A bill to be entitled

An act relating to ambulatory surgical centers; creating ch. 396, F.S., to be entitled "Ambulatory Surgical Centers"; creating s. 396.201, F.S.; providing legislative intent; creating s. 396.202, F.S.; providing definitions; creating s. 396.203, F.S.; providing requirements for licensure and the denial, suspension, and revocation of a license; creating s. 396.204, F.S.; providing for application fees; creating s. 396.205, F.S.; providing requirements for specified clinical and diagnostic results as a condition for issuance or renewal of a license; creating s. 396.206, F.S.; requiring the Agency for Health Care Administration to make or cause to be made specified inspections of licensed facilities; requiring a licensee to pay certain fees at the time of inspection; creating s. 396.207, F.S.; requiring each licensed facility to maintain and provide upon request records of all inspection reports pertaining to that facility; prohibiting the distribution of specified records; providing a fee for a copy of a report; creating s. 396.208, F.S.; requiring the agency to review facility plans and survey the construction of a licensed facility; requiring the agency to approve or disapprove the

plans and specifications within a specified timeframe; providing an extension under certain circumstances; requiring all licensed facilities to submit plans and specifications to the agency for review; authorizing the agency to charge and collect specified fees; creating s. 396.209, F.S.; prohibiting rebates for patients referred to a licensed facility; requiring agency enforcement; providing administrative penalties; creating s. 396.211, F.S.; providing facility requirements for considering and acting upon applications for staff membership and clinical privileges at a licensed facility; requiring a licensed facility to establish rules and procedures for consideration of such applications; requiring a licensed facility to make available specified membership or privileges to physicians under certain circumstances; providing construction; requiring the governing board to set standards and procedures to be applied in considering and acting upon applications; requiring a licensed facility to provide an applicant with reasons for denial within a specified timeframe; providing immunity from monetary liability to certain persons; providing that investigations, proceedings, and records produced or acquired by a review team are not subject to discovery or introduction into evidence

in certain proceedings under certain circumstances; providing for the award of specified fees and costs; creating s. 396.212, F.S.; requiring licensed facilities to provide for peer review of certain physicians and develop procedures to conduct such reviews; providing requirements for the procedures; providing grounds for peer review and reporting requirements; providing immunity from monetary liability to certain persons; providing construction; providing that communications, information, and records produced or acquired by a review team are not subject to discovery or introduction into evidence in certain proceedings under certain circumstances; providing for the award of specified fees and costs; creating s. 396.213, F.S.; requiring licensed facilities to establish an internal risk management program; providing requirements for such program; requiring licensed facilities to hire a risk manager; providing requirements for such manager; requiring licensed facilities to annually report to the Department of Health specified information; requiring the department and the agency to include certain statistical information in their respective annual reports; providing for rulemaking; providing applicability; requiring licensed facilities to

annually report specified information to the agency; authorizing the agency to grant extensions to the reporting requirement under certain circumstances; requiring the agency to publish certain reports and summaries within certain timeframes on its website; providing certain investigative and reporting requirements for internal risk managers; requiring the investigation and reporting of an allegation of sexual misconduct or sexual abuse at licensed facilities; prohibiting false allegations; providing penalties; providing licensure inspection review of the internal risk management program; providing certain monetary or civil liability for licensed risk managers; requiring the agency to report certain investigative results to the regulatory board; prohibiting intimidation of a risk manager; providing a penalty; creating s. 396.214, F.S.; requiring licensed facilities to comply with specified requirements for the transportation of biomedical waste; creating s. 396.215, F.S.; requiring licensed facilities to adopt a patient safety plan, appoint a patient safety officer, and conduct a patient safety culture survey at least biennially; authorizing licensed facilities to develop an internal action plan; creating s. 396.216, F.S.; requiring licensed facilities to adopt protocols for the

treatment of victims of child abuse or neglect; creating s. 396.217, F.S.; providing requirements for notifying parents about adverse incidents; providing construction; creating s. 396.218, F.S.; providing for rulemaking and enforcement; authorizing the agency to impose an immediate moratorium on elective admissions to any licensed facility under certain circumstances; creating s. 396.219, F.S.; providing criminal and administrative penalties; creating s. 396.311, F.S.; providing powers and duties of the agency; creating s. 396.312, F.S.; requiring a licensed facility to provide timely and accurate financial information and quality of service measures to certain individuals; providing an exemption; requiring a licensed facility to make available on its website certain information on payments made to that facility for defined bundles of services and procedures and other information for consumers and patients; requiring facility websites to provide specified information and notify and inform patients or prospective patients of certain information; requiring a licensed facility to provide a written or an electronic good faith estimate of charges to a patient or prospective patient within a certain timeframe; requiring a licensed facility to provide information regarding financial assistance

from the facility which may be available to a patient or a prospective patient; providing a penalty for failing to provide an estimate of charges to a patient; requiring that certain records be made available through electronic means that comply with a specified law; reducing the amount of time afforded to licensed facilities to respond to certain patient requests for information; creating s. 396.313, F.S.; defining the term "extraordinary collection action"; prohibiting certain collection activities by a licensed facility; creating s. 396.314, F.S.; prohibiting the use of a patient's medical records for purposes of solicitation and marketing without specific written release or authorization; providing criminal penalties; creating s. 396.315, F.S.; providing for confidentiality of patient records; providing requirements for appropriate disclosure of patient records; authorizing the department to examine certain records; providing content and use requirements for patient records; requiring a licensed facility to furnish, in a timely manner, a true and correct copy of all patient records to certain persons; providing exemptions from public records requirements for specified personal information relating to employees of licensed facilities who

provide direct patient care or security services and their spouses and children, and for specified personal information relating to other employees of licensed facilities and their spouses and children upon their request; amending ss. 383.145, 383.50, 385.211, 390.011, 394.4787, 395.001, 395.002, 395.003, 395.1055, 395.10973, 395.3025, 395.607, 395.701, 400.518, 400.93, 400.9935, 401.272, 408.051, 408.07, 408.802, 408.820, 409.905, 409.906, 409.975, 456.041, 456.053, 456.056, 458.3145, 458.320, 458.351, 459.0085, 459.026, 465.0125, 468.505, 627.351, 627.357, 627.6056, 627.6405, 627.64194, 627.6616, 627.736, 627.912, 765.101, 766.101, 766.110, 766.1115, 766.118, 766.202, 766.316, 812.014, 945.6041, and 985.6441, F.S.; conforming cross-references and provisions to changes made by the act; providing an effective date.

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

**Section 1.** Chapter 396, Florida Statutes, consisting of sections 396.201, 396.202, 396.203, 396.204, 396.205, 396.206, 396.207, 369.208, 396.209, 396.211, 396.212, 396.213, 396.214, 396.215, 396.216, 396.217, 396.218, 396.219, 396.311, 396.312, 396.313, 396.314, and 396.315, is created and entitled

"Ambulatory Surgical Centers."

**Section 2. Section 396.201, Florida Statutes, is created to read:**

396.201 Legislative intent.—It is the intent of the Legislature to provide for the protection of public health and safety in the establishment, construction, maintenance, and operation of ambulatory surgical centers by providing for licensure of same and for the development, establishment, and enforcement of minimum standards with respect thereto.

**Section 3. Section 396.202, Florida Statutes, is created to read:**

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

(1) "Accrediting organization" means a national accrediting organization approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state.

(2) "Agency" means the Agency for Health Care Administration.

(3) "Ambulatory surgical center" means a facility, the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from within 24 hours, and that is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the

practice of dentistry may not be construed to be an ambulatory surgical center, provided that any facility or office that is certified or seeks certification as a Medicare ambulatory surgical center must be licensed as an ambulatory surgical center pursuant to this chapter.

(4) "Biomedical waste" means any solid or liquid waste as defined in s. 381.0098(2).

(5) "Clinical privileges" means the privileges granted to a physician or other licensed health care practitioner to render patient care services in an ambulatory surgical center, but does not include the privilege of admitting patients.

(6) "Department" means the Department of Health.

(7) "Director" means any member of the official board of directors as reported in the organization's annual corporate report to the Department of State, or, if no such report is made, any member of the operating board of directors. The term does not include members of separate, restricted boards that serve only in an advisory capacity to the operating board.

(8) "Licensed facility" means an ambulatory surgical center licensed under this chapter.

(9) "Lifesafety" means the control and prevention of fire and other life-threatening conditions on a premises for the purpose of preserving human life.

(10) "Managing employee" means the administrator or other similarly titled individual who is responsible for the daily

operation of the licensed facility.

(11) "Medical staff" means physicians licensed under chapter 458 or chapter 459 with privileges in a licensed facility, as well as other licensed health care practitioners with clinical privileges as approved by a licensed facility's governing board.

(12) "Person" means any individual, partnership, corporation, association, or governmental unit.

(13) "Validation inspection" means an inspection of the premises of a licensed facility by the agency to assess whether a review by an accrediting organization has adequately evaluated the licensed facility according to minimum state standards.

**Section 4. Section 396.203, Florida Statutes, is created to read:**

396.203 Licensure; denial, suspension, and revocation.—

(1)(a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to ss. 396.201-396.315 and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 396.201-396.315. A license issued by the agency is required in order to operate an ambulatory surgical center in this state.

(b)1. It is unlawful for a person to use or advertise to the public, in any way or by any medium whatsoever, any facility as an "ambulatory surgical center" unless such facility has

first secured a license under this chapter.

2. This chapter does not apply to veterinary hospitals or to commercial business establishments using the word "hospital" as a part of a trade name if no treatment of human beings is performed on the premises of such establishments.

(2) In addition to the requirements in part II of chapter 408, the agency shall, at the request of a licensee, issue a single license to a licensee for facilities located on separate premises. Such a license shall specifically state the location of the facilities, the services, and the licensed beds available on each separate premises. If a licensee requests a single license, the licensee shall designate which facility or office is responsible for receipt of information, payment of fees, service of process, and all other activities necessary for the agency to carry out this chapter.

(3) In addition to the requirements of s. 408.807, after a change of ownership has been approved by the agency, the transferee shall be liable for any liability to the state, regardless of when identified, resulting from changes to allowable costs affecting provider reimbursement for Medicaid participation or Public Medical Assistance Trust Fund Assessments, and related administrative fines.

(4) An ambulatory surgical center shall comply with ss. 627.64194 and 641.513 as a condition of licensure.

(5) In addition to the requirements of part II of chapter

408, whenever the agency finds that there has been a substantial failure to comply with the requirements established under this chapter or in rules, the agency is authorized to deny, modify, suspend, and revoke:

(a) A license;

(b) That part of a license that is limited to a separate premises, as designated on the license; or

(c) Licensure approval limited to a facility, building, or portion thereof, or a service, within a given premises.

**Section 5. Section 396.204, Florida Statutes, is created to read:**

396.204 Application for license; fees.—In accordance with s. 408.805, an applicant or a licensee shall pay a fee for each license application submitted under this chapter, part II of chapter 408, and applicable rules. The amount of the fee shall be established by rule. The license fee required of a facility licensed under this chapter shall be established by rule, except that the minimum license fee shall be $1,500.

**Section 6. Section 396.205, Florida Statutes, is created to read:**

396.205 Minimum standards for clinical laboratory test results and diagnostic X-ray results; prerequisite for issuance or renewal of license.—

(1) As a requirement for issuance or renewal of its license, each licensed facility shall require that all clinical

laboratory tests performed by or for the licensed facility be performed by a clinical laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.

(2) Each licensed facility, as a requirement for issuance or renewal of its license, shall establish minimum standards for acceptance of results of diagnostic X rays performed by or for the licensed facility. Such standards shall require licensure or registration of the source of ionizing radiation under chapter 404.

(3) The results of clinical laboratory tests and diagnostic X rays performed before admission which meet the minimum standards required by law shall be accepted in lieu of routine examinations required upon admission and in lieu of clinical laboratory tests and diagnostic X rays which may be ordered by a physician for patients of the licensed facility.

**Section 7. Section 396.206, Florida Statutes, is created to read:**

396.206 Licensure inspection.—

(1) In addition to the requirement of s. 408.811, the agency shall make or cause to be made such inspections and investigations as it deems necessary, including all of the following:

(a) Inspections directed by the Centers for Medicare and

Medicaid Services.

(b) Validation inspections.

(c) Lifesafety inspections.

(d) Licensure complaint investigations, including full licensure investigations with a review of all licensure standards as outlined in the administrative rules. Complaints received by the agency from individuals, organizations, or other sources are subject to review and investigation by the agency.

(e) Emergency access complaint investigations.

(2) The agency shall accept, in lieu of its own periodic inspections for licensure, the survey or inspection of an accrediting organization, provided that the accreditation of the licensed facility is not provisional and provided that the licensed facility authorizes release of, and the agency receives the report of, the accrediting organization. The agency shall develop, and adopt by rule, criteria for accepting survey reports of accrediting organizations in lieu of conducting a state licensure inspection.

(3) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this chapter, part II of chapter 408, and applicable rules. With the exception of state-operated licensed facilities, each facility licensed under this chapter shall pay to the agency, at the time of inspection, the following fees:

(a) Inspection for licensure.—A fee shall be paid which is

at least $400 per facility.

(b) Inspection for lifesafety only.—A fee shall be paid which is at least $40 per facility.

(4) The agency shall coordinate all periodic inspections for licensure made by the agency to ensure that the cost to the facility of such inspections and the disruption of services by such inspections is minimized.

**Section 8. Section 396.207, Florida Statutes, is created to read:**

396.207 Inspection reports.—

(1) Each licensed facility shall maintain as public information, available upon request, records of all inspection reports pertaining to that facility. Copies of such reports shall be retained in its records for at least 5 years after the date the reports are filed and issued.

(2) Any records, reports, or documents which are confidential and exempt from s. 119.07(1) may not be distributed or made available for purposes of compliance with this section unless or until such confidential status expires.

(3) A licensed facility shall, upon the request of any person who has completed a written application with intent to be admitted to such facility, any person who is a patient of such facility, or any relative, spouse, guardian, or surrogate of any such person, furnish to the requester a copy of the last inspection report filed with or issued by the agency pertaining

to the licensed facility, as provided in subsection (1), provided that the person requesting such report agrees to pay a reasonable charge to cover copying costs, not to exceed $1 per page.

**Section 9. Section 396.208, Florida Statutes, is created to read:**

396.208 Construction inspections; plan submission and approval; fees.—

(1)(a) The design, construction, erection, alteration, modification, repair, and demolition of all licensed facilities are governed by the Florida Building Code and the Florida Fire Prevention Code under ss. 553.73 and 633.206. In addition to the requirements of ss. 553.79 and 553.80, the agency shall review facility plans and survey the construction of any facility licensed under this chapter. The agency shall make, or cause to be made, such construction inspections and investigations as it deems necessary. The agency may prescribe by rule that any licensee or applicant desiring to make specified types of alterations or additions to its facilities or to construct new facilities shall, before commencing such alteration, addition, or new construction, submit plans and specifications therefor to the agency for preliminary inspection and approval or recommendation with respect to compliance with applicable provisions of the Florida Building Code or agency rules and standards. The agency shall approve or disapprove the plans and

specifications within 60 days after receipt of the fee for review of plans as required in subsection (2). The agency may be granted one 15-day extension for the review period if the director of the agency approves the extension. If the agency fails to act within the specified time, it shall be deemed to have approved the plans and specifications. When the agency disapproves plans and specifications, it shall set forth in writing the reasons for its disapproval. Conferences and consultations may be provided as necessary.

(b) All licensed facilities shall submit plans and specifications to the agency for review under this section.

(2) The agency is authorized to charge an initial fee of $2,000 for review of plans and construction on all projects, no part of which is refundable. The agency may also collect a fee, not to exceed 1 percent of the estimated construction cost or the actual cost of review, whichever is less, for the portion of the review which encompasses initial review through the initial revised construction document review. The agency is further authorized to collect its actual costs on all subsequent portions of the review and construction inspections. The initial fee payment shall accompany the initial submission of plans and specifications. Any subsequent payment that is due is payable upon receipt of the invoice from the agency.

**Section 10. Section 396.209, Florida Statutes, is created to read:**

396.209 Rebates prohibited; penalties.—

(1) It is unlawful for any person to pay or receive any commission, bonus, kickback, or rebate or engage in any split-fee arrangement, in any form whatsoever, with any physician, surgeon, organization, or person, either directly or indirectly, for patients referred to a licensed facility.

(2) The agency shall enforce subsection (1). In the case of an entity not licensed by the agency, administrative penalties may include:

(a) A fine not to exceed $1,000.

(b) If applicable, a recommendation by the agency to the appropriate licensing board that disciplinary action be taken.

**Section 11. Section 396.211, Florida Statutes, is created to read:**

396.211 Staff membership and clinical privileges.—

(1) A licensed facility, in considering and acting upon an application for staff membership or clinical privileges, may not deny the application of a qualified doctor of medicine licensed under chapter 458, a doctor of osteopathic medicine licensed under chapter 459, a doctor of dentistry licensed under chapter 466, a doctor of podiatric medicine licensed under chapter 461, or a psychologist licensed under chapter 490 for such staff membership or clinical privileges within the scope of his or her respective licensure solely because the applicant is licensed under any of such chapters.

(2)(a) Each licensed facility shall establish rules and procedures for consideration of an application for clinical privileges submitted by an advanced practice registered nurse licensed under part I of chapter 464, in accordance with this section. A licensed facility may not deny such application solely because the applicant is licensed under part I of chapter 464 or because the applicant is not a participant in the Florida Birth-Related Neurological Injury Compensation Plan.

(b) An advanced practice registered nurse who is certified as a registered nurse anesthetist licensed under part I of chapter 464 shall administer anesthesia under the onsite medical direction of a professional licensed under chapter 458, chapter 459, or chapter 466, and in accordance with an established protocol approved by the medical staff. The medical direction shall specifically address the needs of the individual patient.

(c) Each licensed facility shall establish rules and procedures for consideration of an application for clinical privileges submitted by a physician assistant licensed pursuant to s. 458.347 or s. 459.022. Clinical privileges granted to a physician assistant pursuant to this subsection shall automatically terminate upon termination of staff membership of the physician assistant's supervising physician.

(3) When a licensed facility requires, as a precondition to obtaining staff membership or clinical privileges, the completion of, eligibility in, or graduation from any program or

society established by or relating to the American Medical Association or the Liaison Committee on Graduate Medical Education, the licensed facility shall also make available such membership or privileges to physicians who have attained completion of, eligibility in, or graduation from any equivalent program established by or relating to the American Osteopathic Association.

(4) This section does not restrict in any way the authority of the medical staff of a licensed facility to review for approval or disapproval all applications for appointment and reappointment to all categories of staff and to make recommendations on each applicant to the governing board, including the delineation of privileges to be granted in each case. In making such recommendations and in the delineation of privileges, each applicant shall be considered individually pursuant to criteria for a doctor licensed under chapter 458, chapter 459, chapter 461, or chapter 466, or for an advanced practice registered nurse licensed under part I of chapter 464, or for a psychologist licensed under chapter 490, as applicable. The applicant's eligibility for staff membership or clinical privileges shall be determined by the applicant's background, experience, health, training, and demonstrated competency; the applicant's adherence to applicable professional ethics; the applicant's reputation; and the applicant's ability to work with others and by such other elements as determined by the governing

board, consistent with this chapter.

(5) The governing board of each licensed facility shall set standards and procedures to be applied by the licensed facility and its medical staff in considering and acting upon applications for staff membership or clinical privileges. These standards and procedures shall be available for public inspection.

(6) Upon the written request of the applicant, any licensed facility that has denied staff membership or clinical privileges to any applicant specified in subsection (1) or subsection (2) shall, within 30 days after such request, provide the applicant with the reasons for such denial in writing. A denial of staff membership or clinical privileges to any applicant shall be submitted, in writing, to the applicant's respective licensing board.

(7) There is no monetary liability on the part of, and no cause of action for injunctive relief or damages shall arise against, any licensed facility, its governing board or governing board members, medical staff, or disciplinary board or against its agents, investigators, witnesses, or employees, or against any other person, for any action arising out of or related to carrying out this section, absent intentional fraud.

(8) The investigations, proceedings, and records of the board, or its agent with whom there is a specific written contract for the purposes of this section, as described in this

section are not subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of matters which are the subject of evaluation and review by such board, and any person who was in attendance at a meeting of such board or its agent is not permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such board or its agent or as to any findings, recommendations, evaluations, opinions, or other actions of such board or its agent or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such board; nor should any person who testifies before such board or who is a member of such board be prevented from testifying as to matters within his or her knowledge, but such witness cannot be asked about his or her testimony before such a board or opinions formed by him or her as a result of such board hearings.

(9)(a) If the defendant prevails in an action brought by an applicant against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section, the court shall award reasonable attorney fees and costs to the defendant.

(b) As a condition of any applicant bringing any action

against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section and before any responsive pleading is due, the applicant shall post a bond or other security, as set by the court having jurisdiction of the action, in an amount sufficient to pay the costs and attorney fees.

**Section 12. Section 396.212, Florida Statutes, is created to read:**

396.212 Licensed facilities; peer review; disciplinary powers; agency or partnership with physicians.—

(1) It is the intent of the Legislature that good faith participants in the process of investigating and disciplining physicians pursuant to the state-mandated peer review process shall, in addition to receiving immunity from retaliatory tort suits pursuant to s. 456.073(12), be protected from federal antitrust suits filed under the Sherman AntiTrust Act, 15 U.S.C.A. ss. 1 et seq. Such intent is within the public policy of the state to secure the provision of quality medical services to the public.

(2) Each licensed facility, as a condition of licensure, shall provide for peer review of physicians who deliver health care services at the facility. Each licensed facility shall develop written, binding procedures by which such peer review shall be conducted. Such procedures shall include all of the following:

(a) Mechanism for choosing the membership of the body or bodies that conduct peer review.

(b) Adoption of rules of order for the peer review process.

(c) Fair review of the case with the physician involved.

(d) Mechanism to identify and avoid conflict of interest on the part of the peer review panel members.

(e) Recording of agendas and minutes which do not contain confidential material, for review by the Division of Health Quality Assurance of the agency.

(f) Review, at least annually, of the peer review procedures by the governing board of the licensed facility.

(g) Focus of the peer review process on review of professional practices at the facility to reduce morbidity and mortality and to improve patient care.

(3) If reasonable belief exists that conduct by a staff member or physician who delivers health care services at the licensed facility may constitute one or more grounds for discipline as provided in this subsection, a peer review panel shall investigate and determine whether grounds for discipline exist with respect to such staff member or physician. The governing board of any licensed facility, after considering the recommendations of its peer review panel, shall suspend, deny, revoke, or curtail the privileges, or reprimand, counsel, or require education, of any such staff member or physician after a

final determination has been made that one or more of the following grounds exist:

(a) Incompetence.

(b) Being found to be a habitual user of intoxicants or drugs to the extent that he or she is deemed dangerous to himself, herself, or others.

(c) Mental or physical impairment which may adversely affect patient care.

(d) Being found liable by a court of competent jurisdiction for medical negligence or malpractice involving negligent conduct.

(e) One or more settlements exceeding $10,000 for medical negligence or malpractice involving negligent conduct by the staff member.

(f) Medical negligence other than as specified in paragraph (d) or paragraph (e).

(g) Failure to comply with the policies, procedures, or directives of the risk management program or any quality assurance committees of any licensed facility.

(4) Pursuant to ss. 458.337 and 459.016, any disciplinary actions taken under subsection (3) shall be reported in writing to the Division of Health Quality Assurance of the agency within 30 working days after its initial occurrence, regardless of the pendency of appeals to the governing board of the ambulatory surgical center. The notification shall identify the disciplined

practitioner, the action taken, and the reason for such action. All final disciplinary actions taken under subsection (3), if different from those which were reported to the agency within 30 days after the initial occurrence, shall be reported within 10 working days to the Division of Health Quality Assurance of the agency in writing and shall specify the disciplinary action taken and the specific grounds therefor. The division shall review each report and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case s. 456.073 shall apply. The reports are not subject to inspection under s. 119.07(1) even if the division's investigation results in a finding of probable cause.

(5) There is no monetary liability on the part of, and no cause of action for damages against, any licensed facility, its governing board or governing board members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, or employees; a committee of an ambulatory surgical center; or any other person for any action taken without intentional fraud in carrying out this section.

(6) For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section or part II of chapter 408, the agency shall first seek to obtain corrective action by the licensed facility. If correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations

of this section or part II of chapter 408, the agency may impose an administrative fine, not to exceed $5,000 for any violation of the reporting requirements of this section or part II of chapter 408. The administrative fine for repeated nonwillful violations may not exceed $10,000 for any violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation, per day. The fine for an intentional and willful violation of this section or part II of chapter 408 may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b).

(7) The proceedings and records of peer review panels, committees, and governing boards or agents thereof which relate solely to actions taken in carrying out this section are not subject to inspection under s. 119.07(1); and meetings held pursuant to achieving the objectives of such panels, committees, and governing boards or agents thereof are not open to the public under chapter 286.

(8) The investigations, proceedings, and records of the peer review panel, a disciplinary board, or a governing board, or any agent thereof with whom there is a specific written contract for that purpose, as described in this section may not be subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services arising out of the matters which

are the subject of evaluation and review by such group or its agent, and a person who was in attendance at a meeting of such group or its agent may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during the proceedings of such group or its agent or as to any findings, recommendations, evaluations, opinions, or other actions of such group or its agent or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were presented during proceedings of such group, and any person who testifies before such group or who is a member of such group may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her testimony before such a group or opinions formed by him or her as a result of such group hearings.

(9)(a) If the defendant prevails in an action brought by a staff member or physician who delivers health care services at the licensed facility against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section, the court shall award reasonable attorney fees and costs to the defendant.

(b) As a condition of any staff member or physician bringing any action against any person or entity that initiated,

participated in, was a witness in, or conducted any review as authorized by this section and before any responsive pleading is due, the staff member or physician shall post a bond or other security, as set by the court having jurisdiction of the action, in an amount sufficient to pay the costs and attorney fees.

**Section 13. Section 396.213, Florida Statutes, is created to read:**

396.213 Internal risk management program.—

(1) Every licensed facility shall, as a part of its administrative functions, establish an internal risk management program that includes all of the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to patients.

(b) The development of appropriate measures to minimize the risk of adverse incidents to patients, including, but not limited to:

1. Risk management and risk prevention education and training of all nonphysician personnel as follows:

a. Such education and training of all nonphysician personnel as part of their initial orientation; and

b. At least 1 hour of such education and training annually for all personnel of the licensed facility working in clinical areas and providing patient care, except those persons licensed as health care practitioners who are required to complete

continuing education coursework pursuant to chapter 456 or the respective practice act.

2. A prohibition, except when emergency circumstances require otherwise, against a staff member of the licensed facility attending a patient in the recovery room, unless the staff member is authorized to attend the patient in the recovery room and is in the company of at least one other person. However, a licensed facility is exempt from the two-person requirement if it has:

a. Live visual observation;

b. Electronic observation; or

c. Any other reasonable measure taken to ensure patient protection and privacy.

3. A prohibition against an unlicensed person from assisting or participating in any surgical procedure unless the licensed facility has authorized the person to do so following a competency assessment, and such assistance or participation is done under the direct and immediate supervision of a licensed physician and is not otherwise an activity that may only be performed by a licensed health care practitioner.

4. Development, implementation, and ongoing evaluation of procedures, protocols, and systems to accurately identify patients, planned procedures, and the correct site of the planned procedure so as to minimize the performance of a surgical procedure on the wrong patient, a wrong surgical

procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition.

(c) The analysis of patient grievances that relate to patient care and the quality of medical services.

(d) A system for informing a patient or an individual identified pursuant to s. 765.401(1) that the patient was the subject of an adverse incident, as defined in subsection (5). Such notice shall be given by an appropriately trained person designated by the licensed facility as soon as practicable to allow the patient an opportunity to minimize damage or injury.

(e) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.

(2) The internal risk management program is the responsibility of the governing board of the licensed facility. Each licensed facility shall hire a risk manager who is responsible for implementation and oversight of the facility's internal risk management program and who demonstrates competence, through education or experience, in all of the following areas:

(a) Applicable standards of health care risk management.

(b) Applicable federal, state, and local health and safety laws and rules.

(c) General risk management administration.

(d) Patient care.

(e) Medical care.

(f) Personal and social care.

(g) Accident prevention.

(h) Departmental organization and management.

(i) Community interrelationships.

(j) Medical terminology.

(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims are encouraged and their implementation and operation facilitated. Such additional approaches may include extending internal risk management programs to health care providers' offices and the assuming of provider liability by a licensed facility for acts or omissions occurring within the licensed facility. Each licensed facility shall annually report to the agency and the Department of Health the name and judgments entered against each health care practitioner for which it assumes liability. The agency and Department of Health, in their respective annual reports, shall include statistics that report the number of licensed facilities that assume such liability and the number of health care practitioners, by profession, for whom they assume

liability.

(4) The agency shall adopt rules governing the establishment of internal risk management programs to meet the needs of individual licensed facilities. Each internal risk management program shall include the use of incident reports to be filed with an individual of responsibility who is competent in risk management techniques in the employ of each licensed facility, such as an insurance coordinator, or who is retained by the licensed facility as a consultant. The individual responsible for the risk management program shall have free access to all medical records of the licensed facility. The incident reports are part of the workpapers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery, but are not admissible as evidence in court. A person filing an incident report is not subject to civil suit by virtue of such incident report. As a part of each internal risk management program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas.

(5) For purposes of reporting to the agency pursuant to this section, the term "adverse incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and

which:

(a) Results in one of the following injuries:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the licensed facility;

6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or

7. Any condition that required the transfer of the patient, within or outside the licensed facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition before the adverse incident.

(b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;

(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was

not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or

(d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure.

(6)(a) Each licensed facility subject to this section shall submit an annual report to the agency summarizing the incident reports that have been filed in the facility for that year. The report shall include:

1. The total number of adverse incidents.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries, and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. A code number using the health care professional's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents to patients, the relationship of the individual to the licensed facility, and the number of incidents in which each individual has been directly involved. Each licensed facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

5. A description of all malpractice claims filed against the licensed facility, including the total number of pending and

closed claims and the nature of the incident which led to, the persons involved in, and the status and disposition of each claim. Each report shall update status and disposition for all prior reports.

(b) The information reported to the agency pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case s. 456.073 shall apply.

(c) The report submitted to the agency must also contain the name of the risk manager of the licensed facility, a copy of its policy and procedures which govern the measures taken by the licensed facility and its risk manager to reduce the risk of injuries and adverse incidents, and the results of such measures. The annual report is confidential and is not available to the public pursuant to s. 119.07(1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The annual report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board.

However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

(7) Any of the following adverse incidents, whether occurring in the licensed facility or arising from health care services administered before admission in the licensed facility, shall be reported by the licensed facility to the agency within 15 calendar days after its occurrence:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

(c) The performance of a surgical procedure on the wrong patient;

(d) The performance of a wrong-site surgical procedure;

(e) The performance of a wrong surgical procedure;

(f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;

(g) The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or

(h) The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by the licensed facility administrator to the agency. The agency may require an additional, final report. These reports may not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case s. 456.073 shall apply.

(8) The agency shall publish on the agency's website, at least quarterly, a summary and trend analysis of adverse

incident reports received pursuant to this section, which may not include information that would identify the patient, the reporting facility, or the practitioners involved. The agency shall publish on the agency's website an annual summary and trend analysis of all adverse incident reports and malpractice claims information provided by licensed facilities in their annual reports, which may not include information that would identify the patient, the reporting facility, or the practitioners involved. The purpose of the publication of the summary and trend analysis is to promote the rapid dissemination of information relating to adverse incidents and malpractice claims to assist in avoidance of similar incidents and reduce morbidity and mortality.

(9) The internal risk manager of each licensed facility shall:

(a) Investigate every allegation of sexual misconduct which is made against a member of the licensed facility's personnel who has direct patient contact, when the allegation is that the sexual misconduct occurred at the facility or on the grounds of the facility.

(b) Report every allegation of sexual misconduct to the administrator of the licensed facility.

(c) Notify the family or guardian of the victim, if a minor, that an allegation of sexual misconduct has been made and that an investigation is being conducted.

(d) Report to the Department of Health every allegation of sexual misconduct, as defined in chapter 456 and the respective practice act, by a licensed health care practitioner that involves a patient.

(10) Any witness who witnessed or who possesses actual knowledge of the act that is the basis of an allegation of sexual abuse shall:

(a) Notify the local police; and

(b) Notify the risk manager and the administrator.

For purposes of this subsection, the term "sexual abuse" means acts of a sexual nature committed for the sexual gratification of anyone upon, or in the presence of, a vulnerable adult, without the vulnerable adult's informed consent, or a minor. The term includes, but is not limited to, the acts defined in s. 794.011(1)(j), fondling, exposure of a vulnerable adult's or minor's sexual organs, or the use of the vulnerable adult or minor to solicit for or engage in prostitution or sexual performance. The term does not include any act intended for a valid medical purpose or any act which may reasonably be construed to be a normal caregiving action.

(11) A person who, with malice or with intent to discredit or harm a licensed facility or any person, makes a false allegation of sexual misconduct against a member of a licensed facility's personnel is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(12) In addition to any penalty imposed pursuant to this section or part II of chapter 408, the agency shall require a written plan of correction from the licensed facility. For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section or part II of chapter 408, the agency shall first seek to obtain corrective action by the licensed facility. If the correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section or part II of chapter 408, the agency may impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of this section or part II of chapter 408. The administrative fine for repeated nonwillful violations may not exceed $10,000 for any violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation, per day. The fine for an intentional and willful violation of this section or part II of chapter 408 may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b).

(13) The agency shall have access to all licensed facility records necessary to carry out this section. The records obtained by the agency under subsection (6), subsection (7), or subsection (9) are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any

civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall records obtained pursuant to s. 456.071 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, s. 766.101 controls.

(14) The meetings of the committees and governing board of a licensed facility held solely for the purpose of achieving the objectives of risk management as provided by this section may not be open to the public under chapter 286. The records of such meetings are confidential and exempt from s. 119.07(1), except as provided in subsection (13).

(15) The agency shall review, as part of its licensure inspection process, the internal risk management program at each licensed facility regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under this section.

(16) There is no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager for the implementation and oversight of the internal risk management program in a facility licensed under this chapter or chapter 390 as required by this section, for any act or proceeding undertaken or performed within the scope of the functions of such internal risk management program if the risk manager acts without intentional fraud.

(17) A privilege against civil liability is granted to any risk manager or licensed facility with regard to information furnished pursuant to this chapter, unless the risk manager or facility acted in bad faith or with malice in providing such information.

(18) If the agency, through its receipt of any reports required under this section or through any investigation, has a reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate regulatory board, the agency shall report this fact to such regulatory board.

(19) It is unlawful for any person to coerce, intimidate, or preclude a risk manager from lawfully executing his or her reporting obligations pursuant to this chapter. Such unlawful action shall be subject to civil monetary penalties not to exceed $10,000 per violation.

**Section 14. Section 396.214, Florida Statutes, is created**

**to read:**

396.214 Identification, segregation, and separation of biomedical waste.—Each licensed facility shall comply with the requirements in s. 381.0098. Any transporter or potential transporter of such waste shall be notified of the existence and locations of such waste.

**Section 15. Section 396.215, Florida Statutes, is created to read:**

396.215 Patient safety.—

(1) Each licensed facility must adopt a patient safety plan. A plan adopted to implement the requirements of 42 C.F.R. s. 482.21 shall be deemed to comply with this requirement.

(2) Each licensed facility shall appoint a patient safety officer for the purpose of promoting the health and safety of patients, reviewing and evaluating the quality of patient safety measures used by the facility, and assisting in the implementation of the facility patient safety plan.

(3) Each licensed facility must, at least biennially, conduct a patient safety culture survey using the applicable Survey on Patient Safety Culture developed by the federal Agency for Healthcare Research and Quality. Each licensed facility shall conduct the survey anonymously to encourage completion of the survey by staff working in or employed by the facility. Each licensed facility may contract to administer the survey. Each facility shall biennially submit the survey data to the agency

in a format specified by rule, which must include the survey participation rate. Each licensed facility may develop an internal action plan between conducting surveys to identify measures to improve the survey and submit the plan to the agency.

**Section 16. Section 396.216, Florida Statutes, is created to read:**

396.216 Child abuse and neglect cases; duties.—Each licensed facility shall adopt a protocol that, at a minimum, requires the facility to:

(1) Incorporate a facility policy that every staff member has an affirmative duty to report, pursuant to chapter 39, any actual or suspected case of child abuse, abandonment, or neglect; and

(2) In any case involving suspected child abuse, abandonment, or neglect, designate, at the request of the department, a staff physician to act as a liaison between the licensed facility and the Department of Children and Families, which is investigating the suspected abuse, abandonment, or neglect, and the Child Protection Team, as defined in s. 39.01, when the case is referred to such a team.

**Section 17. Section 396.217, Florida Statutes, is created to read:**

396.217 Duty to notify patients.—An appropriately trained person designated by each licensed facility shall inform each

patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section do not constitute an acknowledgment or admission of liability and may not be introduced as evidence.

**Section 18. Section 396.218, Florida Statutes, is created to read:**

396.218 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this chapter, which shall include reasonable and fair minimum standards for ensuring that:

(a) Sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care and safety.

(b) Infection control, housekeeping, sanitary conditions, and medical record procedures that will adequately protect patient care and safety are established and implemented.

(c) A comprehensive emergency management plan is prepared and updated annually. The standards must be included in the rules adopted by the agency after consulting with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water;

postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records, and responding to family inquiries. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the licensed facility of necessary revisions.

(d) Licensed facilities are established, organized, and operated consistent with established standards and rules.

(e) Licensed facility beds conform to minimum space, equipment, and furnishings standards as specified by the department.

(f) Each licensed facility has a quality improvement program designed according to standards established by its current accrediting organization. This program will enhance quality of care and emphasize quality patient outcomes, corrective action for problems, governing board review, and reporting to the agency of standardized data elements necessary

to analyze quality of care outcomes. The agency shall use existing data, when available, and may not duplicate the efforts of other state agencies in order to obtain such data.

(g) Licensed facilities make available on their Internet websites, and in a hard copy format upon request, a description of and a link to the patient charge and performance outcome data collected from licensed facilities pursuant to s. 408.061.

(2) The agency shall adopt rules that establish minimum standards for pediatric patient care in ambulatory surgical centers to ensure the safe and effective delivery of surgical care to children in ambulatory surgical centers. Such standards must include quality of care, nurse staffing, physician staffing, and equipment standards. Ambulatory surgical centers may not provide operative procedures to children under 18 years of age which require a length of stay past midnight until such standards are established by rule.

(3) Any rule adopted under this chapter by the agency may not deny a license to a facility required to be licensed under this part, solely by reason of the school or system of practice employed or permitted to be employed by physicians therein, provided that such school or system of practice is recognized by the laws of this state. However, this subsection does not limit the powers of the agency to provide and require minimum standards for the maintenance and operation of, and for the treatment of patients in, those licensed facilities which

receive federal aid, in order to meet minimum standards related to such matters in such licensed facilities which may now or hereafter be required by appropriate federal officers or agencies in pursuance of federal law or adopted in pursuance of federal law.

(4) Any licensed facility which is in operation at the time of adoption of any applicable rules under this chapter shall be given a reasonable time, under the particular circumstances, but not to exceed 1 year after the date of such adoption, within which to comply with such rules.

(5) The agency may not adopt any rule governing the design, construction, erection, alteration, modification, repair, or demolition of any ambulatory surgical center. It is the intent of the Legislature to preempt that function to the Florida Building Commission and the State Fire Marshal through adoption and maintenance of the Florida Building Code and the Florida Fire Prevention Code. However, the agency shall provide technical assistance to the commission and the State Fire Marshal in updating the construction standards of the Florida Building Code and the Florida Fire Prevention Code which govern licensed facilities.

**Section 19. Section 396.219, Florida Statutes, is created to read:**

396.219 Criminal and administrative penalties; moratorium.—

(1) In addition to s. 408.812, any person establishing, conducting, managing, or operating any facility without a license under this chapter commits a misdemeanor and, upon conviction, shall be fined not more than $500 for the first offense and not more than $1,000 for each subsequent offense, and each day of continuing violation after conviction is considered a separate offense.

(2)(a) The agency may impose an administrative fine, not to exceed $1,000 per violation, per day, for the violation of this part, part II of chapter 408, or applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine.

(b) In determining the amount of fine to be levied for a violation, as provided in paragraph (a), the following factors shall be considered:

1. The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted, the severity of the actual or potential harm, and the extent to which this part was violated.

2. Actions taken by the licensee to correct the violations or to remedy complaints.

3. Any previous violations of the licensee.

(c) The agency may impose an administrative fine for the violation of s. 641.3154 or, if sufficient claims due to a

provider from a health maintenance organization do not exist to enable the take-back of an overpayment, as provided under s. 641.3155(5), for the violation of s. 641.3155(5). The administrative fine for a violation cited in this paragraph shall be in the amounts specified in s. 641.52(5), and paragraph (a) does not apply.

(3) In accordance with part II of chapter 408, the agency may impose an immediate moratorium on elective admissions to any licensed facility, building, or portion thereof, or service, when the agency determines that any condition in the licensed facility presents a threat to public health or safety.

(4) The agency shall impose a fine of $500 for each instance of the licensed facility's failure to provide the information required by rules adopted pursuant to s. 396.1055(1)(g).

**Section 20. Section 396.311, Florida Statutes, is created to read:**

396.311 Powers and duties of the agency.—The agency shall:

(1) Adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this part and part II of chapter 408 conferring duties upon it.

(2) Develop a model risk management program for licensed facilities that will satisfy the requirements of s. 395.0197.

(3) Enforce the special-occupancy provisions of the Florida Building Code which apply to ambulatory surgical centers

in conducting any inspection authorized by this chapter and part II of chapter 408.

**Section 21. Section 396.312, Florida Statutes, is created to read:**

396.312 Price transparency; itemized patient statement or bill; patient admission status notification.—

(1) A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to patients and prospective patients of the facility, or to patients' survivors or legal guardians, as appropriate. Such information shall be provided in accordance with this section and rules adopted by the agency pursuant to this chapter and s. 408.05. Licensed facilities operating exclusively as state facilities are exempt from this subsection.

(a) Each licensed facility shall make available to the public on its website information on payments made to that facility for defined bundles of services and procedures. The payment data must be presented and searchable in accordance with, and through a hyperlink to, the system established by the agency and its vendor using the descriptive service bundles developed under s. 408.05(3)(c). At a minimum, the licensed facility shall provide the estimated average payment received from all payors, excluding Medicaid and Medicare, for the descriptive service bundles available at that facility and the estimated payment range for such bundles. Using plain language,

comprehensible to an ordinary layperson, the licensed facility must disclose that the information on average payments and the payment ranges is an estimate of costs that may be incurred by the patient or prospective patient and that actual costs will be based on the services actually provided to the patient. The licensed facility's website must:

1. Provide information to prospective patients on the licensed facility's financial assistance policy, including the application process, payment plans, and discounts, and the facility's charity care policy and collection procedures.

2. If applicable, notify patients and prospective patients that services may be provided in the licensed facility by that facility as well as by other health care providers who may separately bill the patient and that such health care providers may or may not participate with the same health insurers or health maintenance organizations as the facility.

3. Inform patients and prospective patients that they may request from the licensed facility and other health care providers a more personalized estimate of charges and other information, and inform patients that they should contact each health care practitioner who will provide services in the facility to determine the health insurers and health maintenance organizations with which the health care practitioner participates as a network provider or preferred provider.

4. Provide the names, mailing addresses, and telephone

numbers of the health care practitioners and medical practice groups with which it contracts to provide services in the licensed facility and instructions on how to contact the practitioners and groups to determine the health insurers and health maintenance organizations with which they participate as network providers or preferred providers.

(b) Each licensed facility shall post on its website a consumer-friendly list of standard charges for at least 300 shoppable health care services, or an Internet-based price estimator tool meeting federal standards. If a licensed facility provides fewer than 300 distinct shoppable health care services, it shall make available on its website the standard charges for each service it provides. As used in this paragraph, the term:

1. "Shoppable health care service" means a service that can be scheduled by a healthcare consumer in advance. The term includes, but is not limited to, the services described in s. 627.6387(2)(e) and any services defined in regulations or guidance issued by the United States Department of Health and Human Services.

2. "Standard charge" has the same meaning as that term is defined in regulations or guidance issued by the United States Department of Health and Human Services for purposes of ambulatory surgical center price transparency.

(c)1. Before providing any nonemergency medical services, each licensed facility shall provide in writing or by electronic

means a good faith estimate of reasonably anticipated charges by the licensed facility for the treatment of a patient's or prospective patient's specific condition. The licensed facility is not required to adjust the estimate for any potential insurance coverage. The licensed facility must provide the estimate to the patient's health insurer, as defined in s. 627.446(1), and the patient at least 3 business days before the date such service is to be provided, but no later than 1 business day after the date such service is scheduled or, in the case of a service scheduled at least 10 business days in advance, no later than 3 business days after the date the service is scheduled. The licensed facility must provide the estimate to the patient no later than 3 business days after the date the patient requests an estimate. The estimate may be based on the descriptive service bundles developed by the agency under s. 408.05(3)(c) unless the patient or prospective patient requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient. The licensed facility shall inform the patient or prospective patient that he or she may contact his or her health insurer for additional information concerning cost-sharing responsibilities.

2. In the estimate, the licensed facility shall provide to the patient or prospective patient information on the facility's financial assistance policy, including the application process,

payment plans, and discounts and the facility's charity care policy and collection procedures.

3. The estimate shall clearly identify any licensed facility fees and, if applicable, include a statement notifying the patient or prospective patient that a facility fee is included in the estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.

4. The licensed facility shall notify the patient or prospective patient of any revision to the estimate.

5. In the estimate, the licensed facility must notify the patient or prospective patient that services may be provided in the facility by the facility as well as by other health care providers that may separately bill the patient, if applicable.

6. Failure to timely provide the estimate pursuant to this paragraph shall result in a daily fine of $1,000 until the estimate is provided to the patient or prospective patient and the health insurer. The total fine per patient estimate may not exceed $10,000.

(d) Each licensed facility shall make available on its website a hyperlink to the health-related data, including quality measures and statistics that are disseminated by the agency pursuant to s. 408.05. The licensed facility shall also take action to notify the public that such information is electronically available and provide a hyperlink to the agency's

website.

(e)1. Upon request, and after the patient's discharge or release from a licensed facility, the facility must provide to the patient or to the patient's survivor or legal guardian, as appropriate, an itemized statement or a bill detailing in plain language, comprehensible to an ordinary layperson, the specific nature of charges or expenses incurred by the patient. The initial statement or bill shall be provided within 7 days after the patient's discharge or release or after a request for such statement or bill, whichever is later. The initial statement or bill must contain a statement of specific services received and expenses incurred by date and provider for such items of service, enumerating in detail as prescribed by the agency the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The statement or bill must also clearly identify any facility fee and explain the purpose of the fee. The statement or bill must identify each item as paid, pending payment by a third party, or pending payment by the patient, and must include the amount due, if applicable. If an amount is due from the patient, a due date must be included. The initial statement or bill must direct the patient or the patient's survivor or legal guardian, as appropriate, to contact the patient's insurer or health maintenance organization regarding the patient's cost-sharing

responsibilities.

2. Any subsequent statement or bill provided to a patient or to the patient's survivor or legal guardian, as appropriate, relating to the episode of care must include all of the information required by subparagraph 1., with any revisions clearly delineated.

3. Each statement or bill provided pursuant to this subsection:

a. Must include notice of physicians and other health care providers who bill separately.

b. May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

(2) Each itemized statement or bill must prominently display the telephone number of the licensed facility's patient liaison who is responsible for expediting the resolution of any billing dispute between the patient, or the patient's survivor or legal guardian, and the billing department.

(3) A licensed facility shall make available to a patient all records necessary for verification of the accuracy of the patient's statement or bill within 10 business days after the request for such records. The records must be made available in the licensed facility's offices and through electronic means that comply with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. s. 1320d, as amended. Such records must be available to the patient before and after

payment of the statement or bill. The licensed facility may not charge the patient for making such verification records available; however, the facility may charge its usual fee for providing copies of records as specified in s. 396.3025.

(4) Each licensed facility shall establish a method for reviewing and responding to questions from patients concerning the patient's itemized statement or bill. Such response shall be provided within 7 business days after the date a question is received. If the patient is not satisfied with the response, the facility must provide the patient with the contact information of the agency to which the issue may be sent for review.

(5) Each licensed facility shall establish an internal process for reviewing and responding to grievances from patients. Such process must allow a patient to dispute charges that appear on the patient's itemized statement or bill. The licensed facility shall prominently post on its website and indicate in bold print on each itemized statement or bill the instructions for initiating a grievance and the direct contact information required to initiate the grievance process. The licensed facility must provide an initial response to a patient grievance within 7 business days after the patient formally files a grievance disputing all or a portion of an itemized statement or bill.

(6) Each licensed facility shall disclose to a patient, a prospective patient, or a patient's legal guardian whether a

cost-sharing obligation for a particular covered health care service or item exceeds the charge that applies to an individual who pays cash or the cash equivalent for the same health care service or item in the absence of health insurance coverage. Failure to provide a disclosure in compliance with this subsection may result in a fine not to exceed $500 per incident.

**Section 22. Section 396.313, Florida Statutes, is created to read:**

396.313 Billing and collection activities.—

(1) As used in this section, the term "extraordinary collection action" means any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care covered under the licensed facility's financial assistance policy:

(a) Selling the individual's debt to another party.

(b) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

(c) Deferring, denying, or requiring a payment before providing medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the licensed facility's financial assistance policy.

(d) Actions that require a legal or judicial process, including, but not limited to:

1. Placing a lien on the individual's property;

2. Foreclosing on the individual's real property;

3. Attaching or seizing the individual's bank account or any other personal property;

4. Commencing a civil action against the individual;

5. Causing the individual's arrest; or

6. Garnishing the individual's wages.

(2) A licensed facility may not engage in an extraordinary collection action against an individual to obtain payment for services:

(a) Before the licensed facility has made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy for the care provided and, if eligible, before a decision is made by the facility on the patient's application for such financial assistance.

(b) Before the licensed facility has provided the individual with an itemized statement or bill.

(c) During an ongoing grievance process as described in s. 395.301(6) or an ongoing appeal of a claim adjudication.

(d) Before billing any applicable insurer and allowing the insurer to adjudicate a claim.

(e) For 30 days after notifying the patient in writing, by certified mail, or by other traceable delivery method, that a collection action will commence absent additional action by the patient.

(f) While the individual:

1. Negotiates in good faith the final amount of a bill for services rendered; or

2. Complies with all terms of a payment plan with the licensed facility.

**Section 23. Section 396.314, Florida Statutes, is created to read:**

396.314 Patient records; penalties for alteration.—

(1) Any person who fraudulently alters, defaces, or falsifies any medical record, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges.

**Section 24. Section 396.315, Florida Statutes, is created to read:**

396.315 Patient and personnel records; copies; examination.—

(1) Any licensed facility shall, upon written request, and only after discharge of the patient, furnish, in a timely manner, without delays for legal review, to any person admitted to the licensed facility for care and treatment or treated at the licensed facility, or to any such person's 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, a true and correct copy of all patient records, including X rays, and insurance information concerning such person, which records are in the possession of the licensed facility, provided that the person requesting such records agrees to pay a charge. The exclusive charge for copies of patient records may include sales tax and actual postage, and, except for nonpaper records that are subject to a charge not to exceed $2, may not exceed $1 per page. A fee of up to $1 may be charged for each year of records requested. These charges shall apply to all records furnished, whether directly from the licensed facility or from a copy service providing these services on behalf of the licensed facility. However, a patient whose records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search. The licensed facility shall further allow any such person to examine the original records in its possession, or microforms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed to ensure that the records will not be damaged, destroyed, or altered.

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

(a) Licensed facility personnel, attending physicians, or other health care practitioners and providers currently involved in the care or treatment of the patient for use only in connection with the treatment of the patient.

(b) Licensed facility personnel only for administrative purposes or risk management and quality assurance functions.

(c) The agency, for purposes of health care cost containment.

(d) In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice by the party seeking such records to the patient or his or her legal representative.

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

regulatory board. However, the agency must make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause.

(f) Organ procurement organizations, tissue banks, and eye banks required to conduct death records reviews pursuant to s. 396.2050.

(g) The Medicaid Fraud Control Unit in the Department of Legal Affairs pursuant to s. 409.920.

(h) The Department of Financial Services, or an agent, employee, or independent contractor of the department who is auditing for unclaimed property pursuant to chapter 717.

(i) A regional poison control center for purposes of treating a poison episode under evaluation, case management of poison cases, or compliance with data collection and reporting requirements of s. 395.1027 and the professional organization that certifies poison control centers in accordance with federal law.

(3) The Department of Health may examine patient records of a licensed facility, whether held by the licensed facility or the Agency for Health Care Administration, for the purpose of epidemiological investigations. The unauthorized release of information by agents of the department which would identify an individual patient is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(4) Patient records shall contain information required for completion of birth, death, and fetal death certificates.

(5)(a) If the content of any record of patient treatment is provided under this section, the recipient, if other than the patient or the patient's representative, may use such information only for the purpose provided and may not further disclose any information to any other person or entity, unless expressly permitted by the written consent of the patient. A general authorization for the release of medical information is not sufficient for this purpose. The content of such patient treatment record is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(b) Absent a specific written release or authorization permitting utilization of patient information for solicitation or marketing the sale of goods or services, any use of that information for those purposes is prohibited.

(6) Patient records at ambulatory surgical centers are exempt from disclosure under s. 119.07(1), except as provided in subsections (1)-(5).

(7) A licensed facility may prescribe the content and custody of limited-access records which the licensed facility may maintain on its employees. Such records shall be limited to information regarding evaluations of employee performance, including records forming the basis for evaluation and subsequent actions, and shall be open to inspection only by the

employee and by officials of the licensed facility who are responsible for the supervision of the employee. The custodian of limited-access employee records shall release information from such records to other employers or only upon authorization in writing from the employee or upon order of a court of competent jurisdiction. Any licensed facility releasing such records pursuant to this chapter shall be considered to be acting in good faith and may not be held liable for information contained in such records, absent a showing that the facility maliciously falsified such records. Such limited-access employee records are exempt from s. 119.07(1) for a period of 5 years after the date such records are designated limited-access records.

(8) The home addresses, telephone numbers, and photographs of employees of any licensed facility who provide direct patient care or security services; the home addresses, telephone numbers, and places of employment of the spouses and children of such persons; and the names and locations of schools and day care facilities attended by the children of such persons are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, any state or federal agency that is authorized to have access to such information by any provision of law shall be granted such access in the furtherance of its statutory duties, notwithstanding this subsection. The Department of Financial Services, or an agent, employee, or

independent contractor of the department who is auditing for unclaimed property pursuant to chapter 717, shall be granted access to the name, address, and social security number of any employee owed unclaimed property.

(9) The home addresses, telephone numbers, and photographs of employees of any licensed facility who have a reasonable belief, based upon specific circumstances that have been reported in accordance with the procedure adopted by the licensed facility, that release of the information may be used to threaten, intimidate, harass, inflict violence upon, or defraud the employee or any member of the employee's family; the home addresses, telephone numbers, and places of employment of the spouses and children of such persons; and the names and locations of schools and day care facilities attended by the children of such persons are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, any state or federal agency that is authorized to have access to such information by any provision of law shall be granted such access in the furtherance of its statutory duties, notwithstanding this subsection. The licensed facility shall maintain the confidentiality of the personal information only if the employee submits a written request for confidentiality to the licensed facility.

**Section 25. Paragraph (d) of subsection (2) of section 383.145, Florida Statutes, is amended to read:**

383.145 Newborn, infant, and toddler hearing screening.—

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

(d) "Hospital" means a facility as defined in s. 395.002 ~~s. 395.002(13)~~ and licensed under chapter 395 and part II of chapter 408.

**Section 26. Paragraph (b) of subsection (4) of section 383.50, Florida Statutes, is amended to read:**

383.50 Treatment of surrendered infant.—

(4)

(b) Each hospital of this state subject to s. 395.1041 shall, and any other hospital may, admit and provide all necessary emergency services and care, as defined in s. 395.002 ~~s. 395.002(9)~~, to any infant left with the hospital in accordance with this section. The hospital or any of its medical staff or licensed health care professionals shall consider these actions as implied consent for treatment, and a hospital accepting physical custody of an infant has implied consent to perform all necessary emergency services and care. The hospital or any of its medical staff or licensed health care professionals are immune from criminal or civil liability for acting in good faith in accordance with this section. This subsection does not limit liability for negligence.

**Section 27. Subsection (2) of section 385.211, Florida Statutes, is amended to read:**

385.211 Refractory and intractable epilepsy treatment and

research at recognized medical centers.—

(2) Notwithstanding chapter 893, medical centers recognized pursuant to s. 381.925, or an academic medical research institution legally affiliated with a licensed children's specialty hospital as defined in s. 395.002 ~~s. 395.002(28)~~ that contracts with the Department of Health, may conduct research on cannabidiol and low-THC cannabis. This research may include, but is not limited to, the agricultural development, production, clinical research, and use of liquid medical derivatives of cannabidiol and low-THC cannabis for the treatment for refractory or intractable epilepsy. The authority for recognized medical centers to conduct this research is derived from 21 C.F.R. parts 312 and 316. Current state or privately obtained research funds may be used to support the activities described in this section.

**Section 28. Subsection (8) of section 390.011, Florida Statutes, is amended to read:**

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

(8) "Hospital" means a facility as defined in s. 395.002 ~~s. 395.002(12)~~ and licensed under chapter 395 and part II of chapter 408.

**Section 29. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:**

394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789.—As used in this section and ss. 394.4786,

394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002 ~~s. 395.002(28)~~ and part II of chapter 408 as a specialty psychiatric hospital.

**Section 30. Section 395.001, Florida Statutes, is amended to read:**

395.001 Legislative intent.—It is the intent of the Legislature to provide for the protection of public health and safety in the establishment, construction, maintenance, and operation of hospitals ~~and ambulatory surgical centers~~ by providing for licensure of same and for the development, establishment, and enforcement of minimum standards with respect thereto.

**Section 31. Subsections (4) through (33) of section 395.002, Florida Statutes, are renumbered as subsections (3) through (32), respectively, and present subsections (3), (10), (17), (23), and (28) of that section are amended to read:**

395.002 Definitions.—As used in this chapter:

~~(3) "Ambulatory surgical center" means a facility, the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within 24 hours, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained~~

~~for the practice of dentistry may not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003.~~

(9)~~(10)~~ "General hospital" means any facility which meets the provisions of subsection (11) ~~(12)~~ and which regularly makes its facilities and services available to the general population.

(16)~~(17)~~ "Licensed facility" means a hospital ~~or ambulatory surgical center~~ licensed in accordance with this chapter.

(22)~~(23)~~ "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital ~~or ambulatory surgical~~ care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07, reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.

(27)~~(28)~~ "Specialty hospital" means any facility which meets the provisions of subsection (11) ~~(12)~~, and which regularly makes available either:

(a) The range of medical services offered by general hospitals but restricted to a defined age or gender group of the population;

(b) 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

(c) Intensive residential treatment programs for children and adolescents as defined in subsection (16).

**Section 32. Subsection (1) and paragraph (d) of subsection (5) of section 395.003, Florida Statutes, are amended to read:**

395.003 Licensure; denial, suspension, and revocation.—

(1)(a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to ss. 395.001-395.1065 and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 395.001-395.1065. A license issued by the agency is required in order to operate a hospital ~~or ambulatory surgical center~~ in this state.

(b)1. It is unlawful for a person to use or advertise to the public, in any way or by any medium whatsoever, any facility as a "hospital" ~~or "ambulatory surgical center"~~ unless such facility has first secured a license under this part.

2. This part does not apply to veterinary hospitals or to commercial business establishments using the word "hospital" ~~or "ambulatory surgical center"~~ as a part of a trade name if no treatment of human beings is performed on the premises of such establishments.

(5)

(d) A hospital, ~~an ambulatory surgical center,~~ a specialty hospital, or an urgent care center shall comply with ss. 627.64194 and 641.513 as a condition of licensure.

**Section 33. Subsections (4) through (19) of section 395.1055, Florida Statutes, are renumbered as subsections (3) through (18), respectively, and subsection (2) and present subsections (3) and (9) of that section are amended, to read:**

395.1055 Rules and enforcement.—

(2) Separate standards may be provided for general and specialty hospitals~~, ambulatory surgical centers,~~ and statutory rural hospitals as defined in s. 395.602.

~~(3) The agency shall adopt rules that establish minimum standards for pediatric patient care in ambulatory surgical centers to ensure the safe and effective delivery of surgical care to children in ambulatory surgical centers. Such standards must include quality of care, nurse staffing, physician staffing, and equipment standards. Ambulatory surgical centers may not provide operative procedures to children under 18 years of age which require a length of stay past midnight until such~~

~~standards are established by rule.~~

(8)~~(9)~~ The agency may not adopt any rule governing the design, construction, erection, alteration, modification, repair, or demolition of any public or private hospital or~~,~~ intermediate residential treatment facility~~, or ambulatory surgical center~~. It is the intent of the Legislature to preempt that function to the Florida Building Commission and the State Fire Marshal through adoption and maintenance of the Florida Building Code and the Florida Fire Prevention Code. However, the agency shall provide technical assistance to the commission and the State Fire Marshal in updating the construction standards of the Florida Building Code and the Florida Fire Prevention Code which govern hospitals and~~,~~ intermediate residential treatment facilities~~, and ambulatory surgical centers~~.

**Section 34. Subsection (3) of section 395.10973, Florida Statutes, is amended to read:**

395.10973 Powers and duties of the agency.—It is the function of the agency to:

(3) Enforce the special-occupancy provisions of the Florida Building Code which apply to hospitals and~~,~~ intermediate residential treatment facilities~~, and ambulatory surgical centers~~ in conducting any inspection authorized by this chapter and part II of chapter 408.

**Section 35. Subsection (8) of section 395.3025, Florida Statutes, is amended to read:**

395.3025 Patient and personnel records; copies; examination.—

(8) Patient records at hospitals ~~and ambulatory surgical centers~~ are exempt from disclosure under s. 119.07(1), except as provided by subsections (1)-(5).

**Section 36. Subsection (3) of section 395.607, Florida Statutes, is amended to read:**

395.607 Rural emergency hospitals.—

(3) Notwithstanding s. 395.002 ~~s. 395.002(12)~~, a rural emergency hospital is not required to offer acute inpatient care or care beyond 24 hours, or to make available treatment facilities for surgery, obstetrical care, or similar services in order to be deemed a hospital as long as it maintains its designation as a rural emergency hospital, and may be required to make such services available only if it ceases to be designated as a rural emergency hospital.

**Section 37. Paragraphs (b) and (c) of subsection (1) of section 395.701, Florida Statutes, are amended to read:**

395.701 Annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.—

(1) For the purposes of this section, the term:

(b) "Gross operating revenue" or "gross revenue" means the sum of daily hospital service charges, ~~ambulatory service~~

~~charges,~~ ancillary service charges, and other operating revenue.

(c) "Hospital" means a health care institution as defined in s. 395.002 ~~s. 395.002(12)~~, but does not include any hospital operated by a state agency.

**Section 38. Paragraph (b) of subsection (3) of section 400.518, Florida Statutes, is amended to read:**

400.518 Prohibited referrals to home health agencies.—

(3)

(b) A physician who violates this section is subject to disciplinary action by the appropriate board under s. 458.331(2) or s. 459.015(2). A hospital ~~or ambulatory surgical center~~ that violates this section is subject to s. 395.0185(2). An ambulatory surgical center that violates this section is subject to s. 396.209.

**Section 39. Paragraph (h) of subsection (5) of section 400.93, Florida Statutes, is amended to read:**

400.93 Licensure required; exemptions; unlawful acts; penalties.—

(5) The following are exempt from home medical equipment provider licensure, unless they have a separate company, corporation, or division that is in the business of providing home medical equipment and services for sale or rent to consumers at their regular or temporary place of residence pursuant to the provisions of this part:

(h) Hospitals licensed under chapter 395 and ambulatory

surgical centers licensed under chapter 396 ~~395~~.

**Section 40. Paragraph (i) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:**

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(i) Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule may group services by price levels, listing services in each price level. The schedule must be posted in a conspicuous place in the reception area of any clinic that is considered an urgent care center as defined in s. 395.002 ~~s. 395.002(30)(b)~~ and must include, but is not limited to, the 50 services most frequently provided by the clinic. The posting may be a sign that must be at least 15 square feet in size or through an electronic messaging board that is at least 3 square feet in size. The failure of a clinic, including a clinic that is considered an urgent care center, to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted.

**Section 41. Paragraph (b) of subsection (2) of section 401.272, Florida Statutes, is amended to read:**

401.272 Emergency medical services community health care.—

(2) Notwithstanding any other provision of law to the contrary:

(b) Paramedics and emergency medical technicians shall operate under the medical direction of a physician through two-way communication or pursuant to established standing orders or protocols and within the scope of their training when a patient is not transported to an emergency department or is transported to a facility other than a hospital as defined in s. 395.002 ~~s. 395.002(12)~~.

**Section 42. Subsections (4) and (5) of section 408.051, Florida Statutes, are amended to read:**

408.051 Florida Electronic Health Records Exchange Act.—

(4) EMERGENCY RELEASE OF IDENTIFIABLE HEALTH RECORD.—A health care provider may release or access an identifiable health record of a patient without the patient's consent for use in the treatment of the patient for an emergency medical condition, as defined in s. 395.002 ~~s. 395.002(8)~~, when the health care provider is unable to obtain the patient's consent or the consent of the patient representative due to the patient's condition or the nature of the situation requiring immediate medical attention. A health care provider who in good faith releases or accesses an identifiable health record of a

patient in any form or medium under this subsection is immune from civil liability for accessing or releasing an identifiable health record.

(5) HOSPITAL DATA.—A hospital as defined in s. 395.002 ~~s. 395.002(12)~~ which maintains certified electronic health record technology must make available admit, transfer, and discharge data to the agency's Florida Health Information Exchange program for the purpose of supporting public health data registries and patient care coordination. The agency may adopt rules to implement this subsection.

**Section 43. Subsection (6) of section 408.07, Florida Statutes, is amended to read:**

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(6) "Ambulatory surgical center" means a facility licensed as an ambulatory surgical center under chapter 396 ~~395~~.

**Section 44. Subsection (9) of section 408.802, Florida Statutes, is amended to read:**

408.802 Applicability.—This part applies to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, and 765:

(9) Ambulatory surgical centers, as provided under ~~part I of~~ chapter 396 ~~395~~.

**Section 45. Subsection (9) of section 408.820, Florida Statutes, is amended to read:**

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

(9) Ambulatory surgical centers, as provided under ~~part I of~~ chapter 396 ~~395~~, are exempt from s. 408.810(7)-(10).

**Section 46. Subsection (8) of section 409.905, Florida Statutes, is amended to read:**

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(8) NURSING FACILITY SERVICES.—The agency shall pay for

24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital, as defined in s. 395.002 ~~by s. 395.002(10)~~, that is licensed under part I of chapter 395, and in accordance with provisions set forth in s. 409.908(2)(a), which services are ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another nursing facility is not available, the agency must pay for similar services temporarily in a hospital licensed under part I of chapter 395 provided federal funding is approved and available. The agency shall pay only for bed-hold days if the facility has an occupancy rate of 95 percent or greater. The agency is authorized to seek any federal waivers to implement this policy.

**Section 47. Subsection (3) of section 409.906, Florida Statutes, is amended to read:**

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be

provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may pay for services provided to a recipient in an ambulatory surgical center licensed under ~~part I of~~ chapter 396 ~~395~~, by or under the direction of a licensed physician or dentist.

**Section 48. Paragraph (b) of subsection (1) of section 409.975, Florida Statutes, is amended to read:**

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall

comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002 ~~s. 395.002(28)~~.

4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

5. Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v).

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals, and payments to nonparticipating Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v), shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

**Section 49. Subsection (5) of section 456.041, Florida Statutes, is amended to read:**

456.041 Practitioner profile; creation.—

(5) The Department of Health shall include the date of a hospital or ambulatory surgical center disciplinary action taken by a licensed hospital or an ambulatory surgical center, in accordance with the requirements of s. 395.0193 and s. 396.212, in the practitioner profile. The department shall state whether the action related to professional competence and whether it related to the delivery of services to a patient.

**Section 50. Paragraph (n) of subsection (3) of section**

**456.053, Florida Statutes, is amended to read:**

456.053 Financial arrangements between referring health care providers and providers of health care services.—

(3) DEFINITIONS.—For the purpose of this section, the word, phrase, or term:

(n) "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service; or

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

3. The following orders, recommendations, or plans of care shall not constitute a referral by a health care provider:

a. By a radiologist for diagnostic-imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.

d. By a cardiologist for cardiac catheterization services.

e. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the supervision of such referring health care provider or group practice if such supervision complies with all applicable Medicare payment and coverage rules for services; provided, however, a physician licensed pursuant to chapter 458, chapter 459, chapter 460, or chapter 461 or an advanced practice registered nurse registered under s. 464.0123 may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for which the sole provider or group practice billed both the technical and the professional fee for or on behalf of the patient, if the referring physician or advanced practice registered nurse registered under s. 464.0123 has no investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of

practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more than 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services. However, the 15 percent limitation of this sub-subparagraph and the requirements of subparagraph (4)(a)2. do not apply to a group practice entity that owns an accountable care organization or an entity operating under an advanced alternative payment model according to federal regulations if such entity provides diagnostic imaging services and has more than 30,000 patients enrolled per year.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 396 ~~395~~.

h. By a urologist for lithotripsy services.

i. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

j. By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

k. By a nephrologist for renal dialysis services and supplies, except laboratory services.

l. By a health care provider whose principal professional practice consists of treating patients in their private

residences for services to be rendered in such private residences, except for services rendered by a home health agency licensed under chapter 400. For purposes of this sub-subparagraph, the term "private residences" includes patients' private homes, independent living centers, and assisted living facilities, but does not include skilled nursing facilities.

m. By a health care provider for sleep-related testing.

**Section 51. Subsection (3) of section 456.056, Florida Statutes, is amended to read:**

456.056 Treatment of Medicare beneficiaries; refusal, emergencies, consulting physicians.—

(3) If treatment is provided to a beneficiary for an emergency medical condition as defined in s. 395.002 ~~s. 395.002(8)(a)~~, the physician must accept Medicare assignment provided that the requirement to accept Medicare assignment for an emergency medical condition shall not apply to treatment rendered after the patient is stabilized, or the treatment is unrelated to the original emergency medical condition. For the purpose of this subsection "stabilized" is defined to mean with respect to an emergency medical condition, that no material deterioration of the condition is likely within reasonable medical probability.

**Section 52. Subsection (3) of section 458.3145, Florida Statutes, is amended to read:**

458.3145 Medical faculty certificate.—

(3) The holder of a medical faculty certificate issued under this section has all rights and responsibilities prescribed by law for the holder of a license issued under s. 458.311, except as specifically provided otherwise by law. Such responsibilities include compliance with continuing medical education requirements as set forth by rule of the board. A hospital or ambulatory surgical center licensed under chapter 396 ~~395~~, health maintenance organization certified under chapter 641, insurer as defined in s. 624.03, multiple-employer welfare arrangement as defined in s. 624.437, or any other entity in this state, in considering and acting upon an application for staff membership, clinical privileges, or other credentials as a health care provider, may not deny the application of an otherwise qualified physician for such staff membership, clinical privileges, or other credentials solely because the applicant is a holder of a medical faculty certificate under this section.

**Section 53. Subsection (2) of section 458.320, Florida Statutes, is amended to read:**

458.320 Financial responsibility.—

(2) Physicians who perform surgery in an ambulatory surgical center licensed under chapter 396 ~~395~~ and, as a continuing condition of hospital staff privileges, physicians who have staff privileges must also establish financial responsibility by one of the following methods:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), through a plan of self-insurance as provided in s. 627.357, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110. The required coverage amount set forth in this paragraph may not be used for litigation costs or attorney ~~attorney's~~ fees for the defense of any medical malpractice claim.

(c) Obtaining and maintaining an unexpired irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit must be payable to the physician as beneficiary upon presentment of a final judgment indicating liability and

awarding damages to be paid by the physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The letter of credit must be nonassignable and nontransferable. The letter of credit must be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which has its principal place of business in this state or has a branch office that is authorized under the laws of this state or of the United States to receive deposits in this state.

This subsection shall be inclusive of the coverage in subsection (1).

**Section 54. Paragraph (f) of subsection (4) of section 458.351, Florida Statutes, is amended to read:**

458.351 Reports of adverse incidents in office practice settings.—

(4) For purposes of notification to the department pursuant to this section, the term "adverse incident" means an event over which the physician or licensee could exercise control and which is associated in whole or in part with a

medical intervention, rather than the condition for which such intervention occurred, and which results in the following patient injuries:

(f) Any condition that required the transfer of a patient to a hospital licensed under chapter 395 from an ambulatory surgical center licensed under chapter 396 ~~395~~ or any facility or any office maintained by a physician for the practice of medicine which is not licensed under chapter 395.

**Section 55. Subsection (2) of section 459.0085, Florida Statutes, is amended to read:**

459.0085 Financial responsibility.—

(2) Osteopathic physicians who perform surgery in an ambulatory surgical center licensed under chapter 396 ~~395~~ and, as a continuing condition of hospital staff privileges, osteopathic physicians who have staff privileges must also establish financial responsibility by one of the following methods:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per-claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim, with a

minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), through a plan of self-insurance as provided in s. 627.357, or through a plan of self-insurance that meets the conditions specified for satisfying financial responsibility in s. 766.110. The required coverage amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(c) Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit must be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The letter of credit must be nonassignable and

nontransferable. The letter of credit must be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which has its principal place of business in this state or has a branch office that is authorized under the laws of this state or of the United States to receive deposits in this state.

This subsection shall be inclusive of the coverage in subsection (1).

**Section 56. Paragraph (f) of subsection (4) of section 459.026, Florida Statutes, is amended to read:**

459.026 Reports of adverse incidents in office practice settings.—

(4) For purposes of notification to the department pursuant to this section, the term "adverse incident" means an event over which the physician or licensee could exercise control and which is associated in whole or in part with a medical intervention, rather than the condition for which such intervention occurred, and which results in the following patient injuries:

(f) Any condition that required the transfer of a patient to a hospital licensed under chapter 395 from an ambulatory surgical center licensed under chapter 396 ~~395~~ or any facility or any office maintained by a physician for the practice of

medicine which is not licensed under chapter 395.

**Section 57. Paragraph (e) of subsection (1) of section 465.0125, Florida Statutes, is amended to read:**

465.0125 Consultant pharmacist license; application, renewal, fees; responsibilities; rules.—

(1) The department shall issue or renew a consultant pharmacist license upon receipt of an initial or renewal application that conforms to the requirements for consultant pharmacist initial licensure or renewal as adopted by the board by rule and a fee set by the board not to exceed $250. To be licensed as a consultant pharmacist, a pharmacist must complete additional training as required by the board.

(e) For purposes of this subsection, the term "health care facility" means an ambulatory surgical center licensed under chapter 396, a ~~or~~ hospital licensed under chapter 395, an alcohol or chemical dependency treatment center licensed under chapter 397, an inpatient hospice licensed under part IV of chapter 400, a nursing home licensed under part II of chapter 400, an ambulatory care center as defined in s. 408.07, or a nursing home component under chapter 400 within a continuing care facility licensed under chapter 651.

**Section 58. Paragraph (l) of subsection (1) of section 468.505, Florida Statutes, is amended to read:**

468.505 Exemptions; exceptions.—

(1) Nothing in this part may be construed as prohibiting

or restricting the practice, services, or activities of:

(l) A person employed by a nursing facility exempt from licensing under s. 395.002 ~~s. 395.002(12)~~, or a person exempt from licensing under s. 464.022.

**Section 59. Paragraph (h) of subsection (4) of section 627.351, Florida Statutes, is amended to read:**

627.351 Insurance risk apportionment plans.—

(4) MEDICAL MALPRACTICE RISK APPORTIONMENT; ASSOCIATION CONTRACTS AND PURCHASES.—

(h) As used in this subsection:

1. "Health care provider" means hospitals licensed under chapter 395; physicians licensed under chapter 458; osteopathic physicians licensed under chapter 459; podiatric physicians licensed under chapter 461; dentists licensed under chapter 466; chiropractic physicians licensed under chapter 460; naturopaths licensed under chapter 462; nurses licensed under part I of chapter 464; midwives licensed under chapter 467; physician assistants licensed under chapter 458 or chapter 459; physical therapists and physical therapist assistants licensed under chapter 486; health maintenance organizations certificated under part I of chapter 641; ambulatory surgical centers licensed under chapter 396 ~~395~~; other medical facilities as defined in subparagraph 2.; blood banks, plasma centers, industrial clinics, and renal dialysis facilities; or professional associations, partnerships, corporations, joint ventures, or

other associations for professional activity by health care providers.

2. "Other medical facility" means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment, to which facility the patient is admitted and from which facility the patient is discharged within the same working day, and which facility is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy or an office maintained by a physician or dentist for the practice of medicine may not be construed to be an "other medical facility."

3. "Health care facility" means any hospital licensed under chapter 395, health maintenance organization certificated under part I of chapter 641, ambulatory surgical center licensed under chapter 396 ~~395~~, or other medical facility as defined in subparagraph 2.

**Section 60. Paragraph (b) of subsection (1) of section 627.357, Florida Statutes, is amended to read:**

627.357 Medical malpractice self-insurance.—

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

(b) "Health care provider" means any:

1. Hospital licensed under chapter 395.

2. Physician licensed, or physician assistant licensed, under chapter 458.

3. Osteopathic physician or physician assistant licensed under chapter 459.

4. Podiatric physician licensed under chapter 461.

5. Health maintenance organization certificated under part I of chapter 641.

6. Ambulatory surgical center licensed under chapter 396 ~~395~~.

7. Chiropractic physician licensed under chapter 460.

8. Psychologist licensed under chapter 490.

9. Optometrist licensed under chapter 463.

10. Dentist licensed under chapter 466.

11. Pharmacist licensed under chapter 465.

12. Registered nurse, licensed practical nurse, or advanced practice registered nurse licensed or registered under part I of chapter 464.

13. Other medical facility.

14. Professional association, partnership, corporation, joint venture, or other association established by the individuals set forth in subparagraphs 2., 3., 4., 7., 8., 9., 10., 11., and 12. for professional activity.

**Section 61. Section 627.6056, Florida Statutes, is amended to read:**

627.6056 Coverage for ambulatory surgical center service.—An ~~No~~ individual health insurance policy providing coverage on an expense-incurred basis or individual service or indemnity-

type contract issued by a nonprofit corporation, of any kind or description, may not ~~shall~~ be issued unless coverage provided for any service performed in an ambulatory surgical center, as defined in s. 396.202 ~~s. 395.002~~, is provided if such service would have been covered under the terms of the policy or contract as an eligible inpatient service.

**Section 62. Subsection (3) of section 627.6405, Florida Statutes, is amended to read:**

627.6405 Decreasing inappropriate utilization of emergency care.—

(3) As a disincentive for insureds to inappropriately use emergency department services for nonemergency care, health insurers may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments. Higher copayments may not be charged for the utilization of the emergency department for emergency care. For the purposes of this section, the term "emergency care" has the same meaning as the term "emergency services and care" as defined in s. 395.002 ~~s. 395.002(9)~~ and includes services provided to rule out an emergency medical condition.

**Section 63. Paragraph (b) of subsection (1) of section 627.64194, Florida Statutes, is amended to read:**

627.64194 Coverage requirements for services provided by nonparticipating providers; payment collection limitations.—

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

(b) "Facility" means a licensed facility as defined in s. 395.002 ~~s. 395.002(17)~~ and an urgent care center as defined in s. 395.002.

**Section 64. Section 627.6616, Florida Statutes, is amended to read:**

627.6616 Coverage for ambulatory surgical center service.—A ~~No~~ group health insurance policy providing coverage on an expense-incurred basis, or group service or indemnity-type contract issued by a nonprofit corporation, or self-insured group health benefit plan or trust, of any kind or description, may not ~~shall~~ be issued unless coverage provided for any service performed in an ambulatory surgical center, as defined in s. 396.202 ~~s. 395.002~~, is provided if such service would have been covered under the terms of the policy or contract as an eligible inpatient service.

**Section 65. Paragraph (a) of subsection (1) of section 627.736, Florida Statutes, is amended to read:**

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household unless excluded under s. 627.747, persons operating the insured motor vehicle, passengers in the motor

vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a chiropractic physician licensed under chapter 460, or an advanced practice registered nurse registered under s. 464.0123 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or an advanced practice registered nurse registered under s. 464.0123, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced practice registered nurse licensed under chapter 464. Followup services and care may also be provided by the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 396 ~~395~~.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, advanced practice registered nurses registered under s. 464.0123, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based

upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state, or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician

licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if a provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage therapy as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage therapy or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph. Such rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and

such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

**Section 66. Paragraph (a) of subsection (1) of section 627.912, Florida Statutes, is amended to read:**

627.912 Professional liability claims and actions; reports by insurers and health care providers; annual report by office.—

(1)(a) Each self-insurer authorized under s. 627.357 and each commercial self-insurance fund authorized under s. 624.462, authorized insurer, surplus lines insurer, risk retention group, and joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under

chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, or to an ambulatory surgical center as defined in s. 396.202 ~~s. 395.002~~, and each insurer providing professional liability insurance to a member of The Florida Bar shall report to the office as set forth in paragraph (c) any written claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent.

**Section 67. Subsection (2) of section 765.101, Florida Statutes, is amended to read:**

765.101 Definitions.—As used in this chapter:

(2) "Attending physician" means the physician who has primary responsibility for the treatment and care of the patient while the patient receives such treatment or care in a hospital as defined in s. 395.002 ~~s. 395.002(12)~~.

**Section 68. Paragraph (a) of subsection (1) of section 766.101, Florida Statutes, is amended to read:**

766.101 Medical review committee, immunity from

liability.—

(1) As used in this section:

(a) The term "medical review committee" or "committee" means:

1.a. A committee of a hospital or ambulatory surgical center licensed under chapter 396 ~~395~~ or a health maintenance organization certificated under part I of chapter 641;

b. A committee of a physician-hospital organization, a provider-sponsored organization, or an integrated delivery system;

c. A committee of a state or local professional society of health care providers;

d. A committee of a medical staff of a licensed hospital or nursing home, provided the medical staff operates pursuant to written bylaws that have been approved by the governing board of the hospital or nursing home;

e. A committee of the Department of Corrections or the Correctional Medical Authority as created under s. 945.602, or employees, agents, or consultants of either the department or the authority or both;

f. A committee of a professional service corporation formed under chapter 621 or a corporation organized under part I of chapter 607 or chapter 617, which is formed and operated for the practice of medicine as defined in s. 458.305(3), and which has at least 25 health care providers who routinely provide

health care services directly to patients;

g. A committee of the Department of Children and Families which includes employees, agents, or consultants to the department as deemed necessary to provide peer review, utilization review, and mortality review of treatment services provided pursuant to chapters 394, 397, and 916;

h. A committee of a mental health treatment facility licensed under chapter 394 or a community mental health center as defined in s. 394.907, provided the quality assurance program operates pursuant to the guidelines that have been approved by the governing board of the agency;

i. A committee of a substance abuse treatment and education prevention program licensed under chapter 397 provided the quality assurance program operates pursuant to the guidelines that have been approved by the governing board of the agency;

j. A peer review or utilization review committee organized under chapter 440;

k. A committee of the Department of Health, a county health department, healthy start coalition, or certified rural health network, when reviewing quality of care, or employees of these entities when reviewing mortality records; or

l. A continuous quality improvement committee of a pharmacy licensed pursuant to chapter 465,

which committee is formed to evaluate and improve the quality of health care rendered by providers of health service, to determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care, or that the cost of health care rendered was considered reasonable by the providers of professional health services in the area; or

2. A committee of an insurer, self-insurer, or joint underwriting association of medical malpractice insurance, or other persons conducting review under s. 766.106.

**Section 69. Subsection (3) of section 766.110, Florida Statutes, is amended to read:**

766.110 Liability of health care facilities.—

(3) In order to ensure comprehensive risk management for diagnosis of disease, a health care facility, including a hospital or ambulatory surgical center, as defined in chapter 396 ~~395~~, may use scientific diagnostic disease methodologies that use information regarding specific diseases in health care facilities and that are adopted by the facility's medical review committee.

**Section 70. Paragraph (d) of subsection (3) of section 766.1115, Florida Statutes, is amended to read:**

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

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

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 396 ~~395~~.

3. A hospital licensed under chapter 395.

4. A physician or physician assistant licensed under chapter 458.

5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatric physician licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced practice registered nurse licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association and its employees or a corporate medical group and its employees.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes

an office maintained by a provider.

13. A dentist or dental hygienist licensed under chapter 466.

14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.

15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

**Section 71. Subsection (4) and paragraph (b) of subsection (6) of section 766.118, Florida Statutes, are amended to read:**

766.118 Determination of noneconomic damages.—

(4) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF PRACTITIONERS PROVIDING EMERGENCY SERVICES AND CARE.—

Notwithstanding subsections (2) and (3), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners providing emergency services and care, as defined in s. 395.002 ~~s. 395.002(9)~~, or providing services as provided in s. 401.265, or providing services pursuant to obligations imposed by 42 U.S.C. s. 1395dd to persons with whom the practitioner does not have a then-existing health care patient-practitioner relationship for that medical condition:

(a) Regardless of the number of such practitioner defendants, noneconomic damages shall not exceed $150,000 per claimant.

(b) Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such practitioners shall not exceed $300,000.

The limitation provided by this subsection applies only to noneconomic damages awarded as a result of any act or omission of providing medical care or treatment, including diagnosis that occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation provided by this subsection applies to any act or omission of providing medical care or treatment which

occurs prior to the stabilization of the patient following the surgery.

(6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF A PRACTITIONER PROVIDING SERVICES AND CARE TO A MEDICAID RECIPIENT.—Notwithstanding subsections (2), (3), and (5), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of a practitioner committed in the course of providing medical services and medical care to a Medicaid recipient, regardless of the number of such practitioner defendants providing the services and care, noneconomic damages may not exceed $300,000 per claimant, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. A practitioner providing medical services and medical care to a Medicaid recipient is not liable for more than $200,000 in noneconomic damages, regardless of the number of claimants, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. The fact that a claimant proves that a practitioner acted in a wrongful manner does not preclude the application of the limitation on noneconomic damages prescribed elsewhere in this section. For purposes of this subsection:

(b) The term "practitioner," in addition to the meaning prescribed in subsection (1), includes a ~~any~~ hospital ~~or ambulatory surgical center~~ as defined and licensed under chapter

395 or an ambulatory surgical center as defined and licensed under chapter 396.

**Section 72. Subsection (4) of section 766.202, Florida Statutes, is amended to read:**

766.202 Definitions; ss. 766.201-766.212.—As used in ss. 766.201-766.212, the term:

(4) "Health care provider" means a ~~any~~ hospital ~~or ambulatory surgical center~~ as defined and licensed under chapter 395; an ambulatory surgical center as defined and licensed under chapter 396; a birth center licensed under chapter 383; any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, part I of chapter 464, chapter 466, chapter 467, part XIV of chapter 468, or chapter 486; a health maintenance organization certificated under part I of chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.

**Section 73. Section 766.316, Florida Statutes, is amended to read:**

766.316 Notice to obstetrical patients of participation in the plan.—Each hospital with a participating physician on its staff and each participating physician, other than residents, assistant residents, and interns deemed to be participating physicians under s. 766.314(4)(c), under the Florida Birth-

Related Neurological Injury Compensation Plan shall provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan. The hospital or the participating physician may elect to have the patient sign a form acknowledging receipt of the notice form. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not be given to a patient when the patient has an emergency medical condition as defined in s. 395.002 ~~s. 395.002(8)(b)~~ or when notice is not practicable.

**Section 74. Paragraph (b) of subsection (2) of section 812.014, Florida Statutes, is amended to read:**

812.014 Theft.—

(2)

(b)1. If the property stolen is valued at $20,000 or more, but less than $100,000;

2. If the property stolen is cargo valued at less than $50,000 that has entered the stream of interstate or intrastate commerce from the shipper's loading platform to the consignee's receiving dock;

3. If the property stolen is emergency medical equipment,

valued at $300 or more, that is taken from a facility licensed under chapter 395 or from an aircraft or vehicle permitted under chapter 401; or

4. If the property stolen is law enforcement equipment, valued at $300 or more, that is taken from an authorized emergency vehicle, as defined in s. 316.003,

the offender commits grand theft in the second degree, punishable as a felony of the second degree, as provided in s. 775.082, s. 775.083, or s. 775.084. Emergency medical equipment means mechanical or electronic apparatus used to provide emergency services and care as defined in s. 395.002 ~~s. 395.002(9)~~ or to treat medical emergencies. Law enforcement equipment means any property, device, or apparatus used by any law enforcement officer as defined in s. 943.10 in the officer's official business. However, if the property is stolen during a riot or an aggravated riot prohibited under s. 870.01 and the perpetration of the theft is facilitated by conditions arising from the riot; or within a county that is subject to a state of emergency declared by the Governor under chapter 252, the theft is committed after the declaration of emergency is made, and the perpetration of the theft is facilitated by conditions arising from the emergency, the theft is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. As used in this paragraph, the term "conditions arising from the

riot" means civil unrest, power outages, curfews, or a reduction in the presence of or response time for first responders or homeland security personnel and the term "conditions arising from the emergency" means civil unrest, power outages, curfews, voluntary or mandatory evacuations, or a reduction in the presence of or response time for first responders or homeland security personnel. A person arrested for committing a theft during a riot or an aggravated riot or within a county that is subject to a state of emergency may not be released until the person appears before a committing magistrate at a first appearance hearing. For purposes of sentencing under chapter 921, a felony offense that is reclassified under this paragraph is ranked one level above the ranking under s. 921.0022 or s. 921.0023 of the offense committed.

**Section 75. Paragraph (b) of subsection (1) of section 945.6041, Florida Statutes, is amended to read:**

945.6041 Inmate medical services.—

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

(b) "Health care provider" means:

1. A hospital licensed under chapter 395.

2. A physician or physician assistant licensed under chapter 458.

3. An osteopathic physician or physician assistant licensed under chapter 459.

4. A podiatric physician licensed under chapter 461.

5. A health maintenance organization certificated under part I of chapter 641.

6. An ambulatory surgical center licensed under chapter 396 ~~395~~.

7. A professional association, partnership, corporation, joint venture, or other association established by the individuals set forth in subparagraphs 2., 3., and 4. for professional activity.

8. An other medical facility.

a. As used in this subparagraph, the term "other medical facility" means:

(I) A facility the primary purpose of which is to provide human medical diagnostic services, or a facility providing nonsurgical human medical treatment which discharges patients on the same working day that the patients are admitted; and

(II) A facility that is not part of a hospital.

b. The term does not include a facility existing for the primary purpose of performing terminations of pregnancy, or an office maintained by a physician or dentist for the practice of medicine.

**Section 76. Paragraph (a) of subsection (1) of section 985.6441, Florida Statutes, is amended to read:**

985.6441 Health care services.—

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

(a) "Health care provider" means:

1. A hospital licensed under chapter 395.

2. A physician or physician assistant licensed under chapter 458.

3. An osteopathic physician or physician assistant licensed under chapter 459.

4. A podiatric physician licensed under chapter 461.

5. A health maintenance organization certificated under part I of chapter 641.

6. An ambulatory surgical center licensed under chapter 396 ~~395~~.

7. A professional association, partnership, corporation, joint venture, or other association established by the individuals set forth in subparagraphs 2.-4. for professional activity.

8. An other medical facility.

a. As used in this subparagraph, the term "other medical facility" means:

(I) A facility the primary purpose of which is to provide human medical diagnostic services, or a facility providing nonsurgical human medical treatment which discharges patients on the same working day that the patients are admitted; and

(II) A facility that is not part of a hospital.

b. The term does not include a facility existing for the primary purpose of performing terminations of pregnancy, or an office maintained by a physician or dentist for the practice of

medicine.

**Section 77.** This act shall take effect July 1, 2025.