The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Harrell, Chair
Senator Berman, Vice Chair

MEETING DATE: Monday, March 18, 2019
TIME: 1:30—3:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Harrell, Chair; Senator Berman, Vice Chair; Senators Baxley, Bean, Book, Cruz, Diaz, Hooper, Mayfield, and Rouson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1658** Simpson (Similar H 875)	Statewide Task Force on Opioid Drug Abuse; Creating the Statewide Task Force on Opioid Drug Abuse for a specified purpose; providing for reimbursement of per diem and travel expenses for members; requiring the Department of Legal Affairs to provide the task force with necessary staff; requiring the task force to hold an organizational session before a specified date and quarterly meetings thereafter, etc. HP 03/18/2019 Favorable ACJ AP	Favorable Yeas 10 Nays 0
2	**SB 1460** Book (Identical H 993)	Stroke Centers; Revising the criteria for hospitals to be included on the state list of stroke centers by the Agency for Health Care Administration; revising provisions relating to the statewide stroke registry to conform to changes made by the act; revising provisions prohibiting the advertisement of a hospital as a state-listed stroke center, unless certain conditions are met, to conform to changes made by the act, etc. HP 03/18/2019 Fav/CS AHS AP	Fav/CS Yeas 10 Nays 0
3	**SB 1614** Baxley (Identical H 757)	Lakes and Lagoons; Excluding manmade lakes and lagoons over a certain size from the definitions of the terms “public swimming pool” and “swimming pool,” respectively, for certain purposes, etc. HP 03/18/2019 Favorable RC	Favorable Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1712** Harrell (Compare CS/H 21)	Hospital Licensure; Requiring hospitals licensed after a specified date to participate in the Medicaid program as a provider of medical assistance and provide a certain amount of charity care; deleting a provision relating to certificates of need for hospitals; deleting a provision requiring hospitals to submit data to the agency in the certificate-of-need review process; revising the definition of the term "health care facility" to exclude hospitals and long-term care hospitals for purposes of the Health Facility and Services Development Act, etc. HP 03/18/2019 Amendments Adopted - Temporarily Postponed AHS AP	Amendments Adopted - Temporarily Postponed
	Consideration of proposed bill:		
5	**SPB 7078**	Health Care; Requiring a service provider to furnish and provide access to clinical records within a specified timeframe after receiving a request for such records; removing provisions requiring a licensed facility to furnish patient records only after discharge to conform to changes made by the act; revising provisions relating to the records of a resident held by a nursing home facility to conform to changes made by the act; requiring a licensed hospital to provide specified information and data relating to patient safety and quality measures to a patient under certain circumstances or to any person upon request, etc.	Submitted and Reported Favorably as Committee Bill Yeas 8 Nays 2
	(Preliminary Draft Available - final draft will be made available at least 48 hours prior to the meeting)		
	Consideration of proposed bill:		
6	**SPB 7080**	Public Records and Meetings/Interstate Medical Licensure Compact; Providing an exemption from public records requirements for certain information held by the Department of Health, the Board of Medicine, or the Board of Osteopathic Medicine pursuant to the Interstate Medical Licensure Compact; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portions of such meetings; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity, etc.	Submitted and Reported Favorably as Committee Bill Yeas 10 Nays 0
	(Preliminary Draft Available - final draft will be made available at least 48 hours prior to the meeting)		

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: SB 1658

INTRODUCER: Senator Simpson

SUBJECT: Statewide Task Force on Opioid Drug Abuse

DATE: March 15, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			ACJ	
3.			AP	

I. Summary:

SB 1658 creates s. 381.888, F.S., to establish the Statewide Task Force on Opioid Drug Abuse (task force) as an adjunct to the Department of Legal Affairs (DLA) for the purpose of researching opioid drug abuse; evaluating effective strategies for education, interdiction, arrest, prosecution, treatment, and prevention; and providing policy recommendations to the Legislature. The bill specifies the membership of the task force and requires the task force to meet at an organizational session by July 15, 2019, and at least four times annually thereafter. The bill enumerates specific duties of the task force related to its purpose, allows the task force to break into subcommittees that must report to the task force as a whole, and requires the task force to submit interim reports to the Legislature by December 1, 2020, and January 15, 2021, and a final report by December 1, 2022.

The bill's provisions take effect upon becoming law.

II. Present Situation:

Opioid Abuse

Both nationally and in Florida, opioid addiction and abuse has become an epidemic. The Florida Department of Law Enforcement (FDLE) reported that, when compared to 2016, 2017 saw:

- 6,178 (8 percent more) opioid-related deaths;
- 6,932 (4 percent more) individuals died with one or more prescription drugs in their system;[1]
- 3,684 (4 percent more) individuals died with at least one prescription drug in their system that was identified as the cause of death;

[1] The drugs were identified as either the cause of death or merely present in the decedent. These drugs may have also been mixed with illicit drugs and/or alcohol. These drugs were not necessarily opioids.

- Occurrences of heroin increased by 3 percent and deaths caused by heroin increased by 1 percent;
- Occurrences of fentanyl increased by 27 percent and deaths caused by fentanyl increased by 25 percent;
- Occurrences hydrocodone increased by 6 percent while deaths caused by hydrocodone decreased by 8 percent;
- Occurrences of buprenorphine and deaths caused by buprenorphine increased by 19 percent.[2]

The federal Centers for Disease Control and Prevention (CDC) estimates that the nationwide cost of opioid misuse at $78.5 billion per year.[3]

History of the Opioid Crisis in Florida

In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and health care providers began to prescribe them at greater rates. This subsequently led to widespread diversion and misuse of these medications before it became clear that these medications could indeed be highly addictive.[4] Between the early 2000s and the early 2010s, Florida was infamous as the "pill mill capital" of the country. At the peak of the pill mill crisis, doctors in Florida bought 89 percent of all the oxycodone sold in the county.[5]

Between 2009 and 2011, the Legislature enacted a series of reforms to combat prescription drug abuse. These reforms included strict regulation of pain management clinics; creating the Prescription Drug Monitoring Program (PDMP); and stricter regulation on selling, distributing, and dispensing controlled substances.[6] Between 2010 and 2014, deaths from prescription drugs dropped but deaths from illegal opioids, such as heroin, began to rise.[7]

In 2016, the opioid prescription rate was 75 per 100 persons in Florida. This rate was down from a high of 83 per 100. Drug overdose is now the leading cause of non-injury related death in the United States. Since 2000, drug overdose death rates increased by 137 percent, including a 200 percent increase in the rate of overdose deaths involving opioids. In 2015, over 52,000 deaths in the U.S. were attributed to drug poisoning, and over 33,000 (63 percent) involved an opioid. In 2015, 3,535 deaths occurred in Florida where at least one drug was identified as the cause of death. More specifically, 2,535 deaths were caused by at least one opioid in 2015. Stated differently, seven lives per day were lost to opioids in Florida in 2015. Overall the state had a rate of opioid-caused deaths of 13 per 100,000. The three counties with the highest opioid

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[2] FDLE, *Drugs Identified in Deceased Persons by Florida Medical Examiners 2017 Annual Report* (Nov. 2018) http://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2017-Annual-Drug-Report.aspx (last visited on Mar. 14, 2019).

[3] National Institute on Drug Abuse, *Opioid Overdose Crisis* (Jan. 2018) https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis (last visited on Jan. 6, 2018).

[4] Id.

[5] Lizette Alvarez, *Florida Shutting 'Pill Mill' Clinics*, THE NEW YORK TIMES (Aug. 31, 2011), *available at* http://www.nytimes.com/2011/09/01/us/01drugs.html (last visited on Mar. 14, 2018).

[6] See chs. 2009-198, 2010-211, and 2011-141, Laws of Fla.

[7] Supra note 3

death rate were Manatee County (37 per 100,000), Dixie County (30 per 100,000), and Palm Beach County (22 per 100,000).[8]

Early in 2017, the CDC declared the opioid crisis an epidemic and shortly thereafter, on May 3, 2017, Governor Rick Scott signed executive order 17-146 declaring the opioid epidemic a public health emergency in Florida.

House Bill 21

In 2018, the Florida Legislature passed HB 21 (ch. 2018-13, L.O.F.) to combat the opioid crisis. HB 21:

- Required additional training for practitioners on the safe and effective prescribing of controlled substances;
- Restricted the length of prescriptions for Schedule II opioid medications to 3 days or up to 7 days if medically necessary;
- Reworked the PDMP statute to require that prescribing practitioners check the PDMP prior to prescribing a controlled substance and to allow the integration of PDMP data with electronic health records and the sharing of PDMP data between Florida and other states; and
- Provided for additional funding for treatment and other issues related to opioid abuse.

The Attorney General's Opioid Working Group

In 2019, Florida Attorney General Ashley Moody convened an opioid working group with the primary goal of developing an overview of current programs and providing a practical set of recommendations for the Attorney General to combat the opioid crisis and addiction to opioids throughout the State of Florida.[9] The working group published its findings on March 1, 2019, and concluded that Florida should combat this epidemic with a three-pronged approach to include prevention, enforcement, and treatment, with education being a crucial element of each prong.[10]

III. Effect of Proposed Changes:

SB 1658 creates s. 381.888, F.S., to establish the Statewide Task Force on Opioid Drug Abuse as an adjunct to the Department of Legal Affairs (DLA). The bill states the purpose of the task force is researching opioid drug abuse, evaluating effective strategies for education, interdiction, arrest, prosecution, treatment and prevention, and providing policy recommendations to the Legislature.

The membership of the task force is established as follows:

- One representative appointed by the Attorney General, to serve as chair.
- One representative appointed by the Surgeon General, to serve as vice chair.
- One representative appointed by the Commissioner of Education.

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[8] Attorney General's Opioid Working Group, *Florida's Opioid Epidemic: Recommendations and Best Practices* (March 1, 2019), *available at* https://myfloridalegal.com/webfiles.nsf/WF/TDGT-B9UTV9/$file/AG+Opioid+Working+Group+Report+Final+2-28-2019.pdf, (last visited on March 14, 2019).

[9] Id.

[10] For detailed findings, please see https://myfloridalegal.com/webfiles.nsf/WF/TDGT-B9UTV9/$file/AG+Opioid+Working+Group+Report+Final+2-28-2019.pdf, (last visited on March 14, 2019).

- One representative appointed by the Commissioner of the Florida Department of Law Enforcement.
- One representative appointed by the Secretary of Children and Family Services.
- One representative appointed by the Secretary of Health Care Administration.
- One representative appointed by the Secretary of Corrections.
- One representative appointed by the Secretary of Juvenile Justice.
- One representative appointed by the President of the Senate.
- One representative appointed by the Speaker of the House of Representatives.
- Two sheriffs appointed by the Attorney General.
- Two police chiefs appointed by the Attorney General.
- Two state attorneys appointed by the Attorney General.
- Two public defenders appointed by the Attorney General.
- One representative appointed by the State Courts Administrator.
- Three representatives from addiction and recovery associations appointed by the Attorney General, each from different geographic areas of the state.
- One representative of the Florida Medical Association.
- One representative of the Florida Pharmacy Association.
- One representative of the insurance industry appointed by the Insurance Commissioner.

The bill specifies that members of the task force are entitled to receive per diem and travel expenses, and the DLA is required to provide the task force with staff necessary to assist the task force in the performance of its duties.

The task force must hold an organizational session by July 15, 2019, and meet at least four times per year thereafter. The chair of the task force may add additional meetings if extraordinary circumstances require. Additionally, the task force may break into subcommittees at the direction of the chair. Each subcommittee must present its findings to the task force as a whole.

The task force must submit interim reports to the Legislature by December 1, 2020, and January 15, 2021. The task force must submit its final report to the Legislature by December 1, 2022.

The bill requires the task force to do all of the following:

- Collect and organize data concerning:
  - The nature and extent of opioid drug abuse in this state, including, but not limited to, the overdose death rate, neonatal abstinence syndrome statistics, the Florida Youth Substance Abuse Survey, Automated Reports and Consolidated Ordering System data, and United States Drug Enforcement Administration seizure data for opioids, including fentanyl and synthetic fentanyl.
  - The current costs to state and local governments associated with the interdiction, prosecution, incarceration, education, monitoring, and treatment of opioid abuse and misuse in this state.
- Identify:
  - Available federal, state, and local programs that provide services to combat opioid drug abuse.

  - Whether there is any need for additional regulatory activity, including scheduling or emergency scheduling, of synthetic opioid derivatives including synthetic fentanyl derivatives
- Identify and evaluate:
  - Best practices for the treatment of opioid drug abuse.
  - The sources of opioids being abused and misused and causes of opioid drug abuse.
  - Ways to reduce the demand for opioids, including, but not limited to, alternative pain management that does not involve the use of opioids.
  - Ways to reduce the availability of opioids to opioid drug abusers, including increased monitoring, expanded interdiction, and cooperation among law enforcement agencies at all levels.
  - Training and resources needed by law enforcement officers to deal with users and addicts of opioid drugs.
  - Best practices for law enforcement encounters with arrestees and others suffering from opioid addiction.
  - Best practices for treating arrestees in custody suffering from opioid addiction.
  - Alternatives to conviction or incarceration for arrestees suffering from opioid addiction.
  - Programs and protocols for consideration and use with inmates suffering from opioid addiction.
  - Programs for dealing with minors suffering from opioid drug abuse and addiction.
  - Educational programs for children, young adults, and adults on the dangers of opioid abuse and misuse.
- Evaluate methods to increase public awareness of the dangers of opioid abuse and misuse.
- Develop a list of projects and priorities to be funded by the Legislature or from other sources, including the proceeds arising from any judgments or settlements with opioid manufacturers, distributors, or others related to opioid drug abuse.

The provisions of the bill are effective upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

SB 1658 may have an indeterminate fiscal impact on the DLA related to providing staff necessary to assist the task force in the performance of its duties.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill requires the task force to submit interim reports on December 1, 2020, and January 15, 2021. Since these dates are only 45 days apart, it is unclear whether the task force will be able to provide any new information in the second required interim report. It may be advisable to increase the time between the first and second interim reports.

VIII. Statutes Affected:

This bill creates section 381.888 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Simpson

10-01387A-19 20191658__

1 A bill to be entitled
2 An act relating to the Statewide Task Force on Opioid
3 Drug Abuse; creating s. 381.888, F.S.; creating the
4 Statewide Task Force on Opioid Drug Abuse for a
5 specified purpose; providing for the membership of the
6 task force; providing for reimbursement of per diem
7 and travel expenses for members; requiring the
8 Department of Legal Affairs to provide the task force
9 with necessary staff; requiring the task force to hold
10 an organizational session before a specified date and
11 quarterly meetings thereafter; authorizing the chair
12 to call for additional meetings in extraordinary
13 circumstances; specifying duties of the task force;
14 requiring the task force to submit reports to the
15 Legislature by specified dates; providing an effective
16 date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19
20 Section 1. Section 381.888, Florida Statutes, is created to
21 read:
22 381.888 Statewide Task Force on Opioid Drug Abuse.—
23 (1)(a) There is created adjunct to the Department of Legal
24 Affairs the Statewide Task Force on Opioid Drug Abuse, a task
25 force as defined in s. 20.03. The task force is created for the
26 purpose of researching opioid drug abuse, evaluating effective
27 strategies for education, interdiction, arrest, prosecution,
28 treatment and prevention, and providing policy recommendations
29 to the Legislature.

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

30 (b) The task force shall consist of the following members,
31 or their designees:
32 1. One representative appointed by the Attorney General,
33 who shall serve as chair.
34 2. One representative appointed by the Surgeon General, who
35 shall serve as vice chair.
36 3. One representative appointed by the Commissioner of
37 Education.
38 4. One representative appointed by the Commissioner of the
39 Florida Department of Law Enforcement.
40 5. One representative appointed by the Secretary of
41 Children and Family Services.
42 6. One representative appointed by the Secretary of Health
43 Care Administration.
44 7. One representative appointed by the Secretary of
45 Corrections.
46 8. One representative appointed by the Secretary of
47 Juvenile Justice.
48 9. One representative appointed by the President of the
49 Senate.
50 10. One representative appointed by the Speaker of the
51 House of Representatives.
52 11. Two sheriffs appointed by the Attorney General.
53 12. Two police chiefs appointed by the Attorney General.
54 13. Two state attorneys appointed by the Attorney General.
55 14. Two public defenders appointed by the Attorney General.
56 15. One representative appointed by the State Courts
57 Administrator.
58 16. Three representatives from addiction and recovery

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

59 associations appointed by the Attorney General, each from
60 different geographic areas of the state.
61 17. One representative of the Florida Medical Association.
62 18. One representative of the Florida Pharmacy Association.
63 19. One representative of the insurance industry appointed
64 by the Insurance Commissioner.
65 (c) Members of the task force are entitled to receive
66 reimbursement for per diem and travel expenses in accordance
67 with s. 112.061.
68 (d) The Department of Legal Affairs shall provide the task
69 force with staff necessary to assist the task force in the
70 performance of its duties.
71 (2) The task force shall hold an organizational session by
72 July 15, 2019. Thereafter, the task force shall meet at least
73 four times per year. Additional meetings may be held if the
74 chair determines that extraordinary circumstances require an
75 additional meeting. A majority of the members of the task force
76 constitutes a quorum.
77 (3) The task force shall do all of the following:
78 (a) Collect and organize data concerning the nature and
79 extent of opioid drug abuse in this state, including, but not
80 limited to, the overdose death rate, neonatal abstinence
81 syndrome statistics, the Florida Youth Substance Abuse Survey,
82 Automated Reports and Consolidated Ordering System data, and
83 United States Drug Enforcement Administration seizure data for
84 opioids, including fentanyl and synthetic fentanyl.
85 (b) Collect and organize data concerning the current costs
86 to state and local governments associated with the interdiction,
87 prosecution, incarceration, education, monitoring, and treatment

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88 of opioid abuse and misuse in this state.
89 (c) Identify available federal, state, and local programs
90 that provide services to combat opioid drug abuse.
91 (d) Identify and evaluate best practices for the treatment
92 of opioid drug abuse.
93 (e) Identify and evaluate the sources of opioids being
94 abused and misused and causes of opioid drug abuse.
95 (f) Identify whether there is any need for additional
96 regulatory activity, including scheduling or emergency
97 scheduling, of synthetic opioid derivatives including synthetic
98 fentanyl derivatives.
99 (g) Identify and evaluate ways to reduce the demand for
100 opioids, including, but not limited to, alternative pain
101 management that does not involve the use of opioids.
102 (h) Identify and evaluate ways to reduce the availability
103 of opioids to opioid drug abusers, including increased
104 monitoring, expanded interdiction, and cooperation among law
105 enforcement agencies at all levels.
106 (i) Identify and evaluate training and resources needed by
107 law enforcement officers to deal with users and addicts of
108 opioid drugs.
109 (j) Identify and evaluate best practices for law
110 enforcement encounters with arrestees and others suffering from
111 opioid addiction.
112 (k) Identify and evaluate best practices for treating
113 arrestees in custody suffering from opioid addiction.
114 (l) Identify and evaluate alternatives to conviction or
115 incarceration for arrestees suffering from opioid addiction.
116 (m) Identify and evaluate programs and protocols for

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117 consideration and use with inmates suffering from opioid
118 addiction.
119 (n) Identify and evaluate programs for dealing with minors
120 suffering from opioid drug abuse and addiction.
121 (o) Identify and evaluate educational programs for
122 children, young adults, and adults on the dangers of opioid
123 abuse and misuse.
124 (p) Evaluate methods to increase public awareness of the
125 dangers of opioid abuse and misuse.
126 (q) Develop a list of projects and priorities to be funded
127 by the Legislature or from other sources, including the proceeds
128 arising from any judgments or settlements with opioid
129 manufacturers, distributors, or others related to opioid drug
130 abuse.
131 (4) At the chair's direction, the task force may break into
132 subcommittees or small groups that must present their findings
133 to the task force as a whole.
134 (5) The task force shall submit interim reports to the
135 President of the Senate and the Speaker of the House of
136 Representatives by December 1, 2020, and January 15, 2021, and
137 shall submit a final report of its recommendations to the
138 President of the Senate and the Speaker of the House of
139 Representatives by December 1, 2022.
140 Section 2. This act shall take effect upon becoming a law.

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The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: CS/SB 1460

INTRODUCER: Health Policy Committee; and Senators Book and Powell

SUBJECT: Stroke Centers

DATE: March 19, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/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 the Agency for Health Care Administration (AHCA) is required to maintain and make available on its website and to the Department of Health (DOH).

The bill directs the 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 the AHCA to include in the list.

The bill eliminates a hospital's ability to be included in the 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 the 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 the AHCA.

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

The bill directs the DOH to include data from TSCs in its annual list to the medical directors of licensed emergency medical service (EMS) providers and directs the medical directors to develop and implement transportation and rerouting protocols for stroke patients with the intent to reroute them to ASRCs, PSCs, CSCs, and TSCs.

The effect date of the bill is July 1, 2019.

II. Present Situation:

What is a Stroke?

A stroke is a serious medical condition that occurs when the blood supply to the brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients.[1] The brain needs a constant supply of oxygen and nutrients in order to function.[2] Even a brief interruption in blood supply from a stroke can cause significant problems.

During a stroke, brain cells begin to die after just a few minutes without blood or oxygen.[3] Brain cell death causes loss of brain function, including impaired ability with movement, speech, thinking and memory, bowel and bladder, eating, emotional control, and other vital bodily functions. A small stroke may result in problems such as weakness in an arm or leg, whereas larger strokes may cause paralysis, loss of speech, or even death.[4] A stroke is one of the leading causes of death in the United States.[5]

There are two main types of strokes: an ischemic stroke and a hemorrhagic stroke. The former is the most common type and occurs when an artery in the brain becomes blocked. The latter occurs when a brain artery leaks blood or ruptures.[6]

There are two types of ischemic strokes: thrombotic and embolic.[7] In a thrombotic stroke, a blood clot (thrombus) forms in an artery that supplies blood to the brain.[8] In an embolic stroke, a blood clot or other substance, such as plaque or fatty material, travels through the bloodstream to

[1] The Mayo Clinic, *Stroke,* available at http://www.mayoclinic.org/diseases-conditions/stroke/home/ovc-20117264, (last visited Mar. 12, 2019).
[2] UCLA Health, *What is a Stroke?* available at http://stroke.ucla.edu/what-is-a-stroke, (last visited Mar. 12, 2019).
[3] Id.
[4] Id.
[5] National Institutes of Health, National Heart, Lung and Blood Institute, *Stroke - Also known as a Cerebrovascular Accident,* available at https://www.nhlbi.nih.gov/health/health-topics/topics/stroke, (last visited Mar. 12, 2019).
[6] Id.
[7] Id.
[8] Id.

an artery in the brain.[9] With both types of ischemic stroke, the blood clot or other substance blocks the flow of oxygenated blood to a portion of the brain.[10]

The two types of hemorrhagic stroke are intracerebral and subarachnoid.[11] In an intracerebral hemorrhage, a blood vessel inside the brain leaks blood or ruptures.[12] In a subarachnoid hemorrhage, a blood vessel on the surface of the brain leaks blood or ruptures, and bleeding occurs between the inner and middle layers of the membrane that covers the brain.[13] In both types of hemorrhagic stroke, the leaked blood causes swelling of the brain and increased pressure in the skull. This swelling and pressure causes brain damage.[14]

Signs and Symptoms of a Stroke

The signs and symptoms of a stroke often develop quickly. However, they can develop over hours or even days. Signs and symptoms of a stroke may include:
- Sudden weakness;
- Paralysis or numbness of the face, arms, or legs, especially on one side of the body;
- Confusion;
- Trouble speaking or understanding speech;
- Trouble seeing in one or both eyes;
- Problems breathing;
- Dizziness, trouble walking, loss of balance or coordination, and unexplained falls;
- Loss of consciousness; and
- Sudden and severe headache.[15]

Stroke Treatment

Time is of the essence in the treatment of a stroke. Medical personnel begin treatment in the ambulance on the way to the hospital.[16] Treatment for a stroke depends on how much time has elapsed since the symptoms began to appear and whether the stroke is ischemic or hemorrhagic.[17]

Treatment for an ischemic stroke may include medicines,[18] such as antiplatelet medicines and blood thinners, and medical procedures, but a hemorrhagic stroke may require surgery to find and stop the bleeding.[19] In addition to emergency care to treat a stroke, an individual may also receive treatment to prevent another stroke and rehabilitation to treat the side effects of the

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[9] Id. The blood clot or other substance traveling through the bloodstream is called an embolus.
[10] Id.
[11] Id.
[12] Id.
[13] Id.
[14] Id.
[15] Id.
[16] Center for Disease Control and Prevention, *Stroke Treatment* (updated May. 18, 2017) *available at* https://www.cdc.gov/stroke/treatments.htm, (last visited Mar. 12, 2019).
[17] National Institutes of Health, National Heart, Lung and Blood Institute, *Treatment,* available at https://www.nhlbi.nih.gov/health/health-topics/topics/stroke/treatment (last visited Mar. 12, 2019).
[18] Id. Such medication includes a tissue plasminogen activator (TPA), which dissolves, or breaks up the clot. TPA is an injection which must be given within 4 hours of stroke symptoms onset.
[19] Id.

stroke.[20] According to the federal Centers for Disease Control and Prevention (CDC), research indicates that patients receiving care at PSCs have a higher survival and recovery rate than those treated in hospitals without this type of specialized care.[21]

Stroke Centers in Florida

Florida first enacted legislation relating to PSCs and CSCs in 2004.[22] In 2017, the Legislature added ASRCs to the list of PSCs and CSCs, which is made available to licensed emergency medical services (EMS) providers.[23] The AHCA has adopted a rule establishing the criteria for ASRCs, PSCs, and CSCs.[24] There are currently no Florida hospitals designated as ASRCs, 114 designated as PSCs in 40 counties, and 48 CSCs in 22 counties.[25]

National Accrediting Organizations

The Joint Commission, the Healthcare Facilities Accreditation Program, and the DNV GL (formerly known as Det Norske Veritas) offer certifications to hospitals as an ASRC, PSC, CSC, and TSC.[26]

Licensure

A hospital may apply for designation as an ASRC, PSC, or CSC by submitting a hospital licensure application[27] and attaching a License Application Stroke Center Affidavit, both of which must be signed by the hospital's chief executive officer, attesting that the stroke program meets:

- The criteria for one of the designations as specified by rule, or
- Is certified as a stroke center by The Joint Commission, the Health Facilities Accreditation Program, or DNV GL.[28]

A hospital seeking stroke center certification must establish specific procedures for screening patients to recognize that numerous conditions, including cardiac disorders, often mimic stroke

[20] *Supra* note 16.
[21] Centers for Disease Control and Prevention, A *Summary Of Primary Stroke Center Policy In The United States* (2011), *available at* https://www.cdc.gov/dhdsp/pubs/docs/primary_stroke_center_report.pdf, (last visited Mar. 12, 2019)
[22] Section 3, ch. 2004-325, Laws of Fla.
[23] Chapter 2017-172, Laws of Fla.
[24] Section 395.3038(1), F.S. and Fla. Admin. Code R. 59A-3.246(4), (2019).
[25] Agency for Health Care Administration, Hospital & Outpatient Service Unit, Reports, *Stroke Centers* (updated Mar. 1, 2019), *available at* http://www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/Reports.shtml (last visited Mar. 12, 2019).
[26]The Joint Commission, *Certification for Acute Stroke Ready Center,* https://www.jointcommission.org/certification/acute_stroke_ready_hospitals.aspx; *Certification Comprehensive Stroke Center*, available at https://www.jointcommission.org/certification/advanced_certification_comprehensive_stroke_centers.aspx; *Certification for Primary Stroke Centers,* available at https://www.jointcommission.org/certification/primary_stroke_centers.aspx; *Certification for Thrombectomy-Capable Stroke Centers,* available at https://www.jointcommission.org/certification/certification_for_thrombectomycapable_stroke_centers.aspx, (last visited Mar. 13, 2019).
[27] Fla. Admin. Code R. 59A-3.066(2), (2019).
[28] Fla. Admin. Code R. 59A-3.246(4)(a), (2019).

in children. Medical staff must ensure that transfer to an appropriate facility for specialized care is provided to children and young adults with known childhood diagnoses.[29]

Acute Stroke Ready Centers (ASRC)

An ASRC is a hospital that is designated by the AHCA as meeting Florida regulation requirements based on national guidelines to meet the initial needs of stroke patients and support better outcomes for stroke care as part of a stroke care system.[30] A hospital with an ASRC certification is required to notify the ACHA if it no longer meets the criteria.[31]

Many patients with an acute stroke live in areas without ready access to a PSC or CSC; more than half the U.S. population lives more than an hour away from a stroke center.[32] Hospitals in areas with low population densities and relatively small numbers of patients with strokes may be less likely to have the resources to become a stroke center and may lack the experience and expertise to provide ongoing care for a stroke.[33] In such settings, there is a need to distinguish between those that offer enhanced care and expertise for acute stroke versus those with only basic or no organized abilities and expertise.[34]

An ASRC must have an acute stroke team available 24 hours a day, 7 days a week, and be capable of responding to patients who are in the emergency department or an inpatient unit within 15 minutes of being called. An ASRC team must consist of a physician and one or more of the following:
- A registered professional nurse;
- An advanced registered nurse practitioner; or
- A physician assistant.

Each ASRC team member must receive four or more hours of education related to cerebrovascular disease annually. An ASRC must fulfill the educational needs of its acute stroke team members, emergency department staff, and pre-hospital personnel by offering ongoing professional education at least twice per year.

An ASRC must designate a physician with knowledge of cerebrovascular disease to serve as the ASRC medical director. The medical director is responsible for implementing the stroke services protocols. The qualifications for the medical director of an ASRC are determined by the hospital governing board.

An ASRC must have the following services available 24 hours a day, 7 days a week:
- A dedicated emergency department;

[29] Fla. Admin. Code R. 59A-3.346(4)(b), (2019).
[30] Agency for Health Care Administration, Facility/Provider Definitions, *Acute Stroke Ready Center,* available at: http://www.floridahealthfinder.gov/about-ahca/facility-locator-glossary.aspx (last visited Mar. 12, 2019).
[31] Section 395.3038, F.S.
[32] Mark J. Alberts, et al, *Formation and Function of Acute Stroke–Ready Hospitals Within a Stroke System of Care Recommendations From the Brain Attack Coalition,* Stroke, Vol. 44, Issue 12 (Nov. 25, 2013), *available at* http://stroke.ahajournals.org/content/44/12/3382.full, (last visited Mar.12, 2019).
[33] Id.
[34] Id.

- Clinical laboratory services;[35]
- Diagnostic imaging capability for a head computed tomography (CT) and magnetic resonance imaging (MRI);
- Intravenous thrombolytics available;
- Anticoagulate reversal medication available;
- Neurologist services available in person or via telemedicine; and
- A transfer agreement with a PSC or CSC.[36]

Primary Stroke Centers (PSC)

A PSC certification recognizes hospitals that meet standards to support better outcomes for stroke care.[37] Such hospitals must have:

- A dedicated stroke-focused program;
- Be staffed by qualified medical professionals trained in stroke care; and
- Provide individualized care to meet stroke patients' needs based on recommendations of the Brain Attack Coalition and guidelines published by the American Heart Association and American Stroke Association or equivalent guidelines.[38]

These hospitals must also collect and utilize performance data to improve quality of care for stroke patients.[39]

In order for the AHCA to designate a hospital program as a PSC, the hospital program must be certified by the Joint Commission as a PSC or meet the certification criteria applicable to PSCs as outlined in the Joint Commission Disease-Specific Care Certification Manual, 2nd Edition.[40] The manual requires a PSC to:[41]

- Use a standardized method of delivering care;
- Support patient self-management activities;
- Tailor treatment and intervention to individual needs;
- Promote the flow of patient information across settings and providers, while protecting patient rights, security and privacy;
- Analyze and use standardized performance measure data to continually improve treatment plans; and
- Demonstrate the hospital's application of and compliance with clinical practice guidelines published by the American Heart Association and American Stroke Association or equivalent, evidence-based guidelines.[42]

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[35] Fla. Admin. Code R. 59A-3.255(6)(g), (2019).
[36] Fla. Admin. Code R. 59A-3.246(4)(c),5., (2019).
[37] American Heart Association, *Facts*: *Primary Stroke Centers,* available at https://www.yourethecure.org/facts-primary-stroke-centers (last visited Mar. 12, 2019).
[38] Id.
[39] *Supra* note 32.
[40] Fla. Admin. Code R. 59A-3.2085(15)(a), (2019).
[41] The standards are published in the 2019 *Disease-Specific Care Review Process Guide,* available at https://www.jointcommission.org/assets/1/6/2019_Disease_Specific_Care_Organization_RPG.pdf (last visited Mar. 12, 2019).
[42] The Joint Commission, *Discover the Most Comprehensive Stroke Certifications* (March, 2019), *available at* https://www.jointcommission.org/certification/primary_stroke_centers.aspx (last visited Mar. 12, 2019).

A PSC must have an acute stroke team available 24 hours a day, 7 days a week, capable of responding to patients who are in the emergency department or an inpatient unit within 15 minutes of being called. A PSC team must consist of a physician and one or more of the following:

- A registered professional nurse;
- An advanced registered nurse practitioner; or
- A physician assistant.

Each acute stroke team member must receive eight or more hours of education related to cerebrovascular disease annually. A PSC must fulfill the educational needs of its acute stroke team members, emergency department staff, and prehospital personnel by offering ongoing professional education at least twice per year.

A PSC must designate a physician with knowledge of cerebrovascular disease to serve as the PSC medical director. The medical director is responsible for implementing the stroke services protocols. The qualifications for the medical director are determined by the hospital's governing board.

A PSC must have the following services available 24 hours a day, 7 days a week:

- A dedicated emergency department;
- Clinical laboratory services;[43]
- Diagnostic imaging to include head CT, CT angiography (CTA), brain and cardiac magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), and transthoracic and/or transesophageal echocardiography;
- Intravenous thrombolytics;
- Anticoagulate reversal medication available for administration; and
- Neurologist services, available in person or via tele-medicine.

The following services may be available on-site or via a transfer agreement:

- Neurosurgical services within two hours of being deemed clinically necessary;
- Physical, occupational, or speech therapy; and
- Neurovascular interventions for aneurysms, stenting of carotid arteries, carotid endartectomy, and endovascular therapy.

A PSC must develop a quality improvement program designed to analyze data, correct errors, identify system improvements, and ongoing improvement in patient care and delivery of services.
A multidisciplinary institutional Quality Improvement Committee must monitor quality benchmarks and review clinical complications on a regular basis. Specific benchmarks, outcomes, and indicators must be defined, monitored, and reviewed by the Quality Improvement Committee on a regular basis for quality assurance purposes.[44]

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[43] *See* Fla. Admin. Code R. 59A-3.255(6)(g), (2019), for specific laboratory requirements.
[44] Fla. Admin. Code R.59A-3.246(4)(d), (2019).

Comprehensive Stroke Centers (CSC)

A CSC certification recognizes hospitals that meet standards to treat the most complex stroke cases.[45] These hospitals must meet all the criteria of a PSC. They must also have advanced imaging techniques and personnel trained in vascular neurology, neurosurgery, and endovascular procedures available 24 hours a day, 7 days a week, as well as neuroscience intensive care unit (ICU) and experience and expertise treating patients with large ischemic strokes, intracerebral hemorrhage, and subarachnoid hemorrhage.

In order for the AHCA to designate a hospital program as a CSC, the hospital program must have received PSC designation and also have the following:

- Personnel with clinical expertise in specified disciplines available;[46]
- Advanced diagnostic capabilities;[47]
- Neurosurgical and endovascular interventions available;[48]
- Specialized infrastructure; and
- Quality improvement and clinical outcomes measurements.[49]

The specialized infrastructure includes extensive requirements that the EMS and CSC leadership are linked to ensure:

- EMS use a stroke triage assessment tool;
- EMS patient assessment and management at the scene is consistent with evidence-based practice;
- Inter-facility transfers; and
- Ongoing communication with EMS providers regarding availability of services.

A CSC must maintain:

- An acute stroke team available 24 hours a day, 7 days a week;
- A system for facilitating inter-facility transfers;
- Defined access telephone numbers in a system for accepting appropriate transfers;
- Specialized inpatient units including an ICU with medical and nursing personnel who have special training, skills, and knowledge in the management of patients with all forms of neurological or neurosurgical conditions that require intensive care;
- An acute stroke unit with medical and nursing personnel who have training, skills, and knowledge sufficient to care for patients with neurological conditions, particularly acute stroke patients, and who are appropriately trained in neurological assessment and management;

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[45] The American Heart Association, *Get with the Guidelines – Stroke Clinical Tools*, available at https://www.heart.org/en/professional/quality-improvement/get-with-the-guidelines/get-with-the-guidelines-stroke/get-with-the-guidelines-stroke-clinical-tools (last visited Mar. 12, 2019).

[46] *See* Fla. Admin. Code R. 59A-3.2085(15)(b) (2019), for specific qualifications. Medical personnel with neurosurgical expertise must be available in a CSC on a 24 hours per day, 7 days per week basis and in-house within two hours, and neurologist(s) with special expertise in the management of stroke patients should be available 24 hours per day, 7 days per week.

[47] Id.

[48] *Supra* note 42.

[49] Id.

- Inpatient post-stroke rehabilitation and ensure continuing arrangements post-discharge for rehabilitation needs and medical management;
- The education of its medical and paramedical professionals by offering ongoing professional education for all disciplines;
- An ongoing effort to educate inpatients, their families, and the public about risk factor reduction or management, primary and secondary prevention, the warning signs and symptoms of stroke, and medical management and rehabilitation for stroke patients;
- A career development track to develop neuroscience nursing, particularly in the area of cerebrovascular disease; and
- Professional and administrative infrastructure necessary to conduct clinical trials and should have participated in stroke clinical trials within the last year and actively participate in ongoing clinical stroke trials.[50]

Thrombectomy-Capable Stroke Centers (TSC)

The Joint Commission, in collaboration with the American Heart Association and American Stroke Association, is offering a new advanced stroke certification for TSCs in response to the need to identify hospitals that meet rigorous standards for performing endovascular thrombectomy (EVT).[51]

To achieve TSC certification, a hospital must:
- Demonstrate compliance with the new standards for TSC certification;[52]
- Meet the minimum mechanical thrombectomy volume requirements, outlined in the following chart:

Joint Commission Quality Measures for Disease-Specific Care Certification[53]

Measure Set No.	Measure Short Name	Ischemic Stroke	Hemorrhagic Stroke
STK-1	Venous Thromboembolism (VTE) Prophylaxis	X	X
STK-2	Discharged on Antithrombotic Therapy	X	
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	X	
STK-4	Thrombolytic Therapy	X	
STK-5	Antithrombotic Therapy By End of Hospital Day 2	X	

[50] Id.
[51] The Joint Commission, *Certification for Thrombectomy-Capable Stroke Centers,* available at https://www.jointcommission.org/certification/certification_for_thrombectomycapable_stroke_centers.aspx (last visited Mar. 12, 2019)
[52] All certified Thrombectomy-Capable Stroke Center (TSC) programs will be required to collect and report data for the eight Joint Commission stroke (STK) measures in addition to five selected comprehensive stroke (CSTK) measures relating to ischemic strokes for a total performance measurement requirement of 13 measures. In addition to collecting and reporting this data, organizations are expected to use this information for ongoing performance improvement efforts. The Joint Commission, *Thrombectomy-Capable Stroke Performance Measurement Requirements*, available at https://www.jointcommission.org/certification/thrombectomycapable_stroke_performance_measurement_requirements.aspx (last visited Mar. 12, 2019)
[53] Id.

Measure Set No.	Measure Short Name	Ischemic Stroke	Hemorrhagic Stroke
STK-6	Discharged on Statin Medication	X	
STK-8	Stroke Education	X	X
STK-10	Assessed for Rehabilitation	X	X

- Demonstrate the ability to perform mechanical thrombectomy, 24 hours a day, 7 days a week;
- Maintain dedicated intensive care beds for acute ischemic stroke patients;
- Meet the expectations for the availability of staff and practitioners closely aligned with CSC expectations;
- Collect and review data regarding adverse patient outcomes following mechanical thrombectomy; and
- Collect data for 13 standardized performance measures listed in the chart above.[54]

Stroke Center Inventory

The AHCA maintains a list of hospitals offering stroke services.[55] The list of hospitals meeting the criteria as a ASRC, PSC, or CSC is published on the AHCA's website.[56,57]There are also 286 EMS providers[58] that report patient stroke data to the DOH.[59] However, the data are not standardized, and many of the data that the DOH currently collects come from voluntary participation in the DOH's EMS Tracking and Reporting System (EMSTARS) program[60] and only includes data on response, provider impression, procedures and medication, and destination.[61]

Health care records submitted to the DOH from licensed EMS providers are confidential and exempt from public records requests under s. 401.30(4), F.S.

Stroke Patient Transportation

The DOH has also developed a stroke assessment tool.[62] The tool is available on the DOH's website and is provided to EMS providers.[63] Each licensed EMS provider must use a stroke triage assessment tool that is substantially similar to the DOH's stroke triage assessment tool.[64]

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[54] *Supra* note 55.
[55] Section 395.3038, F.S.
[56] *Supra* note 255.
[57] Id. A list of hospitals with a stroke center designation is also available through the facility locator tool on www.floridahealthfinder.gov, (last visited Mar. 12, 2019).
[58] Department of Health, *EMS Provider Licensure Report*, available at http://www.floridahealth.gov/licensing-and-regulation/ems-service-provider-regulation-and-compliance/ems-providers.html (last visited Mar. 12, 2019).
[59]Agency For Health Care Administration, *Hospital ER Services,* available at http://www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/reports/Hospital_ER_Services.pdf, (last visited Mar. 13, 2019).
[60] The EMSTARS program allows emergency medical providers to capture incident level patient care records for every emergency activation.
[61] *Supra* note 59.
[62] Section 395.3041(2), F.S.
[63] Section 395.3041(2), F.S.
[64] Id.

Annually, by June 1, the DOH sends the list of ASRCs, PSCs, and CSCs to the medical director of each licensed EMS provider in Florida.[65]

III. Effect of Proposed Changes:

CS/SB 1460 amends s. 395.3038, F.S., to add TSCs to the AHCA's list of certified stroke centers.

The bill requires that listed hospitals must be certified by a nationally recognized certifying organization as meeting the criteria for an ASRC, PSC, TSC, or CSC. The AHCA's list must include only those hospitals that have submitted documentation to the AHCA verifying their certification as an ASRC, PSC, TSC or CSC. That documentation may include, but is not limited to, any stroke center that offers and performs mechanical endovascular therapy (EVT) consistent with the standards identified by a nationally recognized, guidelines-based organization approved by the AHCA.

The bill eliminates the use of an affidavit attesting that the hospital's stroke program meets the criteria for one of the stroke center designations, as specified by AHCA rule, as an alternate method for the hospital to be listed.

The bill directs that if a hospital chooses to no longer be certified by a nationally recognized certifying organization, or has not attained national certification as an ASRC, PSC, CSC, or TSC, the hospital must notify the AHCA and the AHCA must immediately remove the hospital from its list of stroke centers.

The bill strikes AHCA's rule-making authority to establish criteria for an ASRC, PSC, and CSC which were required to be substantially similar to the certification standards for the same categories of stroke centers of a nationally recognized accrediting organization.

The bill amends s. 395.30381, F.S., to require that the stroke performance data on ASRCs, PSCs, and CSCs, received by DOH from the private data collection entity charged with maintaining the statewide stroke registry (EMSTARS), include TCSs and performance measures on compliance with nationally recognized guidelines.

The bill amends s. 395.3039, F.S., to prohibit a hospital from advertising that it is a state-listed ASRC, PSC, CSC, or TSC, unless the hospital has submitted documentation to the AHCA verifying that it is certified and meets the certification criteria of a nationally recognized certifying organization.

The bill amends s. 395.3041, F.S., to direct the DOH to include data from TSCs in its annual list to the medical directors of licensed EMS providers. The bill directs the medical directors of licensed EMS providers to develop and implement transportation and rerouting protocols, in addition to assessment and treatment protocols, for stroke patients with the intent to reroute them to ASRCs, PSCs, CSCs, and TSCs. The protocols must include plans for the triage and transport of suspected stroke patients, including, but not limited to, patients who may have an emergent

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[65] Section 395.3041(1), F.S.

large vessel occlusion, to an appropriate facility within a specified timeframe after such patients exhibit the sudden onset of stroke-related symptoms.

The bill directs the DOH and the medical directors of licensed EMS providers to specifically consider the capability of an emergency receiving facility to improve outcomes for patients who are suspected, based on clinical severity, of having an emergent large vessel occlusion in developing the protocols.

The effective date of the bill is July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Hospitals that maintain ASRCs, PSCs, CSCs, or TSCs, are required under CS/SB 1460 to be certified by a nationally recognized certifying organization and may incur a cost for their application for certification. They may need to purchase new software and incur labor costs to collect, maintain, and send the required data to the DOH. Such costs, if any, are indeterminate.

C. Government Sector Impact:

The DOH may need additional resources to fund its contract with the private entity engaged to establish and maintain the statewide stroke registry, due to the need to begin collecting and analyzing the additional data required under the bill.

VI. Technical Deficiencies:

CS/SB 1460 removes from the underlying bill the requirement for the DOH to join forces with licensed EMS service providers to develop and implement transportation and rerouting protocols for stroke patients. However, on line 119, the CS fails to also remove the DOH from the process of considering what to include in the protocols. An amendment to correct this technical deficiency should be considered.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.3038, 395.30381, 395.3039, and 395.3041.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 18, 2019:
The CS:

- Removes specific entities that may certify that an ASRCs, PSCs, CSCs, or TSCs meets the standards of a specific type of stroke center and requires only that the certifying entity must be a nationally recognized, guidelines-based organization approved by the AHCA; and
- Removes the DOH from the protocol development and implementation process with licensed EMS medical directors for transportation and rerouting of stroke patients with the intent to reroute them to ASRCs, PSCs, CSCs, and TSCs.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/18/2019	.	
	.	
	.	
	.	

The Committee on Health Policy (Book) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 43 - 110

4 and insert:

5 consistent with the standards identified by a nationally

6 recognized guidelines-based organization approved by the agency

7 ~~that attest in an affidavit submitted to the agency that the~~

8 ~~hospital meets the named criteria, or those hospitals that~~

9 ~~attest in an affidavit submitted to the agency that the hospital~~

10 ~~is certified as an acute stroke ready center, a primary stroke~~

11 ~~center, or a comprehensive stroke center by a nationally~~

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12 ~~recognized accrediting organization~~.
13 (2)(a) If a hospital no longer chooses to be certified by a
14 nationally recognized certifying organization or has not
15 attained certification consistent with ~~meet~~ the criteria in
16 subsection (1) as ~~for~~ an acute stroke ready center, a primary
17 stroke center, a thrombectomy-capable stroke center, or a
18 comprehensive stroke center, the hospital shall notify the
19 agency and the agency shall immediately remove the hospital from
20 the list of stroke centers.
21 ~~(3) The agency shall adopt by rule criteria for an acute~~
22 ~~stroke ready center, a primary stroke center, and a~~
23 ~~comprehensive stroke center which are substantially similar to~~
24 ~~the certification standards for the same categories of stroke~~
25 ~~centers of a nationally recognized accrediting organization.~~
26 Section 2. Section 395.30381, Florida Statutes, is amended
27 to read:
28 395.30381 Statewide stroke registry.—
29 (1) Subject to a specific appropriation, the department
30 shall contract with a private entity to establish and maintain a
31 statewide stroke registry to ensure that the stroke performance
32 measures required to be submitted under subsection (2) are
33 maintained and available for use to improve or modify the stroke
34 care system, ensure compliance with standards and nationally
35 recognized guidelines, and monitor stroke patient outcomes.
36 (2) Each acute stroke ready center, primary stroke center,
37 thrombectomy-capable stroke center, and comprehensive stroke
38 center shall regularly report to the statewide stroke registry
39 information containing ~~specified by the department, including~~
40 nationally recognized stroke performance measures.

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41 (3) The department shall require the contracted private
42 entity to use a nationally recognized platform to collect data
43 from each stroke center on the stroke performance measures
44 required in subsection (2). The contracted private entity shall
45 provide regular reports to the department on the data collected.
46 (4) A ~~No~~ liability of any kind or character for damages or
47 other relief shall not arise or be enforced against any acute
48 stroke ready center, primary stroke center, thrombectomy-capable
49 stroke center, or comprehensive stroke center by reason of
50 having provided such information to the statewide stroke
51 registry.
52 Section 3. Section 395.3039, Florida Statutes, is amended
53 to read:
54 395.3039 Advertising restrictions.—A person may not
55 advertise to the public, by way of any medium whatsoever, that a
56 hospital is a state-listed ~~primary or comprehensive~~ stroke
57 center unless the hospital has submitted documentation to the
58 agency verifying that it is certified and meets the criteria
59 ~~provided notice to the agency~~ as required in s. 395.3038 ~~by this~~
60 ~~act~~.
61 Section 4. Subsections (1), (3), and (4) of section
62 395.3041, Florida Statutes, are amended to read:
63 395.3041 Emergency medical services providers; triage and
64 transportation of stroke victims to a stroke center.—
65 (1) By June 1 of each year, the department shall send the
66 list of acute stroke ready centers, primary stroke centers,
67 thrombectomy-capable stroke centers, and comprehensive stroke
68 centers to the medical director of each licensed emergency
69 medical services provider in the ~~this~~ state.

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70 (3) The medical director of each
71
72 ================= T I T L E A M E N D M E N T ================
73 And the title is amended as follows:
74 Delete line 15
75 and insert:
76 medical director of each

By Senator Book

32-01040A-19 20191460__

1 A bill to be entitled
2 An act relating to stroke centers; amending s.
3 395.3038, F.S.; revising the criteria for hospitals to
4 be included on the state list of stroke centers by the
5 Agency for Health Care Administration; removing
6 provisions requiring the agency to adopt rules
7 establishing the criteria for such list; amending s.
8 395.30381, F.S.; revising provisions relating to the
9 statewide stroke registry to conform to changes made
10 by the act; amending s. 395.3039, F.S.; revising
11 provisions prohibiting the advertisement of a hospital
12 as a state-listed stroke center, unless certain
13 conditions are met, to conform to changes made by the
14 act; amending s. 395.3041, F.S.; requiring the
15 Department of Health and the medical director of each
16 licensed emergency medical services provider to
17 develop and implement protocols for the assessment,
18 treatment, transport, and rerouting of suspected
19 stroke patients to certain stroke centers; requiring
20 that such protocols include specified plans for the
21 triage and transport of suspected stroke patients;
22 providing an effective date.
23
24 Be It Enacted by the Legislature of the State of Florida:
25
26 Section 1. Subsection (1), paragraph (a) of subsection (2),
27 and subsection (3) of section 395.3038, Florida Statutes, are
28 amended to read:
29 395.3038 State-listed stroke centers; notification of

30 hospitals.—
31 (1) The agency shall make available on its website and to
32 the department a list of the name and address of each hospital
33 that is certified by a nationally recognized certifying
34 organization as ~~meets the criteria for~~ an acute stroke ready
35 center, a primary stroke center, a thrombectomy-capable stroke
36 center, or a comprehensive stroke center. The list of stroke
37 centers must include only those hospitals that have submitted
38 documentation to the agency verifying their certification as an
39 acute stroke ready center, a primary stroke center, a
40 thrombectomy-capable stroke center, or a comprehensive stroke
41 center, which may include, but is not limited to, any stroke
42 center that offers and performs mechanical endovascular therapy
43 consistent with the rigorous standards identified by the Joint
44 Commission, the American Heart Association, the American Stroke
45 Association, or any other nationally recognized guidelines-based
46 organization approved by the agency ~~that attest in an affidavit~~
47 ~~submitted to the agency that the hospital meets the named~~
48 ~~criteria, or those hospitals that attest in an affidavit~~
49 ~~submitted to the agency that the hospital is certified as an~~
50 ~~acute stroke ready center, a primary stroke center, or a~~
51 ~~comprehensive stroke center by a nationally recognized~~
52 ~~accrediting organization~~.
53 (2)(a) If a hospital no longer chooses to be certified by a
54 nationally recognized certifying organization or has not
55 attained certification consistent with ~~meet~~ the criteria in
56 subsection (1) as ~~for~~ an acute stroke ready center, a primary
57 stroke center, a thrombectomy-capable stroke center, or a
58 comprehensive stroke center, the hospital shall notify the

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

59 agency and the agency shall immediately remove the hospital from
60 the list of stroke centers.
61 ~~(3) The agency shall adopt by rule criteria for an acute~~
62 ~~stroke ready center, a primary stroke center, and a~~
63 ~~comprehensive stroke center which are substantially similar to~~
64 ~~the certification standards for the same categories of stroke~~
65 ~~centers of a nationally recognized accrediting organization.~~
66 Section 2. Section 395.30381, Florida Statutes, is amended
67 to read:
68 395.30381 Statewide stroke registry.—
69 (1) Subject to a specific appropriation, the department
70 shall contract with a private entity to establish and maintain a
71 statewide stroke registry to ensure that the stroke performance
72 measures required to be submitted under subsection (2) are
73 maintained and available for use to improve or modify the stroke
74 care system, ensure compliance with standards and nationally
75 recognized guidelines, and monitor stroke patient outcomes.
76 (2) Each acute stroke ready center, primary stroke center,
77 thrombectomy-capable stroke center, and comprehensive stroke
78 center shall regularly report to the statewide stroke registry
79 information containing ~~specified by the department, including~~
80 nationally recognized stroke performance measures.
81 (3) The department shall require the contracted private
82 entity to use a nationally recognized platform to collect data
83 from each stroke center on the stroke performance measures
84 required in subsection (2). The contracted private entity shall
85 provide regular reports to the department on the data collected.
86 (4) A ~~No~~ liability of any kind or character for damages or
87 other relief shall not arise or be enforced against any acute

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

88 stroke ready center, primary stroke center, thrombectomy-capable
89 stroke center, or comprehensive stroke center by reason of
90 having provided such information to the statewide stroke
91 registry.
92 Section 3. Section 395.3039, Florida Statutes, is amended
93 to read:
94 395.3039 Advertising restrictions.—A person may not
95 advertise to the public, by way of any medium whatsoever, that a
96 hospital is a state-listed ~~primary or comprehensive~~ stroke
97 center unless the hospital has submitted documentation to the
98 agency verifying that it is certified and meets the criteria
99 ~~provided notice to the agency~~ as required in s. 395.3038 ~~by this~~
100 ~~act~~.
101 Section 4. Subsections (1), (3), and (4) of section
102 395.3041, Florida Statutes, are amended to read:
103 395.3041 Emergency medical services providers; triage and
104 transportation of stroke victims to a stroke center.—
105 (1) By June 1 of each year, the department shall send the
106 list of acute stroke ready centers, primary stroke centers,
107 thrombectomy-capable stroke centers, and comprehensive stroke
108 centers to the medical director of each licensed emergency
109 medical services provider in the ~~this~~ state.
110 (3) The department and the medical director of each
111 licensed emergency medical services provider shall develop and
112 implement assessment, treatment, transport, and rerouting
113 ~~transport-destination~~ protocols for stroke patients with the
114 intent to assess, treat, ~~and~~ transport, and reroute stroke
115 patients to acute stroke ready centers, primary stroke centers,
116 thrombectomy-capable stroke centers, and comprehensive stroke

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

117 centers. The protocols must include plans for the triage and
118 transport of suspected stroke patients, including, but not
119 limited to, patients who may have an emergent large vessel
120 occlusion, to an appropriate facility within a specified
121 timeframe after such patients exhibit the sudden onset of
122 stroke-related symptoms. In developing the protocols, the
123 department and the medical director of each licensed emergency
124 medical services provider must consider the capability of an
125 emergency receiving facility to improve outcomes for patients
126 who are suspected, based on clinical severity, of having an
127 emergent large vessel occlusion ~~the most appropriate hospital~~.
128 (4) Each emergency medical services provider licensed under
129 chapter 401 must comply with ~~all sections of~~ this section and
130 ss. 395.3038-395.3039 ~~act~~.
131 Section 5. This act shall take effect July 1, 2019.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Children, Families, and Elder Affairs, *Chair*
Appropriations
Appropriations Subcommittee on Education
Appropriations Subcommittee on Health and Human Services
Health Policy
Rules

JOINT COMMITTEE:
Joint Legislative Budget Commission

SENATOR LAUREN BOOK
32nd District

March 7, 2019

Chair Gayle Harrell
Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chair Harrell:

I respectfully request that **SB 1460—Stroke Centers** be placed on the agenda for the next Committee on Health Policy meeting.

Should you have any questions or concerns, please feel free to contact my office or me. Thank you in advance for your consideration.

Thank you,

Senator Lauren Book
Senate District 32

Cc: Allen Brown, Staff Director
Celia Georgiades, Administrative Assistant

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: SB 1614

INTRODUCER: Senator Baxley

SUBJECT: Lakes and Lagoons

DATE: March 15, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Williams	Brown	HP	**Favorable**
2.			RC	
3.				
4.				
5.				
6.				

I. Summary:

SB 1614 provides an exemption for a manmade lake or lagoon with a surface area of 43,000 square feet or more from the definition of "public swimming pool" or "swimming pool" as those terms are used in regulation of pools by the Department of Health (DOH).

The bill has no fiscal impact.

The effective date of the bill is July 1, 2019.

II. Present Situation:

Department of Health Regulation of Public and Residential Swimming Pools

The DOH is charged by law with responsibilities relating to environmental health. This is reflected in the inclusion of environmental health services as a key part of the functional system of county health department services. Such services include those relating to swimming pools.[1] This is further reflected in the powers and duties of the DOH, which include administering and enforcing "laws and rules relating to sanitation, control of communicable diseases, illnesses and hazards to health among humans and from animals to humans, and the general health of the people of the state,"[2] and, more specifically, the inclusion of a public swimming and bathing facilities function as provided in chapter 514, F.S., as part of the general environmental health functions of the DOH.[3]

[1] See s. 154.01(1) and (2), F.S.

[2] See s. 381.0011, F.S.

[3] See s. 381.006, F.S.

Chapter 514, F.S., relates to the DOH responsibilities specific to public swimming and bathing facilities. This chapter addresses: definitions, exemptions from supervision or regulation, and variances; DOH authorization; sampling of beach waters, public bathing places, and the issuance of advisories; an advisory committee specific to the sampling of beach waters; assignment of authority to county health departments; an advisory review board; approval for construction, development, or modification of public swimming pools or public bathing places; permitting for public swimming pools; required safety features for public swimming pools and spas; fee schedules; right of entry and inspection; denial, suspension, or revocation of permits and administrative fines; injunctions to restrain violations; certification of swimming instructors and lifeguards; certification of swimming instructors for people who have developmental disabilities; and certification of public pool service technicians.

As a supplement to the statutory provisions, the DOH has adopted rules specific to its public swimming and bathing places responsibilities. The rules address: general provisions; exemptions; operational requirements; supervision and safety; bathing places; fees; variances; enforcement; and technician certification.[4]

The general purpose and intent in regulating public swimming places is to ensure water quality sanitation to prevent disease outbreaks, avoid sanitary nuisances, and to ensure safety engineering to avoid accidents by public swimming pool users.[5]

Exemptions that currently exist include those specific to: private pools and water therapy facilities connected with facilities such as hospitals, medical doctors' offices, and licensed physical therapy establishments; pools serving condominium or cooperative associations of more than 32 units and which are not rented for less than 60 days; a private pool used for private swimming lessons; any pool serving a residential child care agency registered and exempt under s. 409.176, F.S.; a portable pool used for swimming lessons; and a temporary pool. Further, the DOH may grant variances from its own rules under certain circumstances and grant variance under the Florida Building Code under certain circumstances.[6] The DOH rules provide the process and procedures to be followed and the basis for the granting of exemptions.[7]

It should be noted that the Department of Health's involvement with the "supervision over sanitation, healthfulness and cleanliness of swimming pools, bath houses, public swimming and bathing places and all related appurtenances" dates back to 1919, a full 100 years.[8]

Closely related to ch. 514, F.S., specific to public swimming pools and bathing places is ch. 515, F.S., relating to DOH's authority regarding swimming pool safety in the context of residential requirements.[9]

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[4] See Ch. 64E-9, Florida Administrative Code (F.A.C.)
[5] Department of Health, *Senate Bill 1614 Analysis* (Mar. 11, 2019) (on file with the Senate Committee on Health policy).
[6] See s. 514.0115, F.S.
[7] See Rule 64E-0035, F.A.C.
[8] Chapter 7825, section 2, 1919, found at: http://edocs.dlis.state.fl.us/fldocs/leg/actsflorida/1919/LOF1919V1-7783-7906.pdf (last visited Mar. 12, 2019).
[9] See ch. 515, F.S.

Construction Requirements for Pools and Equipment

The construction requirements for pools and equipment are regulated under ch. 553, F.S., the Florida Building Codes Act, and the 2017 Florida Building Code, chapter 4, section 454.1. Section 553.79, F.S., is specific to permits, applications, issuance, and inspections under the Florida Building Code. Subsection (11) of this section provides that the local (county or municipal) enforcing agency may not issue a building permit to construct, develop, or modify a public swimming pool without proof of application, whether complete or incomplete, for an operating permit pursuant to s. 514.031, F.S., from the DOH. A certificate of completion or occupancy from the local enforcing agency may not be issued until such operating permit is issued. The local enforcing agency must conduct its review of the building permit application upon filing and in accordance with this chapter. The local enforcing agency may confer with the DOH, if necessary, but may not delay the building permit application review while awaiting comment from the DOH.

The Florida Building Code, chapter 4, section 454.1, as amended, provides specifications for swimming pool construction. Included are definitions, structural specifications such as slope, depth and markings, signage, color, stairs, handrails and grab-rails, obstructions, sun shelves, electrical equipment and wiring including ground-fault circuit interrupter protection, underwater lighting, ultraviolet light disinfectant equipment, filtration and recirculating system, repairs and alterations, and ionization units and ozone generators.[10]

III. Effect of Proposed Changes:

Section 1 provides an exemption for a manmade lake or lagoon with a surface are of 43,000 square feet or more from the definition of "public swimming pool" as that term is used for the regulation of public swimming pools by the Department of Health under ch. 514, F.S.

Section 2 provides an exemption for a manmade lake or lagoon with a surface are of 43,000 square feet or more from the definition of "swimming pool" as that term is used for the regulation of residential swimming pools by the Department of Health under ch. 515, F.S.

Section 3 provides for an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[10] See the Florida Building Code, chapter 4 revisions, 2017, *available at* http://www.floridapoolpro.com/wp-content/uploads/2014/09/2017-FLORIDA-BUILDING-CODE-6TH-EDITION-RECAP-OF-APPROVED-PUBLIC-POOL-CHANGES-6.16.17-with-logos.pdf (last visited Mar. 13, 2019).

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The DOH indicates that it is unclear if a "manmade lake or lagoon with a surface area of 43,000 square feet or more" would be regulated as a public bathing place, as defined in s. 514.011(4), or not regulated at all. If not regulated, then no sanitation or safety standards would apply, according to the DOH.[11]

On June 15, 2018, a Petition for a Declaratory Statement was entered between Crystal Lagoons U.S. Corp and the State of Florida, Department of Health, and on August 21, 2018, a Final Order was issued stating that "lagoons" are defined as "public bating places" as defined under s. 514.011(4), F.S., not as "swimming pools" as defined under s. 514.011(2), F.S.[12]

The DOH has developed and shared with the Department of Business and Professional Regulation (DBPR) on December 15, 2018, verbiage to be included in the Florida Building Code

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[11] *Supra* note 5

[12] Crystal Lagoons v. State of Florida, Department of Health, DOH Case No.: 2018-0137; Rendition No.: DOH-18-0357-FOI-HO (Available from staff of the Committee on Health policy).

specific to public bathing places.[13] The code does not have any related provisions at present. Specially addressed are proposed standards relating to equipment that delivers chemicals, chemical application, size and capacity of place, liner material, safety considerations, vacuum outlet safety, review of specific structural features, and review of specific activity features. A public meeting is scheduled on March 22, 2019, at which the Florida Building Commission will consider this modification to the Florida Building Code.[14]

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 514.011 and 515.25.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

[13] Proposed Code Modifications document submitted to the Department of Business and Professional Regulation, Dec. 15, 2018 (available from staff of the Senate Committee on Health Policy).

[14] See the link to the Florida Building Commission meeting calendar, and specifically beginning at page 176, *available at* http://www.floridabuilding.org/fbc/commission/FBC_0319/Code_Development/Details/swimming_pool_detail2.pdf (last visited Mar. 14, 2019).

By Senator Baxley

12-01707-19 20191614__

1 A bill to be entitled
2 An act relating to lakes and lagoons; amending ss.
3 514.011 and 515.25, F.S.; excluding manmade lakes and
4 lagoons over a certain size from the definitions of
5 the terms "public swimming pool" and "swimming pool,"
6 respectively, for certain purposes; providing an
7 effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Subsection (2) of section 514.011, Florida
12 Statutes, is amended to read:
13 514.011 Definitions.—As used in this chapter:
14 (2) "Public swimming pool" or "public pool" means a
15 watertight structure of concrete, masonry, or other approved
16 materials which is located either indoors or outdoors, used for
17 bathing or swimming by humans, and filled with a filtered and
18 disinfected water supply, together with buildings,
19 appurtenances, and equipment used in connection therewith. A
20 public swimming pool or public pool shall mean a conventional
21 pool, spa-type pool, wading pool, special purpose pool, or water
22 recreation attraction, to which admission may be gained with or
23 without payment of a fee and includes, but is not limited to,
24 pools operated by or serving camps, churches, cities, counties,
25 day care centers, group home facilities for eight or more
26 clients, health spas, institutions, parks, state agencies,
27 schools, subdivisions, or the cooperative living-type projects
28 of five or more living units, such as apartments,
29 boardinghouses, hotels, mobile home parks, motels, recreational

30 vehicle parks, and townhouses. The term does not include a
31 manmade lake or lagoon with a surface area of 43,000 square feet
32 or more.
33 Section 2. Subsection (11) of section 515.25, Florida
34 Statutes, is amended to read:
35 515.25 Definitions.—As used in this chapter, the term:
36 (11) "Swimming pool" means any structure, located in a
37 residential area, that is intended for swimming or recreational
38 bathing and contains water over 24 inches deep, including, but
39 not limited to, in-ground, aboveground, and on-ground swimming
40 pools; hot tubs; and nonportable spas. The term does not include
41 a manmade lake or lagoon with a surface area of 43,000 square
42 feet or more.
43 Section 3. This act shall take effect July 1, 2019.

2019 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Florida Department of Health

BILL INFORMATION	
BILL NUMBER:	SB 1614
BILL TITLE:	Lakes and Lagoons
BILL SPONSOR:	Baxley
EFFECTIVE DATE:	7-1-2019

COMMITTEES OF REFERENCE
1) Health Policy
2) Rules
3) Click or tap here to enter text.
4) Click or tap here to enter text.
5) Click or tap here to enter text.

CURRENT COMMITTEE
Click or tap here to enter text.

SIMILAR BILLS	
BILL NUMBER:	N/A
SPONSOR:	Click or tap here to enter text.

PREVIOUS LEGISLATION	
BILL NUMBER:	N/A
SPONSOR:	Click or tap here to enter text.
YEAR:	Click or tap here to enter text.
LAST ACTION:	Click or tap here to enter text.

IDENTICAL BILLS	
BILL NUMBER:	757
SPONSOR:	Massullo, Jr.

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	03/01/19
LEAD AGENCY ANALYST:	Bob Vincent
ADDITIONAL ANALYST(S):	Click or tap here to enter text.
LEGAL ANALYST:	Adrienne Rodgers
FISCAL ANALYST:	Darius Pelham

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

The bill adds an exemption to the definition of a public swimming pool in s. 514.011(2), FS, that excludes from this definition a manmade lake or lagoon that is over ~1 acre.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Water quality sanitation to prevent disease outbreaks and safety engineering of public swimming pools came to the department's attention at a new style of a manmade constructed public bathing place. The construction requirements for pools and equipment are regulated under Chapter 553, FS, and the 2017 Florida Building Code Chapter 4, section 454.1. The department has jurisdiction for variances from the FBC and the DOH Chapter 64E-9, FAC, and issues annual operating permits for all public pools, but not for public bathing places. The department's regulation of public swimming pools and bathing places is important in the prevention of disease, sanitary nuisances, and accidents by which the health or safety of an individual(s) may be threatened or impaired.

2. EFFECT OF THE BILL:

The bill specifies in Section 1 and 2 that a manmade lake or lagoon with a surface area of 43,000 square feet or more is not to be considered a swimming pool. If this bill becomes law, these manmade lakes or lagoons would not undergo the same regulation/inspections to ensure health and safety as listed above.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y☐ N☒

If yes, explain:	N/A
Is the change consistent with the agency's core mission?	Y☐ N☐
Rule(s) impacted (provide references to F.A.C., etc.):	

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	Unknown
Opponents and summary of position:	Unknown

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y☐ N☒

If yes, provide a description:	N/A
Date Due:	N/A
Bill Section Number(s):	N/A

6. ARE THERE ANY NEW GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSIONS, ETC. REQUIRED BY THIS BILL? Y☐ N☒

Board:	N/A
Board Purpose:	N/A
Who Appoints:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y☐ N☒

Revenues:	None
Expenditures:	The local county or city building department has authority over these man-made construction permits and inspections.
Does the legislation increase local taxes or fees? If yes, explain.	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	Click or tap here to enter text.

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y☒ N☐

Revenues:	None
Expenditures:	Unknown at this time.
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A FISCAL IMPACT TO THE PRIVATE SECTOR? Y☒ N☐

Revenues:	Unknown
Expenditures:	Unknown
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y☐ N☒

If yes, explain impact.	Click or tap here to enter text.
Bill Section Number:	Click or tap here to enter text.

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y☐ N☒

If yes, describe the anticipated impact to the agency including any fiscal impact.	N/A

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y☒ N☐

If yes, describe the anticipated impact including any fiscal impact.	Click or tap here to enter text.

ADDITIONAL COMMENTS

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	Unclear if a "manmade lake or lagoon with a surface area of 43,000 square feet or more" would then be regulated as a public bathing place, as defined in s. 514.011(4), or not regulated at all. If not regulated, then no sanitation or safety standards would apply.

RECEIVED
DEPARTMENT OF HEALTH
2018 AUG 21 PM 3:55
OFFICE OF THE CLERK

STATE OF FLORIDA
DEPARTMENT OF HEALTH

IN RE:

CRYSTAL LAGOONS U.S. CORP.,

Petition for Declaratory Statement.
_______________________________/

DOH Case No..: 2018-0137
Rendition No.: DOH-18-0357-FOI-HO

FINAL ORDER

THIS CAUSE is before the Department of Health (Department) on the Petition for Declaratory Statement (Petition) filed on June 15, 2018, by Crystal Lagoons U.S. Corp. (Crystal Lagoons). The Department noticed receipt of the Petition on June 29, 2018. See Notice 20603981, 44 Fla. Admin. Reg. 127 (Jun. 29, 2018). No timely-filed motion to intervene has been filed.

The assertions of fact set forth in the Petition are treated as true and materially complete for purposes of issuing this Final Order on the Petition filed by Crystal Lagoons. If material facts were misrepresented or omitted from the Petition, this Final Order will be of no force and effect. This Final Order is inapplicable to, and cannot be relied up by, any person other than Crystal Lagoons.

This Final Order applies only to Chapter 514, Florida Statutes (2017), and the Department's authority to administer and enforce the provisions of that chapter. This Final Order does not represent the opinion of the Department as to the applicability of any other Federal, state, or local statute, rule, regulation, ordinance, or other law applicable to Crystal Lagoons' activities. This Final Order does not bind any agency or entity other than the Department. Legal representations and arguments in the Petition, if any, are not adopted by the Department.

FINDINGS OF FACT

1. Crystal Lagoons seeks a declaratory statement that the bodies of water created and operated by Crystal Lagoons' licensees using the process patented by Crystal Lagoons are "public bathing places" as defined by section 514.011(4), Florida Statutes (2017). Pet. for Decl. Stmt., ¶¶ 17, 18.

2. Crystal Lagoons licenses its patented process to licensees in Florida to create and operate bodies of water that are used for swimming, diving, and recreational bathing and are held out by the owner to the public for this purpose. Pet. for Decl. Stmt., ¶¶ 3, 4.

3. Crystal Lagoons' patented process involves the creation and operation of an artificial impoundment of water. Pet. for Decl. Stmt., ¶ 3.

4. Crystal Lagoons' process does not use filtration of the total volume of the body of water as the primary means to meet established health standards. Pet. for Decl. Stmt., ¶ 16.

CONCLUSIONS OF LAW

1. The Department has jurisdiction of the subject matter of this cause, being authorized to administer and enforce Chapter 514, Florida Statutes, and the rules adopted thereunder. See § 514.021, Fla. Stat. (2017).

2. Crystal Lagoons requests this Final Order pursuant to section 120.565, Florida Statutes, and Chapter 28-105, of the *Florida Administrative Code*. These sections authorize a substantially affected person to petition an agency that has authority to administer a statute or rule to issue a declaratory statement of the applicability of the statute or rule to that person's particular circumstances. See § 120.565, Fla. Stat. (2017); Fla. Admin. Code R. 28-105.

3. Crystal Lagoons has standing to seek a final order on the Petition because Crystal Lagoons has a substantial interest in correctly representing to its licensees that the Crystal Lagoons process creates a public bathing place as opposed to a public swimming pool, as those terms are defined under existing Florida law. See First Nat. Bank & Trust Co. of Muskogee v. Heilman, 62 F.2d 157, 159 (C.C.A. 10th Cir. 1932) (a company licensed in the state is presumed to know the law governing its transactions).

4. A "public swimming pool" is a "structure" that is "filled with a filtered and disinfected water supply." See § 514.011(2), Fla. Stat. (2017). To meet established health standards, filtration systems must maintain the total volume recirculation rate described at rule 64E-9.008(10)(b), *of the Florida Administrative Code*. Crystal Lagoons' process does not employ a total volume recirculation system to meet established health standards. Pet. for Decl. Stmt., ¶ 16. Consequently, bodies of water created using the Crystal Lagoons process are not public swimming pools.

5. A "public bathing place" is "a body of water, natural or modified by humans," held out to the public for swimming, diving, and recreational bathing, the bathing waters of which include, but are not limited to "artificial impoundments." See § 514.011(4), Fla. Stat. (2017).

6. The Crystal Lagoons patented process creates or modifies bodies of water to form artificial impoundments of water having a discernible shoreline. Pet. for Decl. Stmt., ¶ 12. Crystal Lagoons' licensees create, operate, and hold out these bodies of water to the public for swimming, diving, and recreational bathing. Pet. for Decl. Stmt., ¶ 22. Consequently, bodies of water created and operated using Crystal Lagoons' patented process are public bathing places.

7. This Final Order applies solely to persons licensed by Crystal Lagoons to use a process that was patented by Crystal Lagoons and recorded by the United States Patent and Trademark Office as of the date of the filing of the Petition. This Final Order does not apply to non-patented processes developed or in development by Crystal Lagoons, whether or not those processes are currently licensed by Crystal Lagoons for the creation and operation of bodies of water in Florida.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, bodies of water created and operated by Crystal Lagoons' licensees using a process that was patented in the name of Crystal Lagoons, as owner, and recorded by the United States Patent and Trademark Office as of the date of the filing of the Petition are "public bathing places" as that term is defined by section 514.011(4), Florida Statutes (2017).

DONE and ORDERED this 22 day of AUGUST, 2018, in Tallahassee, Leon County, Florida.

Celeste Philip, MD, MPH
Surgeon General and Secretary

By: [signature]
for Marsha Lindeman, ARNP, MSN
Interim Assistant Deputy Secretary for Health

FILED ON THIS DATE PURSUANT TO § 120.52, FLORIDA STATUTES, WITH THE DESIGNATED DEPARTMENT CLERK, RECEIPT OF WHICH IS HEREBY ACKNOWLEDGED.

Shannon Revels
CLERK

8/21/18
DATE

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party adversely affected by this Final Order is entitled to judicial review pursuant to section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings must be initiated by filing a notice of appeal with the Department of Health, Agency Clerk, and a copy of the notice of appeal, with the appropriate filing fee, with the District Court of Appeal having jurisdiction. The notice of appeal must be filed within thirty (30) days of the filing of this Final Order.

Copies to:

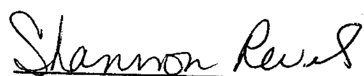
Jason L Unger
Ty Jackson
Attorneys for Petitioner
GrayRobinson PA
301 S Bronough St Ste 600
Tallahassee FL 32301

Lori L Jobe
Senior Attorney
Attorney for the Department
Office of the General Counsel
4052 Bald Cypress Wy Bin A-02
Tallahassee FL 32399-1703

Kendra Goff, PhD, DABT, CPM
State Toxicologist & Chief
Bureau of Environmental Health
Florida Department of Health
4052 Bald Cypress Way, Bin A-08
Tallahassee, Florida 32399

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Final Order has been sent by U.S. Mail, interoffice mail, or hand delivery to each of the above-named persons this 21st day of August, 2018.



Shannon Revels, Agency Clerk
Department of Health
4052 Bald Cypress Way, Bin # A02
Tallahassee, FL 32399-1703

FLORIDA DEPARTMENT OF HEALTH

CRYSTAL LAGOONS U.S. CORP.,

Petitioner,

v. DOH File No.

STATE OF FLORIDA, DEPARTMENT OF HEALTH,

Respondent.

RECEIVED
DEPARTMENT OF HEALTH
2018 JUN 15 PM 2:36
OFFICE OF THE CLERK

PETITION FOR DECLARATORY STATEMENT
BEFORE FLORIDA DEPARTMENT OF HEALTH

Pursuant to Section 120.565, Florida Statutes, and Chapter 28-105, Florida Administrative Code, CRYSTAL LAGOONS U.S. CORP. ("Petitioner" or "Crystal Lagoons") hereby petitions the State of Florida, Department of Health ("Department") for a declaratory statement and states as follows:

I. Parties and Background

1. The Department is the state agency authorized by law to administer the provisions of Chapter 514, Florida Statutes, regulating public swimming and bathing facilities.

2. Petitioner is Crystal Lagoons U.S. Corp., an international company with offices on five continents around the world. For purposes of this proceeding, its address, email address, telephone number, and facsimile number shall be that of its undersigned counsel.

3. Petitioner's primary business is providing the license and technical expertise to its clients to construct and operate large artificial impoundments of pristine, clear water, which are developed using state-of-the-art, patented, sustainable, and environmentally friendly technology to maintain excellent water quality with minimal amounts of chemicals and energy.

4. In 2013, Petitioner established its corporate headquarters to Florida and is currently engaged by numerous clients to develop recreational pristine, clear lagoons throughout Florida.

5. Prior to Petitioner entering into any license agreements in Florida, on September 23, 2014, upon request of Petitioner and after exchanging information related to the Crystal Lagoons® systems and technologies, the Department issued its determination that Petitioner's lagoons would be classified as "public bathing places" rather than "public swimming pools" as those terms are defined in section 514.011, Florida Statutes. *See September 23, 2014 Determination Letter attached as Exhibit A.*

6. Since that time, Petitioner has proceeded with projects throughout Florida in reliance on the Department's prior determination that the lagoons using Crystal Lagoons systems and technologies are classified as "public bathing places". The classification as a "public bathing place" relieved Petitioner's clients of any obligation to acquire a construction and operating permit from the Department. *See* §§ 514.03 and 514.031, Fla. Stat. (requiring a Department permit for the construction and operation of a public swimming pool).

7. Subsequently, in January, 2018, during the construction of a lagoon in Pasco County by one of Petitioner's clients, the Department issued another statement, this time erroneously stating that the lagoon under construction met the definition of a "public swimming pool." *See January 19, 2018 Determination Letter attached as Exhibit B.*

8. Following receipt of this January 19, 2018 Determination Letter, Petitioner provided additional information and design plans to the Department in an attempt to seek clarification of the regulatory classification for the lagoons using Crystal Lagoons systems and technologies.

9. In response, the Department issued another Determination Letter on February 19, 2018 correctly stating again that the lagoons using Crystal Lagoons systems and technologies met the definition of a "public bathing place." *See February 19, 2018 Determination Letter attached as Exhibit C.*

10. Petitioner seeks a Declaratory Statement affirming the classification of its lagoons as "public bathing places" consistent with the Department's September 23, 2014 Determination Letter and February 19, 2018 Determination Letter.

11. Without such determination Petitioner and/or its clients are potentially subject to fines and/or other penalties for the construction and/or operation of a public swimming pool without the appropriate permits for future lagoon projects where Crystal Lagoons systems and technologies may be utilized.

II. Statement of Facts

12. The lagoons constructed and operated by Petitioner's clients are large artificial impoundments of crystalline water developed using Crystal Lagoons' state-of-the-art, patented, sustainable, and environmentally friendly technology to maintain excellent water quality with minimal amounts of chemicals and energy.

13. Petitioner's lagoons have a number of features that distinguish them from swimming pools. For example, its lagoons do not have a complete concrete bottom structure. Instead, the bottom is covered with a specially designed plastic membrane.

14. Also, unlike swimming pools, lagoons do not have bottom drains connected to a filtration system. Rather, Crystal Lagoons technology utilizes a combination of ultrasonic waves and flocculants that first agglomerates sediments and suspended solids into bigger particles and then suctions and vacuums those agglomerated particles once they have settled to the lagoon's

bottom. This system consumes no more than 2% of the energy used for conventional swimming pool filtration techniques.

15. Surface cleaning of the lagoons is achieved through the strategic placement of independent mesh skimmers (similar to pond skimmers) coupled with a small pumping system that allows the skimmers to capture floating material with minimal effort and minimal water consumption.

16. Unlike swimming pool technology, Crystal Lagoons water treatment technology offers several environmental advantages over traditional water treatment and filtration technologies. It does not rely on filtration of the complete water volume four times per day (as required under pool regulations). Also, unlike conventional disinfection systems which use constant application of high levels of chemicals, Crystal Lagoons technology uses a pulse disinfection system which is deployed with a certain time frequency according to specific growth cycles of microorganisms and environmental conditions.

17. Based on the unique nature of the design and construction of its lagoons, the United States Patent and Trademark Office and other world patent offices, in examining Petitioner's patent applications, have determined that the Crystal Lagoons technology is different than swimming pool technology and have granted corresponding patents, the Petitioner having more than 1,800 patents in almost 200 countries and territories worldwide.

18. Petitioner seeks this declaratory statement as to the categorization of future lagoon projects that may be undertaken in the state of Florida utilizing Crystal Lagoons' systems and technology.

III. Analysis

19. A "public swimming pool" is defined as a "watertight structure of concrete, masonry, or other approved materials which is located either indoors or outdoors, used for

bathing or swimming by humans, and filled with a filtered and disinfected water supply . . ." § 514.011(2), Fla. Stat. (2017).

20. By contrast, a "public bathing place" is defined as "a body of water, natural or modified by humans, for swimming, diving, and recreational bathing. . . . The bathing water areas of public bathing places include, but are not limited to, lakes, ponds, rivers, streams, artificial impoundments, and waters along the coastal and intracoastal beaches and shores of the state." § 514.011(4), Fla. Stat. (2017).

21. Petitioner's lagoons lack the primary features of a public swimming pool. For example, its lagoons do not have a complete concrete bottom or masonry structure. Moreover, its lagoons do not use drains connected to a filtration system as in a swimming pool, instead utilizing a system that first agglomerates sediments and suspended solids into bigger particles and then suctions and vacuums those agglomerated particles once they have settled to the lagoon's bottom.

22. Rather, as described above, its lagoons are artificial impoundments of water for swimming, diving, water sports and recreational bathing and are therefore more appropriately classified as "public bathing places."

WHEREFORE, Petitioner Crystal Lagoons U.S. Corp. requests the Department issue a Declaratory Statement that the lagoons using Crystal Lagoons systems and technologies as described herein are "public bathing places" as defined in Section 514.011(4), Florida Statutes.

Respectfully submitted on June 15, 2018.

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The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: SB 1712

INTRODUCER: Senator Harrell

SUBJECT: Hospital Licensure

DATE: March 15, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 1712 amends and repeals various sections of the Florida Statutes to eliminate the requirement that a new freestanding hospital must obtain a certificate of need (CON) from the Agency for Health Care Administration (AHCA) prior to being licensed. The bill maintains the existing CON program for other facility types, such as nursing homes and hospice facilities, and for existing hospitals that wish to provide tertiary services, such as neonatal intensive care, comprehensive rehabilitation, and pediatric cardiac catheterization services.

The bill also establishes additional licensure requirements applicable to hospitals licensed on or after July 1, 2019, including that such hospitals must participate in the Medicaid program and must provide certain amounts of charity care or equivalent donations to the AHCA's Grants and Donations Trust Fund. The bill establishes penalties for a new hospital that does not comply with the charity care requirements and increases penalties for existing hospitals that violate any conditions related to providing Medicaid services or charity care that were agreed to by the hospital when the hospital was issued a CON.

The bill provides an effective date of July 1, 2019.

II. Present Situation:

Hospital Licensure

Hospitals are licensed by the AHCA under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[1] Hospitals must, at a minimum, make clinical laboratory services, diagnostic X-ray services, and treatment

[1] Section 395.002(12), F.S.

facilities for surgery or obstetrical care, or other definitive medical treatment, regularly available.[2]

A specialty hospital, in addition to providing the same services as general hospitals, provides other services, including:
- A range of medical services restricted to a defined age or gender group;
- A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or
- Intensive residential treatment programs for children and adolescents.[3]

Section 395.1041(2), F.S., requires the AHCA to maintain an inventory of hospitals with an emergency department. The inventory must list all services within the service capability of each hospital, and such services must appear on the face of the hospital's license. As of March 12, 2019, 217 of the 308 licensed hospitals in the state have an emergency department.[4]

Unless exempt, a hospital must obtain a CON prior to licensure. Facilities must meet initial licensing requirements by submitting a completed application and required documentation, and the satisfactory completion of a facility survey. The license fee is $1,565.13 or $31.46 per bed, whichever is greater.[5] The survey fee is $400.00 or $12.00 per bed, whichever is greater.[6]

Section 395.1055, F.S., requires the AHCA to adopt rules for hospitals. Separate standards may be provided for general and specialty hospitals.[7] The rules for general and specialty hospitals must include minimum standards to ensure:
- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards.[8]

The minimum standards for hospital licensure are provided under Rule 59A-3, F.A.C. The AHCA may perform inspections of hospitals, including:
- Inspections directed by the federal Centers for Medicare & Medicaid Services;
- Validation inspections;
- Life safety inspections;
- Licensure complaint investigations; and

[2] Id.
[3] Section 395.002(27), F.S.
[4] Agency for Health Care Administration, Facility/Provider Search Results, Hospitals, *available at* http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (reports generated on March 13, 2019).
[5] Rule 59A-3.066(3), F.A.C.
[6] Section 395.0161(3)(a), F.S.
[7] Section 395.1055(2), F.S.
[8] Section 395.1055(1), F.S.

- Emergency access complaint investigations.[9]

The AHCA must accept an inspection performed by an accrediting organization in lieu of its own periodic licensure inspection.[10]

Florida's CON Program

Overview

In Florida, a CON is a written statement issued by the AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service, including hospices. The Florida CON program has three levels of review: full, expedited, and exempt.[11] Unless a hospital project is exempt from the CON program, it must undergo a full comparative review. Expedited review is primarily targeted towards nursing home projects.

Florida's CON program has existed since July 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act of 1974 (Act), which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria.[12] Each state was required to have a CON program in compliance with the Act as a condition for obtaining federal funds for health programs. The Act was repealed in 1986.

Projects Subject to Full CON Review

Some hospital projects are required to undergo a full comparative CON review under the statute, including:

- New construction of general hospitals, long-term care hospitals, and freestanding specialty hospitals;
- Replacement of a hospital if the proposed project site is not located on the same site or within one mile of the existing health care facility;[13]
- Increasing the number of beds for comprehensive rehabilitation; and
- Establishing tertiary health services.[14]

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[9] Section 395.0161(1), F.S.

[10] Section 395.0161(2), F.S.

[11] Section 408.036, F.S.

[12] Pub. L. No. 93-641, 42 U.S.C. §§ 300k et seq.

[13] Section 395.6025, F.S., exempts rural hospitals from the requirement to obtain a CON for building a new hospital, or replacing a hospital, located in a county with a population between 15,000 and 18,000 and a population density of less than 30 persons per square mile as long as the new or replacement hospital is located within 10 miles of the current rural hospital.

[14] Section 408.032(17), F.S., defines "tertiary health service" as a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, pediatric cardiac catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. Pursuant to this section, AHCA established a list of all tertiary health services in Rule 59C-1.002, F.A.C.

Projects Subject to Expedited CON Review

Section 408.036(2), F.S., permits certain projects to undergo expedited CON review. Applicants for expedited review are not subject to the application deadlines associated with full comparative review and may submit an application at any time. Projects subject to an expedited review include the transfer of a CON and certain replacements, relocations, and new construction of nursing homes.[15]

Exemptions from CON Review

Section 408.036(3), F.S., provides many exemptions to CON review for certain hospital projects, including:

- Adding swing beds[16] in a rural hospital, the total of which does not exceed one-half of its licensed beds.
- Converting licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, F.S., so long as the conversion of the beds does not involve the construction of new facilities.
- Adding hospital beds licensed under chapter 395, F.S., for comprehensive rehabilitation, the total of which may not exceed the greater of 10 total beds or 10 percent of the licensed capacity.
- Establishing a Level II neonatal intensive care unit (NICU) if the unit has at least 10 beds, and if the hospital had a minimum of 1,500 births during the previous 12 months.
- Establishing a Level III NICU if the unit has at least 15 beds, and if the hospital had a Level II NICU and a minimum of at least 3,500 births during the previous 12 months.
- Establishing a Level III NICU if the unit has at least five beds, and is a verified trauma center,[17] and if the applicant has a Level II NICU.
- Establishing an adult open heart surgery program in a hospital located within the boundaries of a health service planning district, which:
  - Has experienced an annual net out-migration of at least 600 open heart surgery cases for three consecutive years; and
  - Has a population that exceeds the state average of population per licensed and operational open-heart programs by at least 25 percent.
- For the addition of mental health services or beds if the applicant commits to providing services to Medicaid or charity care patients as a level equal to or greater than the district average.

CON Determination of Need, Application, and Review Processes

A CON is predicated on a determination of need. The future need for services and projects is known as the "fixed need pool,"[18] which the AHCA publishes for each batching cycle. Rule

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[15] Section 408.036(2), F.S.

[16] Section 395.602(2)(c), F.S., defines "swing bed" as a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.

[17] Section 395.4001(15), F.S., defines "trauma center" as a hospital that has been verified by the Department of Health to be in substantial compliance with the requirements in s. 395.4025, F.S., and has been approved to operate as a Level I trauma center, Level II trauma center, or pediatric trauma center, or is designated as a Level II trauma center pursuant to s. 395.4025(15), F.S.

[18] Rule 59C-1.002(19), F.A.C., defines "fixed need pool" as the identified numerical need, as published in the Florida Administrative Register, for new beds or services for the applicable planning horizon established by AHCA in accordance

chapter 59C-1, F.A.C., provides need formulas to calculate the fixed need pool for certain services, including NICU services,[19] adult and child psychiatric services,[20] adult substance abuse services,[21] and comprehensive rehabilitation services.[22]

Upon determining that a need exists, the AHCA accepts applications for CON based on batching cycles. A batching cycle is a means of grouping, for comparative review, of CON applications submitted for beds, services, or programs having a like CON need methodology or licensing category in the same planning horizon and the same applicable district or subdistrict.[23]

The CON review process consists of four batching cycles each year, including two batching cycles each year for two project categories: hospital beds and facilities, and other beds and programs.[24] The "hospital beds and facilities" batching cycle includes applicants for new or expanded:

- Comprehensive medical rehabilitation beds;
- Adult psychiatric beds;
- Child and adolescent psychiatric beds;
- Adult substance abuse beds;
- NICU level II beds; and
- NICU level III beds.[25]

The "other beds and programs" batching cycle includes:

- Nursing home beds;
- Hospice beds;
- Pediatric open heart surgery;
- Pediatric cardiac catheterization services; and
- Organ transplantation services.[26]

Requests for an expedited review or exemption may be made at any time and are not subject to batching requirements.[27]

At least 30 days prior to the application deadline for a batch cycle, an applicant must file a letter of intent with the AHCA.[28] A letter of intent must describe the proposal, specify the number of beds sought, and identify the services to be provided, and the location of the project.[29]

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with need methodologies which are in effect by rule at the time of publication of the fixed need pools for the applicable batching cycle.

[19] Rule 59C-1.042(3), F.A.C.

[20] Rule 59C-1.040(4), F.A.C.

[21] Rule 59C-1.041(4), F.A.C.

[22] Rule 59C-1.039(5), F.A.C.

[23] Rule 59C-1.002(5), F.A.C. Note: s. 408.032(5), F.S., establishes the 11 district service areas in Florida.

[24] Rule 59C-1.008(1)(g), F.A.C.

[25] Rule 59C-1.008(1), F.A.C.

[26] Id.

[27] Section 408.036, F.S., and Rule 59C-1.004(1), F.A.C.

[28] Section 408.039(2)(a), F.S.

[29] Section 408.039(2)(c), F.S.

Applications for CON review must be submitted by the specified deadline for the particular batch cycle.[30] The AHCA must review the application within 15 days of the filing deadline and, if necessary, request additional information for an incomplete application.[31] The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.[32]

Within 60 days of receipt of the completed applications for that batch, the AHCA must issue a State Agency Action Report and Notice of Intent to grant a CON for a project in its entirety, to grant a CON for identifiable portions of a project, or to deny a CON for a project.[33] AHCA must then publish the decision, within 14 days, in the Florida Administrative Weekly.[34] If no administrative hearing is requested within 21 days of the publication, the State Agency Action Report and the Notice of Intent become a final order of the AHCA.[35]

In 2008, the Legislature significantly modified the application and review process for hospital CONs. The revisions included new and separate requirements for general hospital CONs, including:
- Revised contents for CON applications;
- Revised criteria which the AHCA must consider when reviewing a CON application;
- Prohibiting an applicant with a current CON application from submitting a letter of intent for to file another application;
- Requiring the AHCA to hold a public heating upon the request of any applicant or substantially affected person;
- Limiting the period of a continuance for any CON related hearings to four months; and
- Requiring a party appealing a final order for a CON to post a $1 million bond which is forfeited for attorney's fees and costs if the appellant loses.[36]

CON Fees

An applicant for CON review must submit a fee to the AHCA at the time of application submission. The minimum CON application filing fee is $10,000.[37] In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure; however, the total fee may not exceed $50,000.[38] A request for a CON exemption must be accompanied by a $250 fee payable to AHCA.[39]

CON Litigation

Florida law authorizes competitors to challenge CON decisions. A Notice of Intent to Award may be challenged by a competing applicant in the same review cycle or an existing provider in the same district by submitting evidence that they will be substantially affected if the CON is

[30] Rule 59C-1.008(1)(g), F.A.C.
[31] Section 408.039(3)(a), F.S.
[32] Id.
[33] Section 408.039(4)(b), F.S.
[34] Section 408.039(4)(c), F.S.
[35] Section 408.039(4)(d), F.S.
[36] Chapter 2008-29, L.O.F.
[37] Section 408.038, F.S.
[38] Id.
[39] Section 408.036(4), F.S., and Rule 59C-1.005(2)(g), F.A.C.

awarded. For general hospital CONs, only competing applicants and existing hospitals that submitted a written statement of opposition may initiate or intervene in an administrative hearing.[40] A challenge to a CON decision is heard by an administrative law judge under the Division of Administrative Hearings.[41] A recommended order must be issued by the administrative law judge by the earlier of within 30 days after the receipt of the proposed recommended order or the deadline for submission for a proposed recommended order. The AHCA must render a Final Order within 45 days of receiving the recommended order of the administrative law judge.[42] A party to an administrative hearing may challenge a Final Order to the District Court of Appeals for judicial review within 30 days of receipt of a Final Order. Parties challenging a general hospital CON must post a $1 million bond which will be used to pay attorney fees and costs if the appeal is lost.[43]

CON Nationwide

Thirty-five states have some form of CON program while 12 states do not have CON requirements for any type of health care facility or service.[44] The types of facilities covered and the requirements of each CON program vary from state to state.

Purpose and Effect of Certificate of Need

Cost Containment

CON programs are designed to restrain health care costs and provide for directed, measured planning for new services and facilities. Such programs were originally established to regulate the addition of new facilities, or new beds in hospitals and nursing homes, for example, and to prevent overbuying of expensive equipment, under the economic theory that excess capacity directly results in health care price inflation. When a hospital or health care service provider cannot meet its obligations, fixed costs must be met through higher charges for the beds that are used or for the number of patients using the service.[45]

In addition to cost containment, CON regulation is intended to create a "quid pro quo" in which profitability of covered medical services is increased by restricting competition and, in return, medical providers cross-subsidize specified amounts of indigent care, or medical services to the poor that are unprofitable to the provider.[46] Some states address indigent care to underinsured or uninsured patients and the provision of care for the Medicaid program in their CON process.[47] In

[40] Section 408.039(5)(c), F.S.
[41] Id.
[42] Section 408.039(5)(e), F.S.
[43] Section 408.039(6), F.S.
[44] National Conference of State Legislators, *Certificate of Need State Laws* (Feb. 28, 2019), *available at* http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (last viewed March 13, 2019).
[45] Id.
[46] Thomas Stratmann and Jacob Russ, *Do Certificate-of-Need Laws Increase Indigent Care?* Mercatus Center at George Mason University (July 2014) p. 2, *available at* https://www.mercatus.org/publication/do-certificate-need-laws-increase-indigent-care (last viewed March 13, 2019).
[47] For example, Delaware (Del. Code Ann. tit. 16 § 9303), Georgia (Ga. Code Ann. §111-2-2.03) (providing an exemption from CON with a certain percentage of Medicaid and charity care), Rhode Island (216-RICR-40-10-22.14) requiring findings of indigent and Medicaid care that will be offered, and Virginia (12 Va. Admin. Code §5-230-40 and §5-220-270) require CON applicants to comply with such provisions.

Florida applicants may apply a conditions to increase their chances of being issued a CON, including by committing to providing services to Medicaid and charity patients at certain levels.

Some studies have found that CON programs do not meet the goal of limiting costs in health care. One study found that "at best, CON has had a modest cost-containing influence on hospital and other acute care services."[48] Additionally, a literature review conducted in 2004 by the Federal Trade Commission and the Department of Justice concluded that "[O]n balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. . . .[i]ndeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns."[49]

Indigent Care

Studies are split, however, on whether CON regulation has improved access to care for the underinsured and uninsured. Some studies have found that access to care for the underserved populations has increased in states with CON programs,[50] while another has found only insignificant evidence to support such a conclusion.[51] A study of the Illinois CON program, while not opposing the removal of CON in Illinois, was concerned about the effect of eliminating CON on the financial health of safety-net hospitals, stating that "for some of [those hospitals]…new pressures could lead to failures [which] could force the remaining providers to serve an ever-larger number of less profitable patients, which could lead to a cascade of failures."[52]

Medically Underserved Areas

A medically underserved area (MUA) is a geographic area with a lack of access to primary care services. MUAs have a shortage of primary care health services for residents within a geographic area such as:

- A whole county;
- A group of neighboring counties;
- A group of urban census tracts; or
- A group of county or civil divisions.[53]

[48] Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending? Christopher J. Conover and Frank A. Sloan, Journal of Health Politics, Policy, and Law: Vol. 23, No. 3, June 1998, p. 478.

[49] Improving Health Care: *A Dose of Competition*: A Report by the Federal Trade Commission and the Department of Justice (July 23, 2004) p. 22, *available at* https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice (last viewed March 13, 2019). Note: this report is based on 27 days of joint hearings, an FTC-sponsored workshop, and independent research (see p. 1).

[50] Tracy Yee, Lucy B. Stark, et al, *Health Care Certificate-of-Need Laws: Policy or Politics?*, Research Brief, National Institute for Health Care Reform, No. 4, (May 2011), *available at* http://nihcr.org/analysis/improving-care-delivery/prevention-improving-health/con-laws/ (last visited on March 13, 2019).

[51] *Supra* note 46

[52] An Evaluation of Illinois' Certificate of Need Program, The Lewin Group, p. 31 (Feb. 22, 2007) *available at* http://cgfa.ilga.gov/Upload/LewinGroupEvalCertOfNeedPresentation.pdf

[53] See https://bhw.hrsa.gov/shortage-designation/muap (last visited on March 13, 2019)

MUAs are designated by the Health Resources and Services Administration (HRSA) within the federal Department of Health and Human Services. Eligibility for MUA designation depends on the Index of Medical Underservice (IMU) calculated for the area proposed for designation. Under the established criteria, an area or population with an IMU of 62.0 or below qualifies for designation as an MUA.[54]

The IMU scale is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. The HRSA calculates the IMU by assigning a weighted value to an area or population's performance on four demographic and health indicators, then adding the weighted values together. The HRSA uses the following indicators:

- Provider per 1,000 population ratio (28.7 points max);
- Percent of population at 100 percent of the Federal Poverty Level (25.1 points max);
- Percent of population age 65 and over (20.2 points max); and
- Infant Mortality Rate (26 points max).[55]

Currently, there are 70 MUAs designated in Florida. Five of those MUAs have IMU scores of 0 while the other 65 have scores ranging from 43.3 to 61.5.[56]

III. Effect of Proposed Changes:

SB 1712 amends multiple statutes related to hospital licensure and CON.

Section 1 amends s. 395.003, F.S., to apply new licensure criteria to hospitals that are licensed on or after July 1, 2019. Each such hospital must:

- Participate in the Medicaid program;
- Provide charity care, defined as "uncompensated care delivered to uninsured patients having incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures," in an amount equal to or greater than the district average;
  - If a hospital is located in an MUA, the amount of charity care that the hospital must provide is reduced so that it is equal in percentage to that area's IMU;
  - In lieu of providing the required charity care, the hospital may donate to the AHCA's Grants and Donations Trust Fund an amount determined by the AHCA to be functionally equivalent to the amount of charity care required;
- Annually report compliance with these requirements to the AHCA. If a hospital does not report compliance or fails to comply with these requirements, the AHCA must assess a fine equal to one percent of the hospital's net revenue for each 0.5 percent of the required charity care the hospital did not provide or donate.

The section also strikes obsolete language related to off-site hospital emergency departments and makes cross-reference changes.

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[54] See https://bhw.hrsa.gov/shortage-designation/muap-process (last visited on March 13, 2019).
[55] Id.
[56] See https://data.hrsa.gov/tools/shortage-area/mua-find. (last visited on March 14, 2019).

Section 11 amends s. 408.040, F.S., to require the AHCA to assess a fine of $2,500 per day if a health care facility fails to comply with a condition of its CON related to providing charity care or providing care under the Florida Medicaid program. Currently, the AHCA is authorized to assess a fine of up to $1,000 per day.

Sections 2-10, 12, and 13 amend and repeal various sections of the Florida statutes to remove all provisions related to requiring a CON for the establishment of a new, freestanding hospital and to make conforming and cross-reference changes.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 1712 may have an indeterminate negative fiscal impact on existing hospitals if additional hospitals are licensed in the same area and if such hospital projects would not have been licensed under current law.

This bill may have an indeterminate positive fiscal impact on individuals who receive medical services in a hospital if the individual is paying for the services directly, or if there is an increase in the number of hospitals that are licensed under the provisions of the bill and such increase results in a decrease in the amount that hospital charge for such services.

The bill may have an indeterminate positive fiscal impact on individuals who receive the benefits of charity care that new hospitals will be required to offer.

C. Government Sector Impact:

This bill may have an indeterminate fiscal impact on the AHCA by eliminating the CON program for hospitals including the elimination of revenues received from CON application fees.[57]

The bill may have indeterminate fiscal impact on the AHCA by potentially increasing the number of hospitals the AHCA will be required to regulate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.003, 395.0191, 395.1055, 408.032, 408.034, 408.035, 408.036, 408.037, 408.039, 408.040, 408.043, and 395.1065.

This bill repeals section 395.6025 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

[57] Hospital CON application fees were $703,120 in CY 2018. See AHCA, *Senate Bill 1712 Analysis* (March 5, 2019) (on file with Senate Committee on Health Policy)

820832

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
03/18/2019	.	
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	.	
	.	

The Committee on Health Policy (Harrell) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete lines 59 - 94
4 and insert:
5 (8) Applicable only to a hospital that is, or will be,
6 newly licensed on or after July 1, 2019; that has not been
7 issued a certificate of need by the agency; and that is not
8 replacing a currently operating hospital located within 1 mile
9 of the newly licensed hospital:
10 (a) When proposing a new hospital project subject to this

820832

11 subsection and before filing for approval of plans and
12 specifications under s. 395.0163, each prospective applicant for
13 licensure must submit a notice to the agency of its intent to
14 establish a newly licensed hospital which includes the location
15 for the proposed hospital, the number and types of beds to be
16 licensed, and the services that the hospital will offer.
17 (b) The agency may not license a new general hospital
18 subject to this subsection unless:
19 1. The hospital has at least 80 beds and has intensive
20 care, progressive care, and medical-surgical beds. This
21 requirement does not apply if the hospital is a rural hospital,
22 as defined in s. 395.602, or is located in a medically
23 underserved area; and
24 2. The hospital has an onsite emergency department that
25 will operate 24 hours per day, 7 days per week.
26 (c) Each such hospital must participate in the state
27 Medicaid program and the Medicare program.
28 (d) Except as provided in paragraph (e), each such hospital
29 must provide charity care in an amount equal to or greater than
30 the district average for hospitals in the applicable district.
31 The agency shall adopt by rule a method for calculating the
32 district average for charity care for each district. For
33 purposes of this subsection, the term “charity care” means
34 uncompensated care delivered to uninsured patients having an
35 income at or below 200 percent of the federal poverty level when
36 such services are preauthorized by the licensee and not subject
37 to collection procedures, and “district” has the same meaning as
38 in s. 408.032(5). The valuation of charity care must be based on
39 Medicaid reimbursement rates.

820832

40 (e) If such a hospital is located in a medically
41 underserved area, the amount of charity care required to be
42 provided by the hospital under paragraph (d) is equivalent in
43 percentage to the medically underserved area's Index of Medical
44 Underservice score as calculated by the federal Health Resources
45 and Services Administration within the Department of Health and
46 Human Services.
47 (f) In lieu of providing charity care under paragraph (d)
48 or paragraph (e), each such hospital may donate an amount
49 determined by the agency to be functionally equivalent to the
50 amounts required under those paragraphs to the agency's Grants
51 and Donations Trust Fund.
52 (g) Each such hospital shall annually report to the agency
53 its compliance with paragraphs (c)-(f). Failure to report
54 compliance constitutes noncompliance. The agency shall assess an
55 administrative fine on a hospital that fails to comply with this
56 subsection in the amount of 1 percent of its net revenue for
57 each 0.5 percent of the required amount of charity care not
58 provided pursuant to paragraph (d) or paragraph (e) or the
59 required amount as determined by the agency pursuant to
60 paragraph (f).
61 (h) The agency shall adopt rules to implement this
62 subsection.
63
64 ================= T I T L E A M E N D M E N T ================
65 And the title is amended as follows:
66 Delete lines 4 - 15
67 and insert:
68 providing applicability; requiring certain hospitals

820832

69 licensed after a specified date to submit a notice to
70 the Agency for Health Care Administration which
71 contains specified information before filing for
72 approval of plans and specifications to establish a
73 newly licensed hospital; prohibiting the agency from
74 licensing a new general hospital unless certain
75 criteria are met; requiring certain hospitals to
76 participate in the Medicaid program as a provider of
77 medical assistance and to provide a certain amount of
78 charity care; defining the terms “charity care” and
79 “district”; providing a separate calculation of
80 required charity care for such hospitals located in a
81 medically underserved area; authorizing such hospitals
82 to provide a certain donation the agency’s Grants and
83 Donations Trust Fund in lieu of providing the required
84 charity care; requiring such hospitals to annually
85 report compliance to the agency; requiring the agency
86 to impose a specified administrative fine for
87 noncompliance; requiring the agency to adopt rules;

780192

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
03/18/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

1 **Senate Amendment (with directory amendment)**

2

3 Delete lines 225 - 236

4 and insert:

5 ~~(c) An increase in the number of beds for comprehensive~~

6 ~~rehabilitation.~~

7 (2) PROJECTS SUBJECT TO EXPEDITED REVIEW.—Unless exempt

8 pursuant to subsection (3), the following projects are subject

9 to expedited review:

10 (a) Transfer of a certificate of need~~, except that when an~~

780192

11 ~~existing hospital is acquired by a purchaser, all certificates~~
12 ~~of need issued to the hospital which are not yet operational~~
13 ~~shall be acquired by the purchaser without need for a transfer~~.
14
15 The agency shall develop rules to implement the expedited review
16 process, including time schedule, application content that may
17 be reduced from the full requirements of s. 408.037(1), and
18 application processing.
19 (3) EXEMPTIONS.—Upon request, the following projects are
20 subject to exemption from the provisions of subsection (1):
21 ~~(i) For the addition of hospital beds licensed under~~
22 ~~chapter 395 for comprehensive rehabilitation in a number that~~
23 ~~may not exceed 10 total beds or 10 percent of the licensed~~
24 ~~capacity, whichever is greater.~~
25 ~~1. In addition to any other documentation otherwise~~
26 ~~required by the agency, a request for exemption submitted under~~
27 ~~this paragraph must:~~
28 ~~a. Certify that the prior 12-month average occupancy rate~~
29 ~~for the licensed beds being expanded meets or exceeds 80~~
30 ~~percent.~~
31 ~~b. Certify that the beds have been licensed and operational~~
32 ~~for at least 12 months.~~
33 ~~2. The timeframes and monitoring process specified in s.~~
34 ~~408.040(2)(a)-(c) apply to any exemption issued under this~~
35 ~~paragraph.~~
36 ~~3. The agency shall count beds authorized under this~~
37 ~~paragraph as approved beds in the published inventory of~~
38 ~~hospital beds until the beds are licensed.~~
39

780192

40 ====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
41 And the directory clause is amended as follows:
42 Delete lines 212 - 213
43 and insert:
44 Section 8. Paragraphs (c) and (e) of subsection (1)
45 paragraph (a) of subsection (2), and paragraph (i) of subsection
46 (3) of section 408.036, Florida Statutes, are

520418

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
03/18/2019	.	
	.	
	.	
	.	

The Committee on Health Policy (Harrell) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 440 - 448

4 and insert:

5 Section 13. Effective upon this act becoming a law:

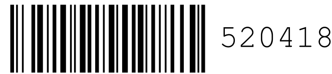
6 (1) The Agency for Health Care Administration may not

7 initiate a review cycle or accept letters of intent or

8 applications for the issuance of a certificate of need for the

9 new construction or establishment of a freestanding hospital.

10 (2) The agency shall issue a certificate of need to any



11 pending applicant for a certificate of need for the new
12 construction or establishment of a freestanding general
13 hospital:
14 (a) With 80 or more beds;
15 (b) With intensive care, progressive care, and medical-
16 surgical beds;
17 (c) With an onsite emergency department that will be
18 operational 24 hours per day, 7 days per week; and
19 (d) Whose application for a certificate of need has been
20 approved by the agency, regardless of the litigation status of
21 the application.
22 (3) For any pending applicant for a certificate of need for
23 the new construction or establishment of a freestanding hospital
24 that does not meet the criteria in subsection (2), sections
25 395.0191, 395.1055, 395.6025, 408.032, 408.034, 408.035,
26 408.036, 408.037, 408.039, and 408.043, Florida Statutes (2018),
27 and any rules adopted thereunder remain in effect until such
28 time as the agency has either issued the applicant a certificate
29 of need or has denied the application and all appeals of the
30 denial have been exhausted.
31 Section 14. Except as otherwise expressly provided in this
32 act and except for this section, which shall take effect upon
33 this act becoming a law, this act shall take effect July 1,
34 2019.
35
36 ================= T I T L E A M E N D M E N T ================
37 And the title is amended as follows:
38 Delete lines 43 - 44
39 and insert:

520418

40 hospitals; prohibiting the agency from initiating a
41 review cycle or from accepting letters of intent or
42 applications for the issuance of certificate of need
43 for the new construction or the establishment of a
44 freestanding hospital; requiring the agency to issue
45 such a certificate of need to certain applicants,
46 regardless of litigation status; providing
47 applicability; providing effective dates.

By Senator Harrell

25-01997-19 20191712__

1 A bill to be entitled
2 An act relating to hospital licensure; amending s.
3 395.003, F.S.; deleting an obsolete provision;
4 requiring hospitals licensed after a specified date to
5 participate in the Medicaid program as a provider of
6 medical assistance and provide a certain amount of
7 charity care; providing a separate calculation of
8 required charity care for such hospitals located in a
9 medically underserved area; authorizing such hospitals
10 to provide a certain donation the Agency for Health
11 Care Administration's Grants and Donations Trust Fund
12 in lieu of providing the required charity care;
13 requiring such hospitals to annually report compliance
14 to the agency; requiring the agency to impose a
15 specified administrative fine for noncompliance;
16 conforming cross-references; amending s. 395.0191,
17 F.S.; deleting a provision relating to certificates of
18 need for hospitals; amending s. 395.1055, F.S.;
19 deleting a provision requiring hospitals to submit
20 data to the agency in the certificate-of-need review
21 process; repealing s. 395.6025, F.S., relating to
22 rural hospital replacement facilities; amending s.
23 408.032, F.S.; revising the definition of the term
24 "health care facility" to exclude hospitals and long-
25 term care hospitals for purposes of the Health
26 Facility and Services Development Act; deleting the
27 definitions of the terms "hospital" and "long-term
28 care hospital"; amending s. 408.034; conforming a
29 provision to changes made by the act; amending ss.

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

30 408.035 and 408.036, F.S.; deleting provisions related
31 to the agency's consideration and review of
32 certificates of need for general hospitals, specialty
33 hospitals, and long-term care hospitals; amending ss.
34 408.037, and 408.039, F.S.; deleting provisions
35 relating to certificate of need applications for
36 general hospitals; amending s. 408.040, F.S.;
37 requiring the agency to assess a specified
38 administrative fine against the holder of a
39 certificate of need or the holder of an exemption that
40 fails to comply with specified conditions; amending s.
41 408.043, F.S.; deleting provisions relating to
42 certificates of need for osteopathic acute care
43 hospitals; amending s. 395.1065, F.S.; conforming a
44 cross-reference; providing an effective date.
45
46 Be It Enacted by the Legislature of the State of Florida:
47
48 Section 1. Present subsections (8), (9), and (10) of
49 section 395.003, Florida Statutes, are redesignated as
50 subsections (9), (10), and (11), respectively, paragraph (c) of
51 subsection (1) and present subsections (9) and (10) of that
52 section are amended, and a new subsection (8) is added to that
53 section, to read:
54 395.003 Licensure; denial, suspension, and revocation.—
55 (1)
56 ~~(c) Until July 1, 2006, additional emergency departments~~
57 ~~located off the premises of licensed hospitals may not be~~
58 ~~authorized by the agency.~~

59 (8) Applicable only to a hospital licensed on or after July
60 1, 2019:
61 (a) Each such hospital must participate in the Medicaid
62 program as a provider of medical assistance.
63 (b) Except as provided in paragraph (c), each such hospital
64 must provide charity care in an amount equal to or greater than
65 the applicable district average among licensed providers of
66 similar services. For purposes of this subsection, the term
67 “charity care” means uncompensated care delivered to uninsured
68 patients having incomes at or below 200 percent of the federal
69 poverty level when such services are preauthorized by the
70 licensee and not subject to collection procedures, and
71 “district” has the same meaning as in s. 408.032(5). The
72 valuation of charity care must be based on Medicaid
73 reimbursement rates.
74 (c) If such a hospital is located in a medically
75 underserved area, the amount of charity care required to be
76 provided by the hospital under paragraph (b) is equivalent in
77 percentage to the medically underserved area’s Index of Medical
78 Underservice score as calculated by the federal Health Resources
79 and Services Administration within the Department of Health and
80 Human Services.
81 (d) In lieu of providing charity care under paragraph (b)
82 or paragraph (c), each such hospital may donate an amount
83 determined by the agency to be functionally equivalent to the
84 amounts required under those paragraphs to the agency’s Grants
85 and Donations Trust Fund.
86 (e) Each such hospital shall annually report to the agency
87 its compliance with this subsection. Failure to report

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

88 compliance constitutes noncompliance. The agency shall assess an
89 administrative fine on a hospital that fails to comply with this
90 subsection in the amount of 1 percent of its net revenue for
91 each 0.5 percent of the required amount of charity care that was
92 not provided pursuant to paragraph (b) or paragraph (c) or the
93 required amount as determined by the agency pursuant to
94 paragraph (d).
95 (10) ~~(9)~~ A hospital licensed as of June 1, 2004, is ~~shall be~~
96 exempt from subsection (9) ~~(8)~~ as long as the hospital maintains
97 the same ownership, facility street address, and range of
98 services that were in existence on June 1, 2004. Any transfer of
99 beds, or other agreements that result in the establishment of a
100 hospital or hospital services within the intent of this section,
101 shall be subject to subsection (9) ~~(8)~~. Unless the hospital is
102 otherwise exempt under subsection (9) ~~(8)~~, the agency shall deny
103 or revoke the license of a hospital that violates any of the
104 criteria set forth in that subsection.
105 (11) ~~(10)~~ The agency may adopt rules implementing the
106 licensure requirements set forth in subsection (9) ~~(8)~~. Within 14
107 days after rendering its decision on a license application or
108 revocation, the agency shall publish its proposed decision in
109 the Florida Administrative Register. Within 21 days after
110 publication of the agency's decision, any authorized person may
111 file a request for an administrative hearing. In administrative
112 proceedings challenging the approval, denial, or revocation of a
113 license pursuant to subsection (9) ~~(8)~~, the hearing must be based
114 on the facts and law existing at the time of the agency's
115 proposed agency action. Existing hospitals may initiate or
116 intervene in an administrative hearing to approve, deny, or

117 revoke licensure under subsection (9) ~~(8)~~ based upon a showing
118 that an established program will be substantially affected by
119 the issuance or renewal of a license to a hospital within the
120 same district or service area.
121 Section 2. Subsection (10) of section 395.0191, Florida
122 Statutes, is amended to read:
123 395.0191 Staff membership and clinical privileges.—
124 ~~(10) Nothing herein shall be construed by the agency as~~
125 ~~requiring an applicant for a certificate of need to establish~~
126 ~~proof of discrimination in the granting of or denial of hospital~~
127 ~~staff membership or clinical privileges as a precondition to~~
128 ~~obtaining such certificate of need under the provisions of s.~~
129 ~~408.043.~~
130 Section 3. Paragraph (f) of subsection (1) of section
131 395.1055, Florida Statutes, is amended to read:
132 395.1055 Rules and enforcement.—
133 (1) The agency shall adopt rules pursuant to ss. 120.536(1)
134 and 120.54 to implement the provisions of this part, which shall
135 include reasonable and fair minimum standards for ensuring that:
136 (f) All hospitals submit ~~such data as necessary to conduct~~
137 ~~certificate-of-need reviews required under part I of chapter~~
138 ~~408. Such data shall include, but shall not be limited to,~~
139 ~~patient origin data,~~ hospital utilization data, type of service
140 reporting, and facility staffing data. The agency may not
141 collect data that identifies or could disclose the identity of
142 individual patients. The agency shall utilize existing uniform
143 statewide data sources when available and shall minimize
144 reporting costs to hospitals.
145 Section 4. Section 395.6025, Florida Statutes, is repealed.

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

146 Section 5. Subsections (8), (11), and (13) of section
147 408.032, Florida Statutes, are amended to read:
148 408.032 Definitions relating to Health Facility and
149 Services Development Act.—As used in ss. 408.031-408.045, the
150 term:
151 (8) "Health care facility" means a ~~hospital, long-term care~~
152 ~~hospital,~~ skilled nursing facility, hospice, or intermediate
153 care facility for the developmentally disabled. A facility
154 relying solely on spiritual means through prayer for healing is
155 not included as a health care facility.
156 ~~(11) "Hospital" means a health care facility licensed under~~
157 ~~chapter 395.~~
158 ~~(13) "Long-term care hospital" means a hospital licensed~~
159 ~~under chapter 395 which meets the requirements of 42 C.F.R. s.~~
160 ~~412.23(e) and seeks exclusion from the acute care Medicare~~
161 ~~prospective payment system for inpatient hospital services.~~
162 Section 6. Subsection (2) of section 408.034, Florida
163 Statutes, is amended to read:
164 408.034 Duties and responsibilities of agency; rules.—
165 (2) In the exercise of its authority to issue licenses to
166 health care facilities and health service providers, as provided
167 under chapter ~~chapters~~ 393 ~~and 395~~ and parts II, IV, and VIII of
168 chapter 400, the agency may not issue a license to any health
169 care facility or health service provider that fails to receive a
170 certificate of need or an exemption for the licensed facility or
171 service.
172 Section 7. Section 408.035, Florida Statutes, is amended to
173 read:
174 408.035 Review criteria.—

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

175 ~~(1)~~ The agency shall determine the reviewability of
176 applications and shall review applications for certificate-of-
177 need determinations for health care facilities and health
178 services in context with the following criteria~~, except for~~
179 ~~general hospitals as defined in s. 395.002~~:
180 (1)~~(a)~~ The need for the health care facilities and health
181 services being proposed.
182 (2)~~(b)~~ The availability, quality of care, accessibility,
183 and extent of utilization of existing health care facilities and
184 health services in the service district of the applicant.
185 (3)~~(c)~~ The ability of the applicant to provide quality of
186 care and the applicant’s record of providing quality of care.
187 (4)~~(d)~~ The availability of resources, including health
188 personnel, management personnel, and funds for capital and
189 operating expenditures, for project accomplishment and
190 operation.
191 (5)~~(e)~~ The extent to which the proposed services will
192 enhance access to health care for residents of the service
193 district.
194 (6)~~(f)~~ The immediate and long-term financial feasibility of
195 the proposal.
196 (7)~~(g)~~ The extent to which the proposal will foster
197 competition that promotes quality and cost-effectiveness.
198 (8)~~(h)~~ The costs and methods of the proposed construction,
199 including the costs and methods of energy provision and the
200 availability of alternative, less costly, or more effective
201 methods of construction.
202 (9)~~(i)~~ The applicant’s past and proposed provision of
203 health care services to Medicaid patients and the medically

204 indigent.
205 (10) ~~(j)~~ The applicant's designation as a Gold Seal Program
206 nursing facility pursuant to s. 400.235, when the applicant is
207 requesting additional nursing home beds at that facility.
208 ~~(2) For a general hospital, the agency shall consider only~~
209 ~~the criteria specified in paragraph (1)(a), paragraph (1)(b),~~
210 ~~except for quality of care in paragraph (1)(b), and paragraphs~~
211 ~~(1)(e), (g), and (i).~~
212 Section 8. Paragraph (c) of subsection (1) and paragraph
213 (a) of subsection (2) of section 408.036, Florida Statutes, are
214 amended to read:
215 408.036 Projects subject to review; exemptions.—
216 (1) APPLICABILITY.—Unless exempt under subsection (3), all
217 health-care-related projects, as described in paragraphs (a)-
218 (f), are subject to review and must file an application for a
219 certificate of need with the agency. The agency is exclusively
220 responsible for determining whether a health-care-related
221 project is subject to review under ss. 408.031-408.045.
222 (c) The conversion from one type of health care facility to
223 another~~, including the conversion from a general hospital, a~~
224 ~~specialty hospital, or a long-term care hospital~~.
225 (2) PROJECTS SUBJECT TO EXPEDITED REVIEW.—Unless exempt
226 pursuant to subsection (3), the following projects are subject
227 to expedited review:
228 (a) Transfer of a certificate of need~~, except that when an~~
229 ~~existing hospital is acquired by a purchaser, all certificates~~
230 ~~of need issued to the hospital which are not yet operational~~
231 ~~shall be acquired by the purchaser without need for a transfer~~.
232

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

25-01997-19 20191712__

233 The agency shall develop rules to implement the expedited review
234 process, including time schedule, application content that may
235 be reduced from the full requirements of s. 408.037(1), and
236 application processing.
237 Section 9. Section 408.037, Florida Statutes, is amended to
238 read:
239 408.037 Application content.—
240 (1) ~~Except as provided in subsection (2) for a general~~
241 ~~hospital,~~ An application for a certificate of need must contain:
242 (a) A detailed description of the proposed project and
243 statement of its purpose and need in relation to the district
244 health plan.
245 (b) A statement of the financial resources needed by and
246 available to the applicant to accomplish the proposed project.
247 This statement must include:
248 1. A complete listing of all capital projects, including
249 new health facility development projects and health facility
250 acquisitions applied for, pending, approved, or underway in any
251 state at the time of application, regardless of whether or not
252 that state has a certificate-of-need program or a capital
253 expenditure review program pursuant to s. 1122 of the Social
254 Security Act. The agency may, by rule, require less-detailed
255 information from major health care providers. This listing must
256 include the applicant's actual or proposed financial commitment
257 to those projects and an assessment of their impact on the
258 applicant's ability to provide the proposed project.
259 2. A detailed listing of the needed capital expenditures,
260 including sources of funds.
261 3. A detailed financial projection, including a statement

262 of the projected revenue and expenses for the first 2 years of
263 operation after completion of the proposed project. This
264 statement must include a detailed evaluation of the impact of
265 the proposed project on the cost of other services provided by
266 the applicant.
267 (c) An audited financial statement of the applicant or the
268 applicant's parent corporation if audited financial statements
269 of the applicant do not exist. In an application submitted by an
270 existing health care facility, health maintenance organization,
271 or hospice, financial condition documentation must include, but
272 need not be limited to, a balance sheet and a profit-and-loss
273 statement of the 2 previous fiscal years' operation.
274 ~~(2) An application for a certificate of need for a general~~
275 ~~hospital must contain a detailed description of the proposed~~
276 ~~general hospital project and a statement of its purpose and the~~
277 ~~needs it will meet. The proposed project's location, as well as~~
278 ~~its primary and secondary service areas, must be identified by~~
279 ~~zip code. Primary service area is defined as the zip codes from~~
280 ~~which the applicant projects that it will draw 75 percent of its~~
281 ~~discharges. Secondary service area is defined as the zip codes~~
282 ~~from which the applicant projects that it will draw its~~
283 ~~remaining discharges. If, subsequent to issuance of a final~~
284 ~~order approving the certificate of need, the proposed location~~
285 ~~of the general hospital changes or the primary service area~~
286 ~~materially changes, the agency shall revoke the certificate of~~
287 ~~need. However, if the agency determines that such changes are~~
288 ~~deemed to enhance access to hospital services in the service~~
289 ~~district, the agency may permit such changes to occur. A party~~
290 ~~participating in the administrative hearing regarding the~~

291 ~~issuance of the certificate of need for a general hospital has~~
292 ~~standing to participate in any subsequent proceeding regarding~~
293 ~~the revocation of the certificate of need for a hospital for~~
294 ~~which the location has changed or for which the primary service~~
295 ~~area has materially changed. In addition, the application for~~
296 ~~the certificate of need for a general hospital must include a~~
297 ~~statement of intent that, if approved by final order of the~~
298 ~~agency, the applicant shall within 120 days after issuance of~~
299 ~~the final order or, if there is an appeal of the final order,~~
300 ~~within 120 days after the issuance of the court's mandate on~~
301 ~~appeal, furnish satisfactory proof of the applicant's financial~~
302 ~~ability to operate. The agency shall establish documentation~~
303 ~~requirements, to be completed by each applicant, which show~~
304 ~~anticipated provider revenues and expenditures, the basis for~~
305 ~~financing the anticipated cash-flow requirements of the~~
306 ~~provider, and an applicant's access to contingency financing. A~~
307 ~~party participating in the administrative hearing regarding the~~
308 ~~issuance of the certificate of need for a general hospital may~~
309 ~~provide written comments concerning the adequacy of the~~
310 ~~financial information provided, but such party does not have~~
311 ~~standing to participate in an administrative proceeding~~
312 ~~regarding proof of the applicant's financial ability to operate.~~
313 ~~The agency may require a licensee to provide proof of financial~~
314 ~~ability to operate at any time if there is evidence of financial~~
315 ~~instability, including, but not limited to, unpaid expenses~~
316 ~~necessary for the basic operations of the provider.~~
317 (2)~~(3)~~ The applicant must certify that it will license and
318 operate the health care facility. For an existing health care
319 facility, the applicant must be the licenseholder of the

320 facility.
321 Section 10. Paragraphs (c) and (d) of subsection (3),
322 paragraphs (b) and (c) of subsection (5), and paragraph (d) of
323 subsection (6) of section 408.039, Florida Statutes, are amended
324 to read:
325 408.039 Review process.—The review process for certificates
326 of need shall be as follows:
327 (3) APPLICATION PROCESSING.—
328 ~~(c) Except for competing applicants, in order to be~~
329 ~~eligible to challenge the agency decision on a general hospital~~
330 ~~application under review pursuant to paragraph (5)(c), existing~~
331 ~~hospitals must submit a detailed written statement of opposition~~
332 ~~to the agency and to the applicant. The detailed written~~
333 ~~statement must be received by the agency and the applicant~~
334 ~~within 21 days after the general hospital application is deemed~~
335 ~~complete and made available to the public.~~
336 ~~(d) In those cases where a written statement of opposition~~
337 ~~has been timely filed regarding a certificate of need~~
338 ~~application for a general hospital, the applicant for the~~
339 ~~general hospital may submit a written response to the agency.~~
340 ~~Such response must be received by the agency within 10 days of~~
341 ~~the written statement due date.~~
342 (5) ADMINISTRATIVE HEARINGS.—
343 (b) Hearings shall be held in Tallahassee unless the
344 administrative law judge determines that changing the location
345 will facilitate the proceedings. The agency shall assign
346 proceedings requiring hearings to the Division of Administrative
347 Hearings of the Department of Management Services within 10 days
348 after the time has expired for requesting a hearing. Except upon

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349 unanimous consent of the parties or upon the granting by the
350 administrative law judge of a motion of continuance, hearings
351 shall commence within 60 days after the administrative law judge
352 has been assigned. ~~For an application for a general hospital,~~
353 ~~administrative hearings shall commence within 6 months after the~~
354 ~~administrative law judge has been assigned, and a continuance~~
355 ~~may not be granted absent a finding of extraordinary~~
356 ~~circumstances by the administrative law judge.~~ All parties,
357 except the agency, shall bear their own expense of preparing a
358 transcript. In any application for a certificate of need which
359 is referred to the Division of Administrative Hearings for
360 hearing, the administrative law judge shall complete and submit
361 to the parties a recommended order as provided in ss. 120.569
362 and 120.57. The recommended order shall be issued within 30 days
363 after the receipt of the proposed recommended orders or the
364 deadline for submission of such proposed recommended orders,
365 whichever is earlier. The division shall adopt procedures for
366 administrative hearings which shall maximize the use of
367 stipulated facts and shall provide for the admission of prepared
368 testimony.
369 (c) In administrative proceedings challenging the issuance
370 or denial of a certificate of need, only applicants considered
371 by the agency in the same batching cycle are entitled to a
372 comparative hearing on their applications. Existing health care
373 facilities may initiate or intervene in an administrative
374 hearing upon a showing that an established program will be
375 substantially affected by the issuance of any certificate of
376 need, whether reviewed under s. 408.036(1) or (2), to a
377 competing proposed facility or program within the same district.

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

378 ~~With respect to an application for a general hospital, competing~~
379 ~~applicants and only those existing hospitals that submitted a~~
380 ~~detailed written statement of opposition to an application as~~
381 ~~provided in this paragraph may initiate or intervene in an~~
382 ~~administrative hearing. Such challenges to a general hospital~~
383 ~~application shall be limited in scope to the issues raised in~~
384 ~~the detailed written statement of opposition that was provided~~
385 ~~to the agency. The administrative law judge may, upon a motion~~
386 ~~showing good cause, expand the scope of the issues to be heard~~
387 ~~at the hearing. Such motion shall include substantial and~~
388 ~~detailed facts and reasons for failure to include such issues in~~
389 ~~the original written statement of opposition.~~
390 (6) JUDICIAL REVIEW.—
391 ~~(d) The party appealing a final order that grants a general~~
392 ~~hospital certificate of need shall pay the appellee's attorney's~~
393 ~~fees and costs, in an amount up to $1 million, from the~~
394 ~~beginning of the original administrative action if the appealing~~
395 ~~party loses the appeal, subject to the following limitations and~~
396 ~~requirements:~~
397 ~~1. The party appealing a final order must post a bond in~~
398 ~~the amount of $1 million in order to maintain the appeal.~~
399 ~~2. Except as provided under s. 120.595(5), in no event~~
400 ~~shall the agency be held liable for any other party's attorney's~~
401 ~~fees or costs.~~
402 Section 11. Paragraph (d) of subsection (1) of section
403 408.040, Florida Statutes, is amended to read:
404 408.040 Conditions and monitoring.—
405 (1)
406 (d) If the holder of a certificate of need or <u>the holder of</u>

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

407 an exemption fails to comply with a condition that is unrelated
408 to the provision of charity care or the provision of care under
409 the Florida Medicaid program upon which the issuance of the
410 certificate or exemption was predicated, the agency may assess
411 an administrative fine against the certificateholder or
412 exemption holder in an amount not to exceed $1,000 per failure
413 per day. If the holder of a certificate of need or the holder of
414 an exemption fails to comply with a condition related to the
415 provision of charity care or the provision of care under the
416 Florida Medicaid program upon which the issuance of the
417 certificate or exemption was predicated, the agency must assess
418 an administrative fine against the certificateholder or
419 exemption holder in the amount of $2,500 per day for each
420 instance of noncompliance. Failure to annually report compliance
421 with any condition upon which the issuance of the certificate or
422 exemption was predicated constitutes noncompliance. In assessing
423 the penalty, the agency shall take into account as mitigation
424 the degree of noncompliance. Proceeds of such penalties shall be
425 deposited in the Public Medical Assistance Trust Fund.
426 Section 12. Subsection (1) of section 408.043, Florida
427 Statutes, is amended to read:
428 408.043 Special provisions.—
429 ~~(1) OSTEOPATHIC ACUTE CARE HOSPITALS.—When an application~~
430 ~~is made for a certificate of need to construct or to expand an~~
431 ~~osteopathic acute care hospital, the need for such hospital~~
432 ~~shall be determined on the basis of the need for and~~
433 ~~availability of osteopathic services and osteopathic acute care~~
434 ~~hospitals in the district. When a prior certificate of need to~~
435 ~~establish an osteopathic acute care hospital has been issued in~~

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

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436 ~~a district, and the facility is no longer used for that purpose,~~
437 ~~the agency may continue to count such facility and beds as an~~
438 ~~existing osteopathic facility in any subsequent application for~~
439 ~~construction of an osteopathic acute care hospital.~~
440 Section 13. Subsection (5) of section 395.1065, Florida
441 Statutes, is amended to read:
442 395.1065 Criminal and administrative penalties;
443 moratorium.—
444 (5) The agency shall impose a fine of $500 for each
445 instance of the facility's failure to provide the information
446 required by rules adopted pursuant to s. 395.1055(1)(g) ~~s.~~
447 ~~395.1055(1)(h)~~.
448 Section 14. This act shall take effect July 1, 2019.

2019 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 1712
BILL TITLE:	Hospital Licensure
BILL SPONSOR:	Senator Harrell
EFFECTIVE DATE:	July 1, 2019

COMMITTEES OF REFERENCE
1)
2)
3)
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	HB 21
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	HB 437
SPONSOR:	Sprowls
YEAR:	2016
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
Y ___ N _x_

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	March 5, 2019
LEAD AGENCY ANALYST:	Marisol Fitch
ADDITIONAL ANALYST(S):	Jack Plagge
LEGAL ANALYST:	
FISCAL ANALYST:	

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

This bill amends Sections 395.003, 395.0191, 395.1055, 395.1065, 408.032, 408.034, 408.035, 408.036, 408.037, 408.039, 408.040, 408.043 and repeals Section 395.6025 to remove all Certificate of Need (CON) provisions for hospitals or hospital services. Under the provisions of the bill, new hospitals and specified hospital services would no longer need to apply and receive a CON prior to licensure. The bill does maintain a form of condition compliance for all hospitals licensed after the bill takes effect, which requires these hospitals to annually report charity care in an amount equal to or greater than the applicable district average among licensed providers of similar services. Hospitals that do not meet this amount of charity care or who do not report are subject to an administrative fine. Language was added to all other types of facilities subject to CON (nursing homes, hospices and intermediate care facilities for the developmentally disabled) increasing the fine (from a maximum of $1000 a day to a maximum of $2500 a day) for those facilities who do not meet the provision of charity care or Medicaid services which the issuance of the CON was predicated (typically self-imposed conditions by the applicant).

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Currently, new general acute care hospitals, replacement hospitals that are located greater than one mile from the existing location, freestanding specialty hospitals, long term care hospitals, as well as certain types of hospital services (transplant services, pediatric cardiovascular services, neonatal intensive care units, mental health services and comprehensive medical rehabilitation units) have to apply for a certificate of need prior to construction and licensure. Applicants must attest to meeting certain minimum standards such as staffing, equipment and financial requirements within the CON application.

Applications are submitted twice a year in batching cycles. Most hospital services are reviewed during the hospital batching cycle (beginning February and August of each year), with transplant and pediatric cardiovascular services being reviewed during the “Other Beds and Services Batch” (beginning April and October of each year). Some services such as neonatal intensive care, psychiatric services, substance abuse and comprehensive rehabilitation have established fixed need pool methodologies to calculate the need for beds in each service area for each type of service. These methodologies are established by rule. Regardless of numeric need, facilities can apply for services under “Not Normal Circumstances” during the applicable batching cycle.

In addition to the batched application process, a number of services (neonatal intensive care units, psychiatric and substance abuse services and additional comprehensive medical rehabilitation beds) can be added to existing hospitals through the exemption process. Exemptions can be submitted at any time and must be reviewed within thirty days.

Additional acute care hospital beds, hospital-based skilled nursing beds and neonatal intensive care beds can be added to facilities through a notification process to the Agency for inventory purposes.

The Agency publishes the inventory and utilization for all pertinent CON services under its review purview twice a year in conjunction with publication of the fixed need pool for each applicable service.

Facilities can predicate conditions above minimum standards for approval of service/facility within a CON application. These conditions are monitored annually after licensure with condition compliance reports due no later than April 1st of the year following (for example condition compliance for calendar year 2018 is due no later than April 1, 2019). The majority of these conditions proposed by the applicant are for a minimum provision of charity care or Medicaid (either separately or combined) patient days. Currently, the Agency is precluded from fining/sanctioning nursing homes for their failure to meet their promised provision of care to Medicaid population due to language within 408.040 (1)(b).

Licensure standards for new hospitals do not include the requirement for applicants to submit proof of financial ability to operate as indicated in s. 408.820(8) and s. 408.810(8)-(9).

Licensure standards do not require hospitals to participate in the Medicaid program. Of the 308 currently licensed hospitals, 18 do not participate:

- 1 specialty children's psychiatric hospital;
- 1 inactive general hospital recently acquired out of bankruptcy by a children’s hospital;
- 2 state-owned hospitals
- 2 long term care hospitals in bankruptcy currently undergoing a change of ownership; and
- 12 psychiatric hospitals.

The following chart shows the number of new hospitals licensed each year since 2014.

Year	Initial Applications Received	Initial Applications Approved	Total licensed Hospitals
2014	4	2	303
2015	2	4	306

2016	1	0	306
2017	3	3	309
2018	3	4	312
2019	0	0	308

2. EFFECT OF THE BILL:

The bill would remove the necessity of hospitals to receive a CON prior to construction and licensure. New hospitals, replacement hospitals, freestanding specialty hospitals, long term care hospitals and specific hospital services would no longer be reviewed for health care planning purposes.

Existing facilities that are currently licensed with CONs would no longer have to fulfill commitments made during the CON review process—the majority of which include serving Medicaid and indigent populations. The bill requires new hospitals to participate in the Medicaid program and meet one of the following:

- Provide charity care in the amount equal to or greater than the applicable district average among similar hospitals—the state average for all hospitals and all hospital types was 3.06 percent in 2017, for all acute care (including teaching) the average was 3.62 percent, for long-term care it was 1.32 percent, for psychiatric hospitals it was 4.68 percent and for CMR it was 2.52 percent.
- For hospitals in a medically underserved area (MUA), provide charity care equal to the MUA's Index of Medical Underservice score as calculated by the federal Health Resources and Services Administration within the Department of Health and Human Services. There are 71 areas identified as MUA. The index scores range from 43 to 62 percent.
- Donate an amount determined by the Agency to be equivalent to the district's average charity care or UMA score to the Agency's Grants and Donations Trust Fund.

New hospitals that fail to report or fail to comply will be assessed a fine in the amount of one percent of its net revenue for each 0.5 percent of the required amount of charity care. Due dates for the compliance reports must be established by Agency rules. Net revenue and charity care percentage (based upon patient revenue) are available from the Florida Hospital Uniform Reporting System (FHURS).

The bill eliminates three hospital publications that are produced twice a year by the Agency, and the requirement to calculate the pertinent fixed need pools semi-annually. Utilization information would be available through the FloridaHealthFinder.gov website.

Hospitals licensed prior to July 1, 2019 will continue to report charity care data through FHURS. FHURS data is submitted based on the hospitals cost report year end date. Data for the previous calendar year is not available until July or August of the subsequent year (CY 2018 data will be available in July or August of 2019). FHURS data is reported by licensee, therefore data is not necessarily available at the hospital level if multiple hospitals operate under a single license. The Index scores for MUAs are considerable and may be cost prohibitive to any applicant attempting to license a hospital in an MUA. The Agency will be required to determine an amount that new hospitals must donate to the Grants and Donations Trust Fund.

Hospitals will no longer be eligible for inactive status as described in s. 408.808(3), F.S. Although infrequently used, inactive status allows a hospital to cease services for a limited period of time in order to make specific changes. Typically, changes are to upgrade the facility's physical plant. During the inactive period, only those sections of the hospital being renovated must be built to current building codes. Without inactive status, the hospital would have to surrender its license upon cessation of services, then apply for a new license at which time, the entire facility would be required to meet current codes. Surrender of licensure will also cause the hospital to lose its Medicare certification. Application for Medicare certification can only occur after a new license is obtained. This would have a significant impact on hospitals regarding renovation costs and the length of time the hospital is unable to provide services. Hospitals may still apply for inactive status pursuant to s. 408.821(3), F.S. This requires the hospital to be located in a geographic area in which a state of emergency was declared by the Governor and suffered damage to its operation during the state of emergency.

The bill increases the maximum fine from $1,000 to $2,500 for those facilities which do not meet their promised provision of care to the indigent or Medicaid (conditions). Compliance with conditions is monitored annually.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y _X__ N ___

If yes, explain:	The statute does not provide new rule authority, although existing rule authority allows the Agency to write rules as required. The statute also increases the maximum fine amount for facilities which fail to meet their condition provision of Medicaid/charity care patient days. Hospital rules will need to be amended to remove references to CON and add charity care reporting requirements if an existing reporting system cannot be utilized. CON rules will need to be amended to remove references to hospital or hospital services.

Is the change consistent with the agency's core mission?	Y _X__ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	59A-3 sections .066, .080, and .278 would be amended. 59C-1.021(3) (for condition compliance). 59C-1.002, 59C-1.004, 59C-1.005, 59C-1.008, 59C-1.0085, 59C-1.010, 59C-1.0105, 59C-1.012, 59C-1.013, 59C-1.018, 59C-1.019, 59C-1.020, 59C-1.021, 59C-1.030 would be amended. 59C-1.032, 59C-1.033, 59C-1.039, 59C-1.040, 59C-1.041, 59C-1.042, 59C-1.044 and 59C-2.100 would be repealed.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	Unknown at this time
Opponents and summary of position:	Unknown at this time

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y _X__ N ___

If yes, provide a description:	An annual compliance report is required of all hospitals that are licensed after July 1, 2019 regarding their provision of charity care.
Date Due:	The bill does not specify when these reports are due.
Bill Section Number(s):	Section 1

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQUIRED BY THIS BILL? Y ___ N _X__

Board:	
Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	
Expenditures:	
Does the legislation increase local taxes or fees? If yes, explain.	
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	Revenues for CON application fees ($50,000 for a new hospital) will no longer exist. In CY 2018, hospital application fees were $703,120. Revenues will increase for new hospital licensure fees. Revenues will increase for those facilities that must contribute to the Grants and Donations Trust Fund. Fine revenues may increase due to increase fine amounts and new fine authority.
Expenditures:	Workload will increase in the hospital licensure unit due to growth in licensees and other associated duties in the bill. Workload may increase in legal with the increase in sanctioning ability on condition compliance. Workload would be expected to increase in the areas of physical plant architectural, engineering plan review and inspections, program costs will be supported by fees. CON staff will be shifted to assist with the new tasks in the bill and program growth.
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y _X__ N ___

Revenues:	
Expenditures:	Hospitals will no longer be required to pay CON application fees. The proposed bill could also increase the hospital fines.
Other:	

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y _X__ N ___

If yes, explain impact.	1. Establishes a fine for hospitals licensed after July 1, 2019 for noncompliance with charity care criteria. 2. Increases the maximum condition compliance fine from $1000 a day to $2500 a day for facilities subject to CON who do not meet their self-promised provision of patient days to the Medicaid and charity care population.
Bill Section Number:	1. Section 1 2. Section 11

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y __X_ N ___

If yes, describe the anticipated impact to the agency including any fiscal impact.	If utilizing the FHURS data is insufficient due to the time delay, a new reporting system will need to be developed. Options range from a manual form hospitals will be required to fill out and submit to the Agency's licensure unit to a new online reporting system. Cost estimates range from $2,000-$3,000 for updated rules, forms and basic data storage to $150,000 for an online reporting system.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y ___ N _X__

If yes, describe the anticipated impact including any fiscal impact.	

ADDITIONAL COMMENTS

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Committee Code Not Found

BILL: SB 7078

INTRODUCER: Health Policy Committee

SUBJECT: Health Care

DATE: March 19, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	Williams, et al	Brown		**HP Submitted as Comm. Bill/Fav**
1.				

I. Summary:

SPB 7078 addresses a variety of health care and health insurance issues, including:

- Access to medical records
- Hospital quality information
- Access to primary and specialist care in a hospital setting
- Notification of hospital observation status
- Direct health care agreements
- Step-therapy protocols
- Price transparency for services covered by health insurance
- The Interstate Medical License Compact

The bill has an indeterminate fiscal impact on the state.

The bill has an effective date of July 1, 2019, except as otherwise provided.

II. Present Situation:

Access to Medical Records

The Baker Act and Mental Health Clinical Records and Confidentiality

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[1] The Baker Act authorized treatment programs for mental, emotional, and behavioral disorders. The Baker Act required programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery. Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health

[1] Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.

examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Section 394.4615, F.S., of The Baker Act, was created in 1996 and modified provisions relating to the confidentiality of a patient's mental health records. Under this statute, patients were provided access to those records.[2] Section 394.4615, F.S., has been substantively amended only twice since being enacted in 1996, as follows:

- In 2000, clinical records relating to a Medicaid recipient were required to be furnished to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request;[3,4] and information from clinical records could be used by the Florida advocacy councils, instead of human rights advocacy committees, for the purpose of monitoring facility activity and complaints concerning facilities;[5] and
- In 2004, clinical records could be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to appropriate mental health professionals, including the service provider identified in s. 394.4655(6)(b)2., F.S., in accordance with state and federal law for the purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan pursuant to s. 394.4655, F.S.[6]

Section 394.4615, F.S., provides the following to maintain the confidentiality of mental health clinical records:

- Mental health clinical records must be maintained for each patient and must include specific data;
- Mental health clinical records are confidential and exempt from the provisions of s. 119.07(1), F.S., unless:
  - Waived by express and informed consent by the patient or the patient's guardian or guardian advocate; or,
  - If the patient is deceased, by the patient's personal representative or the family member who stands next in line of intestate succession.
- The confidential status of a patient's clinical record is not lost by either authorized or unauthorized disclosure to any person, organization, or agency.
- Section 394.4615, F.S., provides the following circumstances when confidential mental health clinical records must be released:
- When the patient or the patient's guardian authorizes the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care;
- When the patient is represented by counsel and the records are needed by counsel for adequate representation;
- When the court orders such release after determining that there is good cause for disclosure after weighing the need for the information to be disclosed against the possible harm of disclosure to the person to whom the information pertains; and

[2] Chapter 96-196, s. 14, Laws of Fla.
[3] Chapter 2000-163, s. 1, Laws of Fla.
[4] Section 394.4615 (5), F.S.
[5] Chapter 2000-263, s. 4, laws of Fla.
[6] Chapter 2004-385, s.14, Laws of Fla.

- When the patient is committed to, or is to be returned to, the Department of Corrections from the DCF, and the Department of Corrections requests such records.
- Section 394.4615, F.S., provides the following circumstances when confidential mental health clinical records may be released:
- When a patient has declared an intention to harm other persons, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient;
- When the administrator of the facility, or Secretary of the Department of Children and Families (DCF) deems that release to a qualified researcher, an aftercare treatment provider, or an employee or agent of the DCF is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs;
- When the state attorney, the public defender, patient's private legal counsel, the court, or an appropriate mental health professional, including the service provider identified in s. 394.4655(7)(b)2., F.S., deem it necessary in determining whether a person meets the criteria for involuntary outpatient placement, or for preparing the proposed treatment plan pursuant to s. 394.4655, F.S.;
- For statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals;
- To the Agency for Health Care Administration (AHCA), the DCF, and the Florida advocacy councils for the purpose of monitoring facility activity and complaints concerning facilities;
- To the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request, if the patient is a Medicaid recipient.

Section 394.4615, F.S., also directs that any person, agency, or entity who receives mental health clinical records must maintain the information as confidential and exempt from the provisions of s. 119.07(1), F.S.; and any facility or private mental health practitioner who acts in good faith in releasing information pursuant to this section is not subject to civil or criminal liability for such release.

The Legislature stated its intent in s. 394.4615, F.S., not to prohibit the parent or next of kin of a person who is held in, or treated under a mental health facility or program, from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Patients are entitled to reasonable access to their mental health clinical records, unless such access is determined by the patient's physician to be harmful to the patient. If a patient's right to inspect his or her mental health clinical record is restricted by a facility, it expires after seven days, but may be renewed, for a subsequent seven days. Written notice of the restriction of a patient's right to inspect his or her mental health clinical records must be given to the patient, the patient's guardian, guardian advocate, attorney, and representative, and the restriction must be recorded in the clinical record, together with the reasons for it.

Any person who fraudulently alters, defaces, or falsifies the mental health clinical records of any person receiving mental health services in a facility, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in ss. 775.082 or 775.083, F.S.

Hospitals

Hospitals are regulated by the AHCA under ch. 395, F.S., and the general licensure provisions of part II, of ch. 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[7] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.[8]

The AHCA must maintain an inventory of hospitals with an emergency department.[9] The inventory must list all services within the capability of each hospital, and such services must appear on the face of the hospital's license. As of March 12, 2019, 217 of the 308 licensed hospitals in the state have an emergency department.[10]

Hospitals must meet initial licensing requirements by submitting a completed application and required documentation, and the satisfactory completion of a facility survey. The license fee is $1,565.13 or $31.46 per bed, whichever is greater.[11] The survey fee is $400 or $12 per bed, whichever is greater.[12]

Section 395.1055, F.S., authorizes the AHCA to adopt rules for hospitals. Separate standards may be provided for general and specialty hospitals.[13] The rules for general and specialty hospitals must include minimum standards to ensure:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards.[14]

The minimum standards for hospital licensure are contained in Chapter 59A-3, F.A.C.

Ambulatory Surgical Centers (ASCs)

An ASC is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.[15] ASCs are licensed and regulated by the AHCA

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[7] Section 395.002(12), F.S.
[8] Id.
[9] Section 395.1041(2), F.S.
[10] Agency for Health Care Administration, Facility/Provider Search Results, Hospitals, *available at* http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (reports generated on Mar. 12, 2019).
[11] Rule 59A-3.066(3), F.A.C.
[12] Section 395.0161(3)(a), F.S.
[13] Section 395.1055(2), F.S.
[14] Section 395.1055(1), F.S.
[15] Section 395.002(3), F.S.

under the same regulatory framework as hospitals.[16] Applicants for ASC licensure must submit certain information to AHCA prior to accepting patients for care or treatment, including:

- An affidavit of compliance with fictitious name;
- Proof of registration of articles of incorporation; and
- A zoning certificate or proof of compliance with zoning requirements.[17]

Upon receipt of an initial application, AHCA is required to conduct a survey to determine compliance with all laws and rules. ASCs are required to provide certain information during the initial inspection, including:

- Governing body bylaws, rules and regulations;
- A roster of registered nurses and licensed practical nurses with current license numbers;
- A fire plan; and
- The comprehensive Emergency Management Plan.[18]

The AHCA is authorized to adopt rules for ASCs.[19] Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals,[20] but the rules for all ASCs must include the minimum standards listed above for hospitals.

The minimum standards for ASCs are contained in Chapter 59A-5, F.A.C.

Hospital Compare

The federal Centers for Medicare & Medicaid Services (CMS) maintains the Hospital Compare website,[21] which provides consumers with data about the quality of care at over 4,000 Medicare-certified hospitals.[22] Hospital Compare allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, heart failure, pneumonia, surgery and other conditions.[23] Performance measures include patient satisfaction survey results[24] and readmission, hospital acquired infection and mortality rates.[25] Overall hospital performance is presented to consumers through a star rating of one to five stars.[26]

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[16] Sections 395.001-1065, F.S., and Part II, Chapter 408, F.S.
[17] Rule 59A-5.003(4), F.A.C.
[18] Rule 59A-5.003(5), F.A.C.
[19] Section 395.1055, F.S.
[20] Section 395.1055(2), F.S.
[21] Centers for Medicare & Medicaid Services, Hospital Compare, available at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalcompare.html (last visited on March 12, 2019)
[22] Medicare.gov, What is Hospital Compare? available at https://www.medicare.gov/hospitalcompare/About/What-Is-HOS.html (last visited March 12, 2018).
[23] Supra note 16
[24] Data is from responses to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. HCAHPS is a national survey that asks patients about their experiences during a recent hospital stay. http://www.hcahpsonline.org/ (last visited March 12, 2019)
[25] Medicare.gov, Measures and current data collection periods, available at https://www.medicare.gov/hospitalcompare/Data/Data-Updated.html# (last visited March 12, 2019).
[26] Medicare.gov, Hospital Compare overall hospital rating, available athttps://www.medicare.gov/hospitalcompare/About/Hospital-overall-ratings.html (last viewed March 12, 2019).

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center) provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data. The Florida Center is housed within the AHCA.[27]

Offices within the Florida Center, which serve different functions, are:

- Data Collection and Quality Assurance, which collects patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units), comprehensive rehabilitation hospitals, ambulatory surgical centers and emergency departments.
- Risk Management and Patient Safety, which conducts in-depth analyses of reported incidents to determine what happened and how the facility responded to the incident.
- Data Dissemination and Communication, which maintains AHCA's health information website, provides technical assistance to data users, and creates consumer brochures and other publications.
- Health Information Exchange and Policy Analysis, which monitors innovations in health information technology, informatics, and the exchange of health information and provides a clearinghouse of technical resources on health information exchange, electronic prescribing, privacy and security, and other relevant issues.[28]

The Florida Center electronically collects patient data from every Florida licensed inpatient hospital, ASC, emergency department, and comprehensive rehabilitation hospital on a quarterly basis. The data is validated for accuracy and maintained in three major databases: the hospital inpatient database, the ambulatory surgery database, and the emergency department database.

- The hospital inpatient database contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data. This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.[29]
- The ambulatory surgery database contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories. Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.[30]
- The emergency department database collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to

[27] Section 408.05, F.S.

[28] See *Florida Center for Health Information and Transparency*, available at http://ahca.myflorida.com/SCHS/ (last visited on March 12, 2019).

[29] See s. 408.061, F.S., and ch. 59E-7, F.A.C.

[30] See s. 408.061, F.S., and ch. 59B-9, F.A.C.

the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.[31]

The Florida Center maintains www.FloridaHealthFinder.gov, which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public that allows easy access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida.

The website also provides tools to researchers and professionals to allow specialized data queries, but requires users to have some knowledge of medical coding and terminology. Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.

The Florida Center also runs Florida Health Price Finder,[32] which provides consumers with the ability to research and compare health care costs in Florida at the national, state and local levels. Supported by a database of more than 15 million lines of insurance claim data sourced directly from Florida insurers, the website displays costs as Care Bundles representing the typical set of services a patient receives as part of treatment for a specific medical conditions. Care Bundles are broken down into logical steps, which may include one or more procedures and tests and the 295 care bundles currently available on Florida Health Price Finder account for 90 percent of consumer searches on national pricing websites.

The Health Insurance Portability and Accountability Act (HIPAA)

The federal HIPAA provides that, except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information [33] in a covered entity's designated record set. The "designated record set" is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider's medical and billing records about individuals or a health plan's enrollment, payment, claims adjudication, and case or medical management record systems. The HIPAA excepts from the right of access the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. For information included within the right of access, covered entities may deny an individual access in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion. Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.[34]

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[31] Id.
[32] see https://pricing.floridahealthfinder.gov/#! (last visited Mar. 12, 2019).
[33] Protected Health Information includes all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.
[34] See Summary of the HIPAA Privacy Rule, *available at* https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html (last visited on Mar. 11, 2019).

Florida Law

In addition to federal requirements, Florida law establishes medical record requirements for various facilities.

Hospital and Ambulatory Surgical Center (ASC) records are governed by s. 395.3025, F.S. Hospitals and ASCs are required to furnish records in a timely manner, without delays for legal review, to a patient or the patient's representative[35] but only after the patient has been discharged from the hospital or ASC. A hospital or ASC may charge up to $1 per page of paper records or up to $2 in total for non-paper records whether the records are furnished by the hospital, the ASC, or a copy service. A hospital or ASC may also charge a fee of up to $1 per year of records requested. Records copied for the purpose of continuing medical care are not subject to a charge and a hospital or ASC must allow any person who is authorized to receive copies of records to examine the original records, or suitable reproductions, with reasonable terms to ensure that such records are not damaged, destroyed, or altered.

The provisions of s. 395.3025, F.S., do not apply to:
- Records maintained at a psychiatric hospital;
- Records or mental or emotional treatment at a facility where the records are governed by the Florida Mental Health Act under s. 394.4165, F.S.; or
- Records of a substance abuse impaired person.

Section 395.3025(4), F.S., specifies that patient records are confidential, exempt from disclosure under public records laws, and may not be disclosed without the consent of the patient or his or her legal representative. The section allows access to a patient's records without the consent of the patient to specific entities for purposes related to the treatment of the patient, licensure actions, investigations, audits, and quality assurance.

Substance Abuse Treatment

Substance Abuse Services are governed by ch. 397, F.S, and the DCF is responsible for the oversight of a statewide system of care for the prevention, treatment, and recovery of children and adults with serious substance abuse issues. The state substance abuse program is designed to support the prevention and remediation of substance abuse through the provision of a comprehensive system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.[36]

The Right to Confidentiality of Individual Substance Abuse Records

A person's right to the confidentiality of their individual substance abuse records demands a service provider protect an individual's identity, diagnosis, prognosis, and service provided. Such records are confidential, in accordance with state and federal law, and are exempt from disclosure state public records laws. Substance abuse records may not be disclosed without the

[35] Specified as the patients guardian, curator, or personal representative, or in the absence of one of those persons, to the next of kin of a decedent or the parent of a minor, or to anyone designated by such person in writing.
[36] OPPAGA, *Department of Children and Families Substance Abuse and Mental Health Community Services* (Jan. 15, 2019), *available at* http://www.oppaga.state.fl.us/profiles/5057/ (last visited Mar. 11, 2019).

written consent of the individual to whom they pertain, except under the following circumstances:

- To medical personnel in a medical emergency;
- To service provider personnel if such personnel need to know the information in order to carry out duties relating to the provision of services to an individual;
- To the secretary of the DCF or his or her designee, for the purposes of scientific research, in accordance with federal confidentiality regulations, but only upon agreement in writing that the individual's name and other identifying information will not be disclosed;
- In the course of review of service provider records by persons who are performing an audit or evaluation on behalf of any federal, state, or local government agency, or third-party payer providing financial assistance or reimbursement to the service provider; or
- Upon court order based on an application showing good cause for disclosure.[37]

The restrictions on the disclosure and use of confidential records held by substance abuse program service providers do not apply to:

- Communications from provider personnel to law enforcement officers which:
  - Are directly related to an individual's commission of a crime on the premises of the provider or against provider personnel or to a threat to commit such a crime; and
  - Are limited to the circumstances of the incident, including the status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.
- The reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law.[38]

Any response to a request for disclosure of an individual's records under ch. 397, F.S., which is not permissible, must be done in such a manner that it will not affirmatively reveal the identity of the individual, or his or her diagnosis, or treatment for substance abuse. However, if the individual is not receiving, or has never received, substance abuse services, that fact may be disclosed.[39]

If a minor has the legal capacity to voluntarily apply for, and obtain, substance abuse treatment only the minor may consent to the disclosure of that minor's substance abuse records. However, when the consent of a parent, legal guardian, or custodian is required in order for a minor to obtain substance abuse treatment, any consent for the disclosure of substance abuse records must be given by both the minor and the parent, legal guardian, or custodian.[40]

A court order authorizing the disclosure and use of a person's confidential substance abuse records only authorizes the disclosure or use of identifying information. It does not compel

[37] Section 397.501(7)(a), F.S. In determining whether there is good cause for disclosure, the court shall examine whether the public interest and the need for disclosure outweigh the potential injury to the individual, to the service provider and the individual, and to the service provider itself.
[38] Section 497.501(7)(c), F.S. However, the confidentiality restrictions continue to apply to the original substance abuse records maintained by the provider, including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.
[39] Section 497.501(7)(d), F.S.
[40] Section 497.501(7)(e), F.S.

disclosure. A subpoena or a similar legal mandate is required in order to compel disclosure. Both the order and subpoena may be requested and entered by the court at the same time.

Any person having a legally recognized interest in the disclosure of an individual's substance abuse records my seek an order and/or subpoena for disclosure. The application may be filed alone, or as part of a pending civil action, active criminal investigation, or criminal action in which it appears that the individual's records are needed to provide evidence. The application must use a fictitious name, such as John Doe or Jane Doe, to refer to the individual and may not contain any other identifying information unless:

- The individual is the applicant;
- The applicant has been given written consent for disclosure from the person or his or her legal representative; or
- The court has ordered the record of the proceeding sealed from public scrutiny.

In a civil action, the individual seeking confidential substance abuse records, and the person holding the records from whom disclosure is sought, must be given adequate notice of the application in a manner which will not disclose the individual's identity. All parties must be given an opportunity to respond to the application, or to appear in person, for the limited purpose of providing evidence on the legality of the request for the issuance of the court order.

Applications for confidential substance abuse records related to an active criminal investigation may be granted disclosure without notice to anyone upon a finding of probable cause by the judge. But, once an order has been issued for confidential substance abuse records, then the agents, owners, and employees of the treatment provider, or to any individual whose records are to be disclosed, must be afforded an opportunity to seek revocation, or limitation, of the order by presenting evidence for the purpose of challenging the legal basis for the issuance of the order. Any oral argument, review of evidence, or hearing on the application must be held in private so as not to disclose to anyone other than a parties to the proceeding, the individual, or the person holding the record, unless the person requests an open hearing. The proceeding may include an *in camera*[41] examination by the judge of the records referred to in the application.

A court may authorize the disclosure and use of confidential substance abuse records for the purpose of conducting a criminal investigation, or prosecution, of an individual only if the court finds that all of the following criteria have been met:

- The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury, including but not limited to homicide, sexual assault, sexual battery, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect;
- There is reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution;
- Other ways of obtaining the information are not available or would not be effective; and

[41] *In Camera* is Latin for, "in chambers." The Law Dictionary, *In Camera* available at https://thelawdictionary.org/search2/?cx=partner-pub-2225482417208543%3A5634069718&cof=FORID%3A11&ie=UTF-8&q=in+camera&x=3&y=6 (last visited Mar. 11, 2019)

- The potential injury to the individual, to the physician-individual relationship, and to the ability of the program to provide services to other individuals is outweighed by the public interest and the need for the disclosure.[42]

Nursing Home Records

Nursing home records are governed by s. 400.145, F.S., which requires a nursing home to provide two copies of patient records to a patient, or their authorized representative, within 14 days for a current resident and 30 days for a former resident when it receives a written request that is compliant with the requirements of HIPAA. A nursing home is required to provide medical records and records concerning the care and treatment of a patient, but is not required to provide progress notes and consultation reports of a psychiatric nature.

A nursing home may refuse to furnish the records directly to the resident if the nursing home determines that disclosure of the records would be detrimental to the resident's physical or mental health; however, a nursing home must still disclose the records to any other medical provider designated by the resident.[43] Additionally, a nursing home is not required to provide a resident's records more than once per month except as necessary to allow effective monitoring of the resident's condition.

Section 400.145(2), F.S., specifies that requests for a deceased resident's records may be made by, in descending order of authority:

- A person appointed by a court to act as the personal representative, executor, administrator, curator, or temporary administrator of the deceased resident's estate;
- A person designated by the resident to act on his or her behalf in the resident's self-proved will;
- A surviving spouse;
- A surviving child; or
- A parent of the resident.

Section 400.145(3), F.S., specifies proof that must be submitted with each request to demonstrate that the person making the request is authorized to receive the records. A nursing home is indemnified from criminal and civil liability for releasing records in good faith to the representative of a deceased resident.[44]

A nursing home is authorized to charge a reasonable fee for copying resident records not to exceed $1 per page for the first 25 pages and 25 cents per page for each additional page. A facility must also allow an authorized person to examine the original records, or suitable reproductions, and may impose reasonable terms to ensure the records are not damaged, destroyed, or altered.[45]

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[42] Section 497.501(7)(f) through (j), F.S.
[43] Section 400.145(5), F.S.
[44] Section 400.145(6)
[45] Section 400.145(4), F.S.

Ownership and Control of Patients' Medical Records

Under Florida law, a patient's medical records are not the property of the patient. A patient's medical records belong to the "records owner," which means any health care practitioner who generates a medical record after making a physical or mental examination of, or administering treatment or dispensing legend drugs to, any person. The term also includes:

- Any health care practitioner to whom a patient's records are transferred to by a previous records owner; or
- Any health care practitioner's employer.[46]

The following persons and entities are not authorized to own medical records, but they are authorized to maintain documents required by ch. 456, F.S., and their respective practice acts:

- Certified nursing assistants;[47]
- Pharmacists and pharmacies;[48]
- Dental hygienists;[49]
- Nursing home administrators;[50]
- Respiratory therapists;[51]
- Athletic trainers;[52]
- Electrologists;[53]
- Clinical laboratory personnel;[54]
- Medical physicists;[55]
- Opticians and optical establishments;[56] and
- Persons or entities performing personal injury protection (PIP) examinations for insurance carriers.[57]

Any health care practitioner licensed by the Department of Health (DOH), or a board within the DOH, who makes an examination of a patient, administers treatment or dispenses legend drugs, must, in a timely manner, furnish to the patient, or his or her legal representative, without delays for legal review, copies of all reports and records relating to the examination, treatment, X-rays and insurance information.[58]

When a patient's psychiatric, psychological, or psychotherapeutic records are requested by the patient, or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's psychiatric records must be provided directly to a subsequent

[46] Section 456.057(1), F.S.
[47] *See* part II, ch. 464, F.S.
[48] *See* ch. 465, F.S.
[49] *See* s. 466.023, F.S.
[50] *See* part II, ch. 468, F.S.
[51] See part V, ch. 468, F.S.
[52] *See* part XIII, ch. 468, F.S.
[53] *See* ch. 478, F.S.
[54] *See* part II, ch. 483, F.S.
[55] *See* part III, ch. 483. F.S.
[56] *See* part I, ch. 484, F.S.
[57] *See* s. 627.736(7), F.S.
[58] Section 456.057(6), F.S.

treating psychiatrist. The furnishing of such report or copies cannot be conditioned upon payment of a fee for services rendered.[59]

A health care practitioner or records owner who furnishes copies of reports or records, or makes the reports or records available for digital scanning, is authorized to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the DOH when there is no board.[60]

Florida Board of Medicine Rule

The Board of Medicine encourages allopathic physicians to provide patients with a copy of their medical records free of charge, especially if the patient is disadvantaged.[61] However, an allopathic physician is authorized to charge a patient or governmental entity a $1 per page for the first 25 pages, and no more than 25 cents for each subsequent page.[62] For all other entities, an allopathic physician may charge up to $1 per page. An allopathic physician may charge the actual cost for reproducing certain documents, such as X-rays and other special kinds of records.[63] Actual costs include the materials, supplies, labor, and overhead costs associated with such duplication.[64] No timeline is specified for the provision of these records.

Florida Board of Osteopathic Medicine Rule

An osteopathic physician may charge up to $1 per page for the first 25 pages, and no more than 25 cents for each subsequent page, regardless of the requestor.[65] An osteopathic physician must comply with a patient's written request for records within 30 days of such request unless there are circumstances beyond the osteopathic physician's control that prevents such compliance.[66] An osteopathic physician may charge the actual cost for reproducing certain documents, such as X-rays and other special kinds of records.[67] Actual costs include the materials, supplies, labor, and overhead costs associated with such duplication.[68]

The provisions of the section do not apply to:
- Records maintained at any hospital or ambulatory surgical center if the primary function of the facility is to provide psychiatric care;
- Records of treatment for any mental or emotional condition if the release of the records is governed by the Florida Mental Health Act under s. 394.4615, F.S.;
- Records of substance abuse impaired persons governed under s. 397.501, F.S.; or
- Requests for records of a deceased resident of a nursing home facility.

[59] *Id.*
[60] Section 456.057(17), F.S.
[61] Fla. Admin Code R. 64B8-10.003 (2019).
[62] *Id.*
[63] *See* note 16.
[64] *Id.*
[65] Fla. Admin. Code R. 64B15-15.003, (2019).
[66] *Id.*
[67] *Supra* note 20.
[68] *Id.*

Notification of Hospital Observation Status

When a patient enters a hospital, the physician or other practitioner responsible for a patient's care must decide whether the patient should be admitted for inpatient care. The factors considered include:

- The severity of signs and symptoms exhibited by the patient;
- The medical probability of something adverse happening to the patient;
- The need for diagnostic studies to assist in the admitting decision; and
- The availability of diagnostic procedures at the time when the patient presents.69

Observation status is commonly ordered for a person who comes to the emergency department and requires treatment or monitoring to determine if he or she should be admitted or discharged.[70] A patient receives observation services when on observation status and can spend one or more nights in the hospital. These services can occur in the hospital's emergency department or in another area of the hospital.[71]

Observation services are covered under Medicare Part B, rather than Part A, so some patients with Medicare will experience an increase in out-of-pocket costs for observation services versus being admitted to the hospital.[72] For example, hospital inpatient services are covered under Medicare Part A and require the patient to pay a one-time deductible ($1,364) for the first 60 days of his or her stay. Alternately, hospital outpatient services, including observation services, are covered under Medicare Part B and require the patient to pay a deductible ($185) as well as 20 percent of the Medicare-approved amount for doctor services.[73] A person who is treated for an extended period of time as a hospital outpatient receiving services may incur greater financial liability. However, it can be difficult for a person to determine his or her status based purely on the type of care provided at the hospital.[74]

Once a person is discharged, additional rehabilitation in a nursing home is often necessary. Hospital admission can also affect a person's eligibility for other services.[75] When a person is admitted and has a three-night stay in a hospital and needs rehabilitative care, Medicare will pay for up to 60 days in a skilled nursing home. However, if a person is not admitted to the hospital and subsequently goes into a nursing home, Medicare will not pay for the nursing home stay.[76]

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[69] Medicare Benefit Policy Manual, ch. 1 sec. 10, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html (last visited Mar. 13, 2019).

[70] *Id* at ch. 6 at 20.6.

[71] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Product No. 11435, *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* (May 2014) available at https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf (last visited Mar. 12, 2019).

[72] AARP Public Policy Institute, *Rapid Growth in Medicare Hospital Observation Services: What's Going On?*, p. 1 (September 2013), available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf (last visited Mar. 12, 2019).

[73] Medicare.gov., *Medicare 2015 costs at a glance,* available at http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html (last visited Mar. 12, 2019) and 42 CFR s. 419.40.

[74] *See* Amanda Cassidy, *The Two-Midnight Rule*, Health Affairs, Health Policy Briefs (Jan. 22, 2015) available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=133 (last visited Mar. 12, 2019).

[75] *Id.*

[76] Medicare.gov., *Skilled nursing facility (SNF) care,* available at http://www.medicare.gov/coverage/skilled-nursing-facility-care.html (last visited Mar. 12, 2019).

Direct Primary Care

Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the provider-patient relationship. Section 624.27, F.S., provides that a direct primary care contractual agreement is not insurance and is not subject to regulation under the Florida Insurance Code (Code). The agreement, however, must meet certain requirements, such as being in writing and including the scope of services, duration of the agreement, amount of the fees, and specifying what the fees cover under the agreement. The section also exempts a primary care provider, which includes a primary care group practice, or his or her agent, from any certification or licensure requirements in the Code for marketing, selling, or offering to sell an agreement, and establishes criteria for direct primary care agreements.

A patient generally pays a monthly retainer fee, on average $77 per individual,[77] to the primary care provider for defined primary care services, such as office visits, preventative care, annual physical examination, and routine laboratory tests. An estimated 1,000 direct primary care practices exist in 48 states and the District of Columbia, covering over 330,000 patients, including Florida.[78]

After paying the monthly fee, a patient can access all services under the agreement at no extra charge contingent upon the agreement's provisions. Typically, DPC practices provide routine preventative services, screenings, or tests, like lab tests, mammograms, Pap screenings, and vaccinations. A primary care provider DPC model can be designed to address most health care issues, including women's health services, pediatric care, urgent care, wellness education, and chronic disease management.

Direct primary care agreements in Florida are currently limited to primary care services offered by primary care providers licensed under chs. 458 (medicine), 459 (osteopathic medicine), 460 (chiropractic), or 464 (nursing), or a primary care group practice.

Not all states call such arrangements direct primary agreements or limit the agreements to primary care physicians. In Missouri, the agreement is a *medical retainer agreement* between a physician and an individual patient or a patient's representative. The Missouri statute requires that the fees for the agreement be paid from a health savings account in compliance with federal law.[79] In Alabama, the agreement is specific to both primary care physicians and dentists and is known as the *Alabama Physicians and Dentists Direct Pay Act.*[80]

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[77] A study of 141 DPC practices found the average monthly retainer fee to be $77.38. Of the 141 practices identified, 116 (82 percent) have cost information available online. When these 116 practices were analyzed, the average monthly cost to the patient was $93.26 (median monthly cost, $75.00; range, $26.67 to $562.50 per month). Of the 116 DPCs noted, 36 charged a one-time enrollment fee and the average enrollment fee was $78. Twenty-eight of 116 DPCs charged a fee for office visits in addition to the retainer fee, and the average visit fee was $16. *See* Phillip M. Eskew and Kathleen Klink, *Direct Primary Care: Practice Distribution and Cost Across the Nation,* Journal of the Amer. Bd. of Family Med. (Nov.-Dec. 2015) Vol. 28, No. 6, p. 797, *available at:* http://www.jabfm.org/content/28/6/793.full.pdf (last viewed Mar. 12, 2019).

[78] Direct Primary Care Coalition, *About the Direct Primary Care Coalition* *https://www.dpcare.org/about* (last viewed Mar. 12, 2019).

[79] Mo. Rev. Stat. §376.1800 (2015).

[80] 2017 Ala. Laws 460.

Step-Therapy Protocols

Insurers and health maintenance organizations (HMOs) use many cost containment and utilization review strategies to manage medical and drug spending and patient safety. For example, plans may impose clinical management or utilization management requirements on the use of certain medical treatments or drugs on their formulary. In some cases, insurers or HMOs require an insured to use a step-therapy protocol for drugs or a medical treatment, which requires the insured to try one drug or medical procedure first to treat the medical condition before the insurer or HMO will authorize coverage for another drug or procedure for that condition.

Regulation of Health Insurance

The Office of Insurance Regulation (OIR) regulates the activities of insurers, HMOs, and other risk-bearing entities.[81] The AHCA regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[82]

The federal Patient Protection and Affordable Care Act (PPACA)[83] requires health insurers to make coverage available to all individuals and employers without exclusions for preexisting conditions, and mandates specified essential health benefits, including prescription drugs.[84] Insurers are required to publish a current and complete list of all covered drugs on its formulary drug list, including any tiered structure and any restrictions on the way a drug can be obtained, in a manner that is easily accessible to insureds, prospective insureds, and the public.[85]

The Florida Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. In Florida, the AHCA oversees the Medicaid program.[86] The Statewide Medicaid Managed Care (SMMC) program comprises a Managed Medical Assistance (MMA) component and a Long-term Care (LTC) managed care component. The AHCA contracts with managed care plans to provide services to eligible enrollees.[87]

The benefit package offered by the MMA plans is comprehensive and covers all Medicaid state plan benefits (with very limited exceptions). This includes all medically necessary services for children. Most Florida Medicaid enrollees who are eligible for the full array of Florida Medicaid benefits are enrolled in an MMA plan. Florida Medicaid managed care plans cannot be more

[81] Section 20.121(3)(a), F.S.
[82] Section 641.21(1), F.S.
[83] The Patient Protection and Affordable Care Act (Pub. L. No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010.
[84] 42 U.S.C. s.18022.
[85] 45 C.F.R. s. 156.122(d).
[86] Parts II and III of ch. 409, F.S., govern the Medicaid managed care program.
[87] A managed care plan that is eligible to provide services under the SMMC program must have a contract with the agency to provide services under the Medicaid program and must also be a health insurer; an exclusive provider organization or a HMO authorized under ch. 624, 627, or 641, F.S., respectively; a provider service network authorized under s. 409.912(2), F.S., or an accountable care organization authorized under federal law. Section 409.962, F.S.

restrictive than these policies or the Florida Medicaid state plan (which is approved by the federal CMS) in providing services to their enrollees.

Licensing of Florida Physicians

The regulation of the practices of medicine and osteopathic medicine fall under chs 458 and 459, F.S., respectively. The practice acts for both professions establish the regulatory boards, a variety of licenses, the application process with eligibility requirements, and financial responsibilities for the practicing physicians. The boards have the authority to establish, by rule, standards of practice and standards of care for particular settings.[88] Such standards may include education and training, medication including anesthetics, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed consent, and policy and procedures manuals.[89] The current licensure application fee for a medical doctor is $350 and is non-refundable.[90] Applications must be completed within one year. If a license is approved, the initial license fee is $355.[91] The entire process may take from 2 to 6 months from the time the application is received.[92]

For osteopathic physicians, the application fee is currently a non-refundable $200 and if approved, the initial licensure fee is $305.00.[93] The same application validity provision of one year applies and the processing time of 2 to 6 months is the range of time that applicants should anticipate for a decision.[94] If an applicant is licensed in another state, the applicant may request that Florida "endorse" those exam scores and demonstrate that the license was issued based on those exam scores. The applicant must also show that the exam was substantially similar to any exam that Florida allows for licensure.[95]

The general requirements for licensure under both practice acts are very similar with the obvious differences found in the educational backgrounds of the applicants. However, the practice acts are not identical in their licensure offerings as shown in the table below which compares some of the contents of the two practice acts. Where the practice acts share the most similarities are the qualifications for licensure. Both the Board of Medicine and the Board of Osteopathic Medicine require their respective applicants to meet these minimum qualifications:

- Complete an application form as designated by the appropriate regulatory board.
- Be at least 21 years of age.
- Be of good moral character.
- Have completed at least 2 years (medical) or 3 years (osteopathic) of pre-professional post-secondary education.

[88] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[89] *Id.*
[90] Florida Board of Medicine, *Medical Doctor - Fees,* https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted /(Last visited Mar. 8, 2019).
[91] A change to Rule 64B-3.002, F.A.C., is effective March 11, 2019 which modifies the fee schedule for licensure applications. The fee for licensure by examination will increase to $500 and the fee for licensure by endorsement will increase also to $500. The time to complete an initial applications is also reduced from one year to six months.
[92] Florida Board of Medicine, *Medical Doctor Unrestricted – Process,* https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited Mar. 8, 2019).
[93] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Fees,* https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited: Mar. 8, 2019).
[94] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Process,* https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/ (last visited Mar. 8, 2019).
[95] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure – Requirements, https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/* (last visited Mar. 8, 2019).

- Have not previously committed any act that would constitute a violation of this chapter or lead to regulatory discipline.
- Have not had an application for a license to practice medicine or osteopathic medicine denied or a licensed revoked, suspended or otherwise acted upon in another jurisdiction by another licensing authority.
- Must submit a set of fingerprints to the DOH for a criminal background check.
- Demonstrate that he or she is a graduate of a medical college recognized and approved by the applicant's respective professional association.
- Demonstrate that she or he has successfully completed a resident internship (osteopathic medicine) or supervised clinical training (medical) of not less than 12 months in a hospital approved for this purpose by the applicant's respective professional association.
- Demonstrate that he or she has obtained a passing score, as established by the applicant's appropriate regulatory board, on all parts of the designated professional examination conducted by the regulatory board's approved medical examiners no more than 5 years before making application to this state; or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than 5 years after the applicant obtained a passing score on the required examination.[96]

Statutory References for Practice Acts - Licensure Medical and Osteopathic Physicians: Ch. 458 and 459, F.S.		
Issue	**Medical Physicians**	**Osteopathic Physicians**
Regulatory Board	Board of Medicine s. 458.307, F.S.	Board of Osteopathic Medicine s. 459.004, F.S.
Rulemaking Authority	s. 458.309., F.S.	s. 459.005, F.S.
General Requirements for Licensure	s. 458.311, F.S.	s. 459.0055, F.S.
Licensure Types		
Restricted License	s. 458.310, F.S.	No provision
Restricted License Certain foreign physicians	s. 458.3115, F.S.	No provision
Licensure by Endorsement	s. 458.313, F.S.	No provision
Temporary Certificate (Approved Cancer Centers)	s. 458.3135, F.S.	No provision
Temporary Certificate (Training Programs)	s. 458.3137, F.S.	No provision
Medical Faculty Certificate	s. 458.3145, F.S.	s. 459.0077, F.S.
Temporary Certificate Areas of Critical Need	s. 458.315, F.S.	s. 459.0076, F.S.
Temporary Certificate Areas of Critical Need – Active Duty Military & Veterans	s. 458.3151, F.S.	s. 459.00761, F.S.
Public Health Certificate	s. 458.316, F.S.	No provision

[96] *See* ss. 458.311, F.S. and 459.0055, F.S.

Statutory References for Practice Acts - Licensure Medical and Osteopathic Physicians: Ch. 458 and 459, F.S.		
Issue	**Medical Physicians**	**Osteopathic Physicians**
Public Psychiatry Certificate	s. 458.3165, F.S.	No provision
Limited Licenses	s. 458.317, F.S.	s. 459.0075, F.S.
Expert Witness	s. 458.3175, F.S.	s. 459.0066, F.S.
License Renewal	s. 458.319, F.S. $500/max/biennal renewal	s. 459.008, F.S.
Financial Responsibility *Condition of Licensure*	s. 458.320, F.S.	s. 459.0085, F.S.
Penalty for Violations	s. 458.327, F.S.	s. 459.013, F.S.

In Florida, to practice medicine an individual must become a licensed medical doctor through licensure by examination[97] or licensure by endorsement.[98] Florida does not recognize automatically another state's medical license or provide licensure reciprocity. Licensure by endorsement requires the medical physician to meet the following requirements:

- Be a graduate of an allopathic United States Medical School recognized and approved by the United States Office of Education (AMG) and completed at least one year of residency training;
- Be a graduate of an allopathic international medical school (IMG) and have a valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate and completed an approved residency of at least two years in one specialty area; or
- Be a graduate who has completed the formal requirements of an international medical school except the internship or social service requirements, passed parts I and II of NBME or ECFMG equivalent examination, and completed an academic year of supervised clinical training (5th pathway) and completed an approved residency of at least two years in one specialty area.
- And both of the following:
  - Passed all parts of a national examination (NBME, FLEX, or USMLE); and
  - Be licensed in another jurisdiction and actively practiced medicine in another jurisdiction for at least two of the immediately preceding 4 years; or passed a board-approved clinical competency examination within the year preceding filing of the application or; successfully completed a board approved postgraduate training program within 2 years preceding filing of the application.[99]

Financial Responsibility

Section 458.320, F.S., requires Florida-licensed allopathic physicians to also maintain professional liability insurance or other financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions. Under s. 458.320(2), F.S., physicians who perform surgeries in a certain setting or have hospital privileges must

[97] Section 458.311, F.S.
[98] Section 458.313, F.S.
[99] Florida Board of Medicine, *Medical Doctor-Unrestricted; Licensure by Endorsement,* https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited Mar. 8, 2019).

maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim.

Physicians without hospital privileges, under s. 458.320(1), F.S., must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim. Physicians who do not carry professional liability insurance must provide notice to their patients. A physician is said to be "going bare" when that physician has elected not to carry professional liability insurance. Physicians who go bare must either provide notice by posting a sign which is prominently displayed in the reception area and clearly noticeable by all parties or provide a written statement to each patient. Under s. 458.320(5), F.S., such sign or statement must specifically state:

> Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

Florida-licensed osteopathic physicians have similar financial responsibility requirements under s. 459.0085, F.S. With specified exceptions, the DOH must suspend, on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.[100]

Disciplinary Process: Fines and Sanctions

Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations under the Division of Medical Quality Assurance (MQA) in the DOH. Section 456.072, F.S., specifies 40 acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Section 458.331, F.S., identifies 43 acts that constitute grounds for which disciplinary actions may be taken against a medical physician and s. 459.015, F.S., identifies those acts which are specific to an osteopathic physician. Some parts of the review process are public and some are confidential.[101]

Complaints and allegations are received by the MQA unit for determination of legal sufficiency and investigation. A determination of legal sufficiency is made if the ultimate facts show that a violation has occurred.[102] The complainant is notified by letter as to the whether the complaint will be investigated and if any additional information is needed. Complaints which involve an immediate threat to public safety are given the highest priority.

[100] Sections 458.320(8) and 459.0085(9), F.S.

[101] Fla. Department of Health, Division of Medical Quality Assurance, *Enforcement Process,* http://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/enforcement-process-chart.pdf (last updated Mar. 11, 2019).

[102] Fla. Department of Health, *Consumer Services – Administrative Complaint Process,* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/consumer-services.html (last visited Mar. 11, 2019).

The DOH is repsonsible for reviewing each report to determine if discipline against the provider is warranted.[103] Authorization for the discipline of allopathic and osteopathic physicians can be found in state law and administrative rule.[104] If held liable for one of the offenses, the fines and sanctions under Rule 648B-8.001, F.A.C., by category, by offense are based on whether it is the physician's first, second or third offense. Fines can vary in some instance from lows of $1,000 per instance in situations such as improper use of a substance to concealment of a material fact. A penalty may also come with a reprimand, a licensure suspension, or revocation followed by some designated period of probation if there is an opportunity for licensure reinstatement. Other sanctions may include supplemental continuing education requirements or require proof of completion before the license can be reinstated.

For minor violations, a written notice of noncompliance may be issued. The administrative rule defines a minor vioaltion as something which does not endanger the public health, safety, and welfare and which does not demonstrate a serious inability to practice. When a physician complaint is received, an investigation is undertaken and the physician is given an opportunity to provide additional information as part of the investigation.

Occupational Licensure Compacts

Interstate compacts are authorized under the U.S. Constitution, art. I, section 10, cl. 3.[105] While the language of the provision says Congressional approval is required, not all compacts require Congressional approval. Only those compacts that affect a power delegated to the federal government or that affect or alter the political balance within the federal system require the consent of Congress.[106] Today, there are more than 200 compacts between the states, including 50 national compacts of which six are for health professions.[107,108]

The licensing of professions is predominantly a state responsibility as each state has developed its own regulations, oversight boards, and requirements for dozens of professions and occupations. Today, more than 25 percent of the American workforce are in a profession that requires a professional license.[109] In September 2018, the Federal Trade Commission (FTC) looked at the issue of state-by-state occupational licensure and its unintended consequences. In particular, the FTC noted that state-by-state licensing can have a particularly hard effect on those

[103] *See* ss. 458.351(5) and 459.026(5), F.S.

[104] *See* ss. 458.307 and 459.004, F.S., for the regulatory boards, and 64B8-8, F.A.C. and 64B15-19, F.A.C. for administrative rules relating to disciplinary procedures.

[105] "No state shall, without the Consent of Congress…enter into any Agreement or Compact with another State, or with a foreign Power[.]" *see* U.S. Constitution, art. I, sect. 10, cl. 3.

[106] This issue was settled in *Virginia v. Tennessee,* 148 U.S. 503 (1893). *See also Interstate Compacts & Agencies (1998),* William Kevin Voit, Sr. Editor and Gary Nitting, Council of State Governments, pg. 7, http://www.csg.org/knowledgecenter/docs/ncic/CompactsAgencies98.pdf (last visited Mar. 8, 2019)

[107] Ann O'M. Bowman and Neal D. Woods, *Why States Join Interstate Compacts,* The Council of State Governments (March 2017) p. 19 and 20, http://knowledgecenter.csg.org/kc/system/files/Bowman%202017.pdf, (last visited Mar. 8, 2019).

[108] Federal Trade Commission, *Policy Perspectives: Options to Enhance Occupational License Portability* (September 2018), p. 9, https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited Mar. 8, 2019). The six health professions are nurses, medical, emergency medical services, physical therapy, psychology, and advanced registered nurse practitioners. The only two compacts currently operational are the Enhanced Nurse Compact and the physicians compacts as the others are awaiting the completion of an administrative structure.

[109] Albert Downs and Iris Hentze, *License Overload? Lawmakers are questioning whether we've gone too far with occupational and professional licensing (April 1, 2018),* STATE LEGISLATURES MAGAZINE, *ncsl.org,* http://www.ncsl.org/bookstore/state-legislatures-magazine/occupational-licensing-can-balance-safety-and-employment-opportunities.aspx (last visited Mar. 8, 2019).

in the military and their spouses who are required to move frequently, those who provide services across state lines, or deliver services through telehealth.[110]

The FTC also suggested that improved licensed portability would enhance competition, choice and access for consumers, especially where services may be in short supply.[111] In remarks about an Alaskan legislative proposal in March 2016, special standards for behavioral health care providers providing services remotely would have been established. Developing additional safeguards and "unnecessary restrictions that only serve to restrict competition" were identified as barriers to the goal of enhancing access to services.[112]

The FTC has also recently commented where professional licensing boards comprised of private professionals recommended restrictions for telehealth and raised concerns over whether the boards had adopted unnecessary restrictions that would serve only to restrict competition.[113]

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (IMLC) provides an expedited pathway for medical and osteopathic physicians to qualify to practice medicine across state lines within a Licensure Compact. Currently, 24 states and one territory which cover 31 medical and osteopathic boards participate in the IMLC, and, as of February 2019, six other states have active legislative to join the IMLC.[114, 115]

The Interstate Commission is created in Section 11 of the Compact and serves as the administrative arm of the Compact and member states. Each member state of the Compact has two voting representatives on the Commission and if the state has separate regulatory boards for allopathic and osteopathic, then the representation is split between the two boards.[116]

Approximately 80 percent of physicians meet the eligibility guidelines for licensure through the Compact.[117] The providers' applications are expedited by using the information previously submitted in their State of Principal Licensure (SPL), then the physician can select which states to practice in after a fresh background check is completed.

To qualify for consideration, the physician must:

- Hold a full, unrestricted medical license from a Compact Member state and meet one of the following additional qualifications:
  - The physician's primary resident is the State of Principal licensure (SPL).
  - The physician's practice of medicine occurs in SPL for at least 25 percent of the time.

[110] Federal Trade Commission, *Policy Perspectives: Options to Enhance Occupational License Portability (September 2018), Executive Summary,* https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited Mar. 8, 2019).
[111] *Id* at 2.
[112] Center for Connected Health Policy, *National Policy: The Federal Trade Commission and Professional Licensure Boards,* https://www.cchpca.org/telehealth-policy/federal-trade-commission-and-professional-licensure-boards (last visited Mar. 8, 2019).
[113] Center for Connected Health Policy, *National Policy: The Federal Trade Commission and Professional Licensure Boards,* https://www.cchpca.org/telehealth-policy/federal-trade-commission-and-professional-licensure-boards (last visited Mar. 8, 2019).
[114] Interstate Medical Licensure Compact, *The IMLC,* https://imlcc.org/ (last visited Mar. 8, 2019).
[115] Interstate Medical Licensure Compact, Draft Executive Committee Meeting Minutes (February 5, 2019), https://imlcc.org/wp-content/uploads/2019/02/2019-IMLC-Executive-Committee-Minutes-February-5-2019-DRAFT.pdf (last visited Mar. 8, 2019).
[116] Interstate Medical Licensure Compact, Section 11, (d), pg. 11, https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf (last visited Mar. 8, 2019).
[117] Interstate Medical Licensure Compact, *The IMLC,* *https://imlcc.org/* (last visited Mar. 7, 2019).

- o The physician's employer is located in the SPL.
- o The physician uses the SPL as his or her state of residence for U.S. federal income tax purposes.

Additionally, the physician must maintain his or her licensure from the SPL at all times. The SPL may be changed after the original qualification. Other requirements for eligibility for a IMLC Compact license include:

- Have graduated from an accredited medical school, or a school listed in the International Medical Education Directory.
- Successfully completed graduate medical education from a school which has received accreditation from Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA).
- Passed each component of the United States Medical Licensing Exam or the Comprehensive Osteopathic Medical Licensing Exam (USMLE or COMLEX-USA) or equivalent in no more than three attempts.
- Hold a current specialty certification or time-unlimited certification by an American Board of Medical Specialties (ABMS) or American Osteopathic Association/Bureau of Osteopathic Specialists (AOABOS) board.
- Must not have any history of disciplinary actions toward medical license.
- Must not have any criminal history.
- Must not have any history of controlled substance actions toward medical license.
- Must not currently be under investigation.[118]

The application cost is $700 plus the cost of the license for the state in which the applicant wishes to practice. The individual state fees currently vary from a low of $75.00 in Alabama to a high of $700 in Maine.[119]

III. Effect of Proposed Changes:

Patient Records

Sections 1 through 5 direct that specified service providers required to release clinical or medical records must furnish applicable records in their possession within 14 working days after receiving a request. These provider types and applicable authority are as follows:

- s. 394.4615, F.S., relating to mental health providers (Section 1),
- s. 395.3025, F.S., relating to hospitals and ambulatory surgical centers (Section 2),
- s. 397.501, F.S., relating to substance abuse treatment providers (Section 3),
- s. 400.145, F.S., relating to nursing facility providers (Section 4), and
- s. 456.057, F.S., relating to health care practitioners (Section 5).

[118] Interstate Medical Licensure Compact, *Do I Qualify,* https://imlcc.org/do-i-qualify/ (last visited Mar. 7, 2019).
[119] Interstate Medical Licensure Compact, *What Does It Cost?* https://imlcc.org/what-does-it-cost/ (last visited Mar. 8, 2019).

If a service provider or facility maintains a system of electronic health records,[120] the bill requires the service provider or facility to provide the records in the manner chosen by the requester, which may include:

- Paper document;
- Electronic format;
- Access through a web-based patient portal; or
- Submission through a patient's electronic personal health record.

The bill authorizes a service provider or facility to charge a requester no more than the reasonable costs of reproducing the clinical records, including reasonable staff time, and defines the reasonable costs of reproducing various forms of clinical records as follows:

- Paper copies of written or typed documents or reports may not exceed $1 per page for the first 25 pages and 25 cents per page for all pages thereafter; and
- X-rays and other forms of images must be the actual costs; and actual costs includes the cost of the material, supplies used to duplicate the record, and the labor and overhead costs associated with the duplication.

In addition to the charges above, a special service charge is authorized if the nature and volume of records requested requires extensive use of technology resources or extensive clerical or supervisory assistance by personnel of the service provider or facility. That special service charge must be reasonable and must be based on costs incurred.

The bill directs that the reproduction charges apply to all records furnished, whether directly from a service provider or facility or from a copy service acting on behalf of a service provider or facility.

The bill directs that a patient whose records are being copied or searched for the purpose of continuing to receive care, may not be required to pay a charge for the copying or searching of their records.

In addition to the above provisions, the bill contains additional provisions applicable to specific provider types and facilities, including:

- Hospitals, ambulatory surgical centers, substance abuse treatment providers, nursing facility providers, and health care practitioners must provide that, within 10 working days of a request to view the provider's or facility's original records pertaining to a particular patient, from a requester who is authorized to have access, such requester must be provided access to examine such original records or other suitable reproductions. Service providers and facilities may impose reasonable terms to ensure that records are not damaged, destroyed, or altered in this process.
- The DOH, rather than the AHCA, is authorized to access records pursuant to a subpoena issued under s. 456.071, F.S. The DOH is responsible for regulating physicians pursuant to ch. 456, F.S.

[120] Section 408.051(2)(a), F.S., defines "Electronic health record" as a record of a person's medical treatment which is created by a licensed health care provider and stored in an interoperable and accessible digital format.

- For purposes of access to substance abuse treatment records and health care practitioner records, the term "legal representative" is defined to mean an individual's guardian or, if the individual is younger than 18 years of age, his or her parent or legal guardian.

Hospital Quality Information

Section 6 amends s. 395.1012, F.S., to require each hospital to provide to any patient upon admission, upon scheduling of non-emergency care, or prior to treatment, written information on a form created by the AHCA that contains data reported for the most recent year available for the hospital and the statewide average for:
- The rate of hospital-acquired infections;
- The overall rating of the Hospital Consumer Assessment of Healthcare Providers Systems Survey; and
- The 15-day readmission rate.

The hospital must also provide the required data to any party upon request. The hospital must also present the data in a manner that is easily understandable and accessible to the patient and with an explanation of the relationship between the data and patient safety.

Patient Access to Primary Care and Specialty Providers

Section 7 creates s. 395.1052, F.S., to require that a hospital notify a patient's primary care provider (PCP) within 24 hours of the patient's admission and discharge from the hospital. A hospital must also notify a patient of his or her right to request that the hospital's treating physician should consult with the patient's PCP or specialist, and, if the patient so requests, the treating physician must make reasonable efforts to consult with the PCP or specialist when developing the patient's plan of care. Additionally, a hospital is required to provide the discharge summary and any related information and records to the PCP within seven days of the patient's discharge.

Notification of Hospital Observation Status

Section 8 amends s. 395.301, F.S., to require a hospital to provide a patient written notice of their observation status immediately when he or she is placed upon observation status. The bill requires Medicare patients receive the notice through the Medicare Outpatient Observation Notice form adopted under 42 C.F.R. s. 489.20, and non-Medicare patients through a form adopted by rule of the AHCA. The bill also makes conforming changes.

Direct Health Care Agreements

Section 9 amends s. 624.27, F.S., to authorize direct care agreements with health care providers licensed under ch. 458 (medicine), 459 (osteopathic medicine), 460 (chiropractic medicine), or 464 (nursing), F.S., or a primary care group practice, for any health care service within their competency and training and adds health care providers licensed under ch. 466, F.S., (dentistry) to the list of providers who can provide direct health care services. Additionally, all references to "primary care" are replaced with "direct" throughout the section.

Step-Therapy Protocols

Sections 10-12 create s. 627.42393 and amend s. 641.31(45), and s. 409.973(6), F.S., respectively, relating to step-therapy protocols of health insurers and HMOs issuing major medical coverage, both individual and group, and Medicaid managed care plans. Sections 15 and 16 are effective January 1, 2020, and will therefore apply to all such health insurance policies and HMO contracts issued or renewed on or after that date.

The sections prohibit an insurer, HMO, or Medicaid managed care plan from requiring a covered individual to undergo a step-therapy protocol under the policy, contract, or plan, respectively, for a covered prescription drug if the insured, subscriber, or recipient has been approved previously to receive the drug through the completion of a step-therapy protocol required by a separate health coverage plan or Medicaid managed care plan, respectively. To trigger this provision, a covered individual must provide documentation originating from the prior health coverage plan that the prescription drug was paid by the health coverage plan on behalf of the covered individual during the 180 days immediately prior to the request. The documentation requirement does not apply to a recipient enrolled in Medicaid managed care plan. For Medicaid managed care, the AHCA must implement this requirement by amending the managed care plan contracts concurrent with the start of a new capitation cycle.

The term, "health coverage plan" means any of the following plans which previously provided coverage or is currently providing major medical or similar comprehensive coverage or benefits to the insured or subscriber: a health insurer or health maintenance organization, a plan established or maintained by an individual employer as provided by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, a multiple-employer welfare arrangement as defined in s. 624.437, F.S., or a governmental entity providing a plan of self-insurance.

Price Transparency for Services Covered by Health Insurance

Section 13 creates s. 627.4303, F.S., which prohibits a "health insurer," as defined in the bill, from limiting a health care provider's ability to disclose whether a patient's cost-sharing obligation under his or her health coverage exceeds the cash price for a covered service in the absence of health insurance coverage or the availability of a more affordable service. The bill also specifies that a health insurer may not require a covered individual to make payment for a covered services in an amount that exceeds the cash price of that service in the absence of health insurance coverage. The term "health insurer" is defined to mean a health insurer issuing major medical coverage through an individual or group policy or an HMO issuing major medical coverage through an individual or group contract.

Interstate Medical Licensure Compact

Section 14 creates the Interstate Medical Licensure Compact (compact) as s. 456.4501, F.S., which enters Florida into the compact. The compact has 24 sections which establish the compact's administration and components and prescribe how the Interstate Medical Licensure Compact Commission will oversee the compact and conduct its business. The table below describes new statutory language by compact section which creates the components of the compact.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
1	Provides the purpose of the Compact Establishes prevailing standard of care	The purpose of the Interstate Medical Licensure Compact (compact) is to provide a streamlined, comprehensive process that allows physicians to become licensed in multiple states. It allows physicians to become licensed without changing a state's Medical Practice Act(s). The compact also adopts the prevailing standard of care based on where the patient is located at the time of the patient-provider encounter. Jurisdiction for disciplinary action or any other adverse actions against a physician's license is retained in the jurisdiction where the license is issued to the physician.
2	Definitions Establishes standard definitions for operation of the compact and the Commission.	Definitions are provided for: - Bylaws: means those Bylaws established by the Commission pursuant to Section 11 for governance, direction, and control of its action and conduct. - Commissioner: means the voting representative appointed by each member board pursuant to Section 11 whereby each member state appoints two members to the Commission. If the member state has two medical boards, the two representatives should be split between the two boards. - Conviction: means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. A conviction also means evidence of an entry of a conviction of a criminal offense by the court shall be considered final for the purposes of disciplinary action by a member board. - Expedited license: means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact. - Interstate Commission: means the interstate commission created pursuant to Section 11. - License: means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization. - Medical Practice Act: means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state. (In Florida, the Medical Practice Act for allopathic medicine is under ch. 458, F.S., and for osteopathic medicine, under ch. 459, F.S.) - Member Board: means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government. (The Florida Board of Medicine and the Florida Board of Osteopathic Medicine are responsible for the licensure, regulation, and education of physicians in Florida.) - Member State: means a state that has enacted the compact. - Practice of medicine: means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other

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		physical, or mental condition, by attendance, advise, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts. - Physician means: any persons who is a graduate of medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent; passed each component of the USMLE or the COMPLEX-USA within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes; successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; holds specialty certification or time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Board of Osteopathic Specialties; however, the times unlimited specialty certificate does not have to be maintained once the physician is initially determined through the expedited compact process; possess a full and unrestricted license to engage in the practice of medicine issued by a member board; has never been convicted received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction; has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license; has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction. - Offense means: A felony, high court misdemeanor, or crime of moral turpitude. - Rule means: A written statement by the Commission promulgated pursuant to Section 12 of the compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the compact, or an organizational, procedural, or practice requirement of the Commission, and has the force and effect of statutory law in a member state, if the rule is not inconsistent with the laws of the member state. The term includes the amendment, repeal, or suspension of an existing rule. - State means: Any state, commonwealth, district, or territory of the United States. - State of Principal License means: A member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the compact.

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Section	**Title**	**Description**
3	Eligibility Provides minimum requirements to receive an expedited license	To be eligible to participate and receive an expedited license, a physician must meet the requirements of Section 2 (definition of physician). A physician who does not meet the requirements of Section 2 may obtain a license to practice medicine in a member state outside of the compact if the individual complies with all of the laws and requirements to practice medicine in that state.
4	State of Principal License (SPL) Defines a SPL	The compact requires participating physicians to designate a State of Principal License (SPL) for purposes of registration for expedited licensure if the physician possesses a full and unrestricted license to practice medicine in that state. The SPL must be a state where: - The physician has his/her primary residence, or - The physician has at least 25 percent of his/her practice, or - The state where the physician's employer is located. If no state qualifies for one of the above options, then the state of residence as designated on physician's federal income taxes. A SPL may be re-designated at any time as long as the physician possesses a full and unrestricted license to practice medicine in that state. The Commission is authorized to develop rules to facilitate the re-designation process.
5	Application and Issuance of Expedited Licensure *Qualifications* *Commission rulemaking provisions*	Section 5 of the compact establishes the process for the issuance of the expedited license. A physician must file an application with the member of the state selected as the SPL. The SPL will evaluate the application to determine whether the physician is eligible for the expedited licensure process and issue a letter of qualification, either verifying or denying eligibility, to the Commission. - Static Qualifications: Include verification of medical education, graduate medical education, results of any medical or licensing examinations and any other qualifications set by the Commission through rule. - Performance of Criminal Background Checks by the member board through FBI, with the exception of federal employees who have suitability determined in accordance with U.S. 5 CFR section 731.202. - Appeals on eligibility determinations are handled through the member state. - Upon completion of eligibility verification process with member state, applicant's suitable for an expedited license are directed to complete the registration process with the Commission, including the payment of any fees. - After receipt of registration and payment of fees, the physician receives his/her expedited license. The license authorizes the physician to practice medicine in the issuing state consistent with the Medical

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		Practice Act and all applicable laws and regulations of the issuing member board and member state. - An expedited license shall be valid for a period consistent with the member state licensure period and in the same manner as required for other physicians holding a full and unrestricted license. - An expedited license obtained through the compact shall be terminated if a physician fails to monitor a license in the SPL for a non-disciplinary reason, without re-designation of a new SPL. - The Commission is authorized to develop rules relating to the application process, including fees and issuing the expedited license.
6	Fees for Expedited Licensure *Rulemaking authority*	A member state is authorized to charge a fee for an expedited license that is issued or renewed through the compact. The Commission is authorized is develop rules relating to fees for expedited licenses. The rules are not permitted to limit the authority of the member states, the regulating authority of the member states, or to impose and determine the amount of the fee charged by the member states.
7	Renewal and Continued Participation *Renewal license process created* *Continuing education required for renewal with member state* *Fees collected, if any, by member state.* *Rulemaking authority.*	A physician with an expedited license in a member state must complete a renewal process with the Commission if the physician: - Maintains a full and unrestricted license in a SPL. - Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction. - Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action relating to non-payment of fees related to a license. - Has not had a controlled substance license or permit suspended or revoked by a state or the United State Drug Enforcement Administration. Physicians are required to comply with all continuing education and professional development requirements for renewal of a license issued by a member state. The Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the appropriate member board. Upon payment of fees, a physician’s license shall be renewed. Any information collected during the renewal process shall also be shared with all member boards. The Commission is authorized to develop rules to address the renewal of licenses.

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Section	**Title**	**Description**
8	Coordinated Information Systems *Authorized to create database of all applicants* *By request, may share data* *Rulemaking authority*	The Commission is required to establish a database of all licensed physicians who have applied for licensure. Member boards are required to report disciplinary or investigatory actions as required by Commission rule. Member boards may also report any non-public complaint, disciplinary, or investigatory information not required to be reported to the Commission. Upon request, member boards shall share complaint or disciplinary information about physicians to another member board. All information provided to the Commission or distributed by the member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters. The Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.
9	Joint Investigations *Permits joint investigations between the state and the member boards*	Licensure and disciplinary records of physicians are deemed investigative. A member board may participate with other member boards in joint investigations of physicians licensed by the member boards in addition to the authority granted by the member board and its respective Medical Practice Act or other respective state law. Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact. Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.
10	Disciplinary Actions *Discipline by a member state has reciprocal actions*	Any disciplinary action taken by any member board against a physician licensed through the compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that State. If the physician's license is revoked, surrendered, or relinquished in lieu of discipline in the SPL, or suspended, then all licenses issued to that physician by member boards shall be automatically placed, without any further action necessary by any member board, on the same status. If the SPL subsequently reinstates the physician's license, a license issued to the physician by any other member board shall remain encumbered until that respective board takes action to specifically reinstate the license in a manner consistent with the Medical Practice Act in that state.

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	Licensure actions specific actions to reinstate	If a disciplinary action is taken against the physician in a member state that is the physician's SPL, any other member state may deem the action conclusive as to matter of law and fact decided, and: - Impose the same or lesser sanction or sanctions against the physician so long as such sanctions are consistent with the Medical Practice Act of that state; or - Pursue separate disciplinary action against the physician under the Medical Practice Act, regardless of the action taken in other member states. If a license granted to a physician by a member board is revoked, surrendered, or relinquished in lieu of discipline, or suspended, then any license issued to the physician by any other member board or boards shall be suspended, automatically, and without further action necessary by the other board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety (90) day suspension period in a manner consistent with the Medical Practice Act of that state.
11	Interstate Medical Licensure Compact Commission *Recognizes creation of Commission and state's representative with 2 Commissioners, one from each regulatory board* *Availability of Commission meetings, except for certain topics* *Availability of public data*	The member states create the Interstate Medical Licensure Compact Commission as a joint agency of the member states and administration of the compact. The Commission has all the duties, powers, and responsibilities set forth in the compact, plus any other powers conferred upon it by the member states through the compact. Each member state has two (2) two voting representatives appointed by each member state to serve as Commissioners. For states with separate regulatory boards for allopathic and osteopathic regulatory boards, the member state shall appoint one representative from each member board. A Commissioner shall be: - An allopathic or osteopathic physician appointed to a member board. - Executive director, executive secretary, or similar executive or a member board, or - Member of the public appointed to a member board. The Commission shall meet at least once per calendar year and at least a portion of the meeting shall be a business meeting which shall include the election of officers. The Chair may call additional meeting and shall call for all meeting upon the request of a majority of the member states.

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	from the Commission *Public notice required* *Creates an executive committee to act on behalf of the Commission*	Meetings are permitted via telecommunication according to the Bylaws. Each Commissioner is entitled to one vote. A majority of Commissioners shall constitute a quorum, unless a larger quorum is required by the Bylaws of the Commission. A Commissioner shall not delegate a vote to another Commissioner. In the absence of its Commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who meets the requirements of being a Commissioner. The Commission shall provide public notice of all meetings and all meetings shall be open to the public. A meeting may be closed to the public, in full or in portion, when it determines by a 2/3 vote of the Commissioners present, that an issue or matter would likely to: - Relate solely to the internal personnel practices and procedures of the Interstate Commission. - Discuss matters specifically exempted from disclosure by federal statute; - Discuss trade secrets, commercial, or financial information that is privileged or confidential; - Involve accusing a person of a crime, or formally censuring a person; - Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy; - Discuss investigative records compiled for law enforcement purposes; or - Specifically relate to the participation in a civil action or other legal proceeding. The Commission shall make its information and official records, to the extent, not otherwise designated in the Compact or by its rules, available to the public for inspection. An executive committee is established which has the authority to act on behalf of the Commission, with the exception of rulemaking, when the Commission is not in session. The executive committee shall oversee the administration of the compact, including enforcement and compliance with the compact, its bylaws and rules, and other such duties as necessary. The Commission may establish other committees for governance and administration of the compact.
12	Powers and Duties of the	The Commission shall have the duties and the powers to: - Oversee and administer the compact. - Promulgate rules which are binding.

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	Interstate Commission *Recognizes creation of the Commission*	- Issue advisory opinions upon the request of member states concerning the meaning or interpretation of the compact or its bylaws, rules, and actions. - Enforce compliance with the compact, provisions, the rules, and the bylaws. - Establish and appoint committees, including the executive committee, which has the power to act on behalf of the Interstate Commission. - Pay, or provide for the payment of Commission expenses. - Establish and maintain one or more offices. - Borrow, accept, hire, or contract for services of personnel. - Purchase and maintain insurance and bonds. - Employ an executive director with power to employ, select, or appoint employees, agents, or consultants, determine their duties, and fix their compensation. - Establish personnel policies and programs. - Accept donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize and dispose of it consistent with conflict of interest policies as established by the Commission. - Lease, purchase, accept contributions, or donation of, or otherwise own, hold, improve or use, any property, real, personal, or mixed. - Establish a budget and make expenditures. - Adopt a seal and bylaws governing the management and operation of the Commission. - Report annually to the legislatures and governors of the members concerning the activities of the Commission during the preceding year, including reports of financial audits and any recommendations that may have been adopted by the Commission. - Coordinate education, training, and public awareness regarding the compact, its implementation and operation. - Maintain records in accordance with bylaws. - Seek and obtain trademarks, copyrights, and patents. - Perform such functions as may be necessary or appropriate to achieve the purpose of the compact.
13	Finance Powers *Provides for annual assessment* *Requires rule for any assessment* *No pledging credit without authorization*	The compact authorizes an annual assessment levied on each member state to cover the costs of operations and activities of the Commission and its staff. The assessment must be sufficient to cover the amount not provided by other sources and needed to cover the annual budget approved each year by the Commission. The compact requires that the assessment be memorialized by rule binding all the member states. The Commission is not authorized to pledge the credit of any of the member states, except by, and with the authority of, the member states.

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	Yearly audits	The compact requires yearly financial audits conducted by a certified or licensed public accountant and the report is to be included in the Commission's annual report.
14	Organization and Operation of the Interstate Commission *Annual officer election* *No officer remuneration* *Liability protection for actions within scope of duties and responsibilities only for officers, employees, and agents*	The compact creates a requirement for the Commission to adopt bylaws by a two-thirds (2/3) vote within twelve months of the first meeting which has already occurred. The first Bylaws were adopted in October 2015.[121] A Chair, Vice Chair, and Treasurer shall be elected or appointed each year by the Commission. Officers serve without remuneration. Officers and employees are immune from suit and liability, either personally or in their professional capacity, for a claim for damage to or loss of property or personal injury or other civil liability cause or arising out of, or relating to, an actual or alleged act, error or omission that occurred with the scope of Commission employment, duties, or responsibilities, provided such person should not be protected from suit or liability for damage or loss, injury or liability caused by the intentional or willful and wanton conduct of such a person. The liability of the executive director and Commission employees or representatives of the Commission, acting within the scope of their employment, may not exceed the limits set forth under the state's Constitution and laws for state officials, employees, and agents. The compact provides that the Commission is considered an instrumentality of the state for this purpose. The compact provides that the Commission shall defend the executive director, its employees, and subject to the approval of the state's attorney general or other appropriate legal counsel, shall defend in any civil action seeking to impose liability within scope of duties. The compact provides that employees and representatives of the Commission shall be held harmless in the amount of any settlement or fees, including attorney fees and costs, that occurred within the scope of employment or responsibilities and not a result of willful or wanton misconduct.
15	Rulemaking Functions of	The Commission is required to promulgate reasonable rules in order to implement and operate the compact and the commission. The compact adds that any attempt to exercise rulemaking beyond the

[121] Interstate Medical Licensure Compact, *Annual Report 2017,* https://imlcc.org/wp-content/uploads/2018/03/IMLCC-Annual-Report-2017-1.pdf (last visited Mar. 11, 2019).

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	the Interstate Commission *Promulgate reasonable rules* *Judicial review at U.S. Federal District Court*	scope of the compact renders the action invalid. The rules should substantially conform to the "Model State Administrative Procedures Act" of 2010 and subsequent amendments thereto. The compact allows for judicial review of any promulgated rule. A petition may be filed thirty (30) days after a rule has been promulgated in the U.S. District Court of Appeal for the 9th District in Washington, D.C. or the federal court where the Commission is located.[122] The compact requests deference to the Commission's action consistent with state law.
16	Oversight of Interstate Contract *Enforcement* *Service of process*	The compact is the responsibility of each state's own executive, legislative, and judicial branch to oversee and enforce. All courts are to take judicial notice of the compact and any adopted administrative rules in a proceeding involving compact subject matter. The compact provides that the Commission is entitled to receive service of process in any proceeding and shall have standing in any proceeding. Failure to serve the Commission shall render a judgment null and void as to the Commission, the compact, or promulgated rule.
17	Enforcement of Interstate Contract	The compact provides the Commission reasonable discretion to enforce the provisions and rules of the compact, including when and where to initiate legal action. The Commission is permitted to seek a range of remedies.
18	Default Procedures	The compact provides a number of reasons a member state may default on the compact, including failure to perform required duties and responsibilities and the options available to the Commission. The compact requires the Commission to promulgate rules to address how physician licenses are affected by the termination of a member state from the compact. The rules must also ensure that a member state does not bear any costs when a state has been found to be in default. The compact provides an appeal process for the terminating state and procedures for attorney's fees and costs.
19	Dispute Resolution	The compact authorizes the Commission to use dispute resolution tools to resolve disputes between states, such as mediation and binding dispute resolution. The Commission shall promulgate rules for the dispute resolution process.

[122] The Interstate Medical Licensure Compact Commission is currently headquartered in Littleton, Colorado. *See* Interstate Medical License Commission, Frequently Asked Questions (FAQS), https://imlcc.org/faqs/

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Section	**Title**	**Description**
20	Member States, Effective Date and Amendment	The compact allows any state to become a member state and that the compact is binding upon the legislative enactment of the compact by no less than seven (7) states.[123]
21	Withdrawal	A member state may withdraw from the compact through repeal of this section of law which inserted the compact into state statute. Any repeal of the compact through repeal of the state law cannot take effect until one (1) year after the effective date of such an action and written notice has been given by the withdrawing state to the governor of each other member state. The compact provision also requires that upon introduction of any repeal legislation, that the withdrawing state immediately notify the Chairperson of the Commission of the legislation. The compact provides that it is the Commission's responsibility to notify the other member states within 60 (sixty) days of its receipt of information about legislation that would repeal that state's participation in the compact. The withdrawing state would be responsible for any dues, obligations, or liabilities incurred through the date of withdrawal. Reinstatement is an option under the compact. The compact authorizes the Commission to develop rules to address the impact of the withdrawal of a member state on licenses.
22	Dissolution	When the membership of the compact is reduced to one, the compact shall be dissolved. Once dissolved, the compact shall be null and void. Once concluded, any surplus funds of the Commission shall be distributed in accordance with the bylaws.
23	Severability and Construction	If any part of this compact is not enforceable, the remaining provisions are still enforceable. The provisions of the compact are to be liberally construed. and nothing is to be construed so as to prohibit the applicability of other interstate compacts to which states might be members.
24	Binding Effect of Compact and Other Laws	This compact does not prohibit the enforcement of other laws which are not in conflict with this compact. All laws which are in a

[123] The Compact is in force now. The Commission was seated for the first time in October 2015 and issued its first letters of qualification to physicians in April 2017. *See* Interstate Medical Licensure Compact, https://imlcc.org/faqs/ (last Mar. 11, 2019).

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		member state which are inconsistent with this compact are superseded to the point of the contact. The actions of the Commission are binding on the member states, including all promulgated rules and the adopted bylaws of the Commission. All agreements between the Commission and the member state are binding in accordance with their terms. In the event that any provision of this Compact exceeds Florida's constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent that the conflict of the constitutional provision in question in that member state.

Section 15 provides for an effective date of July 1, 2019, except as otherwise provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Section 14. The Interstate Commission requires most of its meetings to be open to the public. The notice requirements vary depending on the purpose of the meeting, however. Rulemaking hearings, where rules are proposed in a manner substantially similar to the model state administrative procedure act of 2010, are submitted to the Bylaws and Rules Committee for review and action. Prior to final consideration by the Commission, the final proposed rule must be publicly noticed on the Commission's website or other agreed upon distribution site at least 30 days prior to the meeting at which the vote is scheduled.[124] A reason for the proposed rule action will also be posted.[125] The public must also be provided a reasonable opportunity to provide public comment, orally or in writing, for proposed rules. A committee of the Commission may propose a rule at any time by a majority vote of that committee.

The written procedure states for every proposed rule action that there will also be instruction on how interested parties may attend the scheduled public hearing, may submit their intent to attend the public hearing and submit any written comments.[126] A transcript of these meetings are not made unless one is specifically requested and then the requestor is responsible for the cost the transcription.[127]

[124] Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(c), https://imlcc.org/wp-content/uploads/2018/02/IMLCC-Rule-Chapter-1-Rule-on-Rulemaking-Adopted-June-24-2016.pdf* (last visited Mar. 11, 2019).
[125] *Supra,* Note 42, Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(b).*
[126] *Supra,* Note, 42, Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(d).*
[127] *Supra* Note 42, Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(e).*

Not later than 30 (thirty) days after its adoption, any interested party may petition for judicial review of the rule in the United States District Court for the District of Columbia or in the federal court where the Commission's headquarters are currently located. The Commission's mailing address currently is in Littleton, Colorado.[128]

The compact also permits the commission, with a 2/3 vote of the Commissioners present, to meet in closed, nonpublic meetings if the commission must address any matters that:

- Relate solely to the internal personnel practices and procedures of the Interstate Commission.
- Specifically exempted from disclosure by federal statute;
- Discuss trade secrets, commercial, or financial information that is privileged or confidential;
- Involve accusing a person of a crime, or formally censuring a person;
- Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Discuss investigative records compiled for law enforcement purposes; or
- Specifically relate to the participation in a civil action or other legal proceeding.[129]

The rulemaking process, its timelines and public involvement process, plus the closure of public meetings for some of these detailed reasons, may be inconsistent with Florida law on public meetings.

While the provisions of the compact and its administrative rules and corporate bylaws require minutes to be kept of some of these closed sessions, it is not clear that it is applicable to all closed sessions and it does require an interested party to request a transcriber in some cases to be present and to expend personal funds to ensure the availability of minutes. A third party may or may not be as likely either to fully describe all matters discussed and provide an accurate summary of actions taken, including a record of any roll call votes.130

According to the Commission's Bylaws, the public notice for a regular meeting of the Commission is at least ten (10) days prior to the meeting according to the compact and the notice will be posted on the Commission's website or distributed through another website designated by the Commission for interested parties to receive notice who have requested to receive such notices.[131]

C. Trust Funds Restrictions:

None.

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[128] Interstate Medical Licensure Compact, FAQs, https://imlcc.org/faqs/ (last visited Mar. 10, 2019).

[129] Interstate Medical License Compact Bylaws, *Section 11 – Interstate Medical License Compact Commission, Section (h)-(l),* https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf *(last visited Mar. 11, 2019.)*

[130] *Id.*

[131] *Id.*

D. State Tax or Fee Increases:

Article VII, section 19 of the State Constitution requires that a new state tax or fee, as well as an increased state tax or fee, must be approved by two-thirds of the membership of each house of the Legislature and must be contained in a separate bill that contains no other subject. Article VII, section 19(d)(1) of the State Constitution defines "fee" to mean "any charge or payment required by law, including any fee for service, fee or cost for licenses, and charge for service."
Section 14 of the bill authorizes the Interstate Medical Licensure Compact to assess and collect fees from allopathic and osteopathic physicians who elect to participate in the expedited licensure process.

For physicians who elect this license, a non-refundable service fee of $700.00 for the letter of qualification is charged to the applicant when the initial application is submitted to the Interstate Commission on Medical Licensure (ICML). Of that $700.00, $300.00 is remitted to the applicant's home state or state of principal licensure and the remaining $400.00 is sent to the Interstate Commission's general fund.

Every time the applicant requests that a letter of qualification be disseminated to one or more of the member states that participate in the ICML after the initial dissemination of the letter for the expedited license, the cost to the registrant is $100.00. Of this amount, one hundred percent is sent to the ICML General Fund.

For each expedited licensed that is renewed through the compact, a non-refunded fee of $25 shall be assessed to the physician and paid to the ICML General Fund. The ICML receives 100 percent of these funds.

E. Other Constitutional Issues:

The Interstate Compact authorizes compact administrators to develop rules that member states must adopt, which is potentially an unlawful delegation of legislative authority. If enacted into law, the state will bind itself to rules not yet promulgated and adopted by the commission. The Florida Supreme Court has held that while it is within the province of the Legislature to adopt federal statutes enacted by Congress and rules promulgated by federal administrative bodies that are in existence at the time the Legislature acts, it is an unconstitutional delegation of legislative authority to prospectively adopt federal statutes not yet enacted by Congress and rules not yet promulgated by federal administrative bodies.[132,133] Under this holding, the constitutionality of the bill's adoption of prospective rules might be questioned, and there does not appear to be binding Florida case law that squarely addresses this issue in the context of interstate compacts.

The most recent case Florida courts have had to address this issue was in *Department of Children and Family Services v. L.G.,* involving the Interstate Compact for the Placement

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[132] *Freimuth v. State,* 272 So.2d 473, 476 (Fla. 1972) (quoting *Fla. Ind. Comm'n v. State ex rel Orange State Oil Co.,* 155 Fla. 772 (1945).
[133] This prohibition is based on the separation of powers doctrine, set forth in Article II, Section 3 of the Florida Constitution, which has been construed in Florida to require the Legislature, when delegating the administration of legislative programs, to establish the minimum standards and guidelines ascertainable by reference to the enactment creating the program. *See Avatar Development Corp. v. State,* 723 So.2d 199 (Fla. 1998).

of Children (ICPC).[134] The First District Court of Appeal considered an argument that the regulations adopted by the Association of Administrators of the Interstate Compact were binding and that the lower court's order permitting a mother and child to relocate to another state was in violation of the ICPC. The court denied the appeal and held that the Association's regulations did not apply as they conflicted with the ICPC and the regulations did not apply to the facts of the case.

The court also references language in the ICPC that confers to its compact administrators the "power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact."[135] The court states that "the precise legal effect of the ICPC compact administrators' regulations in Florida is unclear," but noted that it did not need to address the question to decide the case.[136] However, in a footnote, the court provided:

> Any regulations promulgated before Florida adopted the ICPC did not, of course, reflect the vote of a Florida compact administrator, and no such regulations were ever themselves enacted into law in Florida. When the Legislature did adopt the ICPC, it did not (and could not) enact as the law of Florida or adopt prospectively regulations then yet to be promulgated by an entity not even covered by the Florida Administrative Procedure Act. *See Freimuth v. State,* 272 So.2d 473, 476 (Fla.1972); *Fla. Indus. Comm'n v. State ex rel. Orange State Oil Co.,* 155 Fla. 772, 21 So.2d 599, 603 (1945) ("[I]t is within the province of the legislature to approve and adopt the provisions of federal statutes, and all of the administrative rules made by a federal administrative body, that are in existence and in effect at the time the legislature acts, but it would be an unconstitutional delegation of legislative power for the legislature to adopt in advance any federal act or the ruling of any federal administrative body that Congress or such administrative body might see fit to adopt in the future."); *Brazil v. Div. of Admin.,* 347 So.2d 755, 757–58 (Fla. 1st DCA 1977), *disapproved on other grounds by LaPointe Outdoor Adver. v. Fla. Dep't of Transp.,* 398 So.2d 1370, 1370 (Fla.1981). The ICPC compact administrators stand on the same footing as federal government administrators in this regard.[137]

In accordance with the discussion provided by the court in this above-cited footnote, it may be argued that the bill's delegation of rule-making authority to the commission is similar to the delegation to the ICPC compact administrators, and thus, could constitute an unlawful delegation of legislative authority. The referenced case, however, does not appear to be binding as precedent as the court's footnote discussion is dicta.[138]

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[134] 801 So.2d 1047 (Fla. 1st DCA 2001).
[135] Id at 1052.
[136] Id.
[137] *Id.*
[138] Dicta are statements of a court that are not essential to the determination of the case before it and are not a part of the law of the case. Dicta has no biding legal effect and is without force as judicial precedent. 12A FLA JUR. 2D *Courts and Judges* s. 191 (2015).

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Sections 1 through 5, in specifying a specific cost for various forms of copies of clinical and medical records, could reduce the costs of a patient obtaining copies of his or her records.

Section 9, by modifying the availability of direct patient contracting for health care services, access to expanded health care services may be extended to patients who may not otherwise have access to certain types of health care services or in underserved or rural areas of the state. Statistics also show that more than one third of current direct primary care patients nationally are Medicare patients.

Current Florida law allows physicians to contract only for primary care agreements. This bill removes that restriction and expands the scope of those agreements so patients may have additional options. This model is seen as a mechanism for providers to reduce their administrative burdens with payers. By adding reimbursement options for more provider types and health care services, provider access may be improved for Floridians.

C. Government Sector Impact:

Section 12. The bill prohibits Medicaid managed care plans from requiring an enrolled Medicaid recipient to use a step-therapy protocol before the plan approves a requested covered prescription drug if the recipient has already been approved to receive the drug through the completion of a step-therapy protocol employed by another Medicaid managed care plan which paid for the drug on the recipient's behalf during the 180 days immediately prior to the request. This provision could have a negative fiscal impact on the Medicaid program to the extent that it causes Medicaid managed care plans to spend more on prescription drugs than they currently spend under current law. Whether such a result will materialize is indeterminate.

Section 14. As a member state to the compact, the state will see an increased volume in the number of licensure applications at the Division of Medical Quality Assurance, Board of Medicine, and Board of Osteopathic Medicine. Applicants for the expedited licensure process must have a designated state of principal license (SPL) where the physician has acquired his full and unrestricted license to practice medicine, is in good standing, practices medicine at least 25 percent of the time, is the physician's primary state of residence, or is the location of the physician's employer. Applications for an expedited license with a member board through the Interstate Commission would first go through a Florida eligibility vetting process to issue a letter of qualification or to deny a letter of qualification.

The state could experience a need for additional resources at DOH to handle an increase in physician applications for expedited licensure under the compact, as well as additional revenue from application fees. The resulting overall impact is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 9. The Office of Insurance Regulation suggests that several additional terms or conditions be added to the Direct Access Agreements:

- Define the term "health care group practice." Under currently law, the term "primary care group practice" is used and is also not defined.
- Include guaranteed renewal terms or continuity of care provisions for patients who are undergoing treatment or receiving services for a condition to limit risk of a contract being canceled with 30 days' notice and no recourse.
- Add an enforcement mechanism for violations of the statute or failure to include the mandatory provisions in the agreement.[139]

Section 14. The Interstate Medical Licensure Compact is inserted into statute as written by the Interstate Medical Licensing Commission (IMLC). Unlike other compacts entered by the state, existing statutes relating to physician licensure have not been modified to recognize the existence of this new process.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.4615, 395.1012, 395.301, 395.3025, 397.501, 400.145, 409.973, 456.057, 624.27, and 641.31.

This bill creates the following sections of the Florida Statutes: 395.1052, 456.4501, 627.42393, and 627.4303.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[139] Office of Insurance Regulation, *2019 Agency Legislative Bill Analysis – HB 7* (February 20, 2019) (on file with the Senate Committee on Health Policy).

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
03/18/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete lines 111 - 671
4 and insert:
5 service provider must furnish applicable clinical records in its
6 possession.
7 (b) If a service provider maintains a system of electronic
8 health records as defined in s. 408.051, the service provider
9 shall furnish the requested records in the manner chosen by the
10 requester, which may include paper documents, electronic format,

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11 access through a web-based patient portal, or submission through
12 a patient's electronic personal health record.
13 (4) The service provider may charge a requester no more
14 than the reasonable costs of reproducing the clinical records,
15 including reasonable staff time.
16 (a) The reasonable costs of reproducing paper copies of
17 written or typed documents or reports may not exceed $1 per page
18 for the first 25 pages and 25 cents per page for all pages
19 thereafter.
20 (b) The reasonable costs of reproducing X-rays and other
21 forms of images shall be the actual costs. Actual costs shall be
22 the sum of the cost of the material and supplies used to
23 duplicate the record and the labor and overhead costs associated
24 with the duplication.
25 (c) If the nature or volume of the clinical records
26 requested to be copied requires extensive use of information
27 technology resources or extensive clerical or supervisory
28 assistance by personnel of the service provider, or both, the
29 service provider may charge, in addition to the charges imposed
30 under paragraphs (a) and (b), a special service charge, which
31 shall be reasonable and shall be based on the cost incurred for
32 such extensive use of information technology resources or the
33 labor cost of the personnel providing the service which is
34 actually incurred by the service provider or attributable to the
35 service provider for the clerical and supervisory assistance
36 required, or both.
37 (d) The charges established in this subsection apply to all
38 records furnished, whether directly from a service provider or
39 from a copy service acting on behalf of the service provider.

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40 However, a patient whose records are copied or searched for the
41 purpose of continuing to receive care is not required to pay a
42 charge for copying or for the search.
43 Section 2. Subsection (1) and paragraph (e) of subsection
44 (4) of section 395.3025, Florida Statutes, are amended to read:
45 395.3025 Patient and personnel records; copies;
46 examination.—
47 (1)(a) Any licensed facility shall, upon written request,
48 and only after discharge of the patient, furnish, in a timely
49 manner as provided in paragraph (b), without delays for legal
50 review, to any person admitted therein for care and treatment or
51 treated thereat, or to any such person's guardian, curator, or
52 personal representative, or in the absence of one of those
53 persons, to the next of kin of a decedent or the parent of a
54 minor, or to anyone designated by such person in writing, a true
55 and correct copy of all patient records, including X rays, and
56 insurance information concerning such person, which records are
57 in the possession of the licensed facility, provided the person
58 requesting such records agrees to pay a charge as provided in
59 paragraph (d).
60 (b) Within 14 working days after receiving a request made
61 in accordance with paragraph (a), a licensed facility must
62 furnish applicable patient records in its possession.
63 (c) If a licensed facility maintains a system of electronic
64 health records as defined in s. 408.051, the licensed facility
65 shall furnish the requested records in the manner chosen by the
66 requester, which may include paper documents, electronic format,
67 access through a web-based patient portal, or submission through
68 a patient's electronic personal health record.

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69 (d) The licensed facility may charge a requester no more
70 than the reasonable costs of reproducing the patient records,
71 including reasonable staff time.
72 1. The reasonable costs of reproducing paper copies of
73 written or typed documents or reports may not exceed $1 per page
74 for the first 25 pages and 25 cents per page for all pages
75 thereafter.
76 2. The reasonable costs of reproducing X-rays and other
77 forms of images shall be the actual costs. Actual costs shall be
78 the sum of the cost of the material and supplies used to
79 duplicate the record and the labor and overhead costs associated
80 with the duplication.
81 3. If the nature or volume of the patient records requested
82 to be copied requires extensive use of information technology
83 resources or extensive clerical or supervisory assistance by
84 personnel of the licensed facility, or both, the licensed
85 facility may charge, in addition to the charges imposed under
86 subparagraphs 1. and 2., a special service charge, which shall
87 be reasonable and shall be based on the cost incurred for such
88 extensive use of information technology resources or the labor
89 cost of the personnel providing the service which is actually
90 incurred by the licensed facility or attributable to the
91 licensed facility for the clerical and supervisory assistance
92 required, or both.
93 4. The charges established in this paragraph ~~The exclusive~~
94 ~~charge for copies of patient records may include sales tax and~~
95 ~~actual postage, and, except for nonpaper records that are~~
96 ~~subject to a charge not to exceed $2, may not exceed $1 per~~
97 ~~page. A fee of up to $1 may be charged for each year of records~~

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98 ~~requested. These charges shall~~ apply to all records furnished,
99 whether directly from the facility or from a copy service acting
100 ~~providing these services~~ on behalf of the facility. However, a
101 patient whose records are copied or searched for the purpose of
102 continuing to receive ~~medical~~ care is not required to pay a
103 charge for copying or for the search.
104 (e) If a person authorized to receive copies of patient
105 records under paragraph (a) requests to examine the licensed
106 facility's original records pertaining to the patient, the
107 licensed facility shall, within 10 working days after receiving
108 such a request, provide such person with access to examine such
109 original records, microforms, or other suitable reproductions of
110 such records in its possession. A licensed facility may impose
111 any reasonable terms necessary to ensure ~~further allow any such~~
112 ~~person to examine the original records in its possession, or~~
113 ~~microforms or other suitable reproductions of the records, upon~~
114 ~~such reasonable terms as shall be imposed to assure~~ that the
115 records will not be damaged, destroyed, or altered.
116 (4) Patient records are confidential and may ~~must~~ not be
117 disclosed without the consent of the patient or his or her legal
118 representative; however~~, but~~ appropriate disclosure may be made
119 without such consent to:
120 (e) The department ~~agency~~ upon subpoena issued pursuant to
121 s. 456.071, but the records obtained thereby must be used solely
122 for the purpose of the department ~~agency~~ and the appropriate
123 professional board in its investigation, prosecution, and appeal
124 of disciplinary proceedings. If the department ~~agency~~ requests
125 copies of the records, the facility shall charge no more than
126 its actual copying costs, including reasonable staff time. The

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127 records must be sealed and must not be available to the public
128 pursuant to s. 119.07(1) or any other statute providing access
129 to records, nor may they be available to the public as part of
130 the record of investigation for and prosecution in disciplinary
131 proceedings made available to the public by the department
132 ~~agency~~ or the appropriate regulatory board. However, the
133 department ~~agency~~ must make available, upon written request by a
134 practitioner against whom probable cause has been found, any
135 such records that form the basis of the determination of
136 probable cause.
137 Section 3. Present paragraphs (a) through (j) of subsection
138 (7) of section 397.501, Florida Statutes, are redesignated as
139 paragraphs (d) through (m), respectively, and new paragraphs
140 (a), (b), and (c) are added to that subsection, to read:
141 397.501 Rights of individuals.—Individuals receiving
142 substance abuse services from any service provider are
143 guaranteed protection of the rights specified in this section,
144 unless otherwise expressly provided, and service providers must
145 ensure the protection of such rights.
146 (7) RIGHT TO ACCESS TO AND CONFIDENTIALITY OF INDIVIDUAL
147 RECORDS.—
148 (a)1. Within 14 working days after receiving a written
149 request from an individual or an individual's legal
150 representative, a service provider shall furnish a true and
151 correct copy of all records pertaining to that individual in the
152 possession of the service provider.
153 2. For the purpose of this subsection, the term "legal
154 representative" means an individual's legal guardian or, if the
155 individual is younger than 18 years old, the individual's parent

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156 or legal guardian.
157 3. If a service provider maintains a system of electronic
158 health records as defined in s. 408.051, the service provider
159 shall furnish the requested records in the manner chosen by the
160 requester, which may include paper documents, electronic format,
161 access through a web-based patient portal, or submission through
162 an individual's electronic personal health record.
163 (b) A service provider may charge the requester no more
164 than the reasonable costs of reproducing the records, including
165 reasonable staff time.
166 1. The reasonable costs of reproducing paper copies of
167 written or typed documents or reports may not exceed $1 per page
168 for the first 25 pages and 25 cents per page for all pages
169 thereafter.
170 2. The reasonable costs of reproducing X-rays and such
171 other kinds of records shall be the actual costs. Actual costs
172 are the sum of the cost of the material and supplies used to
173 duplicate the records and the labor and overhead costs
174 associated with the duplication.
175 3. If the nature or volume of the records requested to be
176 copied requires extensive use of information technology
177 resources or extensive clerical or supervisory assistance by
178 personnel of the service provider, or both, the service provider
179 may charge, in addition to the charges imposed under
180 subparagraphs 1. and 2., a special service charge, which shall
181 be reasonable and shall be based on the cost incurred for such
182 extensive use of information technology resources or the labor
183 cost of the personnel providing the service which is actually
184 incurred by the service provider or attributable to the service

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185 provider for the clerical and supervisory assistance required,
186 or both.
187 4. The charges established in this paragraph apply to all
188 records furnished, whether directly from a service provider or
189 from a copy service acting on behalf of the service provider.
190 However, an individual whose records are copied or searched for
191 the purpose of continuing to receive care is not required to pay
192 a charge for copying or for the search.
193 (c) Within 10 working days after receiving a request from
194 an individual or an individual's legal representative to examine
195 the service provider's original records pertaining to that
196 individual, a service provider shall provide access to examine
197 such original records, microforms, or other suitable
198 reproductions of such records in its possession. A service
199 provider may impose any reasonable terms necessary to ensure
200 that the records will not be damaged, destroyed, or altered.
201 Section 4. Subsection (4) of section 400.145, Florida
202 Statutes, is amended to read:
203 400.145 Copies of records of care and treatment of
204 resident.—
205 (4)(a) Within 14 working days after receiving a request
206 made in accordance with subsections (1)-(3), a nursing home
207 facility must furnish applicable resident records in its
208 possession in accordance with this subsection.
209 (b) If a nursing home facility maintains a system of
210 electronic health records as defined in s. 408.051, the facility
211 shall furnish the requested records in the manner chosen by the
212 requester, which may include paper documents, electronic format,
213 or access through a web-based portal.

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214 (c) The nursing home facility may charge a requester no
215 more than the reasonable costs of reproducing the records,
216 including reasonable staff time.
217 1. The reasonable costs of reproducing paper copies of
218 written or typed documents or reports may not exceed $1 per page
219 for the first 25 pages and 25 cents per page for all pages
220 thereafter.
221 2. The reasonable costs of reproducing X-rays and other
222 forms of images shall be the actual costs. Actual costs shall be
223 the sum of the cost of the material and supplies used to
224 duplicate the record and the labor and overhead costs associated
225 with the duplication.
226 3. If the nature or volume of the records requested to be
227 copied requires extensive use of information technology
228 resources or extensive clerical or supervisory assistance by
229 personnel of the nursing home facility, or both, the facility
230 may charge, in addition to the charges imposed under
231 subparagraphs 1. and 2., a special service charge, which shall
232 be reasonable and shall be based on the cost incurred for such
233 extensive use of information technology resources or the labor
234 cost of the personnel providing the service which is actually
235 incurred by the facility or attributable to the facility for the
236 clerical and supervisory assistance required, or both.
237 4. The charges established in this paragraph apply to all
238 records furnished, whether directly from a nursing home facility
239 or from a copy service acting on behalf of the facility.
240 However, a resident whose records are copied or searched for the
241 purpose of continuing to receive care is not required to pay a
242 charge for copying or for the search

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243 (d) Within 10 working days after receiving a request from a
244 person who is authorized to act on behalf of a resident to
245 examine the nursing home facility's original records pertaining
246 to the resident, the facility shall provide access to examine
247 such original records, microforms, or other suitable
248 reproductions of such records in its possession. A facility may
249 impose any reasonable terms necessary ~~A nursing home facility~~
250 ~~may charge a reasonable fee for the copying of resident records.~~
251 ~~Such fee may not exceed $1 per page for the first 25 pages and~~
252 ~~25 cents per page for each additional page. The facility shall~~
253 ~~allow a person who is authorized to act on behalf of the~~
254 ~~resident to examine the original records, microfilms, or other~~
255 ~~suitable reproductions of the records in its possession upon any~~
256 ~~reasonable terms imposed by the facility~~ to ensure that the
257 records are not damaged, destroyed, or altered.
258 Section 5. Subsections (6) and (17) of section 456.057,
259 Florida Statutes, are amended to read:
260 456.057 Ownership and control of patient records; report or
261 copies of records to be furnished; disclosure of information.—
262 (6)(a) Any health care practitioner licensed by the
263 department or a board within the department who makes a physical
264 or mental examination of, or administers treatment or dispenses
265 legend drugs to, any person shall, upon written request of such
266 person or the person's legal representative, furnish, within 14
267 working days after such request ~~in a timely manner, without~~
268 ~~delays for legal review~~, copies of all reports and records
269 relating to such examination or treatment, including X-rays ~~X~~
270 ~~rays~~ and insurance information. If the health care practitioner
271 maintains a system of electronic health records as defined in s.

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272 408.051, the health care practitioner shall furnish the
273 requested records in the manner chosen by the requester, which
274 may include paper documents, electronic format, access through a
275 web-based patient portal, or submission through a patient's
276 electronic personal health record.
277 (b) Within 10 working days after receiving a written
278 request by a patient or the patient's legal representative to
279 examine the health care practitioner's original reports and
280 records pertaining to the patient, a health care practitioner
281 must provide access to examine such original reports and
282 records, or microforms or other suitable reproductions of the
283 reports and records in the health care practitioner's
284 possession. The health care practitioner may impose any
285 reasonable terms necessary to ensure that the reports and
286 records will not be damaged, destroyed, or altered.
287 (c) For the purposes of this subsection, the term "legal
288 representative" means a patient's legal guardian or, if the
289 patient is younger than 18 years old, the patient's parent or
290 legal guardian.
291 (d) ~~However,~~ When a patient's psychiatric, chapter 490
292 psychological, or chapter 491 psychotherapeutic records are
293 requested by the patient or the patient's legal representative,
294 the health care practitioner may provide a report of examination
295 and treatment in lieu of copies of records. Upon a patient's
296 written request, complete copies of the patient's psychiatric
297 records shall be provided directly to a subsequent treating
298 psychiatrist. The furnishing of such report or copies may ~~shall~~
299 not be conditioned upon payment of a fee for services rendered.
300 (17) A licensed health care practitioner may charge the

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301 requester no more than the reasonable costs of reproducing the
302 reports and records, including reasonable staff time.
303 (a) The reasonable costs of reproducing paper copies of
304 written or typed documents or reports may not exceed $1 per page
305 for the first 25 pages and 25 cents per page for all pages
306 thereafter.
307 (b) The reasonable costs of reproducing X-rays and such
308 other kinds of records shall be the actual costs. Actual costs
309 are the sum of the cost of the material and supplies used to
310 duplicate the record and the labor and overhead costs associated
311 with the duplication.
312 (c) If the nature or volume of the records requested to be
313 copied requires extensive use of information technology
314 resources or extensive clerical or supervisory assistance by
315 personnel of the health care practitioner, or both, the health
316 care practitioner may charge, in addition to the charges imposed
317 under paragraphs (a) and (b), a special service charge, which
318 shall be reasonable and shall be based on the cost incurred for
319 such extensive use of information technology resources or the
320 labor cost of the personnel providing the service which is
321 actually incurred by the health care practitioner or
322 attributable to the health care practitioner for the clerical
323 and supervisory assistance required, or both.
324 (d) The charges established in this subsection apply to all
325 reports and records furnished, whether directly from a health
326 care practitioner or from a copy service providing such services
327 on behalf of the health care practitioner. However, a patient
328 whose reports and records are copied or searched for the purpose
329 of continuing to receive medical care is not required to pay a

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330 charge for copying or for the search ~~A health care practitioner~~
331 ~~or records owner furnishing copies of reports or records or~~
332 ~~making the reports or records available for digital scanning~~
333 ~~pursuant to this section shall charge no more than the actual~~
334 ~~cost of copying, including reasonable staff time, or the amount~~
335 ~~specified in administrative rule by the appropriate board, or~~
336 ~~the department when there is no board~~.
337
338 ================= T I T L E A M E N D M E N T ================
339 And the title is amended as follows:
340 Delete lines 10 - 56
341 and insert:
342 records; providing for a special service charge under
343 specified conditions; amending s. 395.3025, F.S.;
344 requiring a licensed facility to furnish and provide
345 access to patient records within a specified timeframe
346 after receiving a request for such records; providing
347 a conditional requirement that such records be
348 furnished in the manner chosen by the requester;
349 authorizing the licensed facility to charge a
350 reasonable cost associated with reproducing such
351 records; providing for a special service charge under
352 specified conditions; revising provisions relating to
353 the appropriate disclosure of patient records without
354 consent; amending s. 397.501, F.S.; requiring a
355 service provider to furnish and provide access to
356 records within a specified timeframe after receiving a
357 request from an individual or an individual’s legal
358 representative; defining the term “legal

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359 representative”; providing a conditional requirement
360 that such records be furnished in the manner chosen by
361 the requester; authorizing the service provider to
362 charge a reasonable cost associated with reproducing
363 such records; providing for a special service charge
364 under specified conditions; amending s. 400.145, F.S.;
365 requiring a nursing home facility to furnish and
366 provide access to records within a specified timeframe
367 after receiving a request; providing a conditional
368 requirement that such records be furnished in the
369 manner chosen by the requester; authorizing the
370 nursing home facility to charge a reasonable cost
371 associated with reproducing such records; providing
372 for a special service charge under specified
373 conditions; amending s. 456.057, F.S.; requiring
374 certain licensed health care practitioners to furnish
375 and provide access to copies of reports and records
376 within a specified timeframe after receiving a request
377 from a patient or a patient’s legal representative;
378 authorizing such licensed health care practitioners to
379 impose reasonable terms necessary to preserve such
380 reports and records; defining the term “legal
381 representative”; authorizing such licensed health care
382 practitioners to charge a reasonable cost associated
383 with reproducing such reports and records; providing
384 for a special service charge under specified
385 conditions; amending s. 395.1012, F.S.; requiring a

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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/18/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

1 **Senate Amendment**
2
3 Delete lines 121 - 136
4 and insert:
5 including reasonable staff time. Such charges apply to all
6 records

141012

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/18/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

1 **Senate Amendment**

2

3 Delete lines 258 - 273

4 and insert:

5 reasonable staff time. Such charges apply to all records

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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/18/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

1 **Senate Amendment (with directory amendment)**
2
3 Delete lines 300 - 312.
4
5 ====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
6 And the directory clause is amended as follows:
7 Delete line 281
8 and insert:
9 (6), and (7), respectively, and subsections (1), (5), and

919626

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/18/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

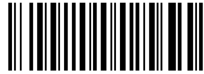
1 **Senate Amendment**

2

3 Delete lines 330 - 374
4 and insert:
5 representative” means a client’s legal guardian or, if the
6 client is younger than 18 years old, the client’s parent or
7 legal guardian.
8 (2)(a) Within 14 working days after receiving a written
9 request from a former or current client or that client’s legal
10 representative, a provider shall furnish a true and correct copy

919626

11 of all records, including medical, care and treatment, and
12 interdisciplinary records, as applicable to that client, in the
13 possession of the provider.
14 (b) If a provider maintains a system of electronic health
15 records as defined in s. 408.051, the provider shall furnish the
16 requested records in the manner chosen by the requester, which
17 may include paper documents, electronic format, access through a
18 web-based patient portal, or submission through a client's
19 electronic personal health record.
20 (3) Within 10 working days after receiving such a request
21 by a former or current client or that client's legal
22 representative, a provider shall provide access to examine the
23 original records, microforms, or other suitable reproductions of
24 the records in its possession. A provider may impose any
25 reasonable terms necessary to ensure that the records will not
26 be damaged, destroyed, or altered.
27 (4) A provider may charge the requester no more than the
28 reasonable costs of reproducing the records, including
29 reasonable staff time. Such charges apply to all records


682214

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/18/2019	.	
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The Committee on Health Policy (Harrell) recommended the following:

1 **Senate Amendment**

2

3 Delete lines 442 - 457

4 and insert:

5 reports and records, including reasonable staff time. Such

6 charges apply to all reports

FOR CONSIDERATION By the Committee on Health Policy

588-02978A-19 20197078pb

1 A bill to be entitled
2 An act relating to health care; amending s. 394.4615,
3 F.S.; requiring a service provider to furnish and
4 provide access to clinical records within a specified
5 timeframe after receiving a request for such records;
6 providing a conditional requirement that such records
7 be furnished in the manner chosen by the requester;
8 authorizing the service provider to charge a
9 reasonable cost associated with reproducing such
10 records; amending s. 395.3025, F.S.; removing
11 provisions requiring a licensed facility to furnish
12 patient records only after discharge to conform to
13 changes made by the act; revising provisions relating
14 to the appropriate disclosure of patient records
15 without consent; amending s. 397.501, F.S.; requiring
16 a service provider to furnish and provide access to
17 records within a specified timeframe after receiving a
18 request from an individual or an individual's legal
19 representative; providing a conditional requirement
20 that such records be furnished in the manner chosen by
21 the requester; authorizing the service provider to
22 charge a reasonable cost associated with reproducing
23 such records; amending s. 400.145, F.S.; revising
24 provisions relating to the records of a resident held
25 by a nursing home facility to conform to changes made
26 by the act; requiring that a nursing home facility
27 furnish such records within a specified timeframe
28 after receiving a request from a representative of a
29 deceased resident; creating s. 408.833, F.S.; defining

30 the term “legal representative”; requiring a provider
31 to furnish and provide access to records within a
32 specified timeframe after receiving a request from a
33 former or current client or that client’s legal
34 representative; providing a conditional requirement
35 that such records be furnished in the manner chosen by
36 the requester; authorizing a provider to impose
37 reasonable terms necessary to preserve such records;
38 authorizing a provider to charge a reasonable cost
39 associated with reproducing such records; authorizing
40 a provider to refuse to furnish such records directly
41 to a client under certain circumstances; providing
42 limitations on the frequency of furnishing copies of
43 records of a client of a nursing home facility;
44 providing applicability; amending s. 456.057, F.S.;
45 requiring certain licensed health care practitioners
46 to furnish and provide access to copies of reports and
47 records within a specified timeframe after receiving a
48 request from a patient or a patient’s legal
49 representative; authorizing such licensed health care
50 practitioners to impose reasonable terms necessary to
51 preserve such reports and records; authorizing such
52 licensed health care practitioners to charge a
53 reasonable cost associated with reproducing such
54 reports and records; amending ss. 316.1932, 316.1933,
55 395.4025, and 440.185, F.S.; conforming cross-
56 references; amending s. 395.1012, F.S.; requiring a
57 licensed hospital to provide specified information and
58 data relating to patient safety and quality measures

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59 to a patient under certain circumstances or to any
60 person upon request; creating s. 395.1052, F.S.;
61 requiring a hospital to notify a patient's primary
62 care provider within a specified timeframe after the
63 patient's admission; requiring a hospital to inform a
64 patient, upon admission, of the option to request
65 consultation between the hospital's treating physician
66 and the patient's primary care provider or specialist
67 provider; requiring a hospital to notify a patient's
68 primary care provider of the patient's discharge and
69 provide specified information and records to the
70 primary care provider within a specified timeframe
71 after discharge; amending s. 395.301, F.S.; requiring
72 a licensed facility, upon placing a patient on
73 observation status, to immediately notify the patient
74 of such status using a specified form; requiring that
75 such notification be documented in the patient's
76 medical records and discharge papers; amending s.
77 624.27, F.S.; expanding the scope of direct primary
78 care agreements, which are renamed "direct health care
79 agreements"; conforming provisions to changes made by
80 the act; creating s. 627.42393, F.S.; prohibiting
81 certain health insurers from employing step-therapy
82 protocols under certain circumstances; defining the
83 term "health coverage plan"; amending s. 641.31, F.S.;
84 prohibiting certain health maintenance organizations
85 from employing step-therapy protocols under certain
86 circumstances; defining the term "health coverage
87 plan"; amending s. 409.973, F.S.; prohibiting Medicaid

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88 managed care plans from employing step-therapy
89 protocols under certain circumstances; creating s.
90 627.4303, F.S.; defining the term “health insurer”;
91 prohibiting limitations on price transparency with
92 patients in contracts between health insurers and
93 health care providers; prohibiting a health insurer
94 from requiring an insured to make a certain payment
95 for a covered service under certain circumstances;
96 creating s. 456.4501, F.S.; implementing the
97 Interstate Medical Licensure Compact in this state;
98 providing for an interstate medical licensure process;
99 providing requirements for multistate practice and
100 telemedicine practice; providing effective dates.
101
102 Be It Enacted by the Legislature of the State of Florida:
103
104 Section 1. Present subsections (3) through (11) of section
105 394.4615, Florida Statutes, are redesignated as subsections (5)
106 through (13), respectively, and new subsections (3) and (4) are
107 added to that section, to read:
108 394.4615 Clinical records; confidentiality.—
109 (3)(a) Within 14 working days after receiving a request
110 made in accordance with paragraphs (2)(a), (b), or (c), a
111 service provider must furnish clinical records in its
112 possession.
113 (b) If a service provider maintains a system of electronic
114 health records as defined in s. 408.051, the service provider
115 shall furnish the requested records in the manner chosen by the
116 requester, which may include paper documents, electronic format,

117 access through a web-based patient portal, or submission through
118 a patient's electronic personal health record.
119 (4) The service provider may charge a requester no more
120 than the reasonable costs of reproducing the clinical records,
121 including reasonable staff time.
122 (a) The reasonable costs of reproducing paper copies of
123 written or typed documents or reports may not exceed $1 per page
124 for the first 25 pages and 25 cents per page for all pages
125 thereafter.
126 (b) The reasonable costs of reproducing X-rays and other
127 forms of images shall be the actual costs. Actual costs shall be
128 the sum of the cost of the material and supplies used to
129 duplicate the record and the labor and overhead costs associated
130 with the duplication.
131 (c) The reasonable costs of producing electronic copies of
132 records or electronic access to records may not exceed $2;
133 however, a service provider may charge up to $1 for each year of
134 records requested.
135
136 The charges established in this subsection apply to all records
137 furnished, whether directly from a service provider or from a
138 copy service providing such services on behalf of a service
139 provider. However, a patient whose records are copied or
140 searched for the purpose of continuing to receive care is not
141 required to pay a charge for copying or for the search.
142 Section 2. Present subsections (4) through (11) of section
143 395.3025, Florida Statutes, are redesignated as subsections (1)
144 through (8), respectively, and present subsections (1), (2), and
145 (3), paragraph (e) of present subsection (4), paragraph (a) of

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146 present subsection (7), and present subsection (8) of that
147 section, are amended to read:
148 395.3025 Patient and personnel records; copies;
149 examination.—
150 ~~(1) Any licensed facility shall, upon written request, and~~
151 ~~only after discharge of the patient, furnish, in a timely~~
152 ~~manner, without delays for legal review, to any person admitted~~
153 ~~therein for care and treatment or treated thereat, or to any~~
154 ~~such person’s guardian, curator, or personal representative, or~~
155 ~~in the absence of one of those persons, to the next of kin of a~~
156 ~~decedent or the parent of a minor, or to anyone designated by~~
157 ~~such person in writing, a true and correct copy of all patient~~
158 ~~records, including X rays, and insurance information concerning~~
159 ~~such person, which records are in the possession of the licensed~~
160 ~~facility, provided the person requesting such records agrees to~~
161 ~~pay a charge. The exclusive charge for copies of patient records~~
162 ~~may include sales tax and actual postage, and, except for~~
163 ~~nonpaper records that are subject to a charge not to exceed $2,~~
164 ~~may not exceed $1 per page. A fee of up to $1 may be charged for~~
165 ~~each year of records requested. These charges shall apply to all~~
166 ~~records furnished, whether directly from the facility or from a~~
167 ~~copy service providing these services on behalf of the facility.~~
168 ~~However, a patient whose records are copied or searched for the~~
169 ~~purpose of continuing to receive medical care is not required to~~
170 ~~pay a charge for copying or for the search. The licensed~~
171 ~~facility shall further allow any such person to examine the~~
172 ~~original records in its possession, or microforms or other~~
173 ~~suitable reproductions of the records, upon such reasonable~~
174 ~~terms as shall be imposed to assure that the records will not be~~

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175 ~~damaged, destroyed, or altered.~~
176 ~~(2) This section does not apply to records maintained at~~
177 ~~any licensed facility the primary function of which is to~~
178 ~~provide psychiatric care to its patients, or to records of~~
179 ~~treatment for any mental or emotional condition at any other~~
180 ~~licensed facility which are governed by the provisions of s.~~
181 ~~394.4615.~~
182 ~~(3) This section does not apply to records of substance~~
183 ~~abuse impaired persons, which are governed by s. 397.501.~~
184 (1)~~(4)~~ Patient records are confidential and may ~~must~~ not be
185 disclosed without the consent of the patient or his or her legal
186 representative; however~~, but~~ appropriate disclosure may be made
187 without such consent to:
188 (e) The Department of Health ~~agency~~ upon subpoena issued
189 pursuant to s. 456.071, but the records obtained thereby must be
190 used solely for the purpose of the department ~~agency~~ and the
191 appropriate professional board in its investigation,
192 prosecution, and appeal of disciplinary proceedings. If the
193 department ~~agency~~ requests copies of the records, the facility
194 shall charge no more than its actual copying costs, including
195 reasonable staff time. The records must be sealed and must not
196 be available to the public pursuant to s. 119.07(1) or any other
197 statute providing access to records, nor may they be available
198 to the public as part of the record of investigation for and
199 prosecution in disciplinary proceedings made available to the
200 public by the department ~~agency~~ or the appropriate regulatory
201 board. However, the department ~~agency~~ must make available, upon
202 written request by a practitioner against whom probable cause
203 has been found, any such records that form the basis of the

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204 determination of probable cause.
205 <u>(2)</u>~~(5)~~ The Department of Health may examine patient records
206 of a licensed facility, whether held by the facility or the
207 Agency for Health Care Administration, for the purpose of
208 epidemiological investigations. The unauthorized release of
209 information by agents of the department which would identify an
210 individual patient is a misdemeanor of the first degree,
211 punishable as provided in s. 775.082 or s. 775.083.
212 <u>(4)</u>~~(7)~~(a) If the content of any record of patient treatment
213 is provided under this section, the recipient~~, if other than the~~
214 ~~patient or the patient's representative,~~ may use such
215 information only for the purpose provided and may not further
216 disclose any information to any other person or entity, unless
217 expressly permitted by the written consent of the patient. A
218 general authorization for the release of medical information is
219 not sufficient for this purpose. The content of such patient
220 treatment record is confidential and exempt from the provisions
221 of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
222 <u>(5)</u>~~(8)~~ Patient records at hospitals and ambulatory surgical
223 centers are exempt from disclosure under s. 119.07(1), except as
224 provided by subsections <u>(1) and (2)</u> ~~(1)-(5)~~.
225 Section 3. Present paragraphs (a) through (j) of subsection
226 (7) of section 397.501, Florida Statutes, are redesignated as
227 paragraphs (d) through (m), respectively, and new paragraphs
228 (a), (b), and (c) are added to that subsection, to read:
229 397.501 Rights of individuals.—Individuals receiving
230 substance abuse services from any service provider are
231 guaranteed protection of the rights specified in this section,
232 unless otherwise expressly provided, and service providers must

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233 ensure the protection of such rights.
234 (7) RIGHT TO ACCESS TO AND CONFIDENTIALITY OF INDIVIDUAL
235 RECORDS.—
236 (a)1. Within 14 working days after receiving a written
237 request from an individual or an individual's legal
238 representative, a service provider shall furnish a true and
239 correct copy of all records pertaining to that individual in the
240 possession of the service provider.
241 2. If a service provider maintains a system of electronic
242 health records as defined in s. 408.051, the service provider
243 shall furnish the requested records in the manner chosen by the
244 requester, which may include paper documents, electronic format,
245 access through a web-based patient portal, or submission through
246 an individual's electronic personal health record.
247 3. For the purpose of this section, the term "legal
248 representative" has the same meaning as provided in s. 408.833.
249 (b) Within 10 working days after receiving such a request
250 from an individual or an individual's legal representative, a
251 service provider shall provide access to examine the original
252 records, microforms, or other suitable reproductions of the
253 records in its possession. A service provider may impose any
254 reasonable terms necessary to ensure that the records will not
255 be damaged, destroyed, or altered.
256 (c) A service provider may charge the requester no more
257 than the reasonable costs of reproducing the records, including
258 reasonable staff time.
259 1. The reasonable costs of reproducing paper copies of
260 written or typed documents or reports may not exceed $1 per page
261 for the first 25 pages and 25 cents per page for all pages

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262 thereafter.
263 2. The reasonable costs of reproducing X-rays and such
264 other kinds of records shall be the actual costs. Actual costs
265 are the sum of the cost of the material and supplies used to
266 duplicate the records and the labor and overhead costs
267 associated with the duplication.
268 3. The reasonable costs of producing electronic copies of
269 records or electronic access to records may not exceed $2. A
270 service provider may charge up to $1 for each year of records
271 requested.
272
273 The charges established in this paragraph apply to all records
274 furnished, whether directly from a service provider or from a
275 copy service providing such services on behalf of the service
276 provider. However, an individual whose records are copied or
277 searched for the purpose of continuing to receive care is not
278 required to pay a charge for copying or for the search.
279 Section 4. Present subsections (6), (8), and (9) of section
280 400.145, Florida Statutes, are redesignated as subsections (5),
281 (6), and (7), respectively, and subsections (1), (4), (5), and
282 (7) of that section are amended, to read:
283 400.145 Copies of records of care and treatment of deceased
284 resident.—
285 (1) Upon receipt of a written request that complies with
286 the federal Health Insurance Portability and Accountability Act
287 of 1996 (HIPAA) and this section, a nursing home facility shall
288 furnish ~~to a competent resident, or~~ to a representative of a
289 deceased ~~that~~ resident who is authorized to make requests for
290 the resident’s records under HIPAA or subsection (2), copies of

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291 the resident's paper and electronic records that are in
292 possession of the facility. Such records must include any
293 medical records and records concerning the care and treatment of
294 the resident performed by the facility, except for progress
295 notes and consultation report sections of a psychiatric nature.
296 The facility shall provide the requested records ~~within 14~~
297 ~~working days after receipt of a request relating to a current~~
298 ~~resident or~~ within 30 working days after receipt of a request
299 relating to a <u>deceased</u> ~~former~~ resident.
300 (4) A nursing home facility may charge a reasonable fee for
301 the copying of resident records. Such fee may not exceed $1 per
302 page for the first 25 pages and 25 cents per page for each
303 additional page <u>for reproducing paper copies of reports or</u>
304 <u>records. The reasonable costs of producing electronic copies of</u>
305 <u>records or electronic access to records may not exceed $2;</u>
306 <u>however, the facility may charge up to $1 for each year of</u>
307 <u>records requested</u>. The facility shall allow a person who is
308 authorized to act on behalf of the resident to examine the
309 original records, microfilms, or other suitable reproductions of
310 the records in its possession upon any reasonable terms imposed
311 by the facility to ensure that the records are not damaged,
312 destroyed, or altered.
313 ~~(5) If a nursing home facility determines that disclosure~~
314 ~~of the records to the resident would be detrimental to the~~
315 ~~physical or mental health of the resident, the facility may~~
316 ~~refuse to furnish the record directly to the resident; however,~~
317 ~~upon such refusal, the resident's records shall, upon written~~
318 ~~request by the resident, be furnished to any other medical~~
319 ~~provider designated by the resident.~~

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320 ~~(7) A nursing home facility is not required to provide~~
321 ~~copies of a resident's records requested pursuant to this~~
322 ~~section more than once per month, except that copies of~~
323 ~~physician reports in the resident's records must be provided as~~
324 ~~often as necessary to allow the effective monitoring of the~~
325 ~~resident's condition.~~
326 Section 5. Section 408.833, Florida Statutes, is created to
327 read:
328 408.833 Client access to medical records.—
329 (1) For the purpose of this section, the term "legal
330 representative" means a client's attorney who has been
331 designated by a former or current client of the licensee to
332 receive copies of the client's medical, care and treatment, or
333 interdisciplinary records; a legally recognized guardian of the
334 client; a court-appointed representative of the client; or a
335 person designated by the client or by a court of competent
336 jurisdiction to receive copies of the client's medical, care and
337 treatment, or interdisciplinary records.
338 (2)(a) Within 14 working days after receiving a written
339 request from a former or current client or that client's legal
340 representative, a provider shall furnish a true and correct copy
341 of all records, including medical, care and treatment, and
342 interdisciplinary records, as applicable to that client, in the
343 possession of the provider.
344 (b) If a provider maintains a system of electronic health
345 records as defined in s. 408.051, the provider shall furnish the
346 requested records in the manner chosen by the requester, which
347 may include paper documents, electronic format, access through a
348 web-based patient portal, or submission through a client's

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349 electronic personal health record.

350 (3) Within 10 working days after receiving such a request
351 by a former or current client or that client's legal
352 representative, a provider shall provide access to examine the
353 original records, microforms, or other suitable reproductions of
354 the records in its possession. A provider may impose any
355 reasonable terms necessary to ensure that the records will not
356 be damaged, destroyed, or altered.

357 (4) A provider may charge the requester no more than the
358 reasonable costs of reproducing the records, including
359 reasonable staff time.

360 (a) The reasonable costs of reproducing paper copies of
361 written or typed documents or reports may not exceed $1 per page
362 for the first 25 pages and 25 cents per page for all pages
363 thereafter.

364 (b) The reasonable costs of reproducing X-rays and other
365 forms of images shall be the actual costs. Actual costs are the
366 sum of the cost of the material and supplies used to duplicate
367 the records and the labor and overhead costs associated with the
368 duplication.

369 (c) The reasonable costs of producing electronic copies of
370 records or electronic access to records may not exceed $2;
371 however, a provider may charge up to $1 for each year of records
372 requested.

373

374 The charges established in this subsection apply to all records
375 furnished, whether directly from a provider or from a copy
376 service providing such services on behalf of the provider.
377 However, a client whose records are copied or searched for the

378 purpose of continuing to receive medical care is not required to
379 pay a charge for copying or for the search.
380 (5) A provider may refuse to furnish records directly to a
381 client if the provider determines that disclosure of the records
382 to the client would be detrimental to the physical or mental
383 health of the client; however, upon such refusal, the client's
384 records must be furnished upon written request by the client to
385 any other medical provider designated by the client.
386 (6) A provider may refuse a request under this section if
387 the client is a resident of a nursing home facility and has been
388 adjudged incompetent. A provider is not required to provide
389 copies of a nursing home facility client's records requested
390 pursuant to this section more frequently than once per month,
391 except that copies of physician reports in the client's records
392 must be provided as often as necessary to allow the effective
393 monitoring of the client's condition.
394 (7) This section does not apply to any of the following:
395 (a) Records maintained at any licensed facility, as defined
396 in s. 395.002, the primary function of which is to provide
397 psychiatric care to its patients, or records of treatment for
398 any mental or emotional condition at any other licensed facility
399 which is governed by s. 394.4615.
400 (b) Records of substance abuse impaired persons which are
401 governed by s. 397.501.
402 (c) Records of a deceased resident of a nursing home
403 facility.
404 Section 6. Subsections (6) and (17) of section 456.057,
405 Florida Statutes, are amended to read:
406 456.057 Ownership and control of patient records; report or

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407 copies of records to be furnished; disclosure of information.—
408 (6)(a) Any health care practitioner licensed by the
409 department or a board within the department who makes a physical
410 or mental examination of, or administers treatment or dispenses
411 legend drugs to, any person shall, upon written request of such
412 person or the person's legal representative, furnish, within 14
413 working days after such request ~~in a timely manner, without~~
414 ~~delays for legal review~~, copies of all reports and records
415 relating to such examination or treatment, including X-rays ~~X~~
416 ~~rays~~ and insurance information. If the health care practitioner
417 maintains a system of electronic health records as defined in s.
418 408.051, the health care practitioner shall furnish the
419 requested records in the manner chosen by the requester, which
420 may include paper documents, electronic format, access through a
421 web-based patient portal, or submission through a patient's
422 electronic personal health record.
423 (b) Within 10 working days after receiving a written
424 request by a patient or a patient's legal representative, a
425 health care practitioner must provide access to examine the
426 original reports and records, or microforms or other suitable
427 reproductions of the reports and records in the health care
428 practitioner's possession. The health care practitioner may
429 impose any reasonable terms necessary to ensure that the reports
430 and records will not be damaged, destroyed, or altered.
431 (c) ~~However,~~ When a patient's psychiatric, chapter 490
432 psychological, or chapter 491 psychotherapeutic records are
433 requested by the patient or the patient's legal representative,
434 the health care practitioner may provide a report of examination
435 and treatment in lieu of copies of records. Upon a patient's

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436 written request, complete copies of the patient’s psychiatric
437 records shall be provided directly to a subsequent treating
438 psychiatrist. The furnishing of such report or copies may ~~shall~~
439 not be conditioned upon payment of a fee for services rendered.
440 (17) A licensed health care practitioner may charge the
441 requester no more than the reasonable costs of reproducing the
442 reports and records, including reasonable staff time.
443 (a) The reasonable costs of reproducing paper copies of
444 written or typed documents or reports may not exceed $1 per page
445 for the first 25 pages and 25 cents per page for all pages
446 thereafter.
447 (b) The reasonable costs of reproducing X-rays and such
448 other kinds of records shall be the actual costs. Actual costs
449 are the sum of the cost of the material and supplies used to
450 duplicate the record and the labor and overhead costs associated
451 with the duplication.
452 (c) The reasonable costs of producing electronic copies of
453 reports and records or electronic access to reports and records
454 may not exceed $2; however, a licensed health care practitioner
455 may charge up to $1 for each year of records requested.
456
457 The charges established in this subsection apply to all reports
458 and records furnished, whether directly from a health care
459 practitioner or from a copy service providing such services on
460 behalf of the health care practitioner. However, a patient whose
461 reports and records are copied or searched for the purpose of
462 continuing to receive medical care is not required to pay a
463 charge for copying or for the search ~~A health care practitioner~~
464 ~~or records owner furnishing copies of reports or records or~~

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465 ~~making the reports or records available for digital scanning~~
466 ~~pursuant to this section shall charge no more than the actual~~
467 ~~cost of copying, including reasonable staff time, or the amount~~
468 ~~specified in administrative rule by the appropriate board, or~~
469 ~~the department when there is no board~~.
470 Section 7. Paragraph (f) of subsection (1) of section
471 316.1932, Florida Statutes, is amended to read:
472 316.1932 Tests for alcohol, chemical substances, or
473 controlled substances; implied consent; refusal.—
474 (1)
475 (f)1. The tests determining the weight of alcohol in the
476 defendant’s blood or breath shall be administered at the request
477 of a law enforcement officer substantially in accordance with
478 rules of the Department of Law Enforcement. Such rules must
479 specify precisely the test or tests that are approved by the
480 Department of Law Enforcement for reliability of result and ease
481 of administration, and must provide an approved method of
482 administration which must be followed in all such tests given
483 under this section. However, the failure of a law enforcement
484 officer to request the withdrawal of blood does not affect the
485 admissibility of a test of blood withdrawn for medical purposes.
486 2.a. Only a physician, certified paramedic, registered
487 nurse, licensed practical nurse, other personnel authorized by a
488 hospital to draw blood, or duly licensed clinical laboratory
489 director, supervisor, technologist, or technician, acting at the
490 request of a law enforcement officer, may withdraw blood for the
491 purpose of determining its alcoholic content or the presence of
492 chemical substances or controlled substances therein. However,
493 the failure of a law enforcement officer to request the

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494 withdrawal of blood does not affect the admissibility of a test
495 of blood withdrawn for medical purposes.
496 b. Notwithstanding any provision of law pertaining to the
497 confidentiality of hospital records or other medical records, if
498 a health care provider, who is providing medical care in a
499 health care facility to a person injured in a motor vehicle
500 crash, becomes aware, as a result of any blood test performed in
501 the course of that medical treatment, that the person's blood-
502 alcohol level meets or exceeds the blood-alcohol level specified
503 in s. 316.193(1)(b), the health care provider may notify any law
504 enforcement officer or law enforcement agency. Any such notice
505 must be given within a reasonable time after the health care
506 provider receives the test result. Any such notice shall be used
507 only for the purpose of providing the law enforcement officer
508 with reasonable cause to request the withdrawal of a blood
509 sample pursuant to this section.
510 c. The notice shall consist only of the name of the person
511 being treated, the name of the person who drew the blood, the
512 blood-alcohol level indicated by the test, and the date and time
513 of the administration of the test.
514 d. Nothing contained in s. 395.3025(1) ~~s. 395.3025(4)~~, s.
515 456.057, or any applicable practice act affects the authority to
516 provide notice under this section, and the health care provider
517 is not considered to have breached any duty owed to the person
518 under s. 395.3025(1) ~~s. 395.3025(4)~~, s. 456.057, or any
519 applicable practice act by providing notice or failing to
520 provide notice. It shall not be a breach of any ethical, moral,
521 or legal duty for a health care provider to provide notice or
522 fail to provide notice.

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523 e. A civil, criminal, or administrative action may not be
524 brought against any person or health care provider participating
525 in good faith in the provision of notice or failure to provide
526 notice as provided in this section. Any person or health care
527 provider participating in the provision of notice or failure to
528 provide notice as provided in this section shall be immune from
529 any civil or criminal liability and from any professional
530 disciplinary action with respect to the provision of notice or
531 failure to provide notice under this section. Any such
532 participant has the same immunity with respect to participating
533 in any judicial proceedings resulting from the notice or failure
534 to provide notice.
535 3. The person tested may, at his or her own expense, have a
536 physician, registered nurse, other personnel authorized by a
537 hospital to draw blood, or duly licensed clinical laboratory
538 director, supervisor, technologist, or technician, or other
539 person of his or her own choosing administer an independent test
540 in addition to the test administered at the direction of the law
541 enforcement officer for the purpose of determining the amount of
542 alcohol in the person's blood or breath or the presence of
543 chemical substances or controlled substances at the time
544 alleged, as shown by chemical analysis of his or her blood or
545 urine, or by chemical or physical test of his or her breath. The
546 failure or inability to obtain an independent test by a person
547 does not preclude the admissibility in evidence of the test
548 taken at the direction of the law enforcement officer. The law
549 enforcement officer shall not interfere with the person's
550 opportunity to obtain the independent test and shall provide the
551 person with timely telephone access to secure the test, but the

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552 burden is on the person to arrange and secure the test at the
553 person's own expense.
554 4. Upon the request of the person tested, full information
555 concerning the results of the test taken at the direction of the
556 law enforcement officer shall be made available to the person or
557 his or her attorney. Full information is limited to the
558 following:
559 a. The type of test administered and the procedures
560 followed.
561 b. The time of the collection of the blood or breath sample
562 analyzed.
563 c. The numerical results of the test indicating the alcohol
564 content of the blood and breath.
565 d. The type and status of any permit issued by the
566 Department of Law Enforcement which was held by the person who
567 performed the test.
568 e. If the test was administered by means of a breath
569 testing instrument, the date of performance of the most recent
570 required inspection of such instrument.
571
572 Full information does not include manuals, schematics, or
573 software of the instrument used to test the person or any other
574 material that is not in the actual possession of the state.
575 Additionally, full information does not include information in
576 the possession of the manufacturer of the test instrument.
577 5. A hospital, clinical laboratory, medical clinic, or
578 similar medical institution or physician, certified paramedic,
579 registered nurse, licensed practical nurse, other personnel
580 authorized by a hospital to draw blood, or duly licensed

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581 clinical laboratory director, supervisor, technologist, or
582 technician, or other person assisting a law enforcement officer
583 does not incur any civil or criminal liability as a result of
584 the withdrawal or analysis of a blood or urine specimen, or the
585 chemical or physical test of a person's breath pursuant to
586 accepted medical standards when requested by a law enforcement
587 officer, regardless of whether or not the subject resisted
588 administration of the test.
589 Section 8. Paragraph (a) of subsection (2) of section
590 316.1933, Florida Statutes, is amended to read:
591 316.1933 Blood test for impairment or intoxication in cases
592 of death or serious bodily injury; right to use reasonable
593 force.—
594 (2)(a) Only a physician, certified paramedic, registered
595 nurse, licensed practical nurse, other personnel authorized by a
596 hospital to draw blood, or duly licensed clinical laboratory
597 director, supervisor, technologist, or technician, acting at the
598 request of a law enforcement officer, may withdraw blood for the
599 purpose of determining the alcoholic content thereof or the
600 presence of chemical substances or controlled substances
601 therein. However, the failure of a law enforcement officer to
602 request the withdrawal of blood shall not affect the
603 admissibility of a test of blood withdrawn for medical purposes.
604 1. Notwithstanding any provision of law pertaining to the
605 confidentiality of hospital records or other medical records, if
606 a health care provider, who is providing medical care in a
607 health care facility to a person injured in a motor vehicle
608 crash, becomes aware, as a result of any blood test performed in
609 the course of that medical treatment, that the person's blood-

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610 alcohol level meets or exceeds the blood-alcohol level specified
611 in s. 316.193(1)(b), the health care provider may notify any law
612 enforcement officer or law enforcement agency. Any such notice
613 must be given within a reasonable time after the health care
614 provider receives the test result. Any such notice shall be used
615 only for the purpose of providing the law enforcement officer
616 with reasonable cause to request the withdrawal of a blood
617 sample pursuant to this section.
618 2. The notice shall consist only of the name of the person
619 being treated, the name of the person who drew the blood, the
620 blood-alcohol level indicated by the test, and the date and time
621 of the administration of the test.
622 3. Nothing contained in s. 395.3025(1) ~~s. 395.3025(4)~~, s.
623 456.057, or any applicable practice act affects the authority to
624 provide notice under this section, and the health care provider
625 is not considered to have breached any duty owed to the person
626 under s. 395.3025(1) ~~s. 395.3025(4)~~, s. 456.057, or any
627 applicable practice act by providing notice or failing to
628 provide notice. It shall not be a breach of any ethical, moral,
629 or legal duty for a health care provider to provide notice or
630 fail to provide notice.
631 4. A civil, criminal, or administrative action may not be
632 brought against any person or health care provider participating
633 in good faith in the provision of notice or failure to provide
634 notice as provided in this section. Any person or health care
635 provider participating in the provision of notice or failure to
636 provide notice as provided in this section shall be immune from
637 any civil or criminal liability and from any professional
638 disciplinary action with respect to the provision of notice or

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639 failure to provide notice under this section. Any such
640 participant has the same immunity with respect to participating
641 in any judicial proceedings resulting from the notice or failure
642 to provide notice.
643 Section 9. Subsection (13) of section 395.4025, Florida
644 Statutes, is amended to read:
645 395.4025 Trauma centers; selection; quality assurance;
646 records.—
647 (13) Patient care, transport, or treatment records or
648 reports, or patient care quality assurance proceedings, records,
649 or reports obtained or made pursuant to this section, s.
650 395.3025(1)(f) ~~s. 395.3025(4)(f)~~, s. 395.401, s. 395.4015, s.
651 395.402, s. 395.403, s. 395.404, s. 395.4045, s. 395.405, s.
652 395.50, or s. 395.51 must be held confidential by the department
653 or its agent and are exempt from the provisions of s. 119.07(1).
654 Patient care quality assurance proceedings, records, or reports
655 obtained or made pursuant to these sections are not subject to
656 discovery or introduction into evidence in any civil or
657 administrative action.
658 Section 10. Subsection (4) of section 440.185, Florida
659 Statutes, is amended to read:
660 440.185 Notice of injury or death; reports; penalties for
661 violations.—
662 (4) Additional reports with respect to such injury and of
663 the condition of such employee, including copies of medical
664 reports, funeral expenses, and wage statements, shall be filed
665 by the employer or carrier to the department at such times and
666 in such manner as the department may prescribe by rule. In
667 carrying out its responsibilities under this chapter, the

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668 department or agency may by rule provide for the obtaining of
669 any medical records relating to medical treatment provided
670 pursuant to this chapter, notwithstanding the provisions of ss.
671 90.503 and 395.3025(1) ~~395.3025(4)~~.
672 Section 11. Subsection (3) is added to section 395.1012,
673 Florida Statutes, to read:
674 395.1012 Patient safety.—
675 (3)(a) Each hospital shall provide to any patient upon
676 admission, upon scheduling of nonemergency care, or prior to
677 treatment, written information on a form created by the agency
678 that contains the following information available for the
679 hospital for the most recent year and the statewide average for
680 all hospitals related to the following quality measures:
681 1. The rate of hospital-acquired infections;
682 2. The overall rating of the Hospital Consumer Assessment
683 of Healthcare Providers and Systems survey; and
684 3. The 15-day readmission rate.
685 (b) A hospital must also provide the written information
686 specified in paragraph (a) to any person upon request.
687 (c) The information required by this subsection must be
688 presented in a manner that is easily understandable and
689 accessible to the patient and must also include an explanation
690 of the quality measures and the relationship between patient
691 safety and the hospital's data for the quality measures.
692 Section 12. Section 395.1052, Florida Statutes, is created
693 to read:
694 395.1052 Patient access to primary care and specialty
695 providers; notification.—A hospital shall:
696 (1) Notify each patient's primary care provider, if any,

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697 within 24 hours after the patient's admission to the hospital.
698 (2) Inform a patient immediately upon admission that he or
699 she may request to have the hospital's treating physician
700 consult with the patient's primary care provider or specialist
701 provider, if any, when developing the patient's plan of care.
702 Upon the patient's request, the hospital's treating physician
703 shall make reasonable efforts to consult with the patient's
704 primary care provider or specialist provider when developing the
705 patient's plan of care.
706 (3) Notify the patient's primary care provider, if any, of
707 the patient's discharge from the hospital within 24 hours after
708 discharge.
709 (4) Provide the discharge summary and any related
710 information or records to the patient's primary care provider,
711 if any, within 7 days after the patient's discharge from the
712 hospital.
713 Section 13. Subsection (3) of section 395.301, Florida
714 Statutes, is amended to read:
715 395.301 Price transparency; itemized patient statement or
716 bill; patient admission status notification.—
717 (3) If a licensed facility places a patient on observation
718 status rather than inpatient status, the licensed facility must
719 immediately notify the patient of such status using the form
720 adopted under 42 C.F.R. s. 489.20 for Medicare patients or a
721 form adopted by agency rule for non-Medicare patients. Such
722 notification must ~~observation services shall~~ be documented in
723 the patient's medical records and discharge papers. The ~~patient~~
724 ~~or the~~ patient's survivor or legal guardian must ~~shall~~ be
725 notified of observation services through discharge papers, which

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726 may also include brochures, signage, or other forms of
727 communication for this purpose.
728 Section 14. Section 624.27, Florida Statutes, is amended to
729 read:
730 624.27 Direct health ~~primary~~ care agreements; exemption
731 from code.—
732 (1) As used in this section, the term:
733 (a) “Direct health ~~primary~~ care agreement” means a contract
734 between a health ~~primary~~ care provider and a patient, a
735 patient’s legal representative, or a patient’s employer, which
736 meets the requirements of subsection (4) and does not indemnify
737 for services provided by a third party.
738 (b) “Health ~~Primary~~ care provider” means a health care
739 provider licensed under chapter 458, chapter 459, chapter 460,
740 ~~or~~ chapter 464, or chapter 466, or a health ~~primary~~ care group
741 practice, who provides health ~~primary~~ care services to patients.
742 (c) “Health ~~Primary~~ care services” means the screening,
743 assessment, diagnosis, and treatment of a patient conducted
744 within the competency and training of the health ~~primary~~ care
745 provider for the purpose of promoting health or detecting and
746 managing disease or injury.
747 (2) A direct health ~~primary~~ care agreement does not
748 constitute insurance and is not subject to the Florida Insurance
749 Code. The act of entering into a direct health ~~primary~~ care
750 agreement does not constitute the business of insurance and is
751 not subject to the Florida Insurance Code.
752 (3) A health ~~primary~~ care provider or an agent of a health
753 ~~primary~~ care provider is not required to obtain a certificate of
754 authority or license under the Florida Insurance Code to market,

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755 sell, or offer to sell a direct health ~~primary~~ care agreement.
756 (4) For purposes of this section, a direct health ~~primary~~
757 care agreement must:
758 (a) Be in writing.
759 (b) Be signed by the health ~~primary~~ care provider or an
760 agent of the health ~~primary~~ care provider and the patient, the
761 patient’s legal representative, or the patient’s employer.
762 (c) Allow a party to terminate the agreement by giving the
763 other party at least 30 days’ advance written notice. The
764 agreement may provide for immediate termination due to a
765 violation of the physician-patient relationship or a breach of
766 the terms of the agreement.
767 (d) Describe the scope of health ~~primary~~ care services that
768 are covered by the monthly fee.
769 (e) Specify the monthly fee and any fees for health ~~primary~~
770 care services not covered by the monthly fee.
771 (f) Specify the duration of the agreement and any automatic
772 renewal provisions.
773 (g) Offer a refund to the patient, the patient’s legal
774 representative, or the patient’s employer of monthly fees paid
775 in advance if the health ~~primary~~ care provider ceases to offer
776 health ~~primary~~ care services for any reason.
777 (h) Contain, in contrasting color and in at least 12-point
778 type, the following statement on the signature page: “This
779 agreement is not health insurance and the health ~~primary~~ care
780 provider will not file any claims against the patient’s health
781 insurance policy or plan for reimbursement of any health ~~primary~~
782 care services covered by the agreement. This agreement does not
783 qualify as minimum essential coverage to satisfy the individual

784 shared responsibility provision of the Patient Protection and
785 Affordable Care Act, 26 U.S.C. s. 5000A. This agreement is not
786 workers' compensation insurance and does not replace an
787 employer's obligations under chapter 440."
788 Section 15. Effective January 1, 2020, section 627.42393,
789 Florida Statutes, is created to read:
790 627.42393 Step-therapy protocol.—
791 (1) A health insurer issuing a major medical individual or
792 group policy may not require a step-therapy protocol under the
793 policy for a covered prescription drug requested by an insured
794 if:
795 (a) The insured has previously been approved to receive the
796 prescription drug through the completion of a step-therapy
797 protocol required by a separate health coverage plan; and
798 (b) The insured provides documentation originating from the
799 health coverage plan that approved the prescription drug as
800 described in paragraph (a) indicating that the health coverage
801 plan paid for the drug on the insured's behalf during the 180
802 days immediately prior to the request.
803 (2) As used in this section, the term "health coverage
804 plan" means any of the following which previously provided or is
805 currently providing major medical or similar comprehensive
806 coverage or benefits to the insured:
807 (a) A health insurer or health maintenance organization.
808 (b) A plan established or maintained by an individual
809 employer as provided by the Employee Retirement Income Security
810 Act of 1974, Pub. L. No. 93-406.
811 (c) A multiple-employer welfare arrangement as defined in
812 s. 624.437.

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813 (d) A governmental entity providing a plan of self-
814 insurance.
815 Section 16. Effective January 1, 2020, subsection (45) is
816 added to section 641.31, Florida Statutes, to read:
817 641.31 Health maintenance contracts.—
818 (45)(a) A health maintenance organization issuing major
819 medical coverage through an individual or group contract may not
820 require a step-therapy protocol under the contract for a covered
821 prescription drug requested by a subscriber if:
822 1. The subscriber has previously been approved to receive
823 the prescription drug through the completion of a step-therapy
824 protocol required by a separate health coverage plan; and
825 2. The subscriber provides documentation originating from
826 the health coverage plan that approved the prescription drug as
827 described in subparagraph 1. indicating that the health coverage
828 plan paid for the drug on the subscriber's behalf during the 180
829 days immediately prior to the request.
830 (b) As used in this subsection, the term "health coverage
831 plan" means any of the following which previously provided or is
832 currently providing major medical or similar comprehensive
833 coverage or benefits to the subscriber:
834 1. A health insurer or health maintenance organization;
835 2. A plan established or maintained by an individual
836 employer as provided by the Employee Retirement Income Security
837 Act of 1974, Pub. L. No. 93-406;
838 3. A multiple-employer welfare arrangement as defined in s.
839 624.437; or
840 4. A governmental entity providing a plan of self-
841 insurance.

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842 Section 17. Present subsection (6) of section 409.973,
843 Florida Statutes, is redesignated as subsection (7), and a new
844 subsection (6) is added to that section, to read:
845 409.973 Benefits.—
846 (6) PROVISION OF PRESCRIPTION DRUG SERVICES.—
847 (a) A managed care plan may not require a step-therapy
848 approval process for a covered prescription drug requested by an
849 enrolled recipient if:
850 1. The recipient has been approved to receive the
851 prescription drug through the completion of a step-therapy
852 approval process required by a managed care plan in which the
853 recipient was previously enrolled under this part; and
854 2. The managed care plan in which the recipient was
855 previously enrolled has paid for the drug on the recipient's
856 behalf during the 180 days immediately before the request.
857 (b) The agency shall implement paragraph (a) by amending
858 managed care plan contracts concurrent with the start of a new
859 capitation cycle.
860 Section 18. Section 627.4303, Florida Statutes, is created
861 to read:
862 627.4303 Price transparency in contracts between health
863 insurers and health care providers.—
864 (1) As used in this section, the term "health insurer"
865 means a health insurer issuing major medical coverage through an
866 individual or group policy or a health maintenance organization
867 issuing major medical coverage through an individual or group
868 contract.
869 (2) A health insurer may not limit a provider's ability to
870 disclose whether a patient's cost-sharing obligation exceeds the

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871 cash price for a covered service in the absence of health
872 insurance coverage or the availability of a more affordable
873 service.
874 (3) A health insurer may not require an insured to make a
875 payment for a covered service in an amount that exceeds the cash
876 price of the service in the absence of health insurance
877 coverage.
878 Section 19. Section 456.4501, Florida Statutes, is created
879 to read:
880 456.4501 Interstate Medical Licensure Compact.—The
881 Interstate Medical Licensure Compact is hereby enacted into law
882 and entered into by this state with all other jurisdictions
883 legally joining therein in the form substantially as follows:
884
885 SECTION 1
886 PURPOSE
887
888 In order to strengthen access to health care, and in
889 recognition of the advances in the delivery of health care, the
890 member states of the Interstate Medical Licensure Compact have
891 allied in common purpose to develop a comprehensive process that
892 complements the existing licensing and regulatory authority of
893 state medical boards, provides a streamlined process that allows
894 physicians to become licensed in multiple states, thereby
895 enhancing the portability of a medical license and ensuring the
896 safety of patients. The Compact creates another pathway for
897 licensure and does not otherwise change a state's existing
898 Medical Practice Act. The Compact also adopts the prevailing
899 standard for licensure and affirms that the practice of medicine

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900 occurs where the patient is located at the time of the
901 physician-patient encounter, and therefore, requires the
902 physician to be under the jurisdiction of the state medical
903 board where the patient is located. State medical boards that
904 participate in the Compact retain the jurisdiction to impose an
905 adverse action against a license to practice medicine in that
906 state issued to a physician through the procedures in the
907 Compact.
908
909 SECTION 2
910 DEFINITIONS
911
912 In this compact:
913 (a) "Bylaws" means those bylaws established by the
914 Interstate Commission pursuant to Section 11 for its governance,
915 or for directing and controlling its actions and conduct.
916 (b) "Commissioner" means the voting representative
917 appointed by each member board pursuant to Section 11.
918 (c) "Conviction" means a finding by a court that an
919 individual is guilty of a criminal offense through adjudication,
920 or entry of a plea of guilt or no contest to the charge by the
921 offender. Evidence of an entry of a conviction of a criminal
922 offense by the court shall be considered final for purposes of
923 disciplinary action by a member board.
924 (d) "Expedited License" means a full and unrestricted
925 medical license granted by a member state to an eligible
926 physician through the process set forth in the Compact.
927 (e) "Interstate Commission" means the interstate commission
928 created pursuant to Section 11.

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929 (f) “License” means authorization by a state for a
930 physician to engage in the practice of medicine, which would be
931 unlawful without the authorization.
932 (g) “Medical Practice Act” means laws and regulations
933 governing the practice of allopathic and osteopathic medicine
934 within a member state.
935 (h) “Member Board” means a state agency in a member state
936 that acts in the sovereign interests of the state by protecting
937 the public through licensure, regulation, and education of
938 physicians as directed by the state government.
939 (i) “Member State” means a state that has enacted the
940 Compact.
941 (j) “Practice of medicine” means the diagnosis, treatment,
942 prevention, cure, or relieving of a human disease, ailment,
943 defect, complaint, or other physical or mental condition, by
944 attendance, advice, device, diagnostic test, or other means, or
945 offering, undertaking, attempting to do, or holding oneself out
946 as able to do, any of these acts.
947 (k) “Physician” means any person who:
948 (1) Is a graduate of a medical school accredited by the
949 Liaison Committee on Medical Education, the Commission on
950 Osteopathic College Accreditation, or a medical school listed in
951 the International Medical Education Directory or its equivalent;
952 (2) Passed each component of the United States Medical
953 Licensing Examination (USMLE) or the Comprehensive Osteopathic
954 Medical Licensing Examination (COMLEX-USA) within three
955 attempts, or any of its predecessor examinations accepted by a
956 state medical board as an equivalent examination for licensure
957 purposes;

958 (3) Successfully completed graduate medical education
959 approved by the Accreditation Council for Graduate Medical
960 Education or the American Osteopathic Association;
961 (4) Holds specialty certification or a time-unlimited
962 specialty certificate recognized by the American Board of
963 Medical Specialties or the American Osteopathic Association's
964 Bureau of Osteopathic Specialists; however, the specialty
965 certification or a time-unlimited specialty certificate does not
966 have to be maintained once a physician is initially determined
967 to be eligible for expedited licensure through the Compact;
968 (5) Possesses a full and unrestricted license to engage in
969 the practice of medicine issued by a member board;
970 (6) Has never been convicted, received adjudication,
971 deferred adjudication, community supervision, or deferred
972 disposition for any offense by a court of appropriate
973 jurisdiction;
974 (7) Has never held a license authorizing the practice of
975 medicine subjected to discipline by a licensing agency in any
976 state, federal, or foreign jurisdiction, excluding any action
977 related to non-payment of fees related to a license;
978 (8) Has never had a controlled substance license or permit
979 suspended or revoked by a state or the United States Drug
980 Enforcement Administration; and
981 (9) Is not under active investigation by a licensing agency
982 or law enforcement authority in any state, federal, or foreign
983 jurisdiction.
984 (l) "Offense" means a felony, high court misdemeanor, or
985 crime of moral turpitude.
986 (m) "Rule" means a written statement by the Interstate

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987 Commission promulgated pursuant to Section 12 of the Compact
988 that is of general applicability, implements, interprets, or
989 prescribes a policy or provision of the Compact, or an
990 organizational, procedural, or practice requirement of the
991 Interstate Commission, and has the force and effect of statutory
992 law in a member state, if the rule is not inconsistent with the
993 laws of the member state. The term includes the amendment,
994 repeal, or suspension of an existing rule.
995 (n) "State" means any state, commonwealth, district, or
996 territory of the United States.
997 (o) "State of Principal License" means a member state where
998 a physician holds a license to practice medicine and which has
999 been designated as such by the physician for purposes of
1000 registration and participation in the Compact.
1001
1002 SECTION 3
1003 ELIGIBILITY
1004
1005 (a) A physician must meet the eligibility requirements as
1006 defined in Section 2(k) to receive an expedited license under
1007 the terms and provisions of the Compact.
1008 (b) A physician who does not meet the requirements of
1009 Section 2(k) may obtain a license to practice medicine in a
1010 member state if the individual complies with all laws and
1011 requirements, other than the Compact, relating to the issuance
1012 of a license to practice medicine in that state.
1013
1014 SECTION 4
1015 DESIGNATION OF STATE OF PRINCIPAL LICENSE

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1016

1017 (a) A physician shall designate a member state as the state
1018 of principal license for purposes of registration for expedited
1019 licensure through the Compact if the physician possesses a full
1020 and unrestricted license to practice medicine in that state, and
1021 the state is:
1022 (1) the state of primary residence for the physician, or
1023 (2) the state where at least 25% of the practice of
1024 medicine occurs, or
1025 (3) the location of the physician's employer, or
1026 (4) if no state qualifies under subsection (1), subsection
1027 (2), or subsection (3), the state designated as state of
1028 residence for purpose of federal income tax.
1029 (b) A physician may redesignate a member state as state of
1030 principal license at any time, as long as the state meets the
1031 requirements in subsection (a).
1032 (c) The Interstate Commission is authorized to develop
1033 rules to facilitate redesignation of another member state as the
1034 state of principal license.
1035
1036 SECTION 5
1037 APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE
1038
1039 (a) A physician seeking licensure through the Compact shall
1040 file an application for an expedited license with the member
1041 board of the state selected by the physician as the state of
1042 principal license.
1043 (b) Upon receipt of an application for an expedited
1044 license, the member board within the state selected as the state

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1045 of principal license shall evaluate whether the physician is
1046 eligible for expedited licensure and issue a letter of
1047 qualification, verifying or denying the physician's eligibility,
1048 to the Interstate Commission.
1049 (i) Static qualifications, which include verification of
1050 medical education, graduate medical education, results of any
1051 medical or licensing examination, and other qualifications as
1052 determined by the Interstate Commission through rule, shall not
1053 be subject to additional primary source verification where
1054 already primary source verified by the state of principal
1055 license.
1056 (ii) The member board within the state selected as the
1057 state of principal license shall, in the course of verifying
1058 eligibility, perform a criminal background check of an
1059 applicant, including the use of the results of fingerprint or
1060 other biometric data checks compliant with the requirements of
1061 the Federal Bureau of Investigation, with the exception of
1062 federal employees who have suitability determination in
1063 accordance with U.S. 5 CFR §731.202.
1064 (iii) Appeal on the determination of eligibility shall be
1065 made to the member state where the application was filed and
1066 shall be subject to the law of that state.
1067 (c) Upon verification in subsection (b), physicians
1068 eligible for an expedited license shall complete the
1069 registration process established by the Interstate Commission to
1070 receive a license in a member state selected pursuant to
1071 subsection (a), including the payment of any applicable fees.
1072 (d) After receiving verification of eligibility under
1073 subsection (b) and any fees under subsection (c), a member board

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1074 shall issue an expedited license to the physician. This license
1075 shall authorize the physician to practice medicine in the
1076 issuing state consistent with the Medical Practice Act and all
1077 applicable laws and regulations of the issuing member board and
1078 member state.
1079 (e) An expedited license shall be valid for a period
1080 consistent with the licensure period in the member state and in
1081 the same manner as required for other physicians holding a full
1082 and unrestricted license within the member state.
1083 (f) An expedited license obtained through the Compact shall
1084 be terminated if a physician fails to maintain a license in the
1085 state of principal licensure for a non-disciplinary reason,
1086 without redesignation of a new state of principal licensure.
1087 (g) The Interstate Commission is authorized to develop
1088 rules regarding the application process, including payment of
1089 any applicable fees, and the issuance of an expedited license.
1090
1091 SECTION 6
1092 FEES FOR EXPEDITED LICENSURE
1093
1094 (a) A member state issuing an expedited license authorizing
1095 the practice of medicine in that state, or the regulating
1096 authority of the member state, may impose a fee for a license
1097 issued or renewed through the Compact.
1098 (b) The Interstate Commission is authorized to develop
1099 rules regarding fees for expedited licenses. However, those
1100 rules shall not limit the authority of a member state, or the
1101 regulating authority of the member state, to impose and
1102 determine the amount of a fee under subsection (a).

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1103

1104 SECTION 7

1105 RENEWAL AND CONTINUED PARTICIPATION

1106

1107 (a) A physician seeking to renew an expedited license
1108 granted in a member state shall complete a renewal process with
1109 the Interstate Commission if the physician:
1110 (1) Maintains a full and unrestricted license in a state of
1111 principal license;
1112 (2) Has not been convicted, received adjudication, deferred
1113 adjudication, community supervision, or deferred disposition for
1114 any offense by a court of appropriate jurisdiction;
1115 (3) Has not had a license authorizing the practice of
1116 medicine subject to discipline by a licensing agency in any
1117 state, federal, or foreign jurisdiction, excluding any action
1118 related to non-payment of fees related to a license; and
1119 (4) Has not had a controlled substance license or permit
1120 suspended or revoked by a state or the United States Drug
1121 Enforcement Administration.
1122 (b) Physicians shall comply with all continuing
1123 professional development or continuing medical education
1124 requirements for renewal of a license issued by a member state.
1125 (c) The Interstate Commission shall collect any renewal
1126 fees charged for the renewal of a license and distribute the
1127 fees to the applicable member board.
1128 (d) Upon receipt of any renewal fees collected in
1129 subsection (c), a member board shall renew the physician's
1130 license.
1131 (e) Physician information collected by the Interstate

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1132 Commission during the renewal process will be distributed to all
1133 member boards.
1134 (f) The Interstate Commission is authorized to develop
1135 rules to address renewal of licenses obtained through the
1136 Compact.
1137
1138 SECTION 8
1139 COORDINATED INFORMATION SYSTEM
1140
1141 (a) The Interstate Commission shall establish a database of
1142 all physicians licensed, or who have applied for licensure,
1143 under Section 5.
1144 (b) Notwithstanding any other provision of law, member
1145 boards shall report to the Interstate Commission any public
1146 action or complaints against a licensed physician who has
1147 applied or received an expedited license through the Compact.
1148 (c) Member boards shall report disciplinary or
1149 investigatory information determined as necessary and proper by
1150 rule of the Interstate Commission.
1151 (d) Member boards may report any non-public complaint,
1152 disciplinary, or investigatory information not required by
1153 subsection (c) to the Interstate Commission.
1154 (e) Member boards shall share complaint or disciplinary
1155 information about a physician upon request of another member
1156 board.
1157 (f) All information provided to the Interstate Commission
1158 or distributed by member boards shall be confidential, filed
1159 under seal, and used only for investigatory or disciplinary
1160 matters.

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1161 (g) The Interstate Commission is authorized to develop
1162 rules for mandated or discretionary sharing of information by
1163 member boards.
1164
1165 SECTION 9
1166 JOINT INVESTIGATIONS
1167
1168 (a) Licensure and disciplinary records of physicians are
1169 deemed investigative.
1170 (b) In addition to the authority granted to a member board
1171 by its respective Medical Practice Act or other applicable state
1172 law, a member board may participate with other member boards in
1173 joint investigations of physicians licensed by the member
1174 boards.
1175 (c) A subpoena issued by a member state shall be
1176 enforceable in other member states.
1177 (d) Member boards may share any investigative, litigation,
1178 or compliance materials in furtherance of any joint or
1179 individual investigation initiated under the Compact.
1180 (e) Any member state may investigate actual or alleged
1181 violations of the statutes authorizing the practice of medicine
1182 in any other member state in which a physician holds a license
1183 to practice medicine.
1184
1185 SECTION 10
1186 DISCIPLINARY ACTIONS
1187
1188 (a) Any disciplinary action taken by any member board
1189 against a physician licensed through the Compact shall be deemed

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1190 unprofessional conduct which may be subject to discipline by
1191 other member boards, in addition to any violation of the Medical
1192 Practice Act or regulations in that state.
1193 (b) If a license granted to a physician by the member board
1194 in the state of principal license is revoked, surrendered or
1195 relinquished in lieu of discipline, or suspended, then all
1196 licenses issued to the physician by member boards shall
1197 automatically be placed, without further action necessary by any
1198 member board, on the same status. If the member board in the
1199 state of principal license subsequently reinstates the
1200 physician's license, a license issued to the physician by any
1201 other member board shall remain encumbered until that respective
1202 member board takes action to reinstate the license in a manner
1203 consistent with the Medical Practice Act of that state.
1204 (c) If disciplinary action is taken against a physician by
1205 a member board not in the state of principal license, any other
1206 member board may deem the action conclusive as to matter of law
1207 and fact decided, and:
1208 (i) impose the same or lesser sanction(s) against the
1209 physician so long as such sanctions are consistent with the
1210 Medical Practice Act of that state;
1211 (ii) or pursue separate disciplinary action against the
1212 physician under its respective Medical Practice Act, regardless
1213 of the action taken in other member states.
1214 (d) If a license granted to a physician by a member board
1215 is revoked, surrendered or relinquished in lieu of discipline,
1216 or suspended, then any license(s) issued to the physician by any
1217 other member board(s) shall be suspended, automatically and
1218 immediately without further action necessary by the other member

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1219 board(s), for ninety (90) days upon entry of the order by the
1220 disciplining board, to permit the member board(s) to investigate
1221 the basis for the action under the Medical Practice Act of that
1222 state. A member board may terminate the automatic suspension of
1223 the license it issued prior to the completion of the ninety (90)
1224 day suspension period in a manner consistent with the Medical
1225 Practice Act of that state.
1226
1227 SECTION 11
1228 INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION
1229
1230 (a) The member states hereby create the "Interstate Medical
1231 Licensure Compact Commission".
1232 (b) The purpose of the Interstate Commission is the
1233 administration of the Interstate Medical Licensure Compact,
1234 which is a discretionary state function.
1235 (c) The Interstate Commission shall be a body corporate and
1236 joint agency of the member states and shall have all the
1237 responsibilities, powers, and duties set forth in the Compact,
1238 and such additional powers as may be conferred upon it by a
1239 subsequent concurrent action of the respective legislatures of
1240 the member states in accordance with the terms of the Compact.
1241 (d) The Interstate Commission shall consist of two voting
1242 representatives appointed by each member state who shall serve
1243 as Commissioners. In states where allopathic and osteopathic
1244 physicians are regulated by separate member boards, or if the
1245 licensing and disciplinary authority is split between multiple
1246 member boards within a member state, the member state shall
1247 appoint one representative from each member board. A

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1248 Commissioner shall be a(n):
1249 (1) Allopathic or osteopathic physician appointed to a
1250 member board;
1251 (2) Executive director, executive secretary, or similar
1252 executive of a member board; or
1253 (3) Member of the public appointed to a member board.
1254 (e) The Interstate Commission shall meet at least once each
1255 calendar year. A portion of this meeting shall be a business
1256 meeting to address such matters as may properly come before the
1257 Commission, including the election of officers. The chairperson
1258 may call additional meetings and shall call for a meeting upon
1259 the request of a majority of the member states.
1260 (f) The bylaws may provide for meetings of the Interstate
1261 Commission to be conducted by telecommunication or electronic
1262 communication.
1263 (g) Each Commissioner participating at a meeting of the
1264 Interstate Commission is entitled to one vote. A majority of
1265 Commissioners shall constitute a quorum for the transaction of
1266 business, unless a larger quorum is required by the bylaws of
1267 the Interstate Commission. A Commissioner shall not delegate a
1268 vote to another Commissioner. In the absence of its
1269 Commissioner, a member state may delegate voting authority for a
1270 specified meeting to another person from that state who shall
1271 meet the requirements of subsection (d).
1272 (h) The Interstate Commission shall provide public notice
1273 of all meetings and all meetings shall be open to the public.
1274 The Interstate Commission may close a meeting, in full or in
1275 portion, where it determines by a two-thirds vote of the
1276 Commissioners present that an open meeting would be likely to:

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1277 (1) Relate solely to the internal personnel practices and
1278 procedures of the Interstate Commission;
1279 (2) Discuss matters specifically exempted from disclosure
1280 by federal statute;
1281 (3) Discuss trade secrets, commercial, or financial
1282 information that is privileged or confidential;
1283 (4) Involve accusing a person of a crime, or formally
1284 censuring a person;
1285 (5) Discuss information of a personal nature where
1286 disclosure would constitute a clearly unwarranted invasion of
1287 personal privacy;
1288 (6) Discuss investigative records compiled for law
1289 enforcement purposes; or
1290 (7) Specifically relate to the participation in a civil
1291 action or other legal proceeding.
1292 (i) The Interstate Commission shall keep minutes which
1293 shall fully describe all matters discussed in a meeting and
1294 shall provide a full and accurate summary of actions taken,
1295 including record of any roll call votes.
1296 (j) The Interstate Commission shall make its information
1297 and official records, to the extent not otherwise designated in
1298 the Compact or by its rules, available to the public for
1299 inspection.
1300 (k) The Interstate Commission shall establish an executive
1301 committee, which shall include officers, members, and others as
1302 determined by the bylaws. The executive committee shall have the
1303 power to act on behalf of the Interstate Commission, with the
1304 exception of rulemaking, during periods when the Interstate
1305 Commission is not in session. When acting on behalf of the

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1306 Interstate Commission, the executive committee shall oversee the
1307 administration of the Compact including enforcement and
1308 compliance with the provisions of the Compact, its bylaws and
1309 rules, and other such duties as necessary.
1310 (l) The Interstate Commission may establish other
1311 committees for governance and administration of the Compact.
1312
1313 SECTION 12
1314 POWERS AND DUTIES OF THE INTERSTATE COMMISSION
1315
1316 The Interstate Commission shall have the duty and power to:
1317 (a) Oversee and maintain the administration of the Compact;
1318 (b) Promulgate rules which shall be binding to the extent
1319 and in the manner provided for in the Compact;
1320 (c) Issue, upon the request of a member state or member
1321 board, advisory opinions concerning the meaning or
1322 interpretation of the Compact, its bylaws, rules, and actions;
1323 (d) Enforce compliance with Compact provisions, the rules
1324 promulgated by the Interstate Commission, and the bylaws, using
1325 all necessary and proper means, including but not limited to the
1326 use of judicial process;
1327 (e) Establish and appoint committees including, but not
1328 limited to, an executive committee as required by Section 11,
1329 which shall have the power to act on behalf of the Interstate
1330 Commission in carrying out its powers and duties;
1331 (f) Pay, or provide for the payment of the expenses related
1332 to the establishment, organization, and ongoing activities of
1333 the Interstate Commission;
1334 (g) Establish and maintain one or more offices;

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1335 (h) Borrow, accept, hire, or contract for services of
1336 personnel;
1337 (i) Purchase and maintain insurance and bonds;
1338 (j) Employ an executive director who shall have such powers
1339 to employ, select or appoint employees, agents, or consultants,
1340 and to determine their qualifications, define their duties, and
1341 fix their compensation;
1342 (k) Establish personnel policies and programs relating to
1343 conflicts of interest, rates of compensation, and qualifications
1344 of personnel;
1345 (l) Accept donations and grants of money, equipment,
1346 supplies, materials and services, and to receive, utilize, and
1347 dispose of it in a manner consistent with the conflict of
1348 interest policies established by the Interstate Commission;
1349 (m) Lease, purchase, accept contributions or donations of,
1350 or otherwise to own, hold, improve or use, any property, real,
1351 personal, or mixed;
1352 (n) Sell, convey, mortgage, pledge, lease, exchange,
1353 abandon, or otherwise dispose of any property, real, personal,
1354 or mixed;
1355 (o) Establish a budget and make expenditures;
1356 (p) Adopt a seal and bylaws governing the management and
1357 operation of the Interstate Commission;
1358 (q) Report annually to the legislatures and governors of
1359 the member states concerning the activities of the Interstate
1360 Commission during the preceding year. Such reports shall also
1361 include reports of financial audits and any recommendations that
1362 may have been adopted by the Interstate Commission;
1363 (r) Coordinate education, training, and public awareness

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1364 regarding the Compact, its implementation, and its operation;
1365 (s) Maintain records in accordance with the bylaws;
1366 (t) Seek and obtain trademarks, copyrights, and patents;
1367 and
1368 (u) Perform such functions as may be necessary or
1369 appropriate to achieve the purposes of the Compact.
1370
1371 SECTION 13
1372 FINANCE POWERS
1373
1374 (a) The Interstate Commission may levy on and collect an
1375 annual assessment from each member state to cover the cost of
1376 the operations and activities of the Interstate Commission and
1377 its staff. The total assessment, subject to appropriation, must
1378 be sufficient to cover the annual budget approved each year for
1379 which revenue is not provided by other sources. The aggregate
1380 annual assessment amount shall be allocated upon a formula to be
1381 determined by the Interstate Commission, which shall promulgate
1382 a rule binding upon all member states.
1383 (b) The Interstate Commission shall not incur obligations
1384 of any kind prior to securing the funds adequate to meet the
1385 same.
1386 (c) The Interstate Commission shall not pledge the credit
1387 of any of the member states, except by, and with the authority
1388 of, the member state.
1389 (d) The Interstate Commission shall be subject to a yearly
1390 financial audit conducted by a certified or licensed public
1391 accountant and the report of the audit shall be included in the
1392 annual report of the Interstate Commission.

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1393

1394 SECTION 14

1395 ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION

1396

1397 (a) The Interstate Commission shall, by a majority of
1398 Commissioners present and voting, adopt bylaws to govern its
1399 conduct as may be necessary or appropriate to carry out the
1400 purposes of the Compact within twelve (12) months of the first
1401 Interstate Commission meeting.
1402 (b) The Interstate Commission shall elect or appoint
1403 annually from among its Commissioners a chairperson, a vice-
1404 chairperson, and a treasurer, each of whom shall have such
1405 authority and duties as may be specified in the bylaws. The
1406 chairperson, or in the chairperson's absence or disability, the
1407 vice-chairperson, shall preside at all meetings of the
1408 Interstate Commission.
1409 (c) Officers selected in subsection (b) shall serve without
1410 remuneration from the Interstate Commission.
1411 (d) The officers and employees of the Interstate Commission
1412 shall be immune from suit and liability, either personally or in
1413 their official capacity, for a claim for damage to or loss of
1414 property or personal injury or other civil liability caused or
1415 arising out of, or relating to, an actual or alleged act, error,
1416 or omission that occurred, or that such person had a reasonable
1417 basis for believing occurred, within the scope of Interstate
1418 Commission employment, duties, or responsibilities; provided
1419 that such person shall not be protected from suit or liability
1420 for damage, loss, injury, or liability caused by the intentional
1421 or willful and wanton misconduct of such person.

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1422 (1) The liability of the executive director and employees
1423 of the Interstate Commission or representatives of the
1424 Interstate Commission, acting within the scope of such person's
1425 employment or duties for acts, errors, or omissions occurring
1426 within such person's state, may not exceed the limits of
1427 liability set forth under the constitution and laws of that
1428 state for state officials, employees, and agents. The Interstate
1429 Commission is considered to be an instrumentality of the states
1430 for the purposes of any such action. Nothing in this subsection
1431 shall be construed to protect such person from suit or liability
1432 for damage, loss, injury, or liability caused by the intentional
1433 or willful and wanton misconduct of such person.
1434 (2) The Interstate Commission shall defend the executive
1435 director, its employees, and subject to the approval of the
1436 attorney general or other appropriate legal counsel of the
1437 member state represented by an Interstate Commission
1438 representative, shall defend such Interstate Commission
1439 representative in any civil action seeking to impose liability
1440 arising out of an actual or alleged act, error or omission that
1441 occurred within the scope of Interstate Commission employment,
1442 duties or responsibilities, or that the defendant had a
1443 reasonable basis for believing occurred within the scope of
1444 Interstate Commission employment, duties, or responsibilities,
1445 provided that the actual or alleged act, error, or omission did
1446 not result from intentional or willful and wanton misconduct on
1447 the part of such person.
1448 (3) To the extent not covered by the state involved, member
1449 state, or the Interstate Commission, the representatives or
1450 employees of the Interstate Commission shall be held harmless in

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1451 the amount of a settlement or judgment, including attorney's
1452 fees and costs, obtained against such persons arising out of an
1453 actual or alleged act, error, or omission that occurred within
1454 the scope of Interstate Commission employment, duties, or
1455 responsibilities, or that such persons had a reasonable basis
1456 for believing occurred within the scope of Interstate Commission
1457 employment, duties, or responsibilities, provided that the
1458 actual or alleged act, error, or omission did not result from
1459 intentional or willful and wanton misconduct on the part of such
1460 persons.
1461
1462 SECTION 15
1463 RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION
1464
1465 (a) The Interstate Commission shall promulgate reasonable
1466 rules in order to effectively and efficiently achieve the
1467 purposes of the Compact. Notwithstanding the foregoing, in the
1468 event the Interstate Commission exercises its rulemaking
1469 authority in a manner that is beyond the scope of the purposes
1470 of the Compact, or the powers granted hereunder, then such an
1471 action by the Interstate Commission shall be invalid and have no
1472 force or effect.
1473 (b) Rules deemed appropriate for the operations of the
1474 Interstate Commission shall be made pursuant to a rulemaking
1475 process that substantially conforms to the "Model State
1476 Administrative Procedure Act" of 2010, and subsequent amendments
1477 thereto.
1478 (c) Not later than thirty (30) days after a rule is
1479 promulgated, any person may file a petition for judicial review

1480 of the rule in the United States District Court for the District
1481 of Columbia or the federal district where the Interstate
1482 Commission has its principal offices, provided that the filing
1483 of such a petition shall not stay or otherwise prevent the rule
1484 from becoming effective unless the court finds that the
1485 petitioner has a substantial likelihood of success. The court
1486 shall give deference to the actions of the Interstate Commission
1487 consistent with applicable law and shall not find the rule to be
1488 unlawful if the rule represents a reasonable exercise of the
1489 authority granted to the Interstate Commission.
1490
1491 SECTION 16
1492 OVERSIGHT OF INTERSTATE COMPACT
1493
1494 (a) The executive, legislative, and judicial branches of
1495 state government in each member state shall enforce the Compact
1496 and shall take all actions necessary and appropriate to
1497 effectuate the Compact's purposes and intent. The provisions of
1498 the Compact and the rules promulgated hereunder shall have
1499 standing as statutory law but shall not override existing state
1500 authority to regulate the practice of medicine.
1501 (b) All courts shall take judicial notice of the Compact
1502 and the rules in any judicial or administrative proceeding in a
1503 member state pertaining to the subject matter of the Compact
1504 which may affect the powers, responsibilities or actions of the
1505 Interstate Commission.
1506 (c) The Interstate Commission shall be entitled to receive
1507 all service of process in any such proceeding, and shall have
1508 standing to intervene in the proceeding for all purposes.

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1509 Failure to provide service of process to the Interstate
1510 Commission shall render a judgment or order void as to the
1511 Interstate Commission, the Compact, or promulgated rules.
1512
1513 SECTION 17
1514 ENFORCEMENT OF INTERSTATE COMPACT
1515
1516 (a) The Interstate Commission, in the reasonable exercise
1517 of its discretion, shall enforce the provisions and rules of the
1518 Compact.
1519 (b) The Interstate Commission may, by majority vote of the
1520 Commissioners, initiate legal action in the United States
1521 District Court for the District of Columbia, or, at the
1522 discretion of the Interstate Commission, in the federal district
1523 where the Interstate Commission has its principal offices, to
1524 enforce compliance with the provisions of the Compact, and its
1525 promulgated rules and bylaws, against a member state in default.
1526 The relief sought may include both injunctive relief and
1527 damages. In the event judicial enforcement is necessary, the
1528 prevailing party shall be awarded all costs of such litigation
1529 including reasonable attorney's fees.
1530 (c) The remedies herein shall not be the exclusive remedies
1531 of the Interstate Commission. The Interstate Commission may
1532 avail itself of any other remedies available under state law or
1533 the regulation of a profession.
1534
1535 SECTION 18
1536 DEFAULT PROCEDURES
1537

1538 (a) The grounds for default include, but are not limited
1539 to, failure of a member state to perform such obligations or
1540 responsibilities imposed upon it by the Compact, or the rules
1541 and bylaws of the Interstate Commission promulgated under the
1542 Compact.
1543 (b) If the Interstate Commission determines that a member
1544 state has defaulted in the performance of its obligations or
1545 responsibilities under the Compact, or the bylaws or promulgated
1546 rules, the Interstate Commission shall:
1547 (1) Provide written notice to the defaulting state and
1548 other member states, of the nature of the default, the means of
1549 curing the default, and any action taken by the Interstate
1550 Commission. The Interstate Commission shall specify the
1551 conditions by which the defaulting state must cure its default;
1552 and
1553 (2) Provide remedial training and specific technical
1554 assistance regarding the default.
1555 (c) If the defaulting state fails to cure the default, the
1556 defaulting state shall be terminated from the Compact upon an
1557 affirmative vote of a majority of the Commissioners and all
1558 rights, privileges, and benefits conferred by the Compact shall
1559 terminate on the effective date of termination. A cure of the
1560 default does not relieve the offending state of obligations or
1561 liabilities incurred during the period of the default.
1562 (d) Termination of membership in the Compact shall be
1563 imposed only after all other means of securing compliance have
1564 been exhausted. Notice of intent to terminate shall be given by
1565 the Interstate Commission to the governor, the majority and
1566 minority leaders of the defaulting state's legislature, and each

1567 of the member states.

1568 (e) The Interstate Commission shall establish rules and
1569 procedures to address licenses and physicians that are
1570 materially impacted by the termination of a member state, or the
1571 withdrawal of a member state.

1572 (f) The member state which has been terminated is
1573 responsible for all dues, obligations, and liabilities incurred
1574 through the effective date of termination including obligations,
1575 the performance of which extends beyond the effective date of
1576 termination.

1577 (g) The Interstate Commission shall not bear any costs
1578 relating to any state that has been found to be in default or
1579 which has been terminated from the Compact, unless otherwise
1580 mutually agreed upon in writing between the Interstate
1581 Commission and the defaulting state.

1582 (h) The defaulting state may appeal the action of the
1583 Interstate Commission by petitioning the United States District
1584 Court for the District of Columbia or the federal district where
1585 the Interstate Commission has its principal offices. The
1586 prevailing party shall be awarded all costs of such litigation
1587 including reasonable attorney's fees.

1588

1589 SECTION 19

1590 DISPUTE RESOLUTION

1591

1592 (a) The Interstate Commission shall attempt, upon the
1593 request of a member state, to resolve disputes which are subject
1594 to the Compact and which may arise among member states or member
1595 boards.

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1596 (b) The Interstate Commission shall promulgate rules
1597 providing for both mediation and binding dispute resolution as
1598 appropriate.
1599
1600 SECTION 20
1601 MEMBER STATES, EFFECTIVE DATE AND AMENDMENT
1602
1603 (a) Any state is eligible to become a member state of the
1604 Compact.
1605 (b) The Compact shall become effective and binding upon
1606 legislative enactment of the Compact into law by no less than
1607 seven (7) states. Thereafter, it shall become effective and
1608 binding on a state upon enactment of the Compact into law by
1609 that state.
1610 (c) The governors of non-member states, or their designees,
1611 shall be invited to participate in the activities of the
1612 Interstate Commission on a non-voting basis prior to adoption of
1613 the Compact by all states.
1614 (d) The Interstate Commission may propose amendments to the
1615 Compact for enactment by the member states. No amendment shall
1616 become effective and binding upon the Interstate Commission and
1617 the member states unless and until it is enacted into law by
1618 unanimous consent of the member states.
1619
1620 SECTION 21
1621 WITHDRAWAL
1622
1623 (a) Once effective, the Compact shall continue in force and
1624 remain binding upon each and every member state; provided that a

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1625 member state may withdraw from the Compact by specifically
1626 repealing the statute which enacted the Compact into law.
1627 (b) Withdrawal from the Compact shall be by the enactment
1628 of a statute repealing the same, but shall not take effect until
1629 one (1) year after the effective date of such statute and until
1630 written notice of the withdrawal has been given by the
1631 withdrawing state to the governor of each other member state.
1632 (c) The withdrawing state shall immediately notify the
1633 chairperson of the Interstate Commission in writing upon the
1634 introduction of legislation repealing the Compact in the
1635 withdrawing state.
1636 (d) The Interstate Commission shall notify the other member
1637 states of the withdrawing state's intent to withdraw within
1638 sixty (60) days of its receipt of notice provided under
1639 subsection (c).
1640 (e) The withdrawing state is responsible for all dues,
1641 obligations and liabilities incurred through the effective date
1642 of withdrawal, including obligations, the performance of which
1643 extend beyond the effective date of withdrawal.
1644 (f) Reinstatement following withdrawal of a member state
1645 shall occur upon the withdrawing state reenacting the Compact or
1646 upon such later date as determined by the Interstate Commission.
1647 (g) The Interstate Commission is authorized to develop
1648 rules to address the impact of the withdrawal of a member state
1649 on licenses granted in other member states to physicians who
1650 designated the withdrawing member state as the state of
1651 principal license.
1652
1653 SECTION 22

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1654 DISSOLUTION
1655
1656 (a) The Compact shall dissolve effective upon the date of
1657 the withdrawal or default of the member state which reduces the
1658 membership in the Compact to one (1) member state.
1659 (b) Upon the dissolution of the Compact, the Compact
1660 becomes null and void and shall be of no further force or
1661 effect, and the business and affairs of the Interstate
1662 Commission shall be concluded and surplus funds shall be
1663 distributed in accordance with the bylaws.
1664
1665 SECTION 23
1666 SEVERABILITY AND CONSTRUCTION
1667
1668 (a) The provisions of the Compact shall be severable, and
1669 if any phrase, clause, sentence, or provision is deemed
1670 unenforceable, the remaining provisions of the Compact shall be
1671 enforceable.
1672 (b) The provisions of the Compact shall be liberally
1673 construed to effectuate its purposes.
1674 (c) Nothing in the Compact shall be construed to prohibit
1675 the applicability of other interstate compacts to which the
1676 states are members.
1677
1678 SECTION 24
1679 BINDING EFFECT OF COMPACT AND OTHER LAWS
1680
1681 (a) Nothing herein prevents the enforcement of any other
1682 law of a member state that is not inconsistent with the Compact.

1683 (b) All laws in a member state in conflict with the Compact
1684 are superseded to the extent of the conflict.
1685 (c) All lawful actions of the Interstate Commission,
1686 including all rules and bylaws promulgated by the Commission,
1687 are binding upon the member states.
1688 (d) All agreements between the Interstate Commission and
1689 the member states are binding in accordance with their terms.
1690 (e) In the event any provision of the Compact exceeds the
1691 constitutional limits imposed on the legislature of any member
1692 state, such provision shall be ineffective to the extent of the
1693 conflict with the constitutional provision in question in that
1694 member state.
1695 Section 20. Except as otherwise expressly provided in this
1696 act, this act shall take effect July 1, 2019.

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March 15, 2019

Senator Gayle Harrell, Chairwoman
Health Policy Committee
Florida Senate
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Chairwoman Harrell,

On behalf of the Federation of State Medical Boards (FSMB), I would like to express our support for Senate Proposed Bill 7078, specifically the Interstate Medical Licensure Compact.

The FSMB was founded in 1912 and represents all 70 of the state medical and osteopathic regulatory boards in the United States and its territories, including the Florida Board of Medicine and the Florida Board of Osteopathic Medicine. The mission of the FSMB is to support its member boards as they fulfill their statutory mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and other health care professionals.

The Interstate Medical Licensure Compact is a new, alternative pathway for expedited medical licensure that will expand access to care, streamline the licensing process for physicians, and facilitate multi-state practice and telemedicine for those physicians that voluntarily choose to participate, benefiting both physicians and patients in Florida.

Beginning in 2013, the FSMB worked with its member boards and special experts to study the feasibility of an interstate compact model to support medical license portability nationwide, while simultaneously ensuring state regulatory authority in the protection of the public. Throughout the two-year drafting process, input and feedback was received and incorporated from a multitude of stakeholders, including state medical boards, provider organizations, patient advocacy organizations, hospitals and health systems, and the telehealth industry.

Since the final model legislation was released in September 2014, 25 states, the District of Columbia, and Guam have formally enacted the Compact, in addition to being introduced in Florida and six other legislatures this year, including Georgia, Kentucky, New Mexico, North Dakota, Oklahoma, and South Carolina. The Compact is supported nationally by the American Medical Association and the American Osteopathic Association.

The Compact created a Compact Commission that is comprised of two representatives from each member state. This Commission, which has been meeting since October 2015, serves as an administrative clearinghouse of licensing and disciplinary information among participating member states and territories. The Commission, like the FSMB, does not have regulatory control

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over physicians or the practice of medicine. It neither issues licenses nor does it revoke licenses. Its only purpose is to facilitate interstate cooperation and the transfer of information between member states and territories. Regulatory control remains with the respective medical boards. The Compact Commission began processing applications on April 6, 2017. As of January 31, 2019, 2,603 applications have been processed through the IMLC, resulting in 4,873 medical licenses issued, as well as 1,019 medical licenses renewed.

The Interstate Medical Licensure Compact is a testament to the work of medical regulatory boards, physicians, and other key stakeholders to reach consensus in support of a state-based solution that simultaneously expedites state medical license portability while ensuring public protection.

Again, the FSMB supports Senate Proposed Bill 7078 and hopes the Health Policy Committee will look at the long-range benefits that this legislation will have on expanding access to care and streamlining the licensing process for physicians in Florida.

Sincerely,

Lisa A. Robin
Chief Advocacy Officer

cc: Members of the Health Policy Committee

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: SPB 7080

INTRODUCER: Health Policy Committee

SUBJECT: Public Records and Meetings/Interstate Medical Licensure Compact

DATE: March 15, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Brown		**HP Submitted as Comm. Bill/Fav**

I. Summary:

SPB 7080 exempts from public record inspection and copying requirements the personal identifying information of a physician, other than the physician's name, licensure status, or licensure number, obtained from the coordinated information system under the Interstate Medical Licensure Compact (IMLC), as defined in s. 456.4501, F.S.,[1] and held by the Department of Health (DOH) or the Board of Medicine or Board of Osteopathic Medicine (boards). This information is not exempt from public records requirements if the state originally reporting the information to the coordinated information system authorizes disclosure of such information by law.

The bill exempts from public meeting requirements a meeting or a portion of the meeting of the Interstate Medical Licensure Commission established under the IMLC. The exemption applies when matters are specifically exempted from disclosure by state or federal law are discussed. The recordings, minutes, and records generated from those meetings are also exempt from requirements to disclose such public records.

The bill takes effect on the same date that SB 7078 or similar legislation takes effect. SB 7078, the substantive bill authorizing Florida's participation in the IMLC, is effective on July 1, 2019.

The bill provides for the repeal of the exemption on October 2, 2024, unless reviewed and reenacted by the Legislature. It also provides statements of public necessity for the public records and public meetings exemptions as required by the State Constitution.

Because the bill creates a new public records exemption, a two-thirds vote of the members present and voting in each house of the Legislature is required for final passage.

[1] Section 456.4501, F.S., is created in SPB 7078 and establishes the state's participation in the Interstate Medical Licensure Compact and the coordinated information system.

II. Present Situation:

The Florida Constitution provides that the public has the right to access government records and meetings. The public may inspect or copy any record made or received in connection with the official business of any public body, officer, or employee received in connection with the official business of any public body, officer, or employee of the state, or of persons acting on their behalf.[2] The public also has a right to be afforded notice and access to meetings of any collegial public body of the executive branch of state government or of any local government.[3] The Legislature's meetings must also be open and noticed to the public, unless there is an exception provided for by the Constitution.[4]

In addition to the Florida Constitution, the Florida Statutes specify conditions under which public access must be provided to government records and meetings. Chapter 119, F.S., the "Public Records Act" constitutes the main body of public records laws, and states that:

> It is the policy of this state that all state, county, and municipal records are open for personal inspection and copying by any person. Providing access to public records is the duty of each agency.[5]

According to the Public Records Act, a public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[6] A violation of the Public Records Act may result in civil or criminal liability.[7]

Section 286.011, F.S., the "Sunshine Law,"[8] requires all meetings of any board or commission or local agency or authority at which official acts are to be taken to be noticed and open to the public.[9]

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[2] FLA. CONST. art. 1, s. 24(a).
[3] FLA. CONST. art. 1, s. 24(b).
[4] FLA. CONST. art. 1, s. 24(b).
[5] Chapter 119, F.S.
[6] Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of their physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purpose of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency." The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes,* 595 So. 2d 32 (Fla. 1992). The Legislature's records are public pursuant to s. 11.0431, F.S.
[7] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are penalties for violations of those laws.
[8] *Board of Public Instruction of Broward County v. Doran,* 224 So. 2d 693, 695 (Fla. 1969).
[9] Section 286.011(1)-(2), F.S. The Sunshine Law does not apply to the Legislature; rather, open meetings requirements for the Legislature are set out in the Florida Constitution. Article III, s. 4(e) of the Florida Constitution provides the legislative committee meetings must be open and noticed to the public. In addition, prearranged gatherings, between more than two members of the Legislature, or between the Governor, the President of the Senate, or the Speaker of the House of Representatives, the purpose of which is to agree upon or to take formal legislative action, must be reasonable open to the public.

The Legislature may, by two-thirds votes of the House and the Senate[10] create an exemption to public records or open meetings requirements.[11] An exemption must explicitly state the public necessity of the exemption[12] and must be tailored to accomplish the stated purpose of the law.[13] A statutory exemption which does not meet these two criteria may be found unconstitutional, and efforts may not be made by the court to preserve the exemption.[14]

Open Government Sunset Review Act

In addition to the constitutional requirements relating to the enactment of a public records exemption, the Legislature may subject the new or broadened exemption to the Open Government Sunset Review Act (OGSR Act).

The OGSR Act prescribes a legislative review process for newly created or substantially amended public records exemptions.[15] The OGSR Act provides that an exemption automatically repeals on October 2nd of the fifth year after creation or substantial amendment. In order to save an exemption from repeal, the Legislature must reenact the exemption.[16] In practice, many exemptions are continued by repealing the sunset date rather than reenacting the exemption.

Under the OGSR Act, the purpose and necessity of reenacting the exemption are reviewed. The Legislature must consider the following questions during its review of an exemption:[17]

- What specific records or meetings are affected by the exemption?
- Who does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?

[10] FLA. CONST. art. I, s. 24(c).
[11] FLA. CONST. art. I, s. 24(c). There is a difference between records the Legislature designates as exempt from public records requirements and those the Legislature designates as *confidential* and exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances. *Williams v. City of Minneola,* 575 So.2d 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential, such record may not be released to anyone other than the persons or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole,* 874 So.2d 48 (Fla. 5th DCA 2004).
[12] FLA. CONST. art. I, s. 24(c).
[13] FLA. CONST. art. I, s. 24(c).
[14] *Halifax Hosp. Medical Center v. News-Journal Corp.,* 724 So.2d 567 (Fla. 1999). In *Halifax Hospital,* the Florida Supreme Court found that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption. In *Baker County Press, Inc. v. Baker County Medical Services, Inc.,* 870 So. 2d 189 (Fla. 1st DCA 2004), the court found that the intent of a statute was to create a public records exemption. The *Baker County Press* court found that since the law did not contain a public necessity statement, it was unconstitutional.
[15] Section 119.15, F.S. According to s. 119.15(4)(b), F.S., a substantially amended exemption is one that is expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System pursuant to s. 119.15(2), F.S. The OGSR process is currently being followed; however, the Legislature is not required to continue to do so. The Florida Supreme Court has found that one Legislature cannot bind a future Legislature. *Scott v. Williams*, 107 So. 3d 379 (Fla. 2013).
[16] Section 119.15(3), F.S.
[17] Section 119.15(6)(a), F.S.

- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

If the Legislature expands an exemption, then a public necessity statement and a two-thirds vote for passage are required.[18] If the exemption is reenacted without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are not required. If the Legislature allows an exemption to sunset, the previously exempt records will remain exempt unless otherwise provided for by law.[19]

Practitioner Profiles

Pursuant to s. 456.041, F.S., the DOH operates a database of Florida's health care practitioners, which includes physicians. The practitioner profile database is online and searchable.[20] The profile may include information that is public record and relates to the practitioner's profession.[21] Practitioners and the DOH are required to update profiles.[22] Information exempt from public disclosure and submitted by another governmental entity that the DOH uses for practitioner profiles continues to maintain its exempt status.[23]

Interstate Medical Licensure Compact and Commission

The Interstate Medical Licensure Compact (IMLC) provides an expedited pathway for medical and osteopathic physicians to qualify to practice medicine across state lines within a licensure compact. Currently, 24 states and one territory which cover 31 medical and osteopathic boards participate in the IMLC, and, as of February 2019, six other states have active legislation to join the IMLC.[24, 25]

Approximately 80 percent of physicians meet the eligibility guidelines for licensure through the Compact.[26] The providers' applications are expedited by using the information previously submitted in their state of principal licensure (SPL). The physician can then seek expedited licensure in member states after a fresh background check is completed.

Interstate Medical Licensure Commission

The Interstate Commission is created in Section 11 of the IMLC and serves as the administrative arm of the IMLC and the member states. Each member state has two voting representatives on the Commission and, if the state has separate regulatory boards for allopathic and osteopathic, then the representation is split between the two boards.[27]

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[18] FLA. CONST. art. I, s. 24(c).
[19] Section 119.15(7), F.S.
[20] Section 456.041(8), F.S.; Department of Health Practitioner Profile Search, https://appsmqa.doh.state.fl.us/MQASearchServices/HealthCareProviders/PractitionerProfileSearch (last visited Mar. 12, 2019).
[21] Section 456.041(7), F.S.
[22] Section 456.042, F.S.
[23] Section 456.046, F.S.
[24] Interstate Medical Licensure Compact, *The IMLC,* https://imlcc.org/ (last visited Mar. 8, 2019).
[25] Interstate Medical Licensure Compact, Draft Executive Committee Meeting Minutes (February 5, 2019), https://imlcc.org/wp-content/uploads/2019/02/2019-IMLC-Executive-Committee-Minutes-February-5-2019-DRAFT.pdf (last visited Mar. 8, 2019).
[26] Interstate Medical Licensure Compact, *The IMLC,* https://imlcc.org/ (last visited Mar. 7, 2019).
[27] Interstate Medical Licensure Compact, Section 11, (d), p. 11, https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf (last visited Mar. 8, 2019).

The Commission meets at least once per calendar year in a publicly noticed meeting. The Compact also creates an Executive Committee which may act on behalf of the Commission, with the exception of rulemaking. Information, rules, and minutes of the Commission and the Committee, with the exception of those areas that may be closed to the public, are available to the public for inspection.[28]

All or a portion of a Commission meeting may be closed to the public if a topic is likely to involve certain matters, based on a two-thirds vote of those Commission members present at the meeting. The areas covered by a closed meeting are:

- Personnel matters;
- Matters specifically exempted from disclosure by federal law;
- Trade secrets, commercial, or financial information that is privileged or confidential;
- Information that involves accusing a person of a crime or that formally censures a person;
- Information of a personal nature where disclosure would clearly constitute an unwarranted invasion of personal privacy;
- Investigative records compiled for law enforcement purposes; or,
- Information that specifically relates to the Commission's participation in a civil action or other legal proceeding. [29]

III. Effect of Proposed Changes:

Section 1 creates s. 456.4502, F.S., to make a physician's personal identifying information, other than the physician's name, licensure status, or licensure number, obtained from the IMLC's coordinated information system, as defined in s. 456.4501, F.S., and held by the DOH or the boards exempt from public disclosure under s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. The personal identifying information is exempt from public disclosure unless the state that originally reported the information to the coordinated information system authorizes the disclosure of such information. Under such circumstances, the information may only be disclosed to the extent permitted by the reporting state's law.

The bill also creates an exemption from s. 286.011, F.S., and s. 24(b), Art. I of the State Constitution for a meeting or any portion of a meeting of the IMLC Commission during which any matters specifically exempted from disclosure by federal or state statute are discussed. Discussion of the following additional matters may result in a closed meeting on a two-thirds vote of the Commission members present at the meeting:

- Personnel matters;
- Trade secrets, commercial, or financial information that is privileged or confidential;
- Information that involves accusing a person of a crime or that formally censures a person;
- Information of a personal nature where disclosure would clearly constitute an unwarranted invasion of personal privacy;
- Investigative records compiled for law enforcement purposes; or,
- Information that specifically relates to the Commission's participation in a civil action or other legal proceeding.

[28] Interstate Medical Licensure Compact, Section 11(d), pg. 13, https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf (last visited Mar. 8, 2019).
[29] *See Interstate Medical Licensure Compact,* Section 11(h), pp. 12-13, https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf (last visited Mar. 8, 2019).

Recordings, minutes, and records generated during an exempt meeting are exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

These exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2024, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2 provides, as required by the State Constitution, a statement of public necessity which states that protection of the specified information is required under the IMLC which the state must adopt in order to become a member state to the IMLC. Without the public records exemption, the state would be unable to effectively and efficiently function as a member of the compact.

Additionally, the bill provides a statement of public necessity, as required by the State Constitution, for protecting any meeting or portion of a meeting of the Commission at which matters specifically exempted from disclosure by federal or state statute are discussed. These meetings or portions of meetings would be exempted from s. 286.011, F.S., and s. 24(b), Art. I. of the State Constitution. Without the public meeting exemption, the state will be prohibited from becoming a party to the compact.

The bill includes a statement of public necessity by the Legislature that the recordings, minutes, and records generated during an exempt meeting of the Commission are exempt pursuant to s. 464.0096, F.S., and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. Release of such information would negate the public meeting exemption.

Section 3 provides that the bill shall take effect on the same date as SB 7078 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Public Records

SPB 7080 provides that personal identifying information obtained from the coordinated information system of the physician's home state may only be disclosed to the extent permitted by the home state's laws.

Public Meetings

Under the compact, SPB 7080 provides that Commission meetings must be open to the public, and the public provided at least 10 days' notice of such meeting. For proposed

rules, notice of rulemaking should follow the model state administrative procedure act of 2010 and the public should have access to a copy of the proposed draft rule and notice of the hearing at least prior 30 days prior to each public hearing.[30] The public must also be provided a reasonable opportunity for public comment, orally or in writing, for proposed rules.

The Commission is required to keep minutes of these closed sessions that fully describe all matters discussed. The Commission is not required to provide an accurate summary of actions taken or to provide any type of report once litigation has concluded. All minutes and documents of a closed meeting shall remain under seal according to the IMLC's provisions.

Vote Requirement

Article I, Section 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public records or public meeting exemption. This bill creates a public records exemption for information obtained from the coordinated information system, and held by the DOH or the boards; therefore, it requires a two-thirds vote.

Public Necessity Statement

Article I, Section 24(c) of the State Constitution requires a public necessity statement for a newly created or expanded public records or public meeting exemption. This bill creates a new public records exemption and includes a public necessity statement that supports the exemption. The exemption is no broader than necessary to accomplish the stated purpose.

Breadth of the Exemption

It is not clear if the public records exemption is broader than necessary to accomplish the purposes outlined in the public necessity statement. The exemption covers personal identifying information (excluding a physician's name, licensure status and license number) that is otherwise exempt in the physician's home state. In the context of the compact, it is not clear what information would be considered "personal identifying information" for purposes of this exemption. Personal identifying information is used throughout Florida statutes, but it may have a different meaning in other states. For example, it is not clear if a state would consider a physician's business address, certifications, or level of education to be personal identifying information. State laws are also subject to change, so it is not clear if this exemption is limited to state laws as currently enacted or in the future. Therefore, the breadth of the exemption is subject to change depending on when or how the DOH and the boards interpret the laws of the physician's home state.

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[30] Interstate Medical Licensure Compact Commission, *Rule on Rulemaking,* (adopted June 24, 2016) https://imlcc.org/wp-content/uploads/2018/02/IMLCC-Rule-Chapter-1-Rule-on-Rulemaking-Adopted-June-24-2016.pdf (last visited Mar. 12, 2019).

It is also unclear if the public meetings exemption is broader than necessary to accomplish the purposes outlined in the public necessity statement. SPB 7078 provides instances during which a public meeting may be closed. Some of those matters are already exempted under Florida's public meetings exemptions.[31] In addition, SPB 7078 provides that the Commission has the authority to vote on when it will close a meeting, so it is not clear exactly which meetings or portions of meetings will be closed. It is unclear if giving the Commission the authority to vote on when it will close its meetings would be considered an overly broad exemption. Finally, one reason the Commission may close a meeting is to protect someone's personal privacy. This may conflict with Article 1, section 23, of the Florida Constitution which provides:

> Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law.

Courts will look to the Legislature to balance these competing interests.[32]

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

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[31] Meetings with attorneys on pending litigation are exempt under s. 286.011(8), F.S. Competitive solicitations team meetings and some negotiations are exempt under s. 286.0113(2), F.S. Meetings to determine if there is probable cause to find that a practitioner is subject to discipline are closed until 10 days after probable cause has been found pursuant to s. 456.073(4), F.S. These exemptions are provided as examples and not an exhaustive list of relevant public meetings exemptions.

[32] *See Campus Communications, Inc. v. Earnhardt*, 821 So. 2d 388, 402-403 (Fla. 5th DCA 2002) ("Thus our function here has not been to weigh these two constitutional rights with respect to autopsy photographs and determine whether the right that helps ensure an open government freely accessible by every citizen is more significant or profound than the right that preserves individual liberty and privacy. Rather, our function has been to determine whether the Legislature has declared that the latter prevails over the former in a manner that is consistent with the constitutional provisions that bestow upon it the power to do so."); *see also Wallace v. Guzman*, 687 So. 2d 1351, 1354 (Fla. 3d DCA 1997) (noting "[t]he [L]egislature has balanced the private/public rights by creating the various exemptions from public disclosure contained in section 119.07, Florida Statutes (1995).").

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 456.4502 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

FOR CONSIDERATION By the Committee on Health Policy

588-02979A-19 20197080pb

1 A bill to be entitled
2 An act relating to public records and meetings;
3 creating s. 456.4502; providing an exemption from
4 public records requirements for certain information
5 held by the Department of Health, the Board of
6 Medicine, or the Board of Osteopathic Medicine
7 pursuant to the Interstate Medical Licensure Compact;
8 providing an exemption from public meeting
9 requirements for certain meetings of the Interstate
10 Medical Licensure Commission; providing an exemption
11 from public records requirements for recordings,
12 minutes, and records generated during the closed
13 portions of such meetings; providing for future
14 legislative review and repeal of the exemptions;
15 providing a statement of public necessity; providing a
16 contingent effective date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19
20 Section 1. Section 456.4502, Florida Statutes, is created
21 to read:
22 456.4502 Interstate Medical Licensure Compact; public
23 records and meetings exemptions.—
24 (1) A physician's identifying information, other than the
25 physician's name, licensure status, or licensure number,
26 obtained from the coordinated information system in Section 8 of
27 the Interstate Medical Licensure Compact and held by the
28 department or the board is exempt from s. 119.07(1) and s.
29 24(a), Art. I of the State Constitution, unless the state that

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

30 originally reported the information to the coordinated
31 information system authorizes the disclosure of such information
32 by law. If disclosure is so authorized, information may be
33 disclosed only to the extent authorized by law by the reporting
34 state.
35 (2)(a) Under Section 11 of the Interstate Medical Licensure
36 Compact, a meeting or a portion of a meeting of the Interstate
37 Medical Licensure Compact Commission established may be closed
38 if it has been determined by a two-thirds vote of commissioners
39 who are present that an open meeting would likely:
40 1. Relate solely to the internal personnel practices and
41 procedures of the commission;
42 2. Discuss matters specifically exempted from disclosure by
43 federal statute;
44 3. Discuss trade secrets or commercial or financial
45 information that is privileged or confidential;
46 4. Involve accusing a person of a crime, or formally
47 censuring a person;
48 5. Discuss information of a personal nature, if disclosure
49 would constitute a clearly unwarranted invasion of personal
50 privacy;
51 6. Discuss investigative records compiled for law
52 enforcement purposes; or
53 7. Relate specifically to participation in a civil action
54 or another legal proceeding.
55 (b) In keeping with the intent of Interstate Medical
56 Licensure Compact, recordings, minutes, and records generated
57 during an exempt proceeding are exempt in accordance with s.
58 119.07(1) and s. 24(a), Art. I of the State Constitution.

59 (3) This section is subject to the Open Government Sunset
60 Review Act in accordance with s. 119.15 and shall stand repealed
61 on October 2, 2024, unless reviewed and saved from repeal
62 through reenactment by the Legislature.
63 Section 2. (1) The Legislature finds that it is a public
64 necessity that a physician's personal identifying information,
65 other than the physician's name, licensure status, or licensure
66 number, obtained from the coordinated information system, as
67 defined in Section 5 of the Interstate Medical Licensure
68 Compact, as enacted in this state by s. 456.4501, Florida
69 Statutes, and held by the Department of Health and the
70 regulatory boards of the respective professions be exempt from
71 s. 119.07(1), Florida Statutes and s. 24, Article I of the State
72 Constitution. Protection of such personal identifying
73 information is required under the Interstate Medical Licensure
74 Compact, which this state must adopt in order to become a member
75 state and a party to the compact. Without the public records
76 agreement, this state will be unable to effectively and
77 efficiently implement and administer the Interstate Medical
78 Licensure Compact.
79 (2)(a) The Legislature finds that it is a public necessity
80 that any meeting of the Interstate Medical Licensure Compact
81 Commission held as provided in that section in which matters
82 specifically exempted from disclosure by federal or state law
83 are discussed be made exempt from s. 286.011, Florida Statutes,
84 and s. 24(b), Article I of the State Constitution.
85 (b) The Interstate Medical Licensure Compact requires the
86 closure of any meeting, or any portion of a meeting, of the
87 Interstate Medical Licensure Compact Commission if two-thirds of

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

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88 the Commission members determine that certain sensitive and
89 confidential subject matters may arise during the meeting and
90 that the meeting should be closed to the public. In the absence
91 of a public meeting exemption, this state would be prohibited
92 from becoming a member state of the compact.
93 (3) The Legislature also finds that it is a public
94 necessity that the recordings, minutes, and records generated
95 during a meeting that is exempt pursuant to s. 456.4502, Florida
96 Statutes, and s. 24 of the State Constitution. Release of such
97 information would negate the value of the public meeting
98 exemption. As such, the Legislature finds that the public
99 records exemption is a public necessity.
100 Section 3. This act shall take effect on the same date that
101 SB 7078 or similar legislation takes effect, if such legislation
102 is adopted in the same legislative session or an extension
103 thereof and becomes a law.

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

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 3/18/2019 1:32:09 PM
Ends: 3/18/2019 2:48:39 PM Length: 01:16:31

1:32:08 PM Meeting called to order
1:32:24 PM Chair comments
1:32:34 PM Roll Call- Quorum is present
1:32:55 PM Chair
1:33:16 PM Senator Rouson
1:33:38 PM Chair
1:34:14 PM Tab 5 - SPB 7078 by Senator Harrell - Health Care
1:34:22 PM Vice Chair Berman in chair
1:34:29 PM Senator Harrell
1:42:40 PM Chair
1:43:40 PM Questions on bill?
1:43:45 PM Senator Cruz
1:44:28 PM Senator Harrell
1:44:55 PM Chair
1:45:56 PM Senator Cruz
1:46:05 PM Senator Harrell
1:46:26 PM Senator Cruz
1:47:25 PM Senator Harrell
1:48:00 PM Senator Cruz
1:48:15 PM Senator Harrell
1:48:35 PM Senator Cruz
1:48:57 PM Senator Harrell
1:50:14 PM Senator Cruz
1:50:21 PM Senator Harrell
1:51:47 PM Senator Cruz
1:51:54 PM Senator Harrell
1:52:26 PM Senator Cruz
1:52:31 PM Senator Harrell
1:53:11 PM Chair
1:53:22 PM Amendment 636166 by Senator Harrell
1:54:35 PM Chair
1:55:34 PM Questions on amendment? None
1:55:42 PM Cynthia Henderson, CIOX, Inc. for information only
1:55:50 PM Debate on amendment
1:55:57 PM Senator Harrell waives close
1:56:03 PM Amendment 636166 is adopted
1:56:07 PM Back on bill as amended
1:56:18 PM Chair
1:56:36 PM Senator Harrell
1:57:13 PM Chair
1:57:18 PM Senator Harrell
1:57:40 PM Chair
1:57:46 PM Senator Harrell
1:57:58 PM Chair
1:58:19 PM Appearance cards on proposed bill
1:58:48 PM Stephen Winn, Exec. Director, Florida Osteopathic Medical Association waives in support
1:58:53 PM Dorene Barker, Associate State Director, AARP, Florida waives in support
1:59:00 PM Jeff Scott, Florida Medical Association, waives in support
1:59:07 PM Wayne Smith, Director, Gov. Relations - Mayo Clinic, speaking in support
1:59:56 PM Cynthia Henderson, for information only
2:00:02 PM Debate?
2:00:08 PM Senator Harrell SPB 7078 be submitted as a Committee Bill

2:00:34 PM Senator Harrell
2:01:08 PM Chair
2:01:14 PM Roll Call - SPB 7078 -Favorable as Committee Bill
2:01:46 PM Tab 6 - SPB 7080 by Health Policy presented by Senator Harrell, Public Records and Meetings/Interstate Medical
2:02:50 PM Questions? None
2:03:50 PM Appearance Cards? None
2:03:53 PM Debate? None
2:03:54 PM Senate Harrell moves that SPB 7080 be submitted as a committee bill
2:04:07 PM Senator Harrell waives close
2:04:13 PM Roll Call - SPB 7080 Favorable as a Committee Bill
2:04:21 PM Senator Harrell back in Chair
2:04:38 PM Tab 1 - SB 1658 by Senator Simpson, Statewide Task Force on Opiod Abuse
2:04:59 PM Questions? None
2:05:35 PM Appearance Cards?
2:05:39 PM Devon West, Legislative Policy Advisor, Broward County, waives in support
2:05:46 PM Chief Gary Hester, Government Affairs, The Florida Police Chiefs Association, waive in support
2:06:01 PM Bill Cervone, State Attorney, 8th Circuit, Florida Prosecuting Attorney's Association, waives in support
2:06:11 PM Lauren Jackson, lobbyist, Seminole County Sherriff, waives in support
2:06:18 PM Jess McCarty, Assistant County Attorney, Miami-Dade County, waives in support
2:06:24 PM Rebecca DeLorasa, Director of Legislative Affairs, Palm Beach County, waives in support
2:06:32 PM Libby Guzzo, Legislative Affairs. Attorney General, waives in support
2:06:40 PM Ron Dizaa, Director of External Affairs, FDLE, waives in support
2:06:51 PM Angela Drezewicki, Florida Sheriff's Association, waives in support
2:07:00 PM Michael Jackson, Executive Vice President and CEO, Florida Pharmacy Association, waives in support
2:07:10 PM Debate?
2:07:14 PM Senator Cruz
2:07:30 PM Senator Berman
2:08:24 PM Debate?
2:09:14 PM Senator Rouson
2:10:37 PM Further debate? None
2:10:42 PM Senator Simpson waives close
2:10:49 PM Roll Call SB 1658 - Favorable
2:11:14 PM Tab 2 - SB 1460 by Senator Book - Stroke Centers
2:12:04 PM Chair
2:12:12 PM Amendment 425468 by Senator Book
2:12:20 PM Objections? None
2:12:26 PM Senator Book to explain amendment
2:12:39 PM Questions? None
2:12:42 PM Appearance Cards? None
2:12:49 PM Debate? None
2:12:53 PM Senator Book waives close
2:12:59 PM Amendment 425468 is passed
2:13:05 PM Questions on Bill as amended
2:13:11 PM Carl Shank, Fire Chief Projects, St. Augustine, speaking in support
2:15:59 PM Chair
2:17:02 PM Kelly Mallette. Society of Neurointerventional Surgery, waives in support
2:17:10 PM Mark Landreth, Government Relations Director, American Heart Association, waives in support
2:17:17 PM Debate? None
2:17:31 PM Senator Book waives close
2:17:37 PM Roll Call SB 1460 - Favorable
2:17:49 PM Chair
2:18:04 PM Tab 3 -SB 1614 by Senator Baxley, Lakes and Pools
2:19:08 PM Questions?
2:19:23 PM Senator Berman
2:19:40 PM Senator Baxley
2:20:13 PM Questions?
2:20:19 PM Senator Cruz
2:20:29 PM Senator Baxley
2:20:58 PM Senator Cruz
2:21:01 PM Senator Baxley
2:21:28 PM Senator Cruz

2:21:47 PM	Senator Baxley
2:21:53 PM	Senator Cruz
2:22:08 PM	Senator Baxley
2:22:17 PM	Chair
2:22:19 PM	Questions? None
2:22:23 PM	Appearance? None
2:22:27 PM	Debate?
2:22:33 PM	Senator Hooper
2:23:31 PM	Senator Cruz a question
2:23:58 PM	Senator Hooper
2:24:45 PM	Chair
2:25:00 PM	Debate? None
2:25:04 PM	Senator Baxley to close
2:25:43 PM	Chair
2:25:45 PM	Roll Call SB 1614 - Favorable
2:26:07 PM	Chair
2:26:10 PM	Tab 4 - SB 1712 by Senator Harrell - Hospital Licensure
2:26:35 PM	Vice Chair Berman in chair
2:26:44 PM	Senator Harrell to explain bill
2:31:28 PM	Amendment 820832 by Senator Harrell
2:32:42 PM	Questions on amendment? None
2:33:43 PM	Appearance Cards? None
2:33:44 PM	Debate on amendment? None
2:33:46 PM	Senator Harrell waives close
2:33:53 PM	Amendment 820832 is adopted
2:34:03 PM	Amendment 780192 by Senator Harrell
2:34:33 PM	Questions on amendment? None
2:34:35 PM	Appearance Cards on amendment? None
2:34:37 PM	Debate on amendment? None
2:34:39 PM	Senator Harrell waives close
2:34:45 PM	Amendment 780192 is adopted
2:34:54 PM	Amendment 520418 by Senator Harrell
2:35:06 PM	Chair
2:35:50 PM	Questions on amendment? None
2:35:51 PM	Appearance Cards on amendment? None
2:35:53 PM	Debate on amendment? None
2:35:55 PM	Senator Harrell waives close
2:36:00 PM	Amendment 520418 is adopted
2:36:06 PM	Back on bill as amended
2:36:11 PM	Questions? None.
2:36:14 PM	Appearance Cards?
2:36:20 PM	Phillip Sudereman Policy Director, Americans for Prosperity, speaking in support
2:38:01 PM	Dr. Rish Templin, Florida AFL-CIO, speaking against the bill
2:40:44 PM	Kyle Gawroriski, Plant City, representing self, waive in opposition
2:41:43 PM	Helen Hamel, Teacher, Summerfield, FL, representing self, waive in opposition
2:41:47 PM	Tyler Avery, Teacher, Ocala, FL, representing self, waive in opposition
2:41:54 PM	Robert Bullock, Ocala, FL, representing self, waive in opposition
2:42:04 PM	Mitchel Estupirian, Senior Electronic Associate, Ocala, representing self, waive in opposition
2:42:07 PM	Anthony Cantu, Tampa, representing self, waive in opposition
2:42:20 PM	Kimberly Smith, Lithia, FL, representing self, waive in opposition
2:42:26 PM	Marsha Beasley, Riverview, FL., representing self, waive in opposition
2:42:36 PM	Stephen Simon, Spring Hill, FL, representing self, waive in opposition
2:42:40 PM	Ferraro Jacobs, Tampa, FL, representing self, waive in opposition
2:42:45 PM	Melissa Braswell, Seffner, FL, representing self, waive in opposition
2:42:50 PM	Phyllis Oeters, VP Governmental Relations, Baptist Health, information
2:44:05 PM	Sheila Price, AFSCME 1363, waives in opposition
2:44:07 PM	Bruce Martin, AFSCME 1363, waives in opposition
2:44:09 PM	Amy Datz, Retired Scientist, representing former and future patients, waive in opposition
2:44:20 PM	Jim Junecko, Business agent, St. Petersburg, FL, representing self, waive in opposition
2:44:27 PM	Michael Williams, business operator, Miami Gardens, representing self, waive in opposition
2:44:32 PM	Alfred Tumin, Altamonte Springs, representing self, waive in opposition
2:44:38 PM	Christopher Maloy, Ocala, FL, representing self, waive in opposition

2:44:42 PM Jeffery Townsley, Business operator, Miami, representing self, waive in opposition
2:44:46 PM Shawntrel Jackson, Business operator, Miami, representing self, waive in opposition
2:44:53 PM Joseph D'Elia, business owner, Transport Workers Union Local 291, Miami, waives in opposition
2:44:57 PM Grida Patenaude, teacher, St. Petersburg, representing self, waive in opposition
2:45:10 PM Marcus L. Dixon, Political Director, SEIU Florida, waives in opposition
2:45:21 PM Debate?
2:45:27 PM Senator Harrell to close
2:47:41 PM Senator Harrell Temporarily Postpone SB 1712
2:47:51 PM Chair - Show SB 1712 as TP'd
2:47:59 PM Senator Harrell is back in chair
2:48:09 PM Any votes that members would like to report?
2:48:17 PM
2:48:18 PM Any other business?
2:48:21 PM Senator Diaz moves we adjourn. Is there objection? Seeing none, show the motion adopted. We are adjourned