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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH REGULATION
ANALYSIS

BILL #: HB 1217 (PCB HR 02-01)

RELATING TO: Health Regulation/Medical Quality Assurance Trust Fund Cost Savings

SPONSOR(S): Committee on Health Regulation, Representative Farkas, and others

TIED BILL(S): None.

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH REGULATION YEAS 10 NAYS 0
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I. SUMMARY:

This bill relates to the regulation of health care practitioners and the cost of such regulation . Most of the issues contained in this bill are derived from several reports by the Auditor General, the Office of Program Policy Analysis and Government Accountability (OPPAGA), and an interim report by the staff of the Committee on Health Regulation. This bill has a positive fiscal impact of $18.4 million.

Specifically, this bill:

- Consolidates the enforcement component of practitioner regulation with the licensure and examination component by transferring the records, personnel, and funds for this component from the Agency for Health Care Administration (AHCA) to the Department of Health (DOH);
- Changes certain time requirements and billing requirements relating to formal hearings before the Division of Administrative Hearings (DOAH) and requires joint study;
- Requires certain co-payments by impaired health care practitioners of a portion of the costs of being in the impaired practitioner programs under certain circumstances;
- Repeals the Standardized Credentialing for Health Care Practitioners Program (CoreSTAT);
- Eliminates state-inspection alternative to national accreditation of office surgery settings;
- Provides permissive authority to privatize particular regulatory functions;
- Requires objective performance measures of all regulatory functions;
- Provides that committees of boards meet via conference call or other electronic means unless the meeting is held concurrently with or on the day before or after an in-person board meeting;
- Provides for a standardized licensure application submission and verification process for allopathic and osteopathic physicians through the Federation of State Medical Boards;
- Eliminates automatic DOH review and prosecution of certain closed malpractice claims;
- Requires practitioners to pay the costs of investigation and prosecution in a case where probable cause exists but is otherwise closed with a letter of guidance in lieu of prosecution;
- Directs OPPAGA to study the investigative field office structure and organization of AHCA;
- Eliminates certain renewal fee adjustment caps imposed during 2001;
- Prohibits cadaveric organ and tissue procurement organizations from pooling cells or tissue;
- Sets fees at a certain level and provides for annual adjustment of fee cap in annual reviser's bill;
- Amends radiation control and respiratory care regulations; and
- Requires electronic applications and continuing education tracking by July 1, 2003.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes [x]	No []	N/A []
2.	Lower Taxes	Yes [x]	No []	N/A []
3.	Individual Freedom	Yes [x]	No []	N/A []
4.	Personal Responsibility	Yes [x]	No []	N/A []
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

This bill eliminates one government program, consolidates another, and provides for privatization under certain circumstances. It holds the individuals served by the program responsible for the cost of the program, instead of relying on others to pay the costs for them. The bill allows practitioners and health care entities the freedom to use private credentials verification programs instead of the state standardized credentialing program (CoreSTAT).

B. PRESENT SITUATION:

Auditor General Reports:

In November 2000, the Auditor General (AG) released Operational Audit Report No. 01-063 regarding the Division of Medical Quality Assurance (MQA) within the Department of Health. Among its findings, the AG found that the Medical Quality Assurance Trust Fund (MQATF) cash balance had declined 33% over the past two fiscal years (FYs 98-99 and 99-00). The AG warned that "should the revenue and expenditure patterns of the past two years continue, the MQATF may eventually fail to support the MQA function."

The AG also found that a significant portion of the MQATF ($22 million) was used to pay for the enforcement component of practitioner regulation which was handled under contract by the Agency for Health Care Administration (AHCA). The report noted that AHCA's indirect costs for handling the enforcement functions were $2.4 million, or 10.9% of the total costs. The AG found that this was contrary to the provisions of s. 216.346, F.S., which specifies that in any contract between state agencies, no more than 5% of the total cost of the contract shall be charged for overhead or indirect costs. The AG found that analyzing the feasibility of maintaining the entire MQA function within one department could provide information needed to determine the operating structure that is in the best interest of the state.

The 2001 Legislature directed the Auditor General to conduct a follow-up audit and provide a report to the Legislature by January 31, 2002. On December 19, 2001, the AG provided a list of preliminary and tentative audit findings and recommendations to the Department of Health. Pursuant to s. 11.45(4)(d), F.S., the Department of Health has 30 days to submit a written response.

On January 8, 2002, the AG released a "Legislative Briefing" of their preliminary and tentative findings pending receipt of the department response. In that "Legislative Briefing," the AG states that their "audit disclosed that the Department generally took actions to implement the

recommendations of audit report No. 01-063." The AG also noted that there were other areas that needed to be addressed.

The AG made numerous findings and recommendations, including the following which relate to the proposed committee bill:

Fees:

- License renewal fees are not sufficient to generate revenue to cover the costs of regulating most health care professions.
- Renewal fees for 25 of 29 professions are not sufficient to cover projected board expenses for the biennial period ending 2003. Shortfalls for the 25 professions totaled $45.8 million and ranged from $20,000 to $21 million.
- For the FY 00-01, total costs charged to the MQATF were reduced by $12.4 million (20%) from the prior fiscal year.
- The fee caps and the limit on increasing fees no more than 10% each biennial period impede raising fees sufficiently to cover costs.
- The Division and Boards should continue to analyze and pursue cost savings where feasible.
- The Legislature should consider removing or modifying statutory fee caps and limits on fee increases.
- The Boards should use all measures available to alleviate, at least partially, deficit account balances, including assessing one-time fees and transferring available balances from unlicensed activity.
- The allocation of division administrative costs is generally equitable.
- Of the $16.5 million the AHCA billed the Department of Health during FY 00-01, $1.6 million (9.9%) was for administrative costs.

CoreSTAT/Standardized Credentialing:

- The annual operating costs of the DOH credentials collection program (CoreSTAT) contribute to the decline of the MQATF without providing intended benefits.
- CoreSTAT did not eliminate duplication in the verification of core credentials and resulted in health care providers paying fees for benefits not received.
- CoreSTAT user fees charged by the department are not sufficient to recoup the costs of developing or operating CoreSTAT.
- Operating costs for CoreSTAT are estimated to be $2.1 million annually.
- The Legislature should consider removing the statutory requirements for maintaining a credentials collection program.

Electronic Tracking of Licensure Requirements:

- The Division has not taken actions to implement a continuing education (CE) tracking system.
- The Division should consider implementing a system that requires licensees to self-report CE received, either electronically or manually, prior to licensure renewal.

Formal Administrative Hearings at the Division of Administrative Hearings:

- The Department's costs related to administrative hearings have increased significantly.
- The Division of Administrative Hearings (DOAH) has submitted a budget request for FY 02-03 which included $2,261,265 from the Department of Health. This amount was

based on 824 scheduled actual hearing hours and 7,740 cancelled hours during the FY 00-01.

- The Department of Health should analyze means for providing hearings in a more efficient manner. The analysis should include the feasibility of the use of internal hearing officers for certain types of complaints and appeals.
- If the analysis documents that hearings could be properly conducted internally for less cost than DOAH, the Legislature should consider providing statutory authority for the Department of Health to conduct formal hearings.

The findings relating to the CoreSTAT/Standardized Credentialing Program were also supported by the findings of Auditor General Report No. 02-031.

Office of Program Policy Analysis and Government Accountability:

As a result of the AG recommendation in Report No. 01-063, the 2001 Legislature required the Office of Program Policy Analysis and Government Accountability (OPPAGA) to study the feasibility of maintaining the entire MQA function, including enforcement, within a single department.

The OPPAGA Report No. 01-50, issued in October 2001, found that it was feasible to maintain the entire MQA function, including enforcement, within a single department. OPPAGA also determined that the optimal placement would be in the Department of Health.

Among its findings, OPPAGA stated that:

- The program's governance structure contributes to problems. Specifically,
  - Some duplication of functions exists between DOH and AHCA because DOH has increased program oversight in an attempt to improve AHCA performance.
  - The division of responsibility hinders accountability for resolving performance problems.
  - Disputes have occurred between the two agencies related to differing program priorities, disagreements over the level of control that DOH should have over the program, and disputes regarding AHCA's administrative charges assessed to the MQATF.
- The governance structure results in diffused accountability.
  - The current arrangement makes it more difficult for the Legislature to place responsibility for resolving overall performance problems clearly on one agency or another.
  - By having this function split, it is easier for both agencies to place blame for performance problems on the other agency and evade taking responsibility for its own performance.
- Agency officials are dissatisfied with the current structure.
  - DOH and AHCA management disagree over the level of control that DOH should have over the program.
  - Most stakeholders interviewed expressed concern about mistrust and poor communication between the two agencies.
  - There is an ongoing dispute between the two agencies regarding AHCA's administrative charges to the MQATF for FY 99-00 and 00-01.

In response to the OPPAGA findings and recommendations, the Report states that the "Department of Health generally agreed with [the OPPAGA] conclusions while the Agency for Health Care Administration generally disagreed." The Report further states that OPPAGA "believe[s] the Agency for Health Care Administration response underscores the conclusion of [OPPAGA's] report

concerning poor communication, diffused accountability, and disputes between the Agency and the Department of Health resulting from the divided governance structure of the MQA program."

Subsequently, the Secretary of Health and the Secretary of the Agency for Health Care Administration agreed to support the transfer of the enforcement component of MQA from AHCA to DOH. The two agencies prepared a "comprehensive joint action plan," at the request of the Chair of the Committee on Health Regulation, to transfer the legal, investigative, and consumer services functions of practitioner regulation from AHCA to DOH. The plan, developed by a workgroup consisting of key staff from both agencies, includes the transfer of all applicable staff. The two secretaries believe that the plan presents "all major issues that must be considered to ensure a smooth transition."

Committee on Health Regulation Interim Study on the Feasibility of Privatizing Certain Health Regulation Functions:

The Executive Summary of the report states:

> The impetus for this interim project was the dissatisfaction with the current health practitioner regulation processes in place within the Department of Health (DOH) and the Agency for Health Care Administration (AHCA) expressed by certain health professions. Most notably, the Florida Board of Dentistry and the Florida Dental Association have expressed serious concerns over the handling of disciplinary cases by the Agency for Health Care Administration under contract with the Department of Health. Additional concerns over other aspects of the regulatory process were also expressed and have been examined as part of this interim project.
>
> The purpose of this study is to review the operation of the Florida Engineers Management Corporation, established by the Legislature in 1997, in comparison to the current health practitioner regulatory model, and determine whether privatization of the administrative, investigative, and prosecutorial activities of health practitioner regulation would result in a cost savings and more efficiency in regulating certain health care professions.
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> There are several types of privatization being used today. According to The Revolution in Privatization by Lawrence W. Reed, printed in the Journal of the James Madison Institute, Summer 2001, pp. 20-24, 32, the most common form of privatization is known as "out-sourcing" or "contracting out." This form of privatization is already being used in health practitioner regulation with regard to licensure renewal, certain national examinations, and standardized credentialing. Also, certain cases have been contracted out to private attorneys for prosecution if the Agency was unable or unwilling to prosecute.
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> In Assessing Privatization in State Agency Programs, Report No. 98-64, published by the Florida Legislature Office of Program Policy Analysis and Government Accountability (OPPAGA), February 1999, there is a list and explanation of potential advantages and disadvantages to privatization of public services.
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> The advantages of privatization noted in the OPPAGA Report No. 98-64 include:
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> - ✓ Cost savings.
>
> - o Lower labor costs.

- Reduced regulatory requirements.
- Reduced overhead.
- More personnel flexibility.
- Better equipment.
- Faster reactions to changing conditions.

✓ Staffing flexibility/obtain needed expertise.

✓ Political factors.

✓ Shift start-up costs to private sector.

The disadvantages of privatization noted in the OPPAGA Report No. 98-64 include:

✓ Reduced public accountability.

✓ Service quality problems.

✓ Higher long-term costs.

✓ Workforce issues.

In addition, the OPPAGA Report No. 98-64 recommends that when considering privatization, the Legislature should consider:

✓ Is it appropriate to privatize the service?

✓ Is there reason to believe that privatization will save money or improve service?

Staff has reviewed the operation of the Florida Engineers Management Corporation and its enabling legislation, the purpose and result of the Management Privatization Act of 2000, and all available analyses and audits relating to the "privatization" of engineering regulation. Staff has also reviewed the current method of regulating health care practitioners. Furthermore, staff has drawn comparisons between engineering and non-health professional regulation versus dentistry and other health practitioner regulation, including a review and comparison of the financial pressures on each.

Research and review of the engineer's regulatory model demonstrates that privatization of regulatory functions is feasible and may be appropriate. However, in evaluating the factors listed above, it has yet to be shown that privatization has reduced costs significantly or that the performance has improved measurably using objective performance standards. Furthermore, the state paid all start-up costs of the corporation, including equipment and space, and the engineers must still contribute to the overhead expenses of the Department of Business and Professional Regulation (DBPR) and for those specific services still provided by DBPR.

Nonetheless, it appears that the persons using the services of the Florida Engineers Management Corporation (FEMC) and the Board of Professional Engineers are satisfied with the services provided by the corporation. Furthermore, based on statements made by the President of FEMC and information reflecting a minimal turnover in employees at FEMC, it appears that the personnel benefits of privatization are being realized.

This review leads staff to the conclusion that the current health practitioner regulatory framework is confusing to the public, hinders clear accountability, and fosters distrust between boards, departments, and professions involved. In considering available options, the Legislature could:

- Provide statutory authority for any profession to out-source/privatize particular functions so long as the size of government is reduced proportionately and the profession has adequate resources to cover the cost of such out-sourcing/privatization. This option would likely necessitate the transfer of the enforcement component of health practitioner regulation from AHCA to DOH to ensure that the size of government is decreased proportionately to the increase in contractual services, and that all costs are closely monitored. Without such a transfer, DOH would have a contract with AHCA which would need to be modified each time a new board wished to privatize. Oversight of the enforcement function, if dually performed by AHCA and contract entities, would become unmanageable, could result in an increase in the number of persons involved in regulation, and may result in higher costs.

- Retain regulation as a service provided by state employees but eliminate overlapping and duplicative services and enhance performance and cost-control measures. This option includes the transfer of the enforcement component from AHCA to DOH thereby eliminating some layers of government that are confusing and create additional overhead costs. This option would ensure that the public, the affected licensees, and the Legislature know which state department is accountable for the quality, quantity, and cost of health care practitioner regulation.

- Maintain the existing regulatory framework. This option maintains the status quo which has resulted in disputes between AHCA and DOH and between DOH and the boards over increased overhead expenses; confusion among the public and the affected licensees; and a lack of definite and identifiable accountability.

Each of the aforementioned options are discussed in detail in this report. The first option is feasible and would address the concerns raised by the dentists, but may raise other issues. The second option is also feasible, would alleviate many of the concerns raised by the dentists, and would reduce costs. While the third option, to maintain the existing regulatory framework, is available, it is not recommended as it does nothing to alleviate the concerns identified herein.

In conclusion, privatization of health practitioner regulation functions is feasible and should be considered as an option whenever the state finds that the advantages outweigh the disadvantages. This can be accomplished by enacting option one and making privatization permissive upon meeting certain conditions.

It is recommended that the state carefully consider the advantages and disadvantages of privatizing the regulation of dentists and other health care practitioners, and only privatize/out-source when the profession in question has a positive balance in their trust fund account in an amount sufficient to cover the full cost of regulation. Since dentistry is currently in a cash balance deficit and the revenues projected do not cover the full costs of regulation, it is recommended that any legislative action to specifically privatize the regulation of dentistry be postponed until such time as there is a positive cash balance adequate to cover the costs of regulation for the full biennium.

In the meantime, it is recommended that the Legislature take steps to eliminate confusion, reduce costs, streamline regulation, and enhance accountability by enacting option two with regard to transferring the enforcement component of practitioner regulation from AHCA to DOH.

On October 11, 2001, after considering the options presented, the Committee on Health Regulation voted, without objection, to move forward with the recommendations of staff regarding permissive privatization with enhanced performance measures and the transfer of the enforcement function from AHCA to DOH. The Committee directed staff to prepare a proposed committee bill which included these issues.

Formal Administrative Hearings Before the Division of Administrative Hearings:

According to the Division of Administrative Hearings (DOAH), it provides services to 28 state agencies and the Ethics Commission. DOAH also provides services to non-state entities, including:

- 5 water management districts;
- 11 regional planning councils;
- 67 school districts;
- 33 community colleges;
- The Division of Community Colleges;
- 10 universities;
- The Board of Regents;
- The Florida School for the Deaf and Blind;
- The State Board of Independent Colleges and Universities;
- The State Board of Independent Vocational, Technical, Trade, and Business Schools; and
- 33 other cities, counties, or local entities with regard to matters involving vested rights, discrimination, land use decisions, zoning appeals, wastewater treatment, etc.

Since 1987, the Division has provided to the Legislature annual reports that provide the total number of hearing hours scheduled by state agencies. These reports are used by the Legislature to determine the extent to which each agency utilizes the Division's services and how the Division's budget should be prorated among those agencies. This allocation takes the form of transfers of funds from state agencies to the Division, as appropriated by the Legislature in the General Appropriations Act. These transfers are based on the hearing hours scheduled by the state agencies two fiscal years prior to the effective date of the General Appropriations Act.

It is important to note that the Legislature does not appropriate transfers from non-state entities to the Division for its services. Hence, the methodology for charging non-state entities for DOAH's services differs from the above formula in several ways. First, contractual agreements between DOAH and some non-state entities govern payment for administrative law judge services. These non-state entities include, but are not limited to, cities, counties, and other local organizations such as utility authorities, environmental protection authorities, housing authorities, boards of county commissioners, and sheriffs' civil service boards. Second, the proviso language contained in each year's General Appropriations Act that is tied to DOAH's budget governs reimbursement for administrative law judge services by other non-state entities including water management districts, regional planning councils, school districts, and other non-state educational entities.

With regard to the funding formula for state agencies, the FY 1987-88 General Appropriations Act provided that DOAH "…shall undertake a study regarding an equitable means of funding the division by all user entities. Recommendations along with any necessary legislation/rule changes

shall be submitted to the Chairmen of the legislative appropriations committees on or before December 1, 1987." After consulting with agencies and staff of the House and Senate Appropriations Committees and Governor's Office of Planning and Budgeting, the Division recommended in the 1987 report that its FY 1988-89 budget should be prorated among state agencies based on hearing hours scheduled. These hearing hours were defined to include prehearing conferences, motion hearings, final hearings, and hearings cancelled or continued with less than 30 days notice. The formula recommended by the Division in its first report was adopted by the 1988 Legislature and applied to its FY 1988-89 budget; this formula has been used every year since 1988.

Subsection 120.65(7) provides that, "The division is authorized to provide administrative law judges on a contract basis to any governmental entity to conduct any hearing not covered by this section." This authorizes DOAH to contract with the non-state entities. The current contract rate for administrative law judge services is $100 per hour. These entities also reimburse DOAH for actual travel expenses incurred.

Each year in the General Appropriations Act, the Legislature ties proviso language to the Division's budget that authorizes reimbursement for administrative law judge services from the other non-state entities. Reimbursement for administrative law judge services is made by these entities at a rate not less than the contract rate in effect on July 1, 2001, which is $100 per hour. These non-state entities also reimburse DOAH for actual travel expenses incurred.

All of the non-state entities identified are charged $100 per hour (the current contract rate) for the actual time that an administrative law judge spends on a case, i.e., the time each judge spends traveling, in hearing, researching, writing orders, etc. These non-state entities are also billed for actual travel expenses.

The FY 2002-03 total appropriation requested by DOAH is $8,609,918. Of that $8.6 million, approximately $2.3 million would be paid from the MQATF.

The number of petitions for hearing received by DOAH has decreased considerably in the last 5-7 fiscal years. The number of petitions received in the following fiscal years were:

FY 95-96:	6,043
FY 96-97:	6,160
FY 97-98:	5,892
FY 98-99:	5,764
FY 99-00:	5,317
FY 00-01:	4,985
FY 01-02:	4,985 (Estimated)

The Division's FY 2002-03 through FY 2006-07 Long-Range Program Plan estimates that the number of petitions filed will remain constant at 4,985 in FY 2002-03. Therefore, the DOAH caseload has decreased.

The number of petitions for hearing that were received from the Department of Health, or its predecessor, the Agency for Health Care Administration, relating to practitioner regulation in the following fiscal years were:

FY 95-96:	347
FY 96-97:	294
FY 97-98:	356
FY 98-99:	201

FY 99-00: 714
FY 00-01: 428
FY 01-02: 428 (Estimated)

According to information provided by DOAH, DOAH's administrative law judges spent a total of 1,030 hours in hearing on health care practitioner regulation cases in FY 1999-00 and FY 2000-01. DOAH does not track billable hours, so the total amount of time spent on these cases cannot be determined.

In FY 1999-00, 56 formal hearings relating to health care practitioner regulation were held, according to DOAH. This number conflicts with the 39 formal hearings reported by AHCA. In FY 2000-01, 106 formal hearings relating to health care practitioner regulation were held, according to DOAH. Again, this number conflicts with the 61 formal hearings reported by AHCA. The difference in numbers reported may be attributed to the difficulty in counting which hearings are post-licensure disciplinary proceedings versus those that are examination challenges or licensure denial hearings.

In FY 1999-00, DOAH conducted 347 formal hearing hours, 20.50 motion hearing hours, and 3 prehearing conference hours for health care practitioner regulation cases. In FY 2000-01, DOAH conducted 629.75 formal hearing hours, 23.50 motion hearing hours, and 5.75 prehearing conference hours for health care practitioner regulation cases.

According to DOAH, in FY 1999-00, 299 formal hearings relating to health care practitioner regulation were cancelled. In FY 2000-01, 740 formal hearings relating to health care practitioner regulation were cancelled. This is a cancellation rate of approximately 90%. While these are categorized as “cancelled hearings,” they really represent the number of cases settled prior to formal hearing. Settlements are generally seen as favorable to both the state and the licensed practitioner as the costs are reduced and the case is resolved more timely. However, because the cost of DOAH has been charged to the agency at the time a case is referred to DOAH, there is little financial benefit shown in the total charges.

When asked how many formal hearings relating to health care practitioner regulation were cancelled more than 30 days prior to the scheduled formal hearing date, DOAH responded that the Division does not compile or maintain statistics that would provide an accurate response to this question. DOAH provided the same response when asked about cancellations 21, 14, 7, and 3 days prior to hearing.

The average cost to conduct a school board case is $2,346.88 per case. DOAH maintains an accounting system that tracks the actual costs associated with each case.

All of DOAH's administrative law judges are paid $52.23 per hour.

The Division does not compile or maintain statistics relating to the average cost of DOAH to conduct a formal hearing in a health care practitioner regulation case. Administrative law judges do not keep hourly time records, nor does administrative staff. It is not possible to determine how many hours an administrative law judge spends on a particular case.

DOAH does not track how much administrative time is spent opening and closing a DOAH case file when a petition for hearing is filed or a motion to close file is filed at DOAH. However, when asked what dollar amount would cover the expenses directly associated with the opening and closing of a DOAH case file when no formal hearing is ever held, DOAH’s Chief Judge asserted that a rate of $100 per hour would cover all DOAH costs.

Currently, 38 administrative law judges are employed by DOAH. DOAH employs 40 support staff. In FY 1999-00, 75 FTEs were authorized. In FY 2000-01 and FY 2001-02, 80 FTEs were authorized.

The Division has requested 80 FTEs for FY 2002-03.

The Division has requested the following in FY 2002-03 for its Adjudication of Disputes program:

Salaries and Benefits:	$6,790,204
Other Personal Services:	481,242
Expenses:	1,247,096
Operating Capital Outlay:	71,550
Risk Management Ins.:	19,826
Total FY 2002-03 LBR:	$8,609,918

It is estimated that all of the Salaries and Benefits appropriation will be spent. Because the Division submitted what is essentially a continuation budget for FY 2002-03, the following expenditures are based on actual data for FY 2000-01, with the exception of rent:

Travel:	$175,752
Rent:	$560,190
Equipment & Furniture:	$182,607

No DOAH positions have been eliminated during the last three fiscal years. The statewide reduction in travel expenses was applied to DOAH's FY 2001-02 budget, totaling $27,454.

Current law requires all requests for formal hearing be sent to DOAH within 15 days of receipt by a state agency. Current law also allows licensees to request a formal hearing at any time after the administrative complaint (formal charging document) is filed, including in the middle of an informal hearing before a board.

Impaired Practitioner Programs:

The Department of Health contracts with two organizations to provide impaired practitioner programs to Florida's health care practitioners. These programs evaluate, refer, and monitor impaired practitioners, but do not provide the actual treatment. Approximately $2 million is paid to these programs from the MQATF. The practitioners are currently required to pay the cost of their treatment program, but are not required by statute to pay for the costs of monitoring incurred by the impaired practitioner programs.

CoreSTAT:

Please see the Auditor General findings above. According to the Department of Health, actual expenditures by the department for development, operations, and maintenance of CoreSTAT was $11.9 million as of June 30, 2001.

Office Surgery Accreditation:

Current law requires physicians who perform certain surgical procedures to register their offices with the Department of Health. The office must either be accredited by a national accrediting body or an organization approved by the Board of Medicine or Board of Osteopathic Medicine, or must be inspected by the Department of Health.

The Board of Medicine has requested that the inspection program be discontinued and that all offices be accredited. The accreditation process involves an inspection by the accreditation body.

Medical Malpractice/Professional Liability Closed Claims:

Current law requires notification to the state of all closed malpractice claims. The closed claims are reported to the Department of Insurance, and in some instances, to the Department of Health. The Department of Health reviews the closed claims to determine if the incident involved a violation of the medical practice act. If the state determines, based on a standard of legal sufficiency, that if the alleged facts were true that a violation of the medical practice act would have occurred, the state opens a complaint and investigates the incident which gave rise to the malpractice lawsuit. As a result, this investigation by the state occurs at a time sometimes far removed from the actual incident.

In addition to learning about the alleged malpractice through a closed claim, the state may be notified by a consumer such as the patient, the patient's family member, the patient's attorney, or a friend of the patient. The state also receives mandatory reports of adverse incidents from doctor's offices, hospitals, and other facilities in which health care services are provided. Moreover, at the time a malpractice lawsuit is filed in Florida, the plaintiff or plaintiff's attorney is required to notify the Department of Health. Thus, there are, at a minimum, 3 other ways that the state might be notified of the incident giving rise to the medical malpractice lawsuit. In many instances, the closed claim is treated by the state as a duplicate to a previously filed complaint and is never independently investigated.

Information provided to the Florida Board of Medicine by the First Professionals Insurance Company, Inc. (FPIC) of Jacksonville, Florida, indicates that the average indemnity paid in professional liability cases in 2000 was approximately $248,000. The information asserts that indemnities paid vary significantly by county. The factors which comprise malpractice claim risk exposure include:

- Venue;
- Medical Specialty;
- Practice Environment;
- Duration of Practice; and
- Level of Care Provided.

FPIC also noted that the majority (52%) of the claims paid are in the amount ranging from $100,000 to $499,999. Approximately 13% of the claims paid exceed $500,000 and approximately 34% result in payment of less than $99,999. Therefore, approximately 65% percent of closed claims result in payments of $100,000 or more.

Proponents of changing the malpractice reporting thresholds argue that many of the lawsuits closed with a payment of less than $100,000 are considered "nuisance" suits, meaning they are settled because it would cost more to defend them than to simply settle.

In an article entitled *Medical Malpractice: A Comprehensive Analysis,* by Vasanthakumar Bhat, published by Auburn House, 2001, the author states:

> More than 19 out of 20 malpractice payments are as a result of settlements. Malpractice payments below $50,000 could be made for economic reasons rather than for genuine negligence. Malpractice payments even if they reflect poor quality of care may not reflect incompetence in a physician. Even the best physicians are sued.

Electronic Tracking of Licensure Requirements:

The Department of Health currently posts the applications for initial licensure on the department's website. Persons interested in applying for licensure can download the application, complete the application, and submit it in paper form to the department. The department does not currently accept electronically submitted applications for initial licensure.

The department has implemented an on-line e-Renewal system that allows practitioners to renew their license electronically. This system requires a pin number to be entered by the practitioner as it appears on the renewal formed which is mailed to the practitioner. The system accepts payment of renewal fees by credit card. The system does not currently require the practitioner to provide documentation or assertion of completion of continuing education requirements or other conditions of license.

The department also allows addresses to be updated electronically. However, name changes, reactivations, and licensure upgrades/downgrades must still be done on paper as these changes require documentation of certain information.

On the Health Licensee and Continuing Education Providers Information system, interested persons can look up practitioners by name and other identifiers and can also locate board-approved continuing education providers and board-approved continuing education courses.

Many other state agencies provide initial and renewed licenses electronically through the internet. These applications can be made through the MyFlorida website.

Radiation Therapy and Respiratory Therapy:

Part IV, ch. 468, F.S., specifies requirements for the regulation of radiation therapy. Under s. 468.302, F.S., a person who is trained and skilled in cardiopulmonary technology and who provides cardiopulmonary technology services at the direction, and under the direct supervision of a licensed practitioner, is exempt from the certification requirements. "Licensed practitioner" is defined to mean a licensed physician or person otherwise authorized by law to practice medicine, chiropody, osteopathic medicine, naturopathy, or chiropractic medicine in Florida.

Section 458.303(2), F.S., provides that nothing in s. 458.331, F.S., relating to grounds for disciplinary action against a medical physician, shall be construed to prohibit services rendered by an unlicensed medical assistant when done under the direct supervision and control of the physician and services rendered by registered nurses or licensed practical nurses when performed under the direct supervision and final approval of the medical physician. Similarly, s. 459.002, F.S., provides that nothing in chapter 459, F.S., shall be construed to prohibit services rendered by any person when performed under the direct supervision and control of a licensed osteopathic physician who must be available when needed, provide specific direction and give final approval to all services performed.

Part V, ch. 468, F.S., governs the practice of respiratory therapy. The part provides definitions and licensure requirements for respiratory care practitioners. Section 468.355, F.S., specifies licensure requirements for a person to become a certified respiratory therapist. To do so, a person must be at least 18 years old and possess a high school diploma or a graduate equivalency diploma. In addition, the applicant must meet at least one of the following criteria: (1) successful completion of a training program for respiratory therapy technicians or respiratory therapists approved by the Commission on Accreditation of Allied Health Education Programs, or the equivalent, as accepted by the Florida Board of Respiratory Care (board); (2) the applicant is currently a "Certified Respiratory Therapist" certified by the National Board for Respiratory Care, or its equivalent, as accepted by the board; (3) the applicant is currently a "Registered Respiratory Therapist" registered by the National Board for Respiratory Care, or its equivalent, as accepted by the board.

To become licensed as a registered respiratory therapist, an applicant must be at least 18 years old and possess a high school diploma or a graduate equivalency diploma. In addition, the applicant must meet at least one of the following criteria: (1) successful completion of a training program for registered respiratory therapists approved by the Commission on Accreditation of Allied Health Education Programs, or the equivalent, as accepted by the Florida Board of Respiratory Care; or (2) the applicant is currently a "Registered Respiratory Therapist" registered by the National Board for Respiratory Care, or its equivalent, as accepted by the board.

A Florida-licensed respiratory therapist may voluntarily be certified as a Certified Respiratory Therapist or registered as a Registered Respiratory Therapist pursuant to the requirements of the National Board for Respiratory Care. The National Board for Respiratory Care is a national organization recognized by the Council that provides voluntary certification for respiratory care practitioners, which is recognized under Florida licensure laws. The National Board for Respiratory Care currently offers five credentialing programs. These examinations include the: certification examination for entry level respiratory therapists for the designation of (CRT); and the registry examination for advanced respiratory therapy practitioners (RRT).

A Florida-licensed respiratory therapist delivers respiratory care services under the order of a Florida-licensed allopathic or osteopathic physician, and in accordance with protocols established by a hospital, other health care provider, or the Board of Respiratory Care, and who functions in situations of unsupervised patient contact requiring individual judgment. A licensed respiratory care practitioner is employed to deliver respiratory care services under a Florida licensed allopathic or osteopathic physician, and in accordance with protocols established by a hospital, other health care provider, or the Florida Board of Respiratory Care. Under s. 468.355, F.S., the Florida Board of Respiratory Care must establish procedures for temporary licensure of eligible individuals entering Florida and temporary licensure of those persons who have graduated from a program approved by the Florida Board of Respiratory Care. The duration of such temporary licensure may not exceed 1 year.

Respiratory care education programs are accredited through the Committee on Accreditation for Respiratory Care (CoARC), previously the Joint Review Committee for Respiratory Therapy Education (JRCRTE). The Committee on Accreditation for Respiratory Care is responsible for assuring that respiratory therapy education programs comply with the standards adopted by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). Its representatives visit respiratory therapy programs to evaluate applications for accreditation and perform periodic reviews.

The Committee on Accreditation for Respiratory Care has established new education standards that require all accredited education programs to award a minimum of an associate degree to all students who enroll beginning January 1, 2002. Persons seeking to qualify for the National Board

for Respiratory Care's certification examination for the designation Certified Respiratory Therapist who enroll on or after January 1, 2002, must graduate from an entry or advanced level respiratory care program with a minimum of an associate degree. Any National Board for Respiratory Care certification applicants who have started or graduated from any respiratory care educational program or entered the credentialing system before January l, 2002, will have until December 31, 2005, to complete the requirements for credentialing without having an associate degree.

Section 468.356, F.S., provides that the approval of educational programs must be in accordance with the Joint Review Committee for Respiratory Therapy Education through the Commission on Accreditation of Allied Health Education Programs, or other accrediting agency recognized by the United States Department of Education. The Board of Respiratory Care may require additional documentation of an intent to achieve full accreditation from any educational program that has not yet received full American Medical Association approval. The board may grant temporary approval for graduates of any program that has not yet achieved full accreditation so that such graduates may sit for the licensure examination.

Section 468.357, F.S., specifies procedures for licensure by examination of persons wishing to practice as certified respiratory therapists. To sit for the examination, the applicant must: complete the required forms and pay the required licensure fee set by the Florida Board of Respiratory Care; submit required documentation; and remit an examination fee set by the examination provider. Examinations for licensure of certified respiratory therapists administered by the Department of Health must be conducted no less than two times a year in a geographical location or method deemed advantageous to the majority of applicants. The licensure examination for certified respiratory therapists must be the same as that given by the National Board for Respiratory Care for entry-level certification of respiratory therapists. The Department of Health must issue a license to any applicant who successfully completes the examination who otherwise qualifies for licensure as a certified respiratory therapist.

The Florida Board of Respiratory Care must prescribe by rule continuing education requirements for respiratory care practitioners and respiratory therapists to meet as a condition for their biennial license renewal. The board must approve continuing education courses and providers of continuing education.

Section 468.368, F.S., specifies exemptions to respiratory care licensure requirements for certain persons including: medical personnel who have been formally trained in modalities used for the delivery of respiratory care services and who are duly licensed or have credentials pertaining to their respective professions; cardiopulmonary testing by individuals who have credentials by the National Board for Respiratory Care as Certified Pulmonary Function Technologists, or individuals who are employed by health care facilities and who are eligible and have applied for that credential; students enrolled in the educational program of any health care profession; gratuitous care of an ill person by a friend or family member who does not hold himself or herself out as a respiratory care practitioner or respiratory therapist; an individual providing respiratory care in an emergency who does not hold himself or herself out as a respiratory care practitioner or respiratory therapist; a person employed in the office of, and who is working under the direct supervision and control of a Florida-licensed allopathic or osteopathic physician; a student who has demonstrated enrollment in the clinical portion of an approved respiratory care educational program to the board and who is employed by a health care facility and who is delivering limited respiratory care support services under the supervision of a licensed respiratory care practitioner or a respiratory care therapist; a graduate of an approved respiratory care educational program who has applied to the board for temporary licensure under s. 468.355, F.S.; a person involved in the delivery, assembly, setup, testing, and demonstration of oxygen, aerosol, and intermittent positive pressure breathing equipment for use in the home upon order of a Florida-licensed allopathic or osteopathic physician; and a surrogate family member who delivers incidental respiratory care of sick or disabled

noninstitutionalized persons as long as such person does not hold himself or herself out as a respiratory care practitioner or respiratory therapist.

Section 468.366, F.S., provides criminal offenses under part V, ch. 468, F.S. (the respiratory care practice act). It is a violation of law for any person, including any firm, association, or corporation: to deliver respiratory care services, as defined by part V, ch. 468, F.S., or by rule of the board, unless such person is duly licensed to do so under the part or unless such person is exempted under s. 468.368, F.S.; and to knowingly employ unlicensed persons in the delivery of respiratory care services, unless exempted by part V, ch. 468, F.S. Such violations constitute a third degree felony punishable by imprisonment up to 5 years and imposition of a fine up to $5,000.

Tissue Banking:

Tissue banking involves the donation of human tissue for transplant. The tissue is first tested and processed to make it as free as possible from disease-causing agents such as bacteria, virus, and prions. According to industry representatives, thousands of Floridians receive tissue transplants every year, and hundreds of thousands of tissue grafts are processed in Florida for transplantation in Florida and elsewhere.

National standards are set by the American Association of Tissue Banks (AATB), the United States Food and Drug Administration (FDA), and the Florida Agency for Health Care Administration (AHCA). The AATB, the FDA in its pending draft regulations, and the Florida Statewide Organ and Tissue Transplantation Advisory Board all believe that "batch processing" or "pooling" of tissue must not occur in order to reduce the possibility of spreading disease from one donor to another person.

According to proponents of this bill, every tissue bank in the United States, except for one in Florida, prohibits "batch processing" or "pooling" of tissue. The tissue bank which allows pooling or batch processing, proponents argue, could potentially be spreading disease through commingled tissues and fluids.

C. EFFECT OF PROPOSED CHANGES:

Please see Section-By-Section Analysis.

D. SECTION-BY-SECTION ANALYSIS:

Sections 1 & 2. Amends s. 20.43, F.S., to transfer the enforcement component of practitioner regulation from AHCA to DOH. Eliminates 281 FTEs at AHCA and authorizes 273 FTEs at DOH, for a total reduction of 8 FTEs.

Sections 3, 4, & 5. Amends s. 456.073, F.S., to require requests for formal hearing to be made within 45 days after service of an administrative complaint. Extends the period in which the department can negotiate a settlement prior to forwarding a case to DOAH from 15 days to 45 days. Requires DOAH to keep time records per case and bill DOH at an hourly rate. Clarifies that DOAH shall bill DOH based on the new formula for all work done after July 1, 2002 instead of based on the current formula.

Section 6. Amends s. 456.076, F.S., to require impaired practitioners to pay a 40% portion of the expenses incurred as a result of their participation in the impaired practitioner program, unless the consultant finds the licensee to be unable to pay.

Sections 7-12. Repeals 456.047, F.S., relating to Standardized Credentialing, known as CoreSTAT. Clarifies that no refunds shall be given for fees paid prior to the effective date of this bill. Conforms cross-references.

Sections 13 & 14. Amends ss. 458.309 and 459.995, F.S., to require all physicians who perform office surgery to have their offices accredited. Eliminates the state inspection program.

Sections 15, 16, & 18. Amends. ss. 456.004, 456.009, and 456.026, F.S., to require objective performance measures of all entities involved in health care practitioner regulation. Also provides permissive statutory authority to out-source or privatize particular regulatory functions under certain circumstances.

Section 17. Amends s. 456.011, F.S., to require committee meetings of the regulatory boards to be held electronically or on the day immediately before or after a regularly-scheduled in-person meeting of the board. Provides exception for certain meetings to be held in Tallahassee if permission is granted in advance and meeting is expected to last more than 5 hours.

Sections 19 & 20. Creates ss. 458.3095 and 459.0053, F.S., to require utilization of the Federation of State Medical Boards' Credentials Verification Service in order to verify credentials for initial licensure application beginning January 1, 2003.

Sections 21, 22, & 23. Amends ss. 458.331, 459.015, and 627.912, F.S., to increase the closed claim payment amount from $25,000 to $50,000 as the threshold for opening a complaint against the practitioner and for disciplining the practitioner for "repeated malpractice." Eliminates review by the Department of Health of certain closed claims.

Section 24. Amends s. 456.073, F.S., to require licensees who receive a letter of guidance in lieu of a finding of probable cause to pay the actual costs of investigation. AHCA estimates that this change will affect approximately 1,340 cases and will result in increased revenues of approximately $938,000 from licensees alleged to have violated the law.

Section 25. Requires OPPAGA to review the investigative field office structure at AHCA to determine the feasibility of combining or eliminating some or all field offices, and the feasibility of requiring field inspectors and investigators to telecommute from home in lieu of paying for office space. Requires report to the Legislature no later than January 1, 2003.

Section 26. Amends s. 456.025, F.S., to remove 10% caps on raising licensure fees by the boards.

Section 27. Creates s. 456.0165, F.S., to allow state colleges, universities, and vocational schools to serve as hosts for licensure exams. Clarifies which expenses may be billed.

Section 28. Sets licensure fees, effective July 1, 2002, at their statutory fee cap or actual per licensee cost to regulate that profession, whichever is less.

Section 29. Amends s. 468.301, F.S., to conform definition of "direct supervision."

Section 30. Amends s. 468.302, F.S., relating to certification requirements for radiologic technology, to modify an existing exemption from the certification requirements so that a person who is trained and skilled in invasive cardiovascular technology, including the radiological technology duties associated with these procedures, rather than cardiopulmonary technology, and who provides invasive cardiovascular, rather than cardiopulmonary, technology services at the direction, and under the direct supervision, of a licensed allopathic or osteopathic physician need

not be certified. Such persons must successfully complete a didactic and clinical training program in specified areas before performing radiologic technology duties. The areas include: principles of x-ray production and equipment operation; biological effects of radiation; radiation exposure and monitoring; radiation safety and protection; evaluation of radiographic equipment and accessories; radiographic exposure and technique factors; film processing; image quality assurance; patient positioning; administration and complications of contrast media; and specific fluoroscopic and digital x-ray imaging procedures related to invasive cardiovascular technology.

Section 31. Substantially rewords s. 468.352, F.S., relating to definitions for the regulation of respiratory care, to revise the definition of the various terms. "Critical care" is redefined to mean care given to a patient in any setting involving a life-threatening emergency. "Direct supervision" is redefined to mean supervision under the direction of a licensed, registered, or certified respiratory therapist who is physically on the premises and readily available, as defined by the board. The definition in current law for "noncritical care" is eliminated. The term, "physician supervision" (currently defined as "direct supervision") is defined to mean supervision and control by a licensed allopathic or osteopathic physician who assumes legal liability for the services rendered by the personnel employed in his or her office.

"Certified respiratory therapist" is redefined to mean any person licensed under part V, ch. 468, F.S., who is certified by the National Board for Respiratory Care or its successor, who is employed to deliver respiratory care services, under the order of a Florida-licensed allopathic or osteopathic physician in accordance with protocols established by a hospital or other health care provider or the Board of Respiratory Care, and who functions in situations of unsupervised patient contact requiring individual judgment. "Registered respiratory therapist" is redefined to mean any person licensed under this part who is registered by the National Board for Respiratory Care or its successor, and who is employed to deliver respiratory care services under the order of a Florida-licensed allopathic or osteopathic physician in accordance with protocols established by a hospital or other health care provider or the Board of Respiratory Care, and who functions in situations of unsupervised patient contact requiring individual judgment.

The "practice of respiratory care" or "respiratory therapy" is defined to mean the allied health specialty associated with the cardiopulmonary system that is practiced under the orders of a Florida-licensed allopathic or osteopathic physician and in accordance with protocols, policies, and procedures established by a hospital or other health care provider or the Board of Respiratory Care. "Respiratory care practitioner" is defined to mean any person licensed under part V, ch. 468, F.S., to deliver respiratory care services under direct supervision and pursuant to an order of a Florida-licensed allopathic or osteopathic physician.

The definition of "respiratory care services" is revised to include evaluation and disease management; diagnostic and therapeutic use of respiratory equipment, devices, or medical gas; administration of drugs, as duly ordered or prescribed by a Florida-licensed allopathic or osteopathic physician and in accordance with protocols, policies, and procedures established by a hospital or other health care provider or the Board of Respiratory Care; initiation, management, and maintenance of equipment to assist and support ventilation and respiration; diagnostic procedures, research, and therapeutic treatment and procedures; cardiopulmonary resuscitation; advanced cardiac life support, neonatal resuscitation, and pediatric advanced life support, or equivalent functions; insertion and maintenance of artificial airways and intravascular catheters; performing sleep-disorder studies; education; and the initiation and management of hyperbaric oxygen.

Section 32. Substantially rewords s. 468.355, F.S., relating to eligibility for respiratory care licensure and temporary licensure, to revise licensure requirements for respiratory therapists. To be eligible for licensure as a respiratory therapist an applicant must be certified as a "Certified

Respiratory Therapist" or registered as a "Registered Respiratory Therapist" by the National Board for Respiratory Care, or its successor.

Section 33. Substantially rewords s. 468.368, F.S., relating to exemptions to respiratory care regulation for certain persons, to substantially revise the exemptions. Under the revised exemptions to respiratory care regulation, the regulation may not be construed to prevent or restrict the practice, service, or activities of: any person licensed in Florida by any other law from engaging in the profession or occupation for which he or she is licensed; any legally qualified person in Florida or another state or territory who is employed by the United States government while such person is discharging his or her official duties; a friend or family member who is providing respiratory care services to an ill person and who does not represent himself or herself to be a respiratory care practitioner or respiratory therapist; an individual providing respiratory care services in an emergency who does not represent himself or herself as a respiratory care practitioner or respiratory therapist; any individual employed to deliver, assemble, setup, or test equipment for use in a home, upon the order of a Florida-licensed allopathic or osteopathic physician; any individual credentialed by the Board of Registered Polysomnographic Technologists, as a registered polysomnographic technologist, who is involved the diagnosis and evaluation of treatment for sleep disorders; any individual certified or registered as a pulmonary function technologist who is credentialed by the National Board for Respiratory Care from performing cardiopulmonary diagnostic studies; any student who is enrolled in an accredited respiratory care program approved by the Florida Board of Respiratory Care, while performing respiratory care as an integral part of a required course; the delivery of incidental respiratory care to noninstitutionalized persons by surrogate family members who do not represent themselves as registered or certified respiratory care therapists; and any individual credentialed in hyperbaric medicine by the Underseas Hyperbaric Society, or its equivalent as determined by the Florida Board of Respiratory Care, while performing related duties.

Section 34. Repeals section 468.356, F.S., which provides requirements for the approval of respiratory care therapy educational programs and repeals s. 468.357, F.S., which specifies procedures for the licensure by examination of persons wishing to practice as certified respiratory therapists.

Section 35. Effective July 1, 2003, requires application forms for initial licensure and licensure renewal to be submitted electronically through the internet. Requires the department to issue the license if all conditions for licensure have been met, including payment of fees, completion of required continuing education, and if applicable, maintenance of financial responsibility.

Section 36. Directs the Division of Statutory Revision to annually prepare a reviser's bill that proposes to increase the statutory fee caps by 2.5 % for the health professions.

Section 37. Renumbers sections 381.0602, 381.6021, 381.6022, 381.6023, 381.6024, and 381.6026, F.S., as sections 765.53, 765.541, 765.542, 765.544, 765.545, and 765.547, F.S., respectively.

Section 38-43. Conforms cross-references.

Section 44. Creates s. 765.539, F.S., to prohibit pooling of human cells or tissues from two or more donors during the retrieval, processing, preservation, or storage procedures.

Section 45. Provides an effective date of July 1, 2002, except as otherwise provided.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The Department of Health estimates that this bill will increase revenue by $7.2 million in year one and $10.6 million in year two.

2. Expenditures:

The Department of Health estimates that this bill will reduce expenditures by $12.1 million annually.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Professions which are not currently paying the actual cost of regulation will see an increase in their biennial licensure fees. Subjects of investigations who currently receive a letter of guidance from the board without having to pay the costs of investigation will have to pay the costs of such investigation similar to those subjects who receive a formal administrative complaint.

D. FISCAL COMMENTS:

According to the Department of Health, this bill will reduce total authorized FTEs by 13, and will have a positive fiscal impact on the MQATF of approximately $18.4 million the first year and $18.8 million the second year.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

The bill does not require a city or county to expend funds or to take any action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

The Board of Medicine and Board of Osteopathic Medicine have rulemaking authority relating to office surgery accreditation. The Department will need to repeal the rules relating to CoreSTAT.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH REGULATION:

Prepared by:	Staff Director:
Wendy Smith Hansen	Lucretia Shaw Collins