. The bill also outlines the importation process, safety standards, drug distribution requirements and penalties for violations of program requirements.

- Drugs must meet the FDA's standards related to safety, effectiveness, misbranding and adulteration;
- Drugs must comply with federal and state track-and-trace laws and regulations;
- Importing the drug would not violate federal patent laws;
- Importing the drug is expected to generate cost savings; and
- The drug is not: a controlled substance as defined in 21 U.S.C. s. 802; a biological product as defined in 42 U.S.C. s. 262; an infused drug; an intravenously injected drug; a drug that is inhaled during surgery; or a drug that is a parenteral drug, the importation of which is determined by the U.S. Secretary of Health and Human Services to pose a threat to the public health.

The bill requires both programs to seek federal approval or cooperation prior to importing prescription drugs.

## PERMIT AND INSPECTION FEES (HB 7073)

HB 7073, which is linked to HB 19, authorizes the DOH Board of Pharmacy and the Department of Business and Professional Regulation (DBPR) to charge fees relating to new permits created under HB 19.

HB 19 seeks to create an International Prescription Drug Importation Program, subject to the negotiation of a "federal arrangement or upon obtaining federal guidance," along with the following permits: an international export pharmacy permit under the Board of Pharmacy and an international prescription drug wholesale distributor permit under the DBPR.

The Florida Constitution requires that legislation that imposes or authorizes new state taxes or fees, or that raises existing ones, must be approved by two-thirds of the membership of each house of the Legislature, and the tax or fee provisions must be passed in a separate bill that contains no other subject. HB 7073 authorizes the imposition of fees for permits created under HB 19 or similar legislation.

## PRESCRIPTION DRUG MONITORING PROGRAM (HB 375)

- Exempts prescribers and dispensers from the requirement to consult the PDMP prior to prescribing or dispensing a controlled substance to a patient who has been admitted to hospice;
- Authorizes DOH to enter into one or more reciprocal agreements to share PDMP data with the U.S. Department of Veterans Affairs, the U.S. Department of Defense, and the federal Indian Health Service. Currently, DOH may only share data with other U.S. states and jurisdictions;
- Defines "electronic health recordkeeping system" as an electronic or computer-based information system used by health care practitioners or providers to create, collect, store, manipulate, exchange or make available personal health information for the delivery of patient care;
- Requires DOH to assess the prescription drug monitoring program's continued compatibility every 4 years with programs from other states, districts, territories, the U.S. Department of Veterans Affairs, the U.S. Department of Defense, or the Indian Health Service.

### PRESCRIPTION DRUG MONITORING PROGRAM (PDMP) (HB 1253)

The bill authorizes the Attorney General to indirectly access PDMP data for an active criminal or civil investigation or pending criminal or civil litigation involving controlled substances cases.

Specifically, the bill:

- Requires the Attorney General ensure that information obtained is not used for any purpose other than the specific matter stated in the petition or motion;
- Requires the Attorney General provide notice to party regarding the petition or motion for pending civil cases. Notice is not required for criminal cases;
- Requires the trial court to grant the petition or motion and authorize release of information when the information appears reasonably calculated to lead to the discovery of admissible evidence;
- Provides that DOH may not release any patient information other than the patient's unique identifier assigned to each patient, year of birth, and the county, city, and zip code where the patient resides;
- Provides the Attorney General must maintain a log of each person with whom the information is shared to document the chain of custody, execute a confidentiality agreement or an agreement bound by a protective order with each person, ensure that the information is maintained in a secure manner, and require each such person to return all information or certify its destruction;
- Provides the Attorney General may introduce information from the system released as evidence in a civil, criminal, or administrative action against a dispenser, manufacturer, or a pharmacy.

## Public Safety & Welfare

### ALZHEIMER'S DISEASE (HB 449)

HB 449 requires the Alzheimer's Disease Advisory Committee to submit an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Secretary of Elder Affairs by September 1 of each year. The report must include recommendations on Alzheimer's disease policy, all state-funded Alzheimer's disease efforts, and proposed updates to

the Alzheimer's disease state plan.

DOEA is required to review and update the Alzheimer's disease state plan, which must address the issues contained within the state plan initially created by the 2012 Purple Ribbon Task Force report.

DOEA must use the report submitted by the Alzheimer's Disease Advisory Committee and collaborate with other organizations and professionals when updating the state plan. DOEA must submit the updated state plan every three years, beginning November 1, 2020, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The bill increases the membership of the Alzheimer's Disease Advisory Committee to 15 members. The bill also requires the Senate President and House Speaker to each appoint two members, to include a sitting member of each chamber, and adds a first responder to the gubernatorial appointments.

The bill establishes a memory disorder clinic at Miami Jewish Health System in Miami-Dade County. It also removes the requirement that memory disorder clinics be funded before June 30, 1995, to avoid decreased funding due solely to additions of memory disorder clinics to the list provided in s. 430.502(2), F.S. This means that the following clinics, and any others subsequently established and funded, would be newly prohibited by statute from having funding reduced due to the funding of additional clinics:

- West Florida Hospital,
- Tallahassee Memorial,
- Orlando Health Center for Aging,
- AdventHealth Orlando (formerly Florida Hospital Orlando),
- Morton Plant,
- St. Mary's Medical Center,
- Florida Atlantic University,
- Sarasota Memorial, and
- Lee Memorial.

## CHILD WELFARE (HB 7099)

- Requires DCF to initiate an investigation when it receives a report from an emergency physician concerning child abuse, abandonment or neglect;
- Provides that if a child is currently being evaluated in a Florida

medical facility, the central abuse hotline is required to accept the report or call for investigation and shall transfer the information on the report or call to the appropriate state or country;

- Expands the types of reports that the department must refer to Child Protection Teams;
- Allows psychiatric nurses to prescribe psychotropic medication to dependent minors, obtain consent from legal guardians for such prescribing, and advise the court and DCF on any continued need for psychotropic medications and other services while in care.

## HUMAN TRAFFICKING (HB 851)

- Requires providers to compete 1-hour of CME on human trafficking as part of their existing hours. The bill also includes new requirements for non-health care providers. The course must address both sex trafficking and labor trafficking, how to identify individuals who may be victims of human trafficking, how to report cases of human trafficking, and resources available to victims;
- Requires by January 1, 2021, health care and other licensees or certificate holders to post in their place of work (in a conspicuous place accessible to employees) a sign at least 11 inches by 15 inches in size, printed in a clearly legible font and in at least a 32-point type, which substantially states in English and Spanish: "If you or someone you know is being forced to engage in an activity and cannot leave, whether it is prostitution, housework, farm work, factory work, retail work, restaurant work, or any other activity, call the National Human Trafficking Resource Center at 888-373-7888 or text INFO or HELP to 233-733 to access help and services. Victims of slavery and human trafficking are protected under United States and Florida law."
- Establishes a direct-support organization and provides contract terms for the organization with the Florida Forensic Institute for Research, Security, and Tactics;
- Requires OPPAGA to complete a study by January 1, 2023 on the effectiveness of the Soliciting for Prostitution Database and provide a recommendation as to whether it should remain in operation or be repealed. Provides that the database will be repealed January 1, 2024, unless reviewed and saved from repeal by the Legislature;
- Provides penalties for the owner, operator or manager of an adult theater who fails to comply with human trafficking requirements

created by the bill.

## IMMUNIZATION REGISTRY (HB 213)

The bill requires physicians, physician assistants, and nurses who administer vaccines to children through age 17 or to certain college and university students, to report the vaccinations to the immunization registry. The bill authorizes college or university students to refuse to be included in the immunization registry. The bill requires a parent or college student to submit an opt-out form to the health care practitioner or entity providing the immunization or directly to DOH. DOH must remove any identifying records of a child or college student who has opted out of the immunization registry. The bill also authorizes automated data uploads to the immunization registry from existing electronic health record systems.

The bill was amended by the Senate and the House concurred, to require that the consent to treatment form provide notice to parents. The notice must communicate that the parent or guardian of a child may refuse to have his or her child included in the immunization registry.

## NONEMERGENCY MEDICAL TRANSPORTATION SERVICES (HB 411)

The bill authorizes a transportation network company under contract with specified Medicaid managed care plans to provide Medicaid nonemergency transportation services to a Medicaid recipient, subject to compliance with requirements of AHCA. The bill directs AHCA to update any regulations, policies and other guidance, including the Non-Emergency Transportation Services Coverage Policy handbook, as necessary, to reflect this authorization by October 1, 2019.

The bill provides that transportation network companies (TNCs) and TNC drivers and prospective drivers must undergo a background screening pursuant to s. 435.03, F.S., or functionally equivalent procedures as determined by AHCA.

## VAPING (SB 7012)

SB 7012 implements Amendment 9 to the Florida Constitution, which was approved by Florida voters on November 6, 2018, to ban the use of vapor-generating electronic devices, such as electronic cigarettes (e-cigarettes), in enclosed indoor workplaces. The use of e-cigarettes is commonly referred to as vaping.

The bill permits the use of vapor-generating electronic devices in the enclosed indoor workplace of "vapor-generating device retailer" or "retail vape shop," which is defined as "any enclosed indoor workplace dedicated to or predominantly for the retail sale of vapor-generating electronic devices and components, parts, and accessories for such products, in which the sale of other products or services is merely incidental." The bill also permits vaping at the same locations currently authorized to permit tobacco smoking, i.e., private residences whenever not being used for certain commercial purposes, stand-alone bars, designated rooms in hotels and other public lodging establishments, retail tobacco shops, facilities owned or leased by a membership association, smoking cessation programs, medical or scientific research, and customs smoking rooms in airport in-transit lounges.

The bill amends the state's preemption of tobacco smoking regulation in s. 386.209, F.S., to adopt and implement the grant of authority to local governments by Amendment 9 to adopt more restrictive local ordinances on the use of vapor-generating electronic devices.

## WIRELESS COMMUNICATIONS WHILE DRIVING (HB 107)

- Revises current enforcement of the ban from a secondary offense to a primary offense, which will allow a law enforcement officer to stop a vehicle solely for texting while driving;
- Maintains the current exceptions to the texting ban and maintains that the texting ban does not apply to a stationary motor vehicle;
- Requires a law enforcement officer who detains a motor vehicle operator for texting while driving to inform the operator that he or she has a right to decline a search of his or her wireless communications device;
- Prohibits a law enforcement officer from accessing the wireless communications device without a warrant, confiscating the device while waiting for the issuance of a warrant, or using coercion or other improper method to convince the operator to provide access to such device without a warrant;
- Provides for a hands-free ban within school zones and work zones;
- Provides a transition period to the end of 2019 in which only warnings will be issued. Citations will be issued beginning in 2020;
- Establishes a public information and awareness campaign.

# Substance Abuse and Mental Health

## ALTERNATIVE TREATMENT OPTIONS FOR VETERANS (HB 501)

HB 501 permits the Florida Department of Veterans Affairs (DVA) to contract with a state university or Florida College System institution to provide alternative treatment options for veterans who have been certified by the VA or any branch of the U.S. Armed Forces as having a TBI or PTSD. A veteran must also have been diagnosed with TBI or PTSD by a health care practitioner in order to qualify for alternative treatment services.

Alternative treatment options include:

- Accelerated resolution therapy;
- Equine therapy;
- Hyperbaric oxygen therapy, which must be provided at a registered hyperbaric oxygen facility;
- Music therapy;
- Service animal training therapy.

Additionally, the bill requires alternative treatment services to be provided under the direction and supervision of a licensed physician, osteopathic physician, chiropractic physician, nurse, psychologist, clinical social worker, marriage and family therapist or mental health counselor.

Lastly, the bill requires DVA to prepare an annual report to the Legislature detailing the number and nature of services provided to veterans under the alternative treatment program.

## INFECTIOUS DISEASE ELIMINATION PROGRAMS (SB 366)

SB 366 establishes the Infectious Disease Elimination Act (IDEA). The bill allows county commissions to establish sterile needle and syringe exchange programs through the adoption of a county ordinance and satisfaction of the specified program requirements. Exchange programs must cooperate with DOH and the local county health department.

The bill:

- Requires programs to be focused on the prevention of disease transmission;
- Defines “exchange program” as a sterile needle and syringe exchange program established by a county commission;

- Provides that a sterile needle and syringe exchange program may not operate unless authorized and approved by a county commission;
- Provides that only the following entities may operate such programs: a hospital licensed under chapter 395; a health care clinic licensed under part X of chapter 400; a medical school in Florida accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation; a licensed addictions receiving facility as defined in s. 397.311(26)(a)1; or a 501(c)(3) HIV/AIDS service organization;
- Requires that the program operator must offer educational materials to program participants whenever needles or syringes are exchanged;
- Requires programs to provide onsite counseling or referrals for drug abuse prevention, education and treatment, and provide onsite HIV and viral hepatitis screening or referrals for such screening. If such services are offered solely by referral, they must be made available to participants within 72 hours.

The bill was amended by the House, and the Senate concurred, to require such programs be funded through grants and donations.

## MENTAL HEALTH (SB 1418)

SB 1418 implements two recommendations of a Department of Children and Families (DCF) task force, which has been studying the issue of Baker Act cases involving minors. The first of the specific recommendations contained in the bill encourages school districts to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of an involuntary examination.

The second recommendation increases the number of days the receiving facility has to submit forms to DCF from the next working day to five working days, to allow DCF to capture data on whether the minor was admitted, released or if a petition was filed with the court. The bill also increases data gathering on involuntary examinations and requires DCF to report every two years on its findings and recommendations related to involuntary examinations initiated on minors.

The bill also requires that when a patient communicates a specific threat against an identifiable individual to a mental health service provider, the provider must release sufficient information from

the clinical record of the patient to inform law enforcement of the potential threat.

## NONOPIOID ALTERNATIVES (HB 451)

HB 451 directs DOH to develop and publish on its website an educational pamphlet regarding the use of non-opioid alternatives to treat pain. The bill requires that a health care practitioner discuss non-opioid alternatives with a patient prior to prescribing an opioid. The health care practitioner must also provide a copy of the DOH-developed pamphlet to the patient and document the discussion in the patient's medical record. These requirements do not apply to emergency care and services.

## PUBLIC RECORDS/MENTAL HEALTH TREATMENT & SERVICES (SB 838)

SB 838 creates new exemptions from the public records inspection and access requirements of Art. 1, s. 24(a) of the State Constitution and s. 119.07(1), F.S. This bill makes confidential and exempt pleadings, orders and personal identifying information on a docket relating to Baker Act proceedings. The information may be disclosed upon request to certain persons involved in the proceedings, certain agencies, or when directed by the court.

## SUBSTANCE ABUSE SERVICES (HB 369)

The Florida Department of Children and Families (DCF) regulates substance abuse treatment through licensure. Individuals in recovery from substance abuse may reside in recovery residences (alcohol- and drug-free living environments). Florida offers voluntary certification for recovery residences and recovery residence administrators. Licensed treatment providers and non-certified recovery residences are limited in the referrals they may make to each other.

The bill:

- Allows a licensed service provider to accept a referral from a noncertified recovery residence if the residence is democratically operated by its residents, pursuant to a charter from a congressionally recognized or sanctioned entity;
- Amends the definition of "recovery residence" to include the community housing component of a licensed day or night treatment facility with community housing;
- Provides that a certified recovery residence that has a discharge policy approved by the credentialing entity to transfer or discharge residents from the recovery residence in accordance

with that policy under certain circumstances;

- Strengths provisions related to patient brokering and deceptive marketing practices in recovery residences; and
- Provides due process procedures for actions taken by an approved credentialing entity on a recovery residence's certification.

In addition, the bill revises background screening for substance abuse treatment providers as follows:

- Expands the screened offenses for owners, directors and chief financial officers of a certified recovery residence seeking certification to include those enumerated in s. 408.809, F.S.;
- Requires a level 2 background screening for peer specialists with direct contact with individuals receiving services, and including the screened offenses enumerated in s. 408.809, F.S.;
- Expands the crimes for which an individual can receive an exemption from disqualification without the statutorily-imposed waiting period, if they are working only with individuals 13 years of age and older;
- Requires DCF to render a decision on an application for exemption from disqualification within 60 days after DCF receives the complete application;
- Allows an individual to work under supervision for up to 90 days while DCF evaluates his or her application for an exemption from disqualification, so long as it has been five or more years, or three or more years for certain peer specialists, since the individual completed all non-monetary conditions associated with his or her most recent disqualifying offense; and
- Grants the head of the appropriate agency authority to grant an exemption from disqualification. The exemption is limited to employment related to providing mental health and substance abuse treatment.

Finally, HB 369 requires DCF to develop and implement a training program for peer specialist certification and provides due process procedures for actions taken by the approved credentialing entity on a peer specialist's certification. A peer specialist must be certified, except in limited circumstances, in order to provide DCF-funded support services.

## TREATMENT-BASED DRUG COURT PROGRAMS (HB 7025)

The Open Government Sunset Review Act (OGSR) requires the Legislature to review each public record exemption and each public meeting exemption five years after enactment. If the Legislature does not reenact the exemption, it automatically repeals on October 2 of the fifth year after enactment.

Treatment-based drug courts are a type of problem-solving court aimed at providing an alternative to criminal imprisonment for offenders impaired by substance abuse. Generally, drug court programs identify individuals in either the criminal justice or dependency system who may benefit from substance abuse treatment. Those individuals may voluntarily enter into pretrial treatment programs or may be sentenced to post-adjudicatory treatment-based programs as a condition of probation or community control.

Current law provides a public record exemption for information relating to a participant or a person considered for participation in a treatment-based drug court program found in certain screening, health evaluation, and treatment records. Such information is confidential and exempt from public record requirements.