Tab 1	**SB 1060** by **Brodeur;** Identical to H 00935 Medicaid Oversight

Tab 2	**SB 1546** by **Grall;** Identical to H 00431 Background Screening of Athletic Coaches

Tab 3	**SB 958** by **Bernard;** Similar to CS/H 00723 Type 1 Diabetes Early Detection

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Tab 4	**CS/SB 1070** by **ED, Simon;** Similar to CS/H 01135 Electrocardiograms for Student Athletes

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Tab 5	**SB 1544** by **Rodriguez;** Identical to H 01323 Opticianry

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Tab 6	**CS/SB 944** by **BI, Davis;** Identical to CS/H 00839 Insurance Overpayment Claims Submitted to Psychologists

Tab 7	**SB 768** by **Calatayud;** Similar to H 01543 Controlling Business Interests by Persons with Ties to Foreign Countries of Concern

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Tab 8	**SB 1370** by **Trumbull;** Similar to H 00475 Ambulatory Surgical Centers

Tab 9	**SB 1808** by **Burton;** Similar to H 01513 Refund of Overpayments Made by Patients

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The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Harrell, Vice Chair

MEETING DATE: Tuesday, March 18, 2025
TIME: 3:30—5:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Burton, Chair; Senator Harrell, Vice Chair; Senators Berman, Calatayud, Davis, Gaetz, Leek, Osgood, Passidomo, and Trumbull

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1060** Brodeur (Identical H 935)	Medicaid Oversight; Establishing the Joint Legislative Committee on Medicaid Oversight within the Office of the Auditor General for specified purposes; requiring the Auditor General and the Agency for Health Care Administration to enter into a data sharing agreement by a specified date; providing that the committee must be given access to certain records, papers, and documents, etc. HP 03/18/2025 Favorable AHS AP	Favorable Yeas 9 Nays 0
2	**SB 1546** Grall (Identical H 431)	Background Screening of Athletic Coaches; Revising the date upon which certain background screenings of athletic coaches must be conducted, etc. HP 03/18/2025 Favorable CJ RC	Favorable Yeas 9 Nays 0
3	**SB 958** Bernard (Similar CS/H 723)	Type 1 Diabetes Early Detection; Requiring the Department of Health, in coordination with local school districts, to develop informational materials on type 1 diabetes for the parents and guardians of students; requiring that such materials be made available to school districts and charter schools through the department's website; specifying requirements for the informational materials, etc. HP 03/18/2025 Fav/CS AHS FP	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**CS/SB 1070** Education Pre-K - 12 / Simon (Similar H 1135)	Electrocardiograms for Student Athletes; Citing this act as the "Second Chance Act"; requiring certain students to receive an electrocardiogram to participate in athletics, beginning on a specified date; requiring the Florida High School Athletic Association (FHSAA) to adopt a schedule requiring that, by a specified date, certain students receive, before competing, at least one electrocardiogram as a part of their medical evaluation; requiring that parents who object to an electrocardiogram provide a specified release from liability, etc. ED 03/11/2025 Fav/CS HP 03/18/2025 Fav/CS RC	Fav/CS Yeas 9 Nays 0
5	**SB 1544** Rodriguez (Identical H 1323)	Opticianry; Deleting the ability of an optician to delegate specified acts to unlicensed supportive personnel; deleting an exception to optician licensure requirements for employees working under the direct supervision of a physician or optometrist, etc. HP 03/18/2025 Temporarily Postponed AHS RC	Temporarily Postponed
6	**CS/SB 944** Banking and Insurance / Davis (Identical CS/H 839)	Insurance Overpayment Claims Submitted to Psychologists; Requiring that insurance overpayment claims submitted to psychologists be submitted within a specified timeframe, etc. BI 03/10/2025 Fav/CS HP 03/18/2025 Favorable RC	Favorable Yeas 9 Nays 0
7	**SB 768** Calatayud (Similar H 1543)	Controlling Business Interests by Persons with Ties to Foreign Countries of Concern; Revising minimum health care provider licensure requirements relating to persons or entities possessing a controlling interest in the licensee; defining the term "controlling interest"; revising the definition of the term "foreign country of concern", etc. HP 03/18/2025 Fav/CS JU RC	Fav/CS Yeas 8 Nays 1

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 1370** Trumbull (Similar H 475)	Ambulatory Surgical Centers; Providing requirements for issuance, denial, suspension, and revocation of ambulatory surgical center licenses; requiring the Agency for Health Care Administration to make or cause to be made specified inspections of licensed facilities; requiring the agency to coordinate periodic inspections to minimize costs and disruption of services; providing that specified provisions govern the design, construction, erection, alteration, modification, repair, and demolition of licensed facilities; requiring licensed facilities to establish an internal risk management program; providing certain investigative and reporting requirements for internal risk managers relating to the investigation and reporting of allegations of sexual misconduct or sexual abuse at licensed facilities, etc. HP 03/18/2025 Favorable AHS RC	Favorable Yeas 9 Nays 0
9	**SB 1808** Burton (Similar H 1513)	Refund of Overpayments Made by Patients; Requiring certain health care practitioners to refund to the patient any overpayment within a specified timeframe; providing for disciplinary action; subjecting certain health care practitioners to disciplinary action for failing to comply with specified provisions, etc. HP 03/18/2025 Fav/CS AHS RC	Fav/CS Yeas 9 Nays 0
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1060
INTRODUCER:	Senator Brodeur
SUBJECT:	Medicaid Oversight
DATE:	March 17, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 1060 creates s. 11.405, F.S., to establish the Joint Legislative Committee on Medicaid Oversight (committee) within the Office of the Auditor General to ensure the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

The bill authorizes the committee chair to create subcommittees and requires the committee to convene at least twice a year, and as often as necessary to conduct its business. Meetings may be held through teleconference or other electronic means.

The bill requires the committee to identify and recommend policies and authorizes the committee to submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

The bill requires the Auditor General and the Florida Agency for Health Care Administration (AHCA) to enter into and maintain a data-sharing agreement by July 1, 2025. The bill requires the Auditor General to assist the committee in its work. The bill also requires the committee to be given access to any relevant record, paper, or document in possession of a state agency, any political subdivision of the state, or any entity engaged in business or under contract with a state agency during the course of its official duties. The committee may compel the attendance and testimony of any state official or employee before the committee or secure any evidence.

The bill requires the AHCA to notify the committee of any change to the Medicaid managed care capitation rates and to appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates before implementation of any change to the capitation rates.

If the AHCA or any division within the AHCA is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the bill requires the AHCA to submit a copy of the report to the committee.

The bill takes effect upon becoming law.

II. Present Situation:

Joint Legislative Committees

A joint legislative committee is composed of members of the Senate and the House of Representatives appointed by their respective presiding officers to oversee a specified legislative function.[1] Joint legislative committees and other joint units of the Legislature are governed by joint rules of the Senate and the House of Representatives.[2]

The 2024-2026 Joint Rules of the Florida Legislature

The Joint Rules of the Florida Legislature, previously adopted in November 2024, address the following subjects:[3]

- JOINT RULE ONE – Lobbyist Registration and Compensation Reporting
- JOINT RULE TWO – General Appropriations Review Period and Budget Conference Committee Rules
- JOINT RULE THREE – Joint Offices and Policies
- JOINT RULE FOUR – Joint Committees
- JOINT RULE FIVE – Auditor General
- JOINT RULE SIX – Joint Legislative Budget Commission
- JOINT RULE SEVEN – Qualifications of Members
- JOINT RULE EIGHT – Adjourning and Reconvening of Each House of the Legislature and Providing for Adjournment Sine Die

JOINT RULE FOUR – Joint Committees

Joint Rule Four establishes the following standing joint committees:[4]

- The Joint Administrative Procedures Committee (JAPC);[5]
- The Joint Committee on Public Counsel Oversight;[6] and

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[1] The Florida Senate, *Glossary*, *available at* https://www.flsenate.gov/reference/glossary (last visited Mar. 16, 2025).
[2] Section 11.147(2), F.S.
[3] SCR 2 ORG (2024), enrolled.
[4] *Id*.
[5] The primary function of the JAPC is to generally review agency action pursuant to the operation of the Florida Administrative Procedure Act, particularly as these actions relate to the rulemaking process.
Florida Administrative Law Central Online Network, *About the Joint Administrative Procedures Committee, available at* https://www.japc.state.fl.us/Pages/About.aspx (last visited Mar. 15, 2025).
[6] The Joint Committee on Public Counsel Oversight appoints a Public Counsel, pursuant to s. 350.061, F.S. The committee may file a complaint with the Commission on Ethics alleging a violation of ch. 350, F.S., by a current or former public service commissioner, an employee of the Public Service Commission, or a member of the Public Service Commission Nominating Council. [SCR 2 ORG (2024), enrolled.]

- The Joint Legislative Auditing Committee (JLAC).[7]

The rule requires that no other joint committee may exist except as agreed to by the presiding officers or by concurrent resolution approved by the Senate and the House of Representatives. The rule also requires that each standing joint committee appoint no fewer than five and no more than seven members from each house.[8]

The rule establishes procedures for the appointment of the chair and vice chair of the standing joint committees and procedures for joint committees other than conference committees. The rule also establishes the powers and administration of joint committees.[9]

JOINT RULE FIVE – Auditor General

Joint Rule Five provides rulemaking authority to the Auditor General and requires the Auditor General to prepare and submit a proposed budget for the ensuing fiscal year annually to the President of the Senate and the Speaker of the House of Representatives for joint approval. The rule has provisions related to the salaries and expenses of the Auditor General. The rule also requires the Auditor General to distribute copies of each audit report to certain state officers, including the Governor; the Chief Financial Officer; the officer or person in charge of the state agency or political subdivision audited; the board of county commissioners of the county in which the audit was made, if applicable; each member of the JLAC; appropriate substantive and fiscal committees of the Senate and House of Representatives; and any other person who, in the opinion of the Auditor General, is directly interested in the audit or who has a connected duty to perform.[10]

The Auditor General

Florida's Auditor General is a constitutional and legislative officer, a certified public accountant, and the state's independent auditor providing unbiased, timely, and relevant information that the Legislature, citizens of the state of Florida, public entity management, and other stakeholders can use to promote government accountability and stewardship, as well as improve government operations.[11]

The Constitution of the State of Florida provides for the Legislature to appoint an auditor to audit public records and perform related duties as prescribed by law or concurrent resolution. Section 11.42, F.S., designates the constitutional auditor as the Auditor General, and

[7] In general, the responsibilities of the JLAC are broad and affect all areas of government in the state. For instance, the JLAC may direct the Auditor General or the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct an audit, review, or examination of any entity or record as specified in s. 11.45(3), F.S. The JLAC is responsible for appointing the Auditor General, pursuant to s. 11.42(2), F.S., when there is a vacancy in the position.
The Florida Legislature, Online Sunshine, *Joint Legislative Auditing Committee, available at* http://www.leg.state.fl.us/cgi-bin/View_Page.pl?File=about.cfm&Directory=committees/joint/Jcla/&Tab=committees (last visited Mar. 15, 2025).
[8] *Supra* note *3*.
[9] *Id*.
[10] *Id*.
[11] Florida Auditor General, *About the Florida Auditor General, available at* https://flauditor.gov/pages/aboutus.html#tab (last visited Mar. 16, 2025).

ss. 11.42, 11.45, and 11.47, F.S., establish the general authority and duties. Independently, and in accordance with applicable professional standards, the Auditor General:[12]

- Conducts financial audits of the accounts and records of state government, state universities, state colleges, and school districts.
- Conducts operational and performance audits of public programs, activities, and functions, as well as information technology systems.
- Adopts rules, in consultation with the Florida Board of Accountancy, for audits performed by independent certified public accountants of local governmental entities, charter schools and technical career centers, school districts, and certain nonprofit and for-profit organizations.
- Conducts reviews of audit reports of local governmental entities, charter schools and technical career centers, school districts, and certain nonprofit and for-profit organizations.
- Conducts examinations of school district records to evaluate compliance with state requirements governing the Florida Education Finance Program student enrollment and student transportation funding allocations.
- Conducts quality assessment reviews of the internal audits performed by state agency offices of inspector general.

The Florida Medicaid Program

The Medicaid program is a voluntary, federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[13] The federal Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services is responsible for administering the Medicaid program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[14]

Statewide Medicaid Managed Care

Approximately 80 percent of Florida Medicaid recipients receive services through a plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and Dental. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.[15]

The AHCA awarded contracts to the current SMMC managed care plans through a competitive procurement process called an Invitation to Negotiate (ITN). The AHCA awarded and executed new contracts for SMMC 3.0 in October 2024 and officially rolled out the new SMMC 3.0 program on February 1, 2025. The rate year for the SMMC contracts is October 1 through September 30 of each contract year.[16]

[12] *Id*.
[13] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Mar. 16, 2025).
[14] Section 20.42, F.S.
[15] Florida Agency for Health Care Administration, *Senate Bill 1060* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[16] *Id*.

Managed care plans providing MMA program services are required to cover acute, preventive, and other health care services, such as:[17]

- Hospital services;
- Physician services;
- Pharmacy services;
- Behavioral health services;
- Transportation to medical services;
- Nursing facility services; and
- Other service benefits, including, but not limited to, medical equipment and supplies, therapies, and home health services.

The AHCA contracts with LTC plans in each region to provide LTC services, including all home and community-based waiver services, through their provider networks. Currently, all of the LTC plans contracted with the AHCA are also contracted to provide MMA services, streamlining care with a more comprehensive enrollment approach where a Medicaid recipient can enroll with one plan for all services.[18]

Managed care plans are considered "at-risk" because they are required to pay for the medically necessary services their members require, regardless of whether the capitation rates are sufficient to cover those costs. For instance, since the AHCA pays a fixed price PMPM capitation rate that covers all (or nearly all) the services a plan provides, if the plan spends more than it is paid, the plan loses money; however, if the plan needs to spend less than it is paid and still fulfills its contract with the AHCA and provides the services it's supposed to provide, then the plan makes money.[19]

Achieved Savings Rebate

Pursuant to s. 409.967(3), F.S., the AHCA implemented the Achieved Savings Rebate (ASR) Program as an incentive for proper use of state funds. The program monitors the premium revenues, medical and administrative costs, and income or losses for each plan. The ASR allows plans to retain a profit margin specified in statute; however, if the profit margin exceeds the limits specified in statute, plans must share a portion of the profits with the state or return the entire dollar amount beyond a certain threshold to the state.

The detailed financial reports for each plan are audited by an independent public accountant. The AHCA has program rules to ensure the independence of the public accountant and to establish criteria for the independent auditor.[20] The plans are responsible for paying the audit expenses incurred by the AHCA and, as part of the audit process, must provide all books, accounts, documents, files, and information pertaining to Medicaid transactions to the AHCA and the contracted certified public accounting firm.[21]

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[17] *Id*.
[18] *Id*.
[19] *Id*.
[20] Office of Program Policy Analysis & Government Accountability, *Report No. 16-03, AHCA Reorganized to Enhance Managed Care Program Oversight and Continues to Recoup Fee-for-Service Overpayments* (Feb. 2016), *available at* https://oppaga.fl.gov/Documents/Reports/16-03.pdf (last visited Mar. 16, 2025).
[21] *Supra* note 15.

The ASR is established by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:[22]

- 100 percent of income up to and including five percent of revenue shall be retained by the plan.
- 50 percent of income above five percent and up to 10 percent shall be retained by the plan, and the other 50 percent shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.
- 100 percent of income above 10 percent of revenue shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.

The program is tied to plan performance; if a plan exceeds the AHCA-defined quality measures in the reporting period, it may retain an additional one percent of revenue.[23]

The following may not be included as allowable expenses in calculating income for determining the achieved savings rebate:[24]

- Payment of achieved savings rebates.
- Any financial incentive payments made to the plan outside of the capitation rate.
- Any financial disincentive payments levied by the state or federal government.
- Expenses associated with any lobbying or political activities.
- The cash value or equivalent cash value of bonuses of any type paid or awarded to the plan's executive staff, other than base salary.
- Reserves and reserve accounts.
- Administrative costs, including, but not limited to, reinsurance expenses, interest payments, depreciation expenses, bad debt expenses, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the AHCA.

Plans that incur a loss in the first contract year may apply the full amount of the loss as an offset to income in the second contract year.[25]

If, after an audit, the AHCA determines that a plan owes an additional rebate, the plan has 30 days after notification to make the payment. Upon failure to timely pay the rebate, the AHCA will withhold future payments to the plan until the entire amount is recouped. If the AHCA determines that a plan has made an overpayment, the AHCA will return the overpayment within 30 days.[26]

[22] Section 409.967(3), F.S.
[23] *Id*.
[24] *Id*.
[25] *Id*.
[26] *Id*.

Fee-for-Service and Managed Care Capitation Payments

In the state of Forida, Medicaid services can be delivered through a fee-for-service (FFS) or managed care delivery model. In FFS, providers contract directly with the AHCA to provide services, followed by billing and receiving direct reimbursement from the AHCA. In a managed care delivery model, managed care plans contract with the AHCA and are paid a per-member, per-month (PMPM) capitation rate for each plan enrollee to provide medical, dental, or home and community-based care, depending on the type of managed care plan. Providers contract with the managed care plans and bill the plans for services rendered to enrollees.[27]

The AHCA maintains provider fee schedules, which include the rates the AHCA pays FFS providers for services. However, in managed care, the managed care plans negotiate mutually agreed-upon rates with contracted providers for most services. The capitation rates reflect historical utilization and spending for covered services projected forward, and the PMPM capitation rate is paid to each plan each month regardless of the actual expenditure or level of claims of an individual enrollee. Currently, managed care plan capitation rates are both calculated and certified as actuarially sound by the AHCA's actuarial services vendor;[28] however, in the past, the AHCA conducted rate setting in-house and the certification was performed independently.[29]

Florida's Medicaid capitation rate-setting process is guided by standards and regulations set by the CMS. Actuaries must adhere to multiple standards and codes of conduct, including:[30]

- All federal requirements related to Medicaid;
- The CMS Medicaid Managed Care Rate Development Guide;[31]
- The American Academy of Actuaries (AAA) Actuarial Standards of Practice (ASOPs);[32] and
- The AAA[33] and Society of Actuaries Code of Conduct.[34]

To ensure full compliance with these standards and regulations, a comprehensive appendix is included in all final rate setting reports to address each relevant item of the CMS Medicaid Managed Care Rate Development Guide. Each rate submission is accompanied by an actuarial

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[27] *Supra* note 15.
[28] *Id*.
[29] The Florida Senate, *Issue Brief 211-226, Medicaid Managed Care Rate-Setting* (November 2010), *available at* https://www.flsenate.gov/UserContent/Session/2011/Publications/InterimReports/pdf/2011-226hr.pdf (last visited Mar. 16, 2025).
[30] *Supra* note 15.
[31] The CMS Medicaid Managed Care Rate Development Guide outlines the necessary documentation required for the CMS review and approval of capitation rates.
U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *2024-25 Medicaid Managed Care Rate Development Guide, available at* https://www.medicaid.gov/medicaid/managed-care/downloads/2024-2025-medicaid-rate-guide-01222024.pdf (last visited Mar. 16, 2025).
[32] Standard 49 of the ASOPs, Medicaid Managed Care Capitation Rate Development and Certification, provides detailed guidance for setting Medicaid managed care capitation rates.
American Academy of Actuaries, Actuarial Standards Board, *All Standards, available at* https://www.actuarialstandardsboard.org/standards-of-practice/ (last visited Mar. 16, 2025).
[33] American Academy of Actuaries, *Code of Professional Conduct, available at* https://www.actuary.org/content/code-professional-conduct (last visited Mar. 16, 2025).
[34] Society of Actuaries, *Code of Professional Conduct, available at* https://www.soa.org/about/governance/about-code-of-professional-conduct/ (last visited Mar. 16, 2025).

certification that verifies the accuracy and regulatory adherence of the rates. Additionally, all capitation rates undergo a thorough review by the CMS, involving multiple rounds of question and answers to validate the methodology utilized to develop rates for the CMS to approve.[35]

The AHCA's actuarial services vendor is Milliman Inc., and using encounter data in conjunction with financial data reported by the plans, Milliman develops capitation rates through the following steps:[36]

- Establishes the base data set using historical utilization and cost data;
- Adjusts the base data for any program changes, fee schedule increases, or legislative directives;
- Applies utilization, trend, seasonality, and acuity adjustments to reflect the new or current rating period; and
- Builds in managed care plan administrative costs and profit margins.

Capitation rates are risk-adjusted monthly for LTC and quarterly for MMA, but once the rates are set on October 1, they generally remain constant throughout the rate year unless a generational event or a material mistake requires a technical correction.[37]

Legislative increases to facility rates or provider fee schedules are built into the capitation rates for the health plans to pass-through to the providers during the following state fiscal year. Administrative expenses and increases to administrative expenses as a result of programmatic changes are built into the capitation rates as well, along with a two-percent profit margin for the plans, which may be more or less depending on the health of a plan's membership.[38]

The total capitated amount the health plans are paid is used to forecast the Medicaid budget for the following state fiscal year. At the Social Services Estimating Conference (SSEC),[39,40] managed care expenditures are combined with FFS expenditures and other appropriations to arrive at a total program cost, which is then trended forward to estimate the budgetary need for the coming state fiscal year.[41]

As part of the rate-setting process, Milliman and the AHCA meet with the managed care plans to share base data and assumptions on costs of upcoming Medicaid program changes and potential changes and trends to the cost of the health care delivery system in general. Draft rates are developed during and shortly after each legislative session and most legislative changes are incorporated into the draft rates. After the legislative session, Milliman and the AHCA meet with the plans again to share and discuss the draft rates, and the plans are given an opportunity to

[35] *Supra* note 15.
[36] *Id*.
[37] *Id*.
[38] *Id*.
[39] The SSEC is a conference body consisting of members of the Legislature, representatives from the Governor's Office, and designees from various state agencies, which meets to develop Medicaid caseload or workload data and revenue/expenditure projections as it relates to TANF/WAGES, Medicaid, and Kidcare to assist in the budgeting and appropriations process. Florida Office of Economic & Demographic Research, *Consensus Estimating Conference Process, available at* https://edr.state.fl.us/Content/conferences/confprocess.pdf (last visited Mar. 16, 2025).
[40] *Supra* note 1.
[41] *Supra* note 15.

provide feedback before the rates are finalized. Managed care plan feedback, post-legislative session changes to the General Appropriations Act, and additional months of experiential data can result in minor changes to the final rates when compared to the draft rates.[42]

Managed Care Plan Accreditation

Accreditation is a "seal of approval" given to a plan by an independent organization that evaluates the practices and performances of the plan. Accreditation indicates the plan meets specific quality standards. Accreditation status is one of the quality selection criteria the AHCA considers in the selection of eligible plans. Section 409.967(f)(3), F.S., requires each plan to be accredited by the National Committee for Quality Assurance (NCQA),[43] the Joint Commission,[44] or another nationally recognized accrediting body, or have initiated the accreditation process, within one year after the contract is executed. Each accrediting organization assesses plan performance against applicable standards and elements and establishes quality and performance standards, including, but not limited to, provider credentialing, prior authorization of services, and prompt payment of provider claims.[45]

SMMC Plan Provider Networks

The SMMC plans must adhere to all requirements as specified in their contract with the AHCA, including requirements to enter into provider agreements with a sufficient number of providers to deliver all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided with reasonable promptness. If the managed care plan declines to include individual or group providers in its provider network, the plan is required to give written notice to the affected provider(s) of the reason for its decision.[46] Managed care plans conduct credentialing and recredentialing for network providers and offer onboarding activities for new providers joining their networks.[47]

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[42] *Id*.

[43] The NCQA Health Plan Accreditation provides a current, rigorous, and comprehensive framework for essential quality improvement and measurement. Organizations use the NCQA to perform a gap analysis and align improvement activities with areas that are most important to states and employers, such as network adequacy and consumer protection. Standards evaluate plans on quality management and improvement, population health management, network management, utilization management, credentialing and recredentialing, members' rights and responsibilities, member connections, and Medicaid benefits and services. The use of Healthcare Effectiveness Data and Information Set (HEDIS) data focuses attention on activities that keep members healthy.
National Committee for Quality Assurance, *Health Plan Accreditation, available at* https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/ (last visited Mar. 16, 2025).

[44] Accreditation by the Joint Commission is the objective evaluation process helping health care organizations measure, assess, and improve performance to provide safe, high-quality care to patients. Accreditation is awarded upon successful completion of an on-site survey. The on-site survey is conducted by a specially trained Joint Commission surveyor, or team of surveyors, who assess the organization's compliance with the Joint Commission standards. During the survey, surveyors select patients randomly and use medical records as a roadmap to evaluate standards compliance. As surveyors trace a patient's experience in a health care organization, they speak to doctors, nurses, and other staff who interacted with the patient. Surveyors also observe doctors and nurses providing care and often speak to the patients themselves. All regular Joint Commission accreditation surveys are unannounced. Accreditation for most types of organizations is a three-year award. The exception is laboratory accreditation, which is a two-year award.
The Joint Commission, *What is Accreditation, available at* https://www.jointcommission.org/what-we-offer/accreditation/become-accredited/what-is-accreditation/ (last visited Mar. 16, 2025).

[45] *Supra* note 15.

[46] 42 C.F.R. § 438.12(a)(1)

[47] *Supra* note 15.

The new SMMC 3.0 contracts include strict requirements for improving quality and incorporating value-based purchasing (VBP) in provider agreements. VBP is a reimbursement strategy that links provider payments to high-quality performance. This agreement holds the providers accountable for both the quality and cost of care rendered. VBP supports a holistic approach to care that addresses both mental and physical health needs. VBP promotes the use of innovative health care models, such as telehealth and patient-centered medical homes, enhancing accessibility and coordination of care.[48]

Provider Credentialing Timeframes

Credentialing is the systematic process of verifying the qualifications of health care workers providing medical services. This important safety check ensures health care workers have the proper education, training, and licenses to care for patients, and reduces improper payments in Medicaid by minimizing the risk of unscrupulous providers billing the Medicaid program.[49]

To become a plan provider, the health care provider must obtain a Medicaid identification number from the AHCA and complete the plan's credentialing process. The average time required for a provider to obtain a Medicaid provider identification number from the AHCA is 61 days. The AHCA's contracts require the SMMC plans to fully enroll or on-board providers it chooses to contract with within 60 days of the provider submitting a complete application to the plan. Plans that fail to meet provider credentialing requirements could pay up to $5,000 per occurrence to the AHCA in liquidated damages.[50]

Both federal regulations[51] and state law[52] require each plan to have a system for verification and examination of the credentials of each of its providers. The same is true for plan accrediting bodies; however, no timeliness standard exists for the credentialing of plan providers.[53]

As part of the AHCA's federally required redesign of the Florida Medicaid Management Information System (FLMMIS), the AHCA contracted with an NCQA-certified vendor for its Provider Services Module to handle all aspects of the provider credentialing process, including those currently performed by the plans. The Provider Services Module will combine the Medicaid provider enrollment and plan credentialing processes into a single source to minimize errors and confusion in the provider community. Transitioning providers from the current FLMMIS to the new Provider Services Module is scheduled to begin in fall of 2025.[54]

Prior Authorization Timeframes

Prior authorization is part of the overall utilization management program for a plan, which serves to identify patterns of over-utilization and under-utilization of services, identifying fraud, waste, and abuse. Prior authorization is a decision-making process conducted by a plan to determine

[48] *Id*.
[49] *Id*.
[50] *Id*.
[51] 42 C.F.R. § 438.214
[52] See Part IV of ch. 409, F.S., and s. 641.495(6), F.S.
[53] *Supra* note 15.
[54] *Id*.

whether a health care service or good is medically necessary before it is rendered. Not all Medicaid services require prior authorization. Federal regulations[55] require Medicaid managed care plans to conduct a prior authorization program that complies with the requirements of s. 1927(d)(5) of the Social Security Act. State Medicaid programs and contracted plans have the discretion to determine which services require prior authorization. Prior authorization processes are most often required for costly services and for services subject to a high-risk of fraud, waste, or abuse; however, plans are prohibited from requiring authorization for emergency services.[56]

Federal regulations[57] require Medicaid managed care plans to provide standard authorization decisions within 14 calendar days following receipt of the request for service. An additional 14 calendar day extension is available upon request of the enrollee or provider, or if the plan justifies a need for additional information and how the extension is in the enrollee's interest. The AHCA reduced this timeframe by negotiating a standard authorization timeframe of seven days with an extension period of four additional days, if necessary, reducing the authorization period from a maximum of 28 days to 11 days.

Federal regulations[58] also require Medicaid managed care plans to provide expedited authorization decisions within 72 hours following receipt of the request for service; an additional 14 calendar day extension remains available, if applicable. The AHCA further reduced this timeframe by negotiating an expedited authorization timeframe of two days with an extension period of one additional day, reducing the authorization period from a maximum of 17 days to three days.[59]

The AHCA currently requires plans to report monthly on all service authorization requests completed during the previous reporting month. Service authorizations are identified in one of four categories: standard authorization, extended standard authorization, expedited authorization, or extended expedited authorization. Plans that fail to meet provider credentialing requirements could pay up to $2,500 per occurrence to the AHCA in liquidated damages.[60]

Prompt Payment Timeframes

Federal Medicaid law[61] sets requirements for timely claims payment to providers and defines a "claim" to mean a bill for services, a line item of service, or all services for one beneficiary within a bill. It also defines a "clean claim" to mean one that can be processed without obtaining additional information from the provider of the service or from a third-party. A clean claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.[62]

To receive timely payment, a provider must submit a clean claim that includes multiple, mandatory pieces of information about the patient and medical service. A claim that contains

[55] 42 C.F.R. § 438.3(s)(6)
[56] *Supra* note 15.
[57] 42 C.F.R. § 438.210(d)
[58] *Id*.
[59] *Supra* note 15.
[60] *Id*.
[61] 42 C.F.R. § 447.45
[62] *Supra* note 15.

invalid or missing data elements required for acceptance of the claim into the claim processing system can be rejected. If all minimum edits pass and the claim is accepted, it will be entered into the system for processing. A denial is a claim that has passed minimum edits and is entered into the system but has been billed with invalid or inappropriate information causing the claim to be denied. There are hundreds of legitimate reasons a plan could and should deny payment for a health care service, all of which are standardized across the industry in the X12 Claim Adjustment Reason Code set,[63] referenced in the Health Care Claim Payment/Advice (835) Consolidated Guide, available from the Washington Publishing Company.[64]

Federal regulations[65] require state Medicaid programs to pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. States must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. States must pay all other claims within 12 months of the date of receipt, except in certain circumstances that allow the states to have additional time.[66]

Section 409.966(3)(c)6., F.S., requires SMMC plans to have a claims payment process that ensures claims that are not contested or denied will be promptly paid pursuant to s. 641.3155, F.S. Section 641.3155(3), F.S., specifies electronic claims payment standards and requires the plan to pay the claim or notify a provider if the claim is denied or contested within 20 days after receipt of the claim. If required, a provider must submit additional information and documentation as requested by the plan within 35 days after receipt of the plan notification. The claim must be paid or denied within 90 days of receipt of the claim. If the plan neither pays nor denies the electronic claim within 120 days, the plan is then obligated to pay the claim.[67]

For non-electronically submitted claims, a plan must pay the claim or notify a provider if the claim is denied or contested within 40 days after receipt of the claim. If required, a provider must submit additional information and documentation as requested by the plan within 35 days after receipt of the plan notification. The claim must be paid or denied within 90 days of receipt of the claim. If the plan has not paid or denied the nonelectronic claim within 120 days, the plan is then obligated to pay the claim within 140 days.[68]

As with the provider credentialing and prior authorization standards, the AHCA further reduced the claims payment timeframes by negotiating more stringent claims payment standards for the 2025-2030 SMMC contracts. Pursuant to the contracts, a plan must pay or notify the provider that the claim is denied or contested within 10 business days of receipt of nursing facility and hospice clean claims and within 15 days after receipt of all other claims. If the claim is denied or contested, the claim must be paid or denied within 90 days after receipt of the claim. If the plan neither pays nor denies the electronic claim within 120 days, the plan is then obligated to pay the claim. For non-electronically submitted claims, the plan must pay the paper claim or notify the

[63] X12, *External Code Lists, Claim Adjustment Reason Codes, available at* https://x12.org/codes/claim-adjustment-reason-codes (last visited Mar. 16, 2025).
[64] *Supra* note 15.
[65] *Supra* note 61.
[66] *Supra* note 15.
[67] *Id.*
[68] *Id.*

provider that the claim is denied or contested within 20 days after receipt of the claim. If the plan neither pays nor denies the non-electronic claim within 140 days, the plan is then obligated to pay the claim.[69]

Additionally, the AHCA applies the following timely claims processing standards, which if not met, could result in a plan compliance action from the AHCA:[70]

- The managed care plan must pay 85 percent of all clean claims submitted within seven days.
- The managed care plan must pay 95 percent of all clean claims submitted within 10 days.
- The managed care plan must pay 98 percent of all clean claims submitted within 20 days.

Plans that fail to comply with claims processing requirements could pay up to $10,000 per month to the AHCA in liquidated damages for each month the AHCA determines the managed care plan is not in compliance.[71]

Managed Care Plan Complaints

The AHCA has a centralized complaint operations center to resolve Medicaid complaints timely and to determine if plans are complying with contract terms. All complaints are captured, whether substantiated or not, and the AHCA collects, aggregates, and trends the data for quality improvement initiatives.[72]

Federal laws and rules governing the Medicaid managed care plans do not define enrollee complaints. Instead, the AHCA has distinguished between "complaint" and "grievance" in the SMMC plan contracts, which are reviewed and approved by the CMS. Federal regulation[73] defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination.[74]

For purposes of the SMMC program, the AHCA's contracts with the plans define a "complaint" as any oral or written expression of dissatisfaction by an enrollee submitted to the managed care plan or to a state agency and resolved by close of business the following business day. A complaint is a subcomponent of the grievance and appeal system. A complaint that is not resolved timely by close of business the following day becomes a grievance, for which the plan must provide the enrollee with a written notice of resolution within 90 days from receipt of the grievance. This process of escalation can continue from grievance to plan appeal, from plan appeal to Medicaid fair hearing, from Medicaid fair hearing to District Court of Appeals (DCA), and from DCA to the Florida Supreme Court. Each of these processes includes maximum timeframes mandated by the Code of Federal Regulations.[75]

Consistent with federal law, s. 409.967(2)(h), F.S., requires that each plan establish an internal process for reviewing and responding to grievances from enrollees. Each plan submits quarterly

[69] *Id*.
[70] *Id*.
[71] *Id*.
[72] *Id*.
[73] 42 C.F.R. § 438.400(b)
[74] *Supra* note 15.
[75] *Id*.

reports to the AHCA on the number, description, and outcome of grievances filed by enrollees. Plans that do not comply with grievance and appeal requirements could pay between $250 and $10,000 per occurrence to the AHCA in liquidated damages depending on the contract requirement the plan was out of compliance with.[76]

External Quality Review Organization

Federal regulations[77] require states to contract with a qualified external quality review organization (EQRO) to perform an annual, independent assessment of each managed care organization with which the state contracts. To conduct this assessment, the EQRO conducts activities consistent with the associated external quality review protocols developed by the CMS. The purpose of these activities, in general, is to improve the state's ability to oversee and manage plans they contract with for services and help plans improve their performance with respect to quality, timeliness, and access to care. Activities conducted by the EQRO each year are as follows:[78]

- Review of compliance, determining the extent to which plans comply with federal managed care regulations and state standards.
- Validation of performance measures, monitoring the performance of individual plans to track performance over time and to compare performance among the plans.
- Validation of performance improvement projects (PIPs), assessing the validity and reliability of PIPs.
- Validation of network adequacy, ensuring health plans maintain sufficient provider networks to provide adequate access to covered services for all enrollees.

Each April, the AHCA must submit the Annual Technical Report (ATR)[79] produced by the EQRO to the CMS and publish the report on the AHCA's external website. The ATR is a comprehensive report that describes the collection and analysis of data from all external quality review activities, as well as provides conclusions drawn related to the quality, timeliness, and access to care provided by the plans. Another element in the ATR is an assessment of the degree to which each plan has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's external quality review activities. The CMS reviews the EQRO's recommendations, including the ATR's overall compliance with federally required elements, and provides the state with its findings.[80]

Healthcare Effectiveness Data and Information Set Measures

By July 1 of each year, Medicaid health plans are required to report to the AHCA a number of Healthcare Effectiveness Data and Information Set (HEDIS) measures, and Medicaid and CHIP Core Sets of Health Care Quality measures (the Child and Adult Core Set measures). HEDIS measures are developed and validated by the NCQA and used by over 90 percent of managed care plans in the nation to track their performance. The CMS requires states to report the Child

[76] *Id*.
[77] 42 C.F.R. § 438.358
[78] *Supra* note 15.
[79] Florida Agency for Health Care Administration, *SFY 2022-23 External Quality Review Technical Report* (April 2024), *available at* https://ahca.myflorida.com/content/download/24499/file/FL_2022-2023_EQR-TR_Report_F1.pdf (last visited Mar. 16, 2025).
[80] *Supra* note 15.

Core Set and Adult Behavioral Health Core Set measures to the CMS on an annual basis. Many of the core set measures are HEDIS measures but there are also non-HEDIS measures in the core sets.[81]

Plans report HEDIS data based on the services enrollees received in the previous calendar year (e.g., performance measure data reported on July 1, 2025, represents calendar year 2024 services). The AHCA requires the plans to use NCQA-certified software vendors for running and calculating performance measures and requires the plans to have performance measures reviewed and certified by NCQA-certified HEDIS auditors prior to submitting performance measure results to the AHCA. Examples of required performance measures are well-child visits, immunizations, mammograms and other cancer screenings, pregnancy-related care, mental and behavioral health care, and diabetes care. The performance measure data provided by the plans are reviewed by the AHCA's staff and validated by the AHCA's EQRO. The AHCA compares performance measure data to national benchmarks to calculate performance measure liquidated damages and create the Florida Medicaid Health Plan Report Card.[82,83]

The AHCA compares plan performance on performance measures to benchmarks that are set in the plan contracts and plans may be assessed liquidated damages for measures where performance is worse than the benchmarks. When assessed liquidated damages, plans are required to pay the AHCA within 30 days after receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. Plans may dispute the imposition of liquidated damages by requesting that the AHCA's Deputy Secretary for Medicaid or designee hear and decide the dispute.[84]

Under the 2025-2030 SMMC contracts, the AHCA established a new quality continuum of incentives and accountability based on performance measure results. There is a quality withhold that plans may earn back based on their performance on specified performance measures, as well as a Quality Bonus Pool, built with the funds from plans that have not earned their full withhold back. Plans that earn their whole withhold may also earn funds from the Quality Bonus Pool, and the top plans may earn a quality preferred assignment incentive. The highest performing plans may qualify for the Achieved Savings Rebate one percent quality incentive. The plans that do not meet specific benchmarks set in the contract may be assessed for liquidated damages or sanctions.[85]

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[81] *Id*.
[82] The Florida Medicaid Health Plan Report Card is a tool that enrollees can use when comparing and choosing plans based on quality of care. Plans are compared using a five-star rating scale in five categories: Pregnancy-related Care, Keeping Kids Healthy, Keeping Adults Healthy, Living with Illness, and Behavioral Health Care.
Florida Agency for Health Care Administration, Health Care Transparency, *Quality of Care Indicators – Ratings, Medicaid Health Plan Report Cards, available at* https://quality.healthfinder.fl.gov/Facility-Provider/Medicaid-ReportCard?&type=-13 (last visited Mar. 16, 2025).
[83] *Supra* note 15.
[84] *Id*.
[85] *Id*.

Performance Improvement Projects

In accordance with federal law[86] and as part of a comprehensive quality assessment and performance improvement program, states must require managed care plans to implement performance improvement projects (PIPs). The purpose of these projects is to achieve significant improvement in measurement of quality performance with objective indicators, as well as to generally sustain this improvement over time.[87]

States must[88] require plans to conduct clinical and nonclinical PIPs to examine access to and quality of care. PIPs must include four key elements:[89]

- Performance measurement;
- Implementation of interventions;
- Evaluation of the interventions' impact using the performance measures; and
- Activities to increase or sustain improvement.

Under the 2025-2030 SMMC contracts, the MMA plans are required to conduct PIPs focused on the following topics: promoting healthy birth outcomes for mothers and infants, improving child and adolescent mental health, Hope Florida, and closing gaps in health care outcomes between plan sub-populations. Plans providing specialty product lines are required to conduct an additional PIP focused on a clinical area in need of improvement for each specialty area. Plans providing LTC services are also required to conduct a PIP focused on improving mental health in adults and a PIP focused on maximizing home and community-based placement, as well as services to improve independence, well-being, and safety.[90]

Historically, the plans have submitted PIP documentation annually for the AHCA's review and validation by the EQRO. Under the 2025-2030 SMMC contracts, the AHCA is requiring the plans to submit quarterly progress reports on PIPs to allow for more frequent monitoring of the plans' progress toward reaching the goals identified in the PIPs.[91]

Plan Performance Dashboard

The AHCA maintains an extensive internal plan performance dashboard, which allows the AHCA to comprehensively track the performance of each plan on executing the terms of their contract. The AHCA first launched this dashboard in January 2020. The dashboard visualizes how the SMMC plans are performing and compares the performance of each plan across key performance areas, such as Potentially Preventable Events, Performance Measures, Provider Network Adequacy, Quality Indicators, Birth Outcomes, LTC Performance, Administrative and Financial, and Delivery System Performance. The AHCA posts a new dashboard every quarter for plans to review performance compared to their peers.[92]

[86] 42 C.F.R. § 438.330
[87] *Supra* note 15.
[88] *Supra* note 86.
[89] *Supra* note 15.
[90] *Id*.
[91] *Id*.
[92] *Id*.

Compliance Actions

The AHCA is responsible for imposing compliance actions as a result of plan failure to meet any aspect of the responsibilities of a contract and its exhibits. The three types of compliance actions that may be imposed include liquidated damages, sanctions, and/or corrective action plans. Liquidated damages are the lowest level of compliance actions and are considered non-punitive, as they reflect the projected financial loss or damage to the AHCA. Sanctions may be monetary or non-monetary (e.g., freeze in enrollment) and are issued for more egregious non-compliance issues. Corrective action plans are utilized when non-compliance rises to the level of immediate remediation and steps are put into place to ensure the non-compliance does not reoccur.[93]

Ongoing plan monitoring is a responsibility across all the AHCA's functional units. Functional units contain subject matter experts (SMEs) needed to monitor and improve plan or program performance. Monitoring is conducted through a variety of channels including review of reports, ad hoc requests, standard contract monitoring, and monitoring of complaints received by the AHCA.[94]

For the state fiscal year 2023-2024, the AHCA executed 354 compliance actions, which resulted in a total of approximately $33.8 million in liquidated damages paid by the plans.[95]

Medical Care Advisory Committee (MCAC)

Federal regulations[96] require each state Medicaid program to establish a committee to serve in an advisory capacity on health and medical care issues. The committee must include the following:[97]

- Board-certified physicians and other representatives of the health professions familiar with the medical needs of low-income people and the resources available for their care;
- Members of consumer groups, including Medicaid recipients; and
- Agency heads from the Florida Department of Children and Families and the Florida Department of Health.

The committee may be asked to provide the AHCA with advice on improving Medicaid recipients' access to specialists and enhancing communication with Medicaid recipients. Members may also be asked to review and provide input on a variety of Medicaid materials and to make recommendations to the AHCA about Medicaid policies, rules, and procedures.[98]

Medicaid Oversight Committees in Other States

Medicaid oversight committees similar to the committee created by the bill exist in the following states:

[93] *Id*.
[94] *Id*.
[95] *Id*.
[96] 42 C.F.R. § 431.12
[97] Florida Agency for Health Care Administration, *Medical Care Advisory Committee, available at* https://ahca.myflorida.com/medicaid/medical-care-advisory-committee (last visited Mar. 16, 2025).
[98] *Id*.

- Connecticut;[99]
- Illinois;[100]
- Indiana;[101]
- Iowa;[102]
- Louisiana;[103]
- North Carolina;[104] and

[99] The Connecticut Council on Medical Assistance Program Oversight, referred to as the Medical Assistance Program Oversight Council (MAPOC), biannually reports to the General Assembly as required under state law. The Medical Assistance Program Oversight Council (previously called the Medicaid Managed Care Council) is a collaborative body established by the General Assembly in 1994 to initially advise the Connecticut Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program (HUSKY A). Legislation in 2011 revised state law to include council oversight of the Medicaid HUSKY Health Program that encompasses all Medicaid enrollees' health care. State statute charges the council with monitoring and advising DSS on matters including, but not limited to, program planning and implementation of the new delivery system under Administrative Service Organizations (ASOs), transitional issues from managed care, eligibility standards, benefits, health care access, and quality measures. Connecticut General Assembly, *Council on Medical Assistance Program Oversight, available at* https://www.cga.ct.gov/ph/med/ (last visited Mar. 16, 2025).

[100] The Illinois Medicaid Managed Care Oversight Commission was created within the Illinois Department of Healthcare and Family Services (HFS) to evaluate the effectiveness of the Illinois managed care program. The HFS details the membership composition and the commission requirements.
Illinois Department of Healthcare and Family Services, *Medicaid Managed Care Oversight Commission, available at* https://hfs.illinois.gov/about/boardsandcommisions/medicaidmanagedcareoversightcommission.html (last visited Mar. 16, 2025).

[101] The Indiana Medicaid Oversight Committee was created to review, consider, and make recommendations concerning all requests for new services and changes in existing services for the state Medicaid program.
Indiana General Assembly, *Medicaid Oversight Committee, available at* https://iga.in.gov/2023/committees/interim/medicaid-oversight-committee (last visited Mar. 16, 2025).

[102] The Iowa Joint Health Policy Oversight Committee was established in 2015 to provide continuing oversight for Medicaid managed care, ensure effective and efficient administration of the program, address stakeholder concerns, monitor program costs and expenditures, and make recommendations to the General Assembly.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).
The Iowa Legislature, *Health Policy Oversight Committee (J), available at* https://www.legis.iowa.gov/committees/committee?groupID=24165&ga=91 (last visited Mar. 16, 2025).

[103] The Louisiana Joint Medicaid Oversight Committee was established in 2020 to improve oversight and teach appointed legislators the complexities of the program, which consists of nearly half of the state's budget. Duties of the committee are as follows: to monitor, review, and make recommendations; to review the compliance of the Louisiana Department of Health; and to plan, advertise, organize, and conduct forums, conferences, and other meetings in which representatives of state agencies, and other individuals with expertise in the state Medicaid program, may participate to increase knowledge and understanding of the state Medicaid program, as well as propose improvements. The committee can hold hearings, require the production of books and records, and may call upon staff of any department, agency, or official of the state for data and assistance.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).

[104] North Carolina's Joint Legislative Oversight Committee on Medicaid and NC Health Care is responsible for examining the budget, finance, administration, and operational issues related to the programs. The committee can gain access to any paper or document and may compel the attendance of any state official or employee before the committee or secure any evidence and issue subpoenas. The committee receives reports from the North Carolina Department of Health and Human Services (DHHS) throughout the session, and the DHHS is required to send a copy of any report to the General Assembly or committee to the co-chairs of the Medicaid Oversight Committee.

- Ohio.[105]

III. Effect of Proposed Changes:

Section 1 creates s. 11.405, F.S., to establish the Joint Legislative Committee on Medicaid Oversight (committee) within the Office of the Auditor General, established under s. 11.42, F.S., to ensure the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

The bill requires that the committee be composed of three members of the Senate appointed by the President of the Senate and three members of the House of Representatives appointed by the Speaker of the House of Representatives, with each member serving a two-year term. The chair and vice chair must be appointed for one-year terms, with the appointments alternating between the President of the Senate and the Speaker of the House of Representatives. The chair and vice chair may not be members of the same house of the Legislature, and if both the chair and the vice chair are absent at any meeting, the members present must elect a temporary chair by a majority vote.

The bill requires that members serve without compensation, but authorizes reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S. The bill authorizes the chair to establish subcommittees as needed to fulfill committee duties. The bill also requires the committee to convene at least twice a year, and as often as necessary to conduct its business. Meetings may be held through teleconference or other electronic means.

The bill requires the committee to evaluate all aspects of the state Medicaid program related to program financing, quality of care and health outcomes, administrative functions, and operational functions to ensure the program is providing transparency in the provision of health care plans and providers, ensuring access to quality health care services to Medicaid recipients, and providing stability to the state's budget through a health care delivery system designed to contain costs.

The bill requires the committee to identify and recommend policies that limit Medicaid spending growth while improving health care outcomes for Medicaid recipients. In developing its recommendations, the committee must do all of the following:

Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).

[105] The Ohio General Assembly established the Joint Medicaid Oversight Committee in 2014 to continuously oversee the state's Medicaid program. The committee's responsibilities include ensuring Medicaid compliance aligns with legislative objectives, assessing the long-term effects of legislation on Medicaid, and aiding in controlling spending growth while enhancing the quality of care and health outcomes for Medicaid beneficiaries in the state. Apart from possessing subpoena power, the committee and its staff are authorized to conduct unannounced inspections of Medicaid offices within state and local governments. The committee requires regular reports from the Ohio Department of Medicaid on issues, including access barriers, program participation, and the needs of low-income pregnant women and children. The State Auditor provides reports to the committee upon request.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).

- Evaluate legislation for its long-term impact on the state Medicaid program.
- Review data submitted to the AHCA by Medicaid managed care plans pursuant to statutory and contract requirements, including, but not limited to, timeliness of provider credentialing, timely payment of claims, rate of claim denials, prior authorization for services, and consumer complaints.
- Review the Medicaid managed care plans' encounter data, financials, and audits and the data used to calculate the plans' achieved savings rebates and medical loss ratios.
- Review data related to health outcomes of Medicaid recipients, including, but not limited to, HEDIS measures for each Medicaid managed care plan, each Medicaid managed care plan's performance improvement projects, and outcome data related to all quality goals included in the Medicaid managed care organization contracts to improve quality for recipients.
- Identify any areas for improvement in statute and rule relating to the state Medicaid program.
- Develop a plan of action for the future of the state Medicaid program.

The bill authorizes the committee to submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

The bill requires the Auditor General and the AHCA to enter into and maintain a data sharing agreement by July 1, 2025, to ensure the committee has full access to all data needed to fulfill its responsibilities. The Auditor General must assist the committee in its work by providing credentialed professional staff or consulting services, including, but not limited to, an actuary not associated with the state Medicaid program or any Medicaid managed care organization who currently has a contract with the state.

The bill requires the committee to be given access to any relevant record, paper, or document in possession of a state agency, any political subdivision of the state, or any entity engaged in business or under contract with a state agency during the course of its official duties. The committee may compel the attendance and testimony of any state official or employee before the committee or secure any evidence as provided in s. 11.143, F.S. The bill provides that the committee shall also have any other powers conferred on it by joint rules of the Senate and the House of Representatives, and any joint rules of the Senate and the House of Representatives applicable to joint legislative committees apply to the proceedings of the committee.

The bill requires the AHCA to notify the committee of any change to the Medicaid managed care capitation rates and to appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates before implementation of any change to the capitation rates. The report must include the AHCA's historical and projected Medicaid program expenditure and utilization trend rates by Medicaid program and service category for the rate year, an explanation of how the trend rates were calculated, and the policy decisions that were included in setting the capitation rates.

If the AHCA or any division within the AHCA is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the bill requires the AHCA to submit a copy of the report to the committee.

Section 2 provides that the bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

SB 1060 creates statutory language to establish a joint legislative committee, which may bind future legislative bodies to the organization and structure proposed in this bill. The general rule of law[106] is that one legislature cannot bind to limit or enlarge the powers of a subsequent legislature or inhibit it from amending or repealing any legislation so long as it does not act contrary to or inconsistently with any constitutional limitations on the legislative power in any given case.[107]

The Florida Legislature has an absolute right to repeal or modify any statute, so long as its actions do not transgress constitutional requirements. Thus, the power of a future legislature cannot be limited by the acts of a present or prior legislature. In 2011, the Florida Legislature removed statutory language creating or directing joint legislative committees and offices, allowing the current Legislature to assert direct administrative oversight through the adoption of joint rules.[108]

As such, a joint legislative committee enacted by SB 1060 might be able to exist only as part of the organizational structure of the current Legislature. At this time, the JAPC, the Joint Committee on Public Counsel Oversight, and the JLAC are Florida's only standing joint legislative committees, and Joint Rule 4.1 requires that no other joint committee exist except as agreed to by the presiding officers or by concurrent resolution approved by the Senate and the House of Representatives.[109]

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[106] See *Nue v. Miami Herald Publishing Co.*, 462 So. 2d 821 (Fla. 1985); *Internal Improvement Fund v. St. Johns River Co.*, 16 Fla. 531 (Fla. 1878); *Gonzales v. Sullivan*, 16 Fla. 791 (Fla. 1878).
[107] State of Florida's Office of the Attorney General, *Postaudit Expenditures, Counties, available at* https://www.myfloridalegal.com/ag-opinions/postaudit-expenditures-counties (last visited Mar. 16, 2025).
[108] The Florida Senate, *Senate Bill 1204 Final Bill Analysis* (2011) (on file with Senate Committee on Health Policy).
[109] *Supra* note 3.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill could result in an indeterminate fiscal impact on the state. While member reimbursement for per diem and travel expenses, pursuant to s. 112.061, F.S., is nominal, the Office of the Auditor General, the AHCA, and the managed care plans may experience an increased workload, impacting all entities administratively and/or operationally, potentially creating a need for additional staff and resources.

According to the AHCA, the function of the committee would result in the duplication of efforts already conducted by the AHCA, its contracted vendors, the Office of the Auditor General, the managed care plans, and the CMS.[110]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill creates the Joint Legislative Committee on Medicaid Oversight (committee) within the Office of the Auditor General. This may cause issues with the organizational structuring of the Legislature as it is unclear whether a joint legislative committee can be housed within a legislative entity, such as the Office of the Auditor General. As the JLAC has the authority to appoint and direct the Auditor General, it would appear that the bill establishes that the committee would be servicing or supporting another joint legislative committee (JLAC).

As the Office of the Auditor General is responsible for auditing the AHCA and the Medicaid program, the AHCA indicated a conflict of interest may exist in that the Auditor General would ultimately have oversight responsibilities, including the development of policy recommendations, of an entity that it independently audits. As independence rules for certified public accountants require the maintenance of independence in both fact and appearance, the Auditor General could be placed in a situation in which its independence is impaired or questioned with respect to the Medicaid program.[111]

Lines 110-115 of the bill establish applicability in that the committee shall also have any other powers conferred on it by joint rules of the Senate and the House of Representatives, and any joint rules of the Senate and the House of Representatives applicable to joint legislative

[110] *Supra* note 15.
[111] *Id*.

committees apply to the proceedings of the committee. As such, the bill may benefit from an amendment for clarity as it requires committee membership consisting of three members of the Senate and three members of the House of Representatives; however, Joint Rule 4.1 requires no fewer than five and no more than seven members from each house be appointed to each standing joint committee.[112]

Joint Rule 4.1 also establishes a schedule or timeframe in which the chair and vice chair will serve. While the bill does provide for alternating chair and vice chair appointments between the President of the Senate and the Speaker of the House of Representatives similar to the Joint Rules of the Legislature, it remains unclear which house will appoint the chair or vice chair first and the language is inconsistent with that of other joint legislative committees, as indicated in Joint Rule 4.1.[113]

The AHCA expressed the bill may cause delays in managed care rate setting that could impact the AHCA's ability to comply with federal Medicaid managed care laws.[114]

VIII. Statutes Affected:

This bill creates section 11.405 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

[112] *Supra* note 3.
[113] *Id*.
[114] *Supra* note 15.

By Senator Brodeur

10-01068-25 20251060__

A bill to be entitled

An act relating to Medicaid oversight; creating s. 11.405, F.S.; establishing the Joint Legislative Committee on Medicaid Oversight within the Office of the Auditor General for specified purposes; providing for membership, subcommittees, and meetings of the committee; specifying duties of the committee; requiring the Auditor General and the Agency for Health Care Administration to enter into a data sharing agreement by a specified date; requiring the Auditor General to assist the committee; providing that the committee must be given access to certain records, papers, and documents; authorizing the committee to compel testimony and evidence according to specified provisions; providing for additional powers of the committee; providing that certain joint rules of the Legislature apply to the proceedings of the committee; requiring the agency to notify the committee of certain changes and provide a report of specified information to the committee; requiring the agency to submit a copy of certain reports to the committee; providing an effective date.

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

Section 1. Section 11.405, Florida Statutes, is created to read:

11.405 Joint Legislative Committee on Medicaid Oversight.—The Joint Legislative Committee on Medicaid Oversight is created

within the Office of the Auditor General established under s. 11.42 to ensure that the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

(1) MEMBERSHIP; SUBCOMMITTEES; MEETINGS.—

(a) The committee shall be composed of three members of the Senate appointed by the President of the Senate and three members of the House of Representatives appointed by the Speaker of the House of Representatives, with each member serving a 2-year term. The chair and vice chair shall be appointed for 1-year terms, with the appointments alternating between the President of the Senate and the Speaker of the House of Representatives. The chair and vice chair may not be members of the same house of the Legislature. If both the chair and vice chair are absent at any meeting, the members present must elect a temporary chair by a majority vote.

(b) Members shall serve without compensation but may be reimbursed for per diem and travel expenses pursuant to s. 112.061.

(c) The chair may establish subcommittees as needed to fulfill the committee's duties.

(d) The committee shall convene at least twice a year, and as often as necessary to conduct its business as required under this section. Meetings may be held through teleconference or other electronic means.

(2) COMMITTEE DUTIES.—

(a) The committee shall evaluate all aspects of the state Medicaid program related to program financing, quality of care and health outcomes, administrative functions, and operational

functions to ensure the program is providing transparency in the provision of health care plans and providers, ensuring access to quality health care services to Medicaid recipients, and providing stability to the state's budget through a health care delivery system designed to contain costs.

(b) The committee shall identify and recommend policies that limit Medicaid spending growth while improving health care outcomes for Medicaid recipients. In developing its recommendations, the committee shall do all of the following:

1. Evaluate legislation for its long-term impact on the state Medicaid program.

2. Review data submitted to the agency by the Medicaid managed care plans pursuant to statutory and contract requirements, including, but not limited to, timeliness of provider credentialing, timely payment of claims, rate of claim denials, prior authorizations for services, and consumer complaints.

3. Review the Medicaid managed care plans' encounter data, financials, and audits and the data used to calculate the plans' achieved savings rebates and medical loss ratios.

4. Review data related to health outcomes of Medicaid recipients, including, but not limited to, Health Effectiveness Data and Information Set measures for each Medicaid managed care plan, each Medicaid managed care plan's performance improvement projects, and outcome data related to all quality goals included in the Medicaid managed care organization contracts to improve quality for recipients.

5. Identify any areas for improvement in statute and rule relating to the state Medicaid program.

6. Develop a plan of action for the future of the state Medicaid program.

(c) The committee may submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

(3) COOPERATION.—

(a) The Auditor General and the Agency for Health Care Administration shall enter into and maintain a data sharing agreement by July 1, 2025, to ensure the committee has full access to all data needed to fulfill its responsibilities.

(b) The Auditor General shall assist the committee in its work by providing credentialed professional staff or consulting services, including, but not limited to, an actuary not associated with the state Medicaid program or any Medicaid managed care organization who currently has a contract with the state.

(c) The committee, in the course of its official duties, must be given access to any relevant record, paper, or document in possession of a state agency, any political subdivision of the state, or any entity engaged in business or under contract with a state agency, and may compel the attendance and testimony of any state official or employee before the committee or secure any evidence as provided in s. 11.143. The committee shall also have any other powers conferred on it by joint rules of the Senate and the House of Representatives, and any joint rules of the Senate and the House of Representatives applicable to joint legislative committees apply to the proceedings of the committee under this section.

(4) AGENCY REPORTS.—

(a) Before implementing any change to the Medicaid managed care capitation rates, the Agency for Health Care Administration shall notify the committee of the change and appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates. The report must include the agency's historical and projected Medicaid program expenditure and utilization trend rates by Medicaid program and service category for the rate year, an explanation of how the trend rates were calculated, and the policy decisions that were included in setting the capitation rates.

(b) If the Agency for Health Care Administration or any division within the agency is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the agency must also submit a copy of the report to the committee.

Section 2. This act shall take effect upon becoming a law.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 3, 2025

I respectfully request that **Senate Bill #1060**, relating to Medicaid Oversight, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Jason Brodeur

Senator Jason Brodeur
Florida Senate, District 10

File signed original with committee office

Tab 1

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3/18/25
Meeting Date

Health Policy
Committee

1060
Bill Number or Topic

Amendment Barcode (if applicable)

Name ADAM POTTS

Phone 850 591-5921

Address 113 E. College Ave
Street

Email adam@libertypartnersfl.com

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Assisted Living Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3/18/24
Meeting Date

HP
Committee

SB 1060
Bill Number or Topic

Amendment Barcode (if applicable)

Name DAVID MICA, Jr. Phone

Address Email

Street

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: FL Hospital Assn.

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1546
INTRODUCER:	Senator Grall
SUBJECT:	Background Screening of Athletic Coaches
DATE:	March 17, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			CJ	
3.			RC	

I. Summary:

SB 1546 amends s. 943.0438, F.S., to extend the effective date for requiring a Level 2 background screening for athletic coaches from January 1, 2025, to July 1, 2026.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Background Screening

Florida provides standard procedures for screening a prospective employee[1] where the Legislature has determined it is necessary to conduct a criminal history background check to protect vulnerable persons.[2] Chapter 435, F.S., establishes procedures for criminal history background screening of prospective employees and outlines the screening requirements. There are two levels of background screening: Level 1 and Level 2.

- Level 1 screening includes, at a minimum, employment history checks, statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE), and a check of the Dru Sjodin National Sex Offender Public Website,[3] and may include criminal records checks through local law enforcement agencies. A Level 1 screening may be paid for and conducted through FDLE's website, which provides immediate results.[4]

[1] Section 435.02(2), F.S., defines "employee" to mean any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers.
[2] Chapter 435, F.S.
[3] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. Available at www.nsopw.gov (last visited Mar. 14, 2025).
[4] Florida Department of Law Enforcement, State of Florida Criminal History Records Check. Available at http://www.fdle.state.fl.us/Criminal-History-Records/Florida-Checks.aspx (last visited Mar. 14, 2025).

- Level 2 screening includes, at a minimum, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[5]

Florida law authorizes and outlines specific elements required for Level 1 and Level 2 background screening and establishes requirements for determining whether an individual passes a screening regarding an individual's criminal history. All individuals subject to background screening must be confirmed to have not been arrested for and waiting final disposition of, been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or been adjudicated delinquent, and the record has not been sealed or expunged for, any of the offenses prohibited under Florida law.[6]

Background Screening of Youth Athletic Team Coaches

An independent sanctioning authority is a private, non-governmental entity that organizes, operates, or coordinates a youth athletic team in Florida which includes one or more minors and is not affiliated with a private school.[7] Beginning January 1, 2025, an independent sanctioning authority is required to conduct a Level 2 background screening of each current and prospective athletic coach. The authority is not authorized to delegate the responsibility to conduct the required screening to an individual team and may not authorize any person to serve as an athletic coach[8] unless a Level 2 screening has been conducted, and the screening does not result in his or her disqualification.

Before January 1, 2026, or a later date as determined by the Agency for Health Care Administration (AHCA), the authority must disqualify any person who does not pass the background screening qualifications established in s. 435.04, F.S., from acting as an athletic coach except that the authority may authorize such person to serve as an athletic coach if the person meets the requirements for an exemption in s. 435.07, F.S. Additionally, on or after January 1, 2026, or a later date as determined by the AHCA, an authority may not allow any person to act as an athletic coach if he or she does not pass the required background screening except that the authority may allow such a person to serve if he or she successfully completes the exemption process under s. 435.07, F.S.

Timing of Athletic Coach Background Screening Requirements

In 2014, the Legislature expanded background screening requirements for athletic coaches, assistant coaches, and referees of independent sanctioning authorities and allowed a background screening conducted by a commercial consumer reporting agency in compliance with federal standards to satisfy the state level requirement so long as such screening includes a Level 1

[5] Section 435.04, F.S.
[6] *Id.*
[7] Sections 1002.01 and 943.0438(1)(b), F.S.
[8] "Athletic coach" means a person who is authorized by an independent sanctioning authority to work as a coach, assistant coach, or referee for whether for compensation or as a volunteer, for a youth athletic team in this state; and has direct contact with one or more minors on the youth athletic team. Section 943.0438(1)(a), F.S.

background screening and a search against the state and federal registries of sexual predators and sexual offenders to meet the requirements under s. 943.0438, F.S.[9]

In 2023, the Legislature updated the required background screening for athletic coaches to require that they pass a Level 2 background screening and, by January 1, 2026, be included in the background screening clearinghouse[10] run by the AHCA.[11] The Legislature further amended this requirement in 2024 to extend the start date for the requirement for the authority to begin conducting the Level 2 background screenings to January 1, 2025.[12]

III. Effect of Proposed Changes:

SB 1546 amends s. 943.0438, F.S., to extend the effective date for requiring a Level 2 background screening for athletic coaches from January 1, 2025, to July 1, 2026.

The bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

[9] Chapter 2014-9, L.O.F.
[10] Section 435.12, F.S.
[11] Chapter 2023-220, L.O.F.
[12] Chapter 2024-243, L.O.F.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 943.0438 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Grall

29-01414A-25 20251546__

A bill to be entitled

An act relating to background screening of athletic coaches; amending s. 943.0438, F.S.; revising the date upon which certain background screenings of athletic coaches must be conducted; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) of section 943.0438, Florida Statutes, is amended to read:

943.0438 Athletic coaches for independent sanctioning authorities.—

(2) An independent sanctioning authority shall:

(a) Effective July 1, 2026, ~~January 1, 2025~~, conduct a level 2 background screening under s. 435.04 of each current and prospective athletic coach. The authority may not delegate this responsibility to an individual team and may not authorize any person to act as an athletic coach unless a level 2 background screening is conducted and does not result in disqualification under paragraph (b).

Section 2. This act shall take effect July 1, 2025.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 6, 2025

I respectfully request that **Senate Bill #1546**, relating to Background Screening of Athletic Coaches, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Erin K. Grall

Senator Erin Grall
Florida Senate, District 29

File signed original with committee office

S-020 (03/2004)

Tab 2

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3/18/25
Meeting Date

HEALTH POLICY
Committee

SB 1546
Bill Number or Topic

Amendment Barcode (if applicable)

Name PRADEEP VAIDURI

Phone 954-882-9642

Address 10242 LIMA STREET
Street

Email pvaiduri@gmail.com

COOPER CITY FL 33026
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☑ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

ATHLETIC TRAINERS' ASSOCIATION OF FLORIDA

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3/18/25
Meeting Date

Health Policy
Committee

1546
Bill Number or Topic

~~Health Policy~~
Amendment Barcode (if applicable)

Name Joel Dragan

Phone 734-83-8446

Address 7828 Lake myrtle Park Rd
Street

Email jdragan@fysa.com

Auburndale FL 33823
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Youth Soccer Association

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3/18/25
Meeting Date

Health Policy
Committee

SB 1546
Bill Number or Topic

Amendment Barcode (if applicable)

Name Angela Drzewiecki (Drez-wick-ee)

Phone 850-545-8872

Address 301 S Bronough St.
Street

Email Angela.Drzewiecki@gray-robinson.com

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Amateur Athletic Union (AAU)

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 958
INTRODUCER:	Health Policy Committee and Senator Bernard
SUBJECT:	Type 1 Diabetes Early Detection
DATE:	March 19, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 958 creates s. 381.992, F.S., to require the Florida Department of Health (DOH), in collaboration with school districts, to develop Type 1 diabetes informational materials, as well as a standardized methodology for distribution. The materials must be developed and posted on the DOH's website by September 29, 2025. Parents and guardians of VPK, kindergarten, and first-grade students must be notified of the availability of the informational materials by September 30, 2025, and annually thereafter.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Diabetes

Diabetes is a chronic health condition that affects how the human body converts food into energy.

The human digestive system breaks down carbohydrates consumed as food into glucose[1] and releases it into the bloodstream, which increases the blood's glucose level. Such an increase in

[1] Glucose is the simplest type of carbohydrate (chemical formula $C_6H_{12}O_6$), and all carbohydrates consumed as food must be broken down into glucose before the body can metabolize them.

blood glucose should signal the pancreas[2] to release the hormone insulin, which acts as a catalyst to allow the body's cells to metabolize the glucose and convert it to energy, or to convert the glucose into forms suitable for short-term or long-term storage.

Depending on the type of diabetes, the pancreas either does not make any insulin or does not make enough insulin, or the body cannot use insulin as well as it should. When there is not enough insulin, or cells stop responding to insulin, blood glucose levels elevate and stay elevated for extended periods. Over time, that can cause serious health problems, such as heart disease, vision loss, kidney disease, vascular disease, and other maladies. Such outcomes are often known as long-term complications of diabetes.

Type 1 Diabetes

Type 1 diabetes is thought to be caused by an autoimmune reaction in which the body's immune system attacks and destroys the cells in the pancreas that normally produce insulin. Roughly 5 to 10 percent of people with diabetes have Type 1. Symptoms of Type 1 often develop quickly. It is usually diagnosed in children, teens, and young adults. Someone with Type 1 diabetes must take insulin, usually through subcutaneous injection, on a regular basis to survive, one or more times per day. Currently, Type 1 diabetes can neither be prevented nor cured.[3] In 2022-2023, there were 6,568 students with Type 1 diabetes in Florida public schools.[4]

While the exact cause of Type 1 diabetes remains unknown, scientists believe there is a strong genetic component. The risk of developing the disease with no family history is approximately 0.4 percent. If an individual's biological mother has Type 1 diabetes, the risk of developing the condition is 1 to 4 percent. If an individual's biological father has Type 1 diabetes, the risk of developing the disease is 3 to 8 percent. If both biological parents have Type 1 diabetes, the risk of developing the condition is as high as 30 percent.[5]

Scientists also believe certain factors, such as a virus or environmental toxins, can trigger the immune system to attack cells in the pancreas if an individual has a genetic predisposition for developing Type 1 diabetes.[6]

Symptoms of Type 1

Symptoms of Type 1 diabetes are typically mild in the beginning, becoming progressively worse or more intense over time as the pancreas makes less insulin. Symptoms of Type 1 diabetes include:[7]

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[2] The pancreas is an organ located in the abdomen. It plays an essential role in converting food into fuel. The pancreas has two main functions: an exocrine function that helps in digestion and an endocrine function that regulates blood sugar. See: https://columbiasurgery.org/pancreas/pancreas-and-its-functions (last visited Mar. 15, 2025).
[3] Centers for Disease Control and Prevention, *What Is Diabetes?,* available at: https://www.cdc.gov/diabetes/basics/diabetes.html (last visited Mar. 15, 2025).
[4] Florida Department of Health, *Florida Diabetes Advisory Council Legislative Report (January 2025), available at* https://www.floridahealth.gov/%5C/provider-and-partner-resources/dac/_documents/2025-dac-report.pdf (last visited Mar. 14, 2025).
[5] Cleveland Clinic, *Type 1 Diabetes, available at* https://my.clevelandclinic.org/health/diseases/21500-type-1-diabetes#management-and-treatment (last visited Mar. 15, 2025).
[6] *Id.*
[7] *Id.*

- Excessive thirst;
- Frequent urination, including frequent full diapers in infants and bedwetting in children;
- Excessive hunger;
- Unexplained weight loss;
- Fatigue;
- Blurred vision;
- Slow healing of cuts and sores; and
- Vaginal yeast infections.

Type 2 Diabetes

With Type 2 diabetes, the body does not use insulin well and cannot keep blood glucose at normal levels. About 90 to 95 percent of people with diabetes have Type 2. It develops over many years and is usually diagnosed in overweight, middle-aged adults, although it can sometimes manifest in adolescents and young adults. Type 2 diabetes can often be prevented or delayed, or even eliminated altogether, with healthy lifestyle changes, such as losing weight, eating healthy food, and exercising regularly.[8] Type 2 diabetes is usually treated with oral medications but can require insulin injections in some cases.

Diagnosis and Tests

Type 1 diabetes can be diagnosed using the following tests:[9]

- Blood Glucose Test – Checks the amount of sugar in the blood. A health care provider may request a random test (without fasting) and a fasting test (no food or drink for at least eight hours before the test). If the result shows very high blood sugar, it typically means the patient has Type 1 diabetes.
- Glycosylated Hemoglobin Test (A1c) – If blood glucose test results indicate a diagnosis of diabetes, a health care provider may do an A1c test. This measures average blood sugar levels over roughly three months.
- Antibody Test – This blood test checks for autoantibodies to determine if a patient has Type 1 or Type 2 diabetes. Autoantibodies are proteins that attack the body's tissue by mistake. The presence of certain autoantibodies indicates Type 1 diabetes. Autoantibodies are not usually present in people diagnosed with Type 2 diabetes.

Management and Treatment

People with Type 1 diabetes need synthetic insulin every day, multiple times a day, in order to live and be healthy. Insulin can be taken in the following ways:[10]

- Multiple daily injections using a vial and syringe – Insulin should be injected into fatty tissue in the belly, upper arm, thigh, or buttocks. Injections are usually the least expensive way to take insulin.
- Pre-filled insulin pens – Disposable pen needles can be more convenient than syringes, as well as a good option for individuals with poor vision.

[8] *Id.*
[9] *Id.*
[10] *Id.*

- Insulin pumps – Devices that deliver insulin continuously and on-demand, mimicking the pancreas. Pumps deliver insulin through a tiny catheter that goes in a fleshy area of the body.
- Rapid-acting inhaled insulin – Works more quickly than other types of insulin and is inhaled through the mouth, much like an asthma inhaler.

The amount of insulin needed daily varies over time and under specific circumstances. For instance, a larger dose of insulin is typically needed during puberty, pregnancy, and while taking steroid medication.[11]

People with Type 1 diabetes must monitor blood sugar levels closely throughout the day. Maintaining a healthy blood sugar range is the best way to avoid health complications. Blood sugar can be monitored using a:[12]

- Blood Glucose Meter – A finger is pricked with a lance, and a small drop of blood is placed on the meter's test strip. The blood glucose level appears on the meter within seconds. A blood glucose meter is usually the least expensive home testing option, but it only reports blood sugar at the time of the check.
- Continuous Glucose Monitor (CGM) – There are different types of CGMs, but most require a small sensor to be inserted under the skin at home every seven to 14 days. Some CGMs are implanted by a health care provider. The sensor continuously records blood glucose levels. People using a CGM require fewer finger sticks. CGM systems can be more expensive than fingerstick blood glucose meters but provide much more information about glucose levels, including previous and future trends. Different alarms can be set to alert the user when blood sugar is trending too low or too high.

A large part of Type 1 diabetes management is monitoring the carbohydrates in food and drinks consumed to determine proper doses of insulin. Carbohydrate counting at its basic level involves counting the number of grams of carbohydrate in a meal by reading nutrition labels and then matching the dose of insulin. An insulin-to-carb ratio is used to calculate the amount of insulin that should be taken to manage blood sugars when eating. Insulin-to-carb ratios vary from person to person and may even be different at different times of the day.[13]

Complications

Low blood sugar (hypoglycemia) can occur from taking too much insulin based on food intake and/or activity level and needs to be treated right away. Hypoglycemia is usually considered to be below 70 milligrams per deciliter. Symptoms and consequences may include:[14]

- Shaking, trembling, sweating, and chills;
- Dizziness, lightheadedness, and faster heart rate;
- Headaches;
- Hunger;
- Nausea;
- Nervousness or irritability;

[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] *Id.*

- Disorientation and confusion;
- In severe instances, seizure; and
- In the most severe instances, brain damage or death.

Poorly managed diabetes, over the long-term, results in continuous high blood sugar, leading to numerous complications, such as:[15]

- Eye problems, including diabetes-related retinopathy, diabetes-related macular edema, cataracts, and glaucoma;
- Foot problems, including ulcers and infections that can lead to gangrene and amputation;
- Heart disease;
- High blood pressure;
- Kidney disease;
- Oral health problems;
- Diabetes-related neuropathy or nerve damage;
- Skin conditions, including dry skin, bacterial and fungal infections, and diabetes-related dermopathy; and
- Strokes.

The School Health Services Program of the DOH

In partnership with the Florida Department of Education (DOE), the DOH's School Health Services Program (program) provides services required in ss. 381.0056, 381.0057, and 402.3026, F.S. School health services are intended to minimize health barriers to learning for public school students in pre-kindergarten through grade 12. To ensure the provision of safe and appropriate county-level school health services, the program provides funding, technical assistance, and oversight of health services provided in Florida's public schools. The three program components are: basic school health services, comprehensive school health services, and full-service schools.[16]

Basic School Health Services

Basic school health services are required by s. 381.0056, F.S., to promote student health through a variety of day-to-day health services to public school students. All 67 counties provide basic school health services, which include:[17]

- Nursing assessments, health counseling, referrals, and follow-up for suspected or confirmed health problems;
- Individualized health care plan development;
- In-school care management for chronic and acute health conditions, such as diabetes, asthma, allergies, and epilepsy;
- Assistance with medication administration and health care procedures;
- Vision, hearing, scoliosis, and growth and development screenings;
- First-aid and emergency health services;

[15] *Id.*
[16] Florida Department of Health, *School Health Program, available at* https://www.floridahealth.gov/programs-and-services/childrens-health/school-health/school-health-program.html (last visited Mar. 14, 2025).
[17] *Id.*

- Communicable disease prevention and intervention; and
- Emergency preparedness.

Comprehensive School Health Services

Comprehensive school health services are supplemental services provided in addition to basic school health services to promote the health of students, reduce risk-taking behavior, and reduce teen pregnancy. Currently, 46 counties receive funding to provide these services in locally selected schools with high rates of teen birth, substance abuse, and other high-risk behaviors.[18]

Full-Service Schools

Pursuant to s. 402.3026, F.S., full-service schools provide additional school-based health and social services, such as:[19]

- Nutritional services;
- Economic and job placement services;
- Parenting classes;
- Counseling for abused children;
- Mental health and substance abuse counseling; and
- Adult education for parents.

Currently, 66 counties receive funding to provide full-service school programs in schools with high numbers of medically underserved, high-risk students.[20]

School Health Services Plan

Every two years, the program ensures each county health department (CHD) and school district submits a School Health Services Plan (plan). This plan details how the local program will meet the requirements for school health services. Each local CHD and school district collaborates to meet the requirements outlined in its plan. The plan includes provisions related to the management and care of students living with diabetes, in accordance with s. 1002.20(3)(j), F.S. Additional guidance from the DOE can be found in Rule 6A-6.0253, F.A.C.[21]

Guidelines for the Care and Delegation of Care for Students with Diabetes in Florida Schools[22]

In 2014, the DOH collaborated with multiple partners to develop the "Guidelines for the Care and Delegation of Care for Students with Diabetes in Florida Schools." This reference manual is a key resource for Florida school health nurses and local programs serving students with diabetes. The DOH is in the process of making revisions to this manual.[23]

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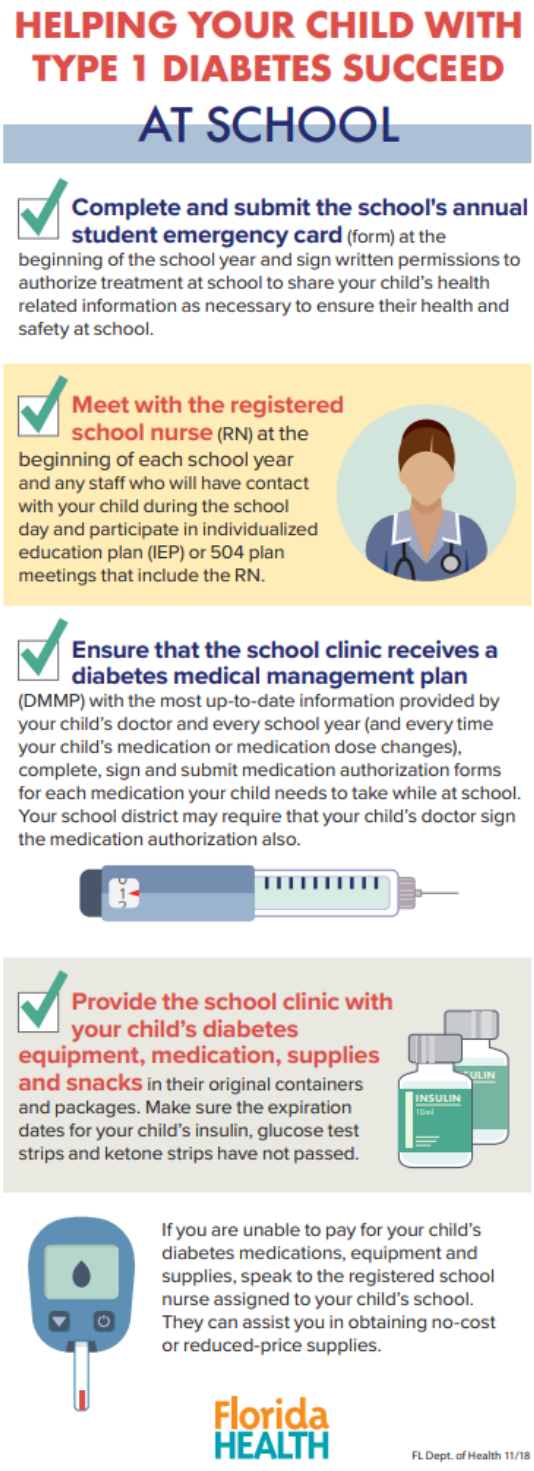
[18] *Id*.
[19] *Id.*
[20] *Id*.
[21] Florida Department of Health, *House Bill 723 Analysis* (Mar. 3, 2025) (on file with Senate Committee on Health Policy).
[22] Florida Department of Health, *Guidelines for the Care and Delegation of Care for Students with Diabetes in Florida Schools*, *available at* https://www.floridahealth.gov/programs-and-services/childrens-health/school-health/_documents/diabetes-guidelines-for-the-care-delegation-of-care-for-students-with-diabetes-in-florida-schools.pdf (last visited Mar. 14, 2025).
[23] *Supra* note 21.

Program Infographic: "Helping your Child with Type 1 Diabetes Succeed at School[24]"



[24] Florida Department of Health, *Helping your Child with Type 1 Diabetes Succeed at School, available at* https://www.floridahealth.gov/programs-and-services/childrens-health/school-health/diabetes-school-card-2up.pdf (last visited Mar. 14, 2025).

III. Effect of Proposed Changes:

Section 1 creates s. 381.992, F.S., to require the DOH, in collaboration with school districts throughout the state, to develop Type 1 diabetes informational materials for the parents and guardians of students. The informational materials must be made available to each school district, school board, and charter school through the DOH's website.

Within 90 days after July 1, 2025, the DOH must develop the materials related to the early detection of Type 1 diabetes and post the information on its website. The DOH must develop a standardized methodology for each school district, school board, and charter school for the notification of the parents or guardians of public school VPK, kindergarten, and first-grade students. Parents and guardians must be notified of the availability of the Type 1 diabetes early detection materials by September 30, 2025, and annually thereafter.

The bill requires the informational materials on Type 1 diabetes to include, at minimum:

- A description of Type 1 diabetes.
- A description of the risk factors and warning signs associated with Type 1 diabetes.
- A description of the process for screening students for early detection of Type 1 diabetes using a blood autoantibody test.
- A recommendation for further evaluation for students displaying warning signs associated with Type 1 diabetes or positive early detection screening results.

Section 2 provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

CS/SB 958 could result in a nominal fiscal impact on the state. The operational impact resulting from this bill can be absorbed using existing resources.[25]

VI. Technical Deficiencies:

None.

VII. Related Issues:

CS/SB 958 does not provide for rulemaking authority. The DOH indicates that this authority may better allow the department to implement the methodology under which schools are required to notify parents and guardians of the informational materials.[26]

VIII. Statutes Affected:

This bill creates section 381.992 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on March 18, 2025:
The committee substitute:

- Creates the Type 1 Diabetes Early Detection Program within ch. 381, F.S., instead of ch. 385, F.S.
- Includes school boards, in addition to the previously included school districts and charter schools, as parties to whom the bill's informational materials must be available.
- Includes parents of VPK and kindergarten students, in addition to first-grade students, as parties who must be notified of the availability of the materials.
- Adjusts the timeframes for the development of informational materials and the notification of the availability of the materials to parents and guardians, i.e. the DOH must develop the materials within 90 days after July 1, 2025, and parents or guardians

[25] *Supra* note 21.
[26] *Id.*

must be notified of the availability of the materials by September 30, 2025, and annually thereafter.

B. Amendments:

None.

371944

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2025	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 381.992, Florida Statutes, is created to read:

381.992 Type 1 diabetes early detection program.—

(1) The Department of Health, in collaboration with school districts throughout the state, shall develop informational materials for the early detection of Type 1 diabetes for parents

371944

and guardians of students. The informational materials shall be made available to each school district, school board, and charter school through the department's website.

(2) Within 90 days after July 1, 2025, the department shall develop the materials related to the early detection of Type 1 diabetes and post the information on its website. The department shall develop a standardized methodology for each school district, school board, and charter school for the notification of the parents or guardians of public school voluntary prekindergarten, kindergarten, and first-grade students, by September 30, 2025, and annually thereafter, of the availability of the Type 1 diabetes early detection materials.

(3) Information provided to parents and guardians shall include, but not be limited to, all of the following:

(a) A description of Type 1 diabetes.

(b) A description of the risk factors and warning signs associated with Type 1 diabetes.

(c) A description of the process for screening students for early detection of Type 1 diabetes using a blood autoantibody test.

(d) A recommendation for further evaluation for students displaying warning signs associated with Type 1 diabetes or positive early detection screening results.

Section 2. This act shall take effect July 1, 2025.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete everything before the enacting clause and insert:

371944

A bill to be entitled

An act relating to a Type 1 diabetes early detection program; creating s. 381.992, F.S.; requiring the Department of Health, in collaboration with school districts throughout the state, to develop informational materials for the early detection of Type 1 diabetes for parents and guardians of certain students; providing requirements for such informational materials; providing an effective date.

By Senator Bernard

24-01617-25 2025958__

A bill to be entitled

An act relating to type 1 diabetes early detection; creating s. 385.2045, F.S.; requiring the Department of Health, in coordination with local school districts, to develop informational materials on type 1 diabetes for the parents and guardians of students; requiring that such materials be made available to school districts and charter schools through the department's website; specifying requirements for the informational materials; requiring the department to develop the informational materials and a certain methodology by a specified date; providing an effective date.

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

Section 1. Section 385.2045, Florida Statutes, is created to read:

385.2045 Type 1 diabetes early detection.—

(1) The Department of Health, in coordination with local school districts throughout this state, shall develop type 1 diabetes informational materials for the parents and guardians of students. The informational materials must be made available to each school district and charter school through the department's website.

(2) The informational materials on type 1 diabetes must include, but need not be limited to, all of the following:

(a) A description of type 1 diabetes, including the associated risk factors and warning signs of type 1 diabetes.

(b) A description of the process for screening students for early detection of type 1 diabetes using a blood autoantibody test.

(c) A recommendation for further evaluation of those students who display warning signs associated with type 1 diabetes or receive positive early detection screening results.

(3) By October 1, 2025, the department shall develop the informational materials and a standardized methodology for each school district and charter school to provide the parents and guardians of first graders with the instructional materials within 30 days after the beginning of each school year.

Section 2. This act shall take effect July 1, 2025.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 6, 2025

I respectfully request that **Senate Bill #958**, relating to Type 1 Diabetes Early Detection, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Mack Bernard

Senator Mack Bernard
Florida Senate, District 24

File signed original with committee office

S-020 (03/2004)

Tab 3

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3/18/25
Meeting Date

Health Policy
Committee

958
Bill Number or Topic

Amendment Barcode (if applicable)

Name Gary Hunter

Phone 850-567-5763

Address 119 S. Monroe St Suite 500
Street

Email ghunter@holtzmanvogel.com

Tallahassee FL 32301
City State Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Sanofi Pharmaceuticals

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Education Pre-K -12

BILL:	CS/CS/SB 1070
INTRODUCER:	Health Policy Committee; Education Pre-K - 12 Committee; and Senator Simon
SUBJECT:	Electrocardiograms for Student Athletes
DATE:	March 20, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Sabitsch	Bouck	ED	**Fav/CS**
2.	Brown	Brown	HP	**Fav/CS**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1070 amends the Education Code to require electrocardiogram (EKG) assessments for student athletes participating in interscholastic athletic competitions at Florida public and private schools. Specifically, the bill:

- Provides that, once enacted, it may be cited as the "Second Chance Act."
- Amends s. 1002.20, F.S., to add an EKG, when applicable under s. 1006.20, F.S., to the annual medical evaluation that is required for participation in interscholastic athletic competition, with exceptions.
- Amends s. 1006.20, F.S., to provide that the bylaws adopted by the Florida High School Athletic Association (FHSAA) must require that, beginning with the 2026-2027 school year, students identified by the FHSAA must receive an electrocardiogram as part of the student's medical evaluation.
- Requires the FHSAA to adopt a schedule in its bylaws to require that, by the 2028-2029 school year, each student who participates in interscholastic athletic competitions or is a candidate for an interscholastic athletic team must have received at least one EKG prior to participation.
- Requires that FHSAA bylaws must include criteria used to determine the students who must receive an EKG in the 2029-2030 school year and thereafter.
- Requires the FHSAA to develop a standard form for exceptions to the bill's EKG requirement and the existing requirement for a medical evaluation.

- Provides requirements for parents who object to an EKG on religious grounds regarding legal documentation that must be provided in order to trigger an exception to the EKG requirement on that basis.
- Provides requirements for parents seeking an exception to the EKG requirement based on the documentation of a medical opinion.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

About Electrocardiograms

An electrocardiogram (EKG)[1] is a recording of the heart's electrical activity. An EKG is an integral part of the initial evaluation of a patient suspected of having a cardiac-related medical problem.[2]

The inventor of the EKG in 1902, William Einthoven, was named the "father of electrocardiography" and was awarded the Nobel Prize in Medicine in 1924 for his work that laid the foundation of the most fundamental technique for investigating heart disorders. The EKG was soon recognized as a robust screening and clinical diagnostic tool, and today it is used globally in almost every health care setting.[3]

The EKG is a non-invasive diagnostic modality that has a substantial clinical impact on investigating the severity of cardiovascular diseases. The use of an electrocardiogram has expanded from simple heart rate and essential rhythm monitoring to interpreting complex arrhythmias, myocardial infarction, and other abnormalities. The EKG is increasingly being used for monitoring patients who are taking antiarrhythmics or other drugs, as an integral part of preoperative assessment of patients undergoing non-cardiac surgery, and for screening individuals in high-risk occupations and those participating in sports. Also, the EKG serves as a research tool for surveillance and experimental trials of drugs with recognized cardiac effects.[4]

Electrocardiograms for High School Student Athletes

In 2021 the Office of Program Policy Analysis and Governmental Accountability (OPPAGA) published a report that collected information on the following topics:[5]

- Benefits and challenges of requiring EKG assessments for student athletes.
- Cost of EKG assessments.
- Accuracy of EKG assessments.

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[1] EKG and ECG are both used as abbreviations for electrocardiogram.
[2] National Library of Medicine, National Center for Biotechnology Information, *Electrocardiogram*, https://www.ncbi.nlm.nih.gov/books/NBK549803/ (last visited Mar. 17, 2025).
[3] *Id.*
[4] *Id.*
[5] OPPAGA Report, Office of Program Policy Analysis and Governmental Accountability, *Electrocardiograms for High School Student Athletes*, (Dec. 2021), *available at* https://oppaga.fl.gov/Documents/Presentations/OPPAGA%20Dec%201%202021%20Presentation%20Slides--EKG--Sec%20Ed%20and%20Career%20Dev.pdf, at slide 2. (last visited Mar. 17, 2025).

- Current school district practices related to requiring or recommending EKGs for student athletes.
- Nationally recognized or accepted criteria to identify athletes who should receive an EKG assessment.

The report stated that sudden cardiac death, while rare, is the leading cause of non-traumatic deaths among young athletes and provided the following:

- The incidence of sudden cardiac death among high school athletes ranges from 1 in 23,000 to 1 in 300,000.
- Intense athletic activity can trigger sudden cardiac death.
- Athletes often have no symptoms of obvious injury prior to sudden cardiac death.
- Hypertrophic cardiomyopathy is the leading cause of sudden cardiac death in athletes and its prevalence among athletes ranges from 1-in-1,426 to 1-in-1,667. (The prevalence in the general population is 1-in-500.)[6]

The OPPAGA report stated that EKG assessments may detect certain heart abnormalities by recording the heart's electrical signals and providing information on strength, speed, rhythm, and number of heart beats. The EKG may help identify 60 percent of diagnoses related to sudden cardiac death.[7] The EKG is non-invasive, only takes a few minutes, and if abnormal results are found, the individual is recommended to seek follow-up with a cardiologist who is trained in diagnosing and treating conditions of the heart and blood vessels.

The OPPAGA report contained information from a study conducted by the Brevard County School District that showed that fewer than one percent of student athletes who received an EKG assessment in 2019-2020 had a heart condition that put them at risk for sudden cardiac arrest. Of 5,877 students who received an EKG assessment, 199 (3.4 percent) of those students had abnormal EKG assessment results, but only eight (one-tenth of one percent) reported a diagnosis that put them at risk of sudden cardiac arrest.[8] The Brevard County School District began requiring EKG assessments in the 2019-2020 school year for grades 7-12 but authorized parents to opt-out for any reason. In the 2020-2021 school year, 35 percent of student athletes opted-out of receiving an EKG assessment.[9]

The OPPAGA report provided information from two other states, Texas and Pennsylvania, that at that time had passed recent legislation to address the use of EKG assessments. Neither state has mandated EKG assessments but have stressed providing information to students and parents about sudden cardiac arrests and EKGs.[10]

The American Heart Association (AHA) asserts that annual prescreening of competitive athletes can improve detection of cardiac abnormalities and minimize the risks associated with athletic participation. However, the AHA does not recommend the use of tests such as a standard 12-lead

[6] *Id.* at slide 4.
[7] *Id.* at slide 5.
[8] *Id.* at slide 19.
[9] *Id.* at slide 18.
[10] *Id.* at slide 11.

EKG[11] or echocardiogram[12] in mandatory pre-participation screening programs. Instead, the AHA claims these tests are best used as follow-up if an initial screening raises suspicions about the presence of a cardiovascular disease. Reasons given include the strain on the health care system, access to testing, and the rate of false-positive results.[13]

Regulation of Florida High School Athletics

The Florida High School Athletic Association (FHSAA) is designated in Florida law as a governing nonprofit organization of athletics in Florida public schools.[14] Any high school in Florida, including charter schools, virtual schools, and home education cooperatives, may become a member of the FHSAA and participate in the activities of the FHSAA. Membership in the FHSAA is not mandatory for any school. A private school that wishes to engage in high school athletic competition with a public high school can become a member of the FHSAA. Florida middle schools may also become members of the FHSAA.

The FHSAA is required to adopt bylaws that, unless specifically provided otherwise by statute, establish eligibility requirements for all students who participate in high school athletic competition in its member schools.

The FHSAA is specifically required to adopt bylaws that require all students participating in interscholastic athletic competition or who are candidates for an interscholastic athletic team to satisfactorily pass a medical evaluation each year before participating in interscholastic athletic competition. Such participation includes engaging in any practice, tryout, workout, conditioning, or other physical activity, during or outside the school year, associated with the student's candidacy for an interscholastic athletic team. The medical evaluation must be conducted by a practitioner licensed under ch. 458 or ch. 459, F.S.,[15] a practitioner licensed under ch. 460, F.S.,[16] or an advanced practice registered nurse licensed under s. 464.012, F.S., and such practitioner must be in good standing with his or her regulatory board.[17]

The FHSAA conducts an annual Sports Participation Survey. The most recent survey found that for the 2023-2024 school year, there were 299,383 student athletes among 19 different sports from an overall student enrollment population of 873,804 from member schools (grades 9-12).[18]

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[11] The standard EKG provides a comprehensive view of the heart's electrical activity from 12 different angles using 10 electrodes. Simplified versions use six leads or only one lead under certain circumstances.
[12] An echocardiogram uses sound waves to show how blood flows through the heart and heart valves.
[13] American Heart Association, *Pre-participation Cardiovascular Screening of Young Competitive Athletes: Policy Guidance, available at* https://www.heart.org/-/media/Files/About-Us/Policy-Research/Policy-Positions/Healthy-Children-and-Schools/Athlete-Screening.pdf (last visited Mar. 16, 2025)
[14] Section 1006.20(1), F.S.
[15] Chapter 458, F.S., is the Medical Practice Act, and chapter 459, F.S., is the Osteopathic Medicine Practice Act. Allopathic physicians, osteopathic physicians, physician assistants, anesthesiologist assistants, and medical assistants are all practitioners who are licensed under those two chapters.
[16] Chapter 460, F.S., is the Chiropractic Medicine Practice Act. Chiropractic physicians and certified chiropractic physician's assistants are practitioners licensed under that chapter.
[17] Section 1006.20(2)(c), F.S.
[18] Florida High School Athletic Association, *Sports Participation Survey* (2023-2024), *available at* https://fhsaa.com/documents/2024/7/11//2023_24_Total_Participation_Study_for_website.pdf?id=5591 (last visited Mar. 16, 2025)

III. Effect of Proposed Changes:

CS/CS/SB 1070, the "Second Chance Act,"[19] amends s. 1002.20, F.S., requiring that students receive an electrocardiogram (EKG) before participating in athletics, as applicable under s. 1006.20, F.S. The bill makes the EKG requirement subject to the current-law exception that already applies to the requirement for a medical evaluation, i.e. when a student's parent objects in writing based on religious tenets or practices. The bill also creates an additional exception to the EKG requirement if a student's parent provides a written statement from a physician licensed under ch. 458 or ch. 459, F.S.,[20] stating that the student does not require an EKG, in accordance with s. 1006.20(2)(d), F.S.

The bill also amends s. 1006.20, F.S., to provide that the bylaws adopted by the Florida High School Athletic Association (FHSAA) must require that, beginning with the 2026-2027 school year, students identified by the FHSAA must receive an electrocardiogram as part of the student's medical evaluation to be conducted prior to participation in interscholastic athletic competition.

The bill requires the FHSAA to adopt a schedule to require that, by the 2028-2029 school year, each student who participates in or is a candidate for interscholastic athletic competition has received at least one EKG as part of the required medical evaluation prior to participation.

The bill requires the FHSAA to adopt bylaws that include criteria used to determine the students who must receive an EKG in the 2029-2030 school year and thereafter.

The bill also specifies, in s. 1006.20(2)(d), F.S., that if a parent objects to the student receiving an EKG on the grounds of the parent's or student's religious tenets or practices, the parent must provide a written release of liability that has been prepared by an attorney in good standing with The Florida Bar. Alternately, the bill provides that the parent may provide a written statement from a physician licensed under ch. 458 or ch. 459, F.S., and who is in good standing with his or her regulatory board, indicating that the student does not require the EKG. Under either of those circumstances, the student would be allowed under the bill to participate in interscholastic athletics or be a candidate for an interscholastic athletic team without having an EKG.

The FHSAA is required by the bill to develop a standard form for exceptions to the bill's EKG requirement and the existing requirement for a medical evaluation.

The bill provides an effective date of July 1, 2025.

[19] The bill provides this citation in honor of Chance Gainer, an 18-year old senior and Port St. Joe High School football player who died after collapsing during a football game on September 6, 2024.
[20] *Supra*, note 15.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires an EKG as part of the medical evaluation requirement for student athletes, which could be a cost to the student's parent or health insurance, unless the EKG is provided free of charge or one of the bill's exceptions applies. If a parent seeks an exception to the EKG requirement based on religious tenets or practices, the bill requires the parent to engage an attorney in good standing with The Florida Bar and incur legal fees, unless the attorney provides his or her services pro bono.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 1002.20 and 1006.20.

IX. Additional Information:

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

CS/CS by Health Policy on March 18, 2025:
The committee substitute clarifies provisions in the underlying bill by:

- Specifying that a written medical opinion designed to trigger an exception to the bill's EKG requirement must be issued by a physician licensed under ch. 458 or ch. 459, F.S., not by other types of physicians or practitioners; and
- Providing that the FHSAA must include in its bylaws the criteria for determining which students must have an EKG, as opposed to specifying the students who must have one.

CS by Education Pre-K – 12 Committee on March 11, 2025:
The committee substitute establishes the bill as the "Second Chance Act" and requires that, beginning with the 2026-2027 school year, participating and prospective student athletes identified by the Florida High School Athletic Association (FHSAA) must receive an EKG as part of the student athlete's medical evaluation, unless one of the underlying bill's exceptions applies. The bill requires the FHSAA to develop a schedule to require that, by the 2028-2029 school year, each participating and prospective student athlete has received at least one EKG prior to participation. The bill also requires the FHSAA bylaws to specify those students who must receive an EKG in the 2029-2030 school year and thereafter.

B. Amendments:

None.

290226

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2025	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. This act may be cited as the "Second Chance Act."

Section 2. Paragraph (b) of subsection (17) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information

290226

regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(17) ATHLETICS; PUBLIC HIGH SCHOOL.—

(b) *Medical evaluation and electrocardiogram.*—Students must satisfactorily pass a medical evaluation each year and, as applicable under s. 1006.20, receive an electrocardiogram before participating in athletics, unless the parent objects in writing based on religious tenets or practices or provides a written statement from a physician licensed under chapter 458 or chapter 459 that the student does not require an electrocardiogram, in accordance with ~~the provisions of~~ s. 1006.20(2)(d).

Section 3. Paragraphs (c) and (d) of subsection (2) of section 1006.20, Florida Statutes, are amended to read:

1006.20 Athletics in public K-12 schools.—

(2) ADOPTION OF BYLAWS, POLICIES, OR GUIDELINES.—

(c) The FHSAA shall adopt bylaws that require the following:

1. ~~Require~~ All students participating in interscholastic athletic competition or who are candidates for an interscholastic athletic team to satisfactorily pass a medical evaluation each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity associated with the student's candidacy for an interscholastic athletic team, including activities that occur outside of the school year. Such medical evaluation may be administered only by a practitioner licensed under chapter 458, chapter 459, chapter

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460, or s. 464.012 or registered under s. 464.0123 and in good standing with the practitioner's regulatory board. The bylaws shall establish requirements for eliciting a student's medical history and performing the medical evaluation required under this paragraph, which shall include a physical assessment of the student's physical capabilities to participate in interscholastic athletic competition as contained in a uniform preparticipation physical evaluation and history form. The evaluation form must ~~shall~~ incorporate the recommendations of the American Heart Association for participation cardiovascular screening and must ~~shall~~ provide a place for the signature of the practitioner performing the evaluation with an attestation that each examination procedure listed on the form was performed by the practitioner or by someone under the direct supervision of the practitioner. The form must ~~shall~~ also contain a place for the practitioner to indicate if a referral to another practitioner was made in lieu of completion of a certain examination procedure. The form must ~~shall~~ provide a place for the practitioner to whom the student was referred to complete the remaining sections and attest to that portion of the examination. The preparticipation physical evaluation form must ~~shall~~ advise students to complete a cardiovascular assessment and must ~~shall~~ include information concerning alternative cardiovascular evaluation and diagnostic tests. Results of such medical evaluation must be provided to the school. A student is not eligible to participate, as provided in s. 1006.15(3), in any interscholastic athletic competition or engage in any practice, tryout, workout, or other physical activity associated with the student's candidacy for an interscholastic athletic

290226

team until the results of the medical evaluation have been received and approved by the school.

2. Beginning with the 2026-2027 school year, students identified by the FHSAA who participate in interscholastic athletic competition or are candidates for an interscholastic athletic team to receive an electrocardiogram as a part of the student's medical evaluation. The FHSAA shall adopt a schedule to require that, by the 2028-2029 school year, each student who participates in interscholastic athletic competition or is a candidate for an interscholastic athletic team has received at least one electrocardiogram as a part of the student's medical evaluation before participation. The FHSAA bylaws must include the criteria used to determine the students required to receive an electrocardiogram in the 2029-2030 school year and thereafter.

(d)1. Notwithstanding ~~the provisions of~~ paragraph (c), a student may participate in interscholastic athletic competition or be a candidate for an interscholastic athletic team if the parent of the student objects in writing to the student undergoing a medical evaluation or receiving an electrocardiogram because such evaluation or electrocardiogram is contrary to his or her religious tenets or practices. However, in such case, there shall be no liability on the part of any person or entity in a position to otherwise rely on the results of such medical evaluation or electrocardiogram for any damages resulting from the student's injury or death arising directly from the student's participation in interscholastic athletics when ~~where~~ an undisclosed medical condition that would have been revealed in the medical evaluation or

290226

electrocardiogram is a proximate cause of the injury or death. If a parent of a student objects in writing to the student receiving an electrocardiogram on the grounds that it is contrary to the parent's or student's religious tenets or practices, the parent must provide a written release of liability prepared by an attorney in good standing with The Florida Bar. Alternatively, a parent may provide a written statement from a physician licensed under chapter 458 or chapter 459 and in good standing with the applicable regulatory board that the student does not require an electrocardiogram.

2. The FHSAA shall develop a standard form to document exceptions granted under this paragraph.

Section 4. This act shall take effect July 1, 2025.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to electrocardiograms for student athletes; providing a short title; amending s. 1002.20, F.S.; conforming provisions to changes made by the act; amending s. 1006.20, F.S.; requiring certain students to receive an electrocardiogram to participate in athletics, beginning on a specified date; requiring the Florida High School Athletic Association (FHSAA) to adopt a schedule requiring that, by a specified date, certain students receive, before competing, at least one electrocardiogram as a

290226

part of their medical evaluation; requiring that the FHSAA bylaws include the criteria used to determine the students required to receive an electrocardiogram; revising provisions related to parental objections to requirements for participation in athletics to include objection to electrocardiograms; requiring that parents who object to an electrocardiogram provide a specified release from liability; requiring the FHSAA to develop a standard form to document exceptions; providing an effective date.

By the Committee on Education Pre-K - 12; and Senator Simon

581-02305-25 20251070c1

A bill to be entitled

An act relating to electrocardiograms for student athletes; providing a short title; amending s. 1002.20, F.S.; conforming provisions to changes made by the act; amending s. 1006.20, F.S.; requiring certain students to receive an electrocardiogram to participate in athletics, beginning on a specified date; requiring the Florida High School Athletic Association (FHSAA) to adopt a schedule requiring that, by a specified date, certain students receive, before competing, at least one electrocardiogram as a part of their medical evaluation; requiring that the FHSAA bylaws specify those students who must receive an electrocardiogram; revising provisions related to parental objections to requirements for participation in athletics to include objection to electrocardiograms; requiring that parents who object to an electrocardiogram provide a specified release from liability; requiring the FHSAA to develop a standard form to document exceptions; providing an effective date.

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

Section 1. This act may be cited as the "Second Chance Act."

Section 2. Paragraph (b) of subsection (17) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public

school students must receive accurate and timely information regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(17) ATHLETICS; PUBLIC HIGH SCHOOL.—

(b) *Medical evaluation and electrocardiogram.*—Students must satisfactorily pass a medical evaluation each year and, as applicable under s. 1006.20, receive an electrocardiogram before participating in athletics, unless the parent objects in writing based on religious tenets or practices or provides a written statement from a physician that the student does not require an electrocardiogram, in accordance with ~~the provisions of~~ s. 1006.20(2)(d).

Section 3. Paragraphs (c) and (d) of subsection (2) of section 1006.20, Florida Statutes, are amended to read:

1006.20 Athletics in public K-12 schools.—

(2) ADOPTION OF BYLAWS, POLICIES, OR GUIDELINES.—

(c) The FHSAA shall adopt bylaws that require the following:

1. ~~Require~~ All students participating in interscholastic athletic competition or who are candidates for an interscholastic athletic team to satisfactorily pass a medical evaluation each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity associated with the student's candidacy for an interscholastic athletic team, including activities that occur outside of the school year. Such medical evaluation may be administered only by a

practitioner licensed under chapter 458, chapter 459, chapter 460, or s. 464.012 or registered under s. 464.0123 and in good standing with the practitioner's regulatory board. The bylaws shall establish requirements for eliciting a student's medical history and performing the medical evaluation required under this paragraph, which shall include a physical assessment of the student's physical capabilities to participate in interscholastic athletic competition as contained in a uniform preparticipation physical evaluation and history form. The evaluation form must ~~shall~~ incorporate the recommendations of the American Heart Association for participation cardiovascular screening and must ~~shall~~ provide a place for the signature of the practitioner performing the evaluation with an attestation that each examination procedure listed on the form was performed by the practitioner or by someone under the direct supervision of the practitioner. The form must ~~shall~~ also contain a place for the practitioner to indicate if a referral to another practitioner was made in lieu of completion of a certain examination procedure. The form must ~~shall~~ provide a place for the practitioner to whom the student was referred to complete the remaining sections and attest to that portion of the examination. The preparticipation physical evaluation form must ~~shall~~ advise students to complete a cardiovascular assessment and must ~~shall~~ include information concerning alternative cardiovascular evaluation and diagnostic tests. Results of such medical evaluation must be provided to the school. A student is not eligible to participate, as provided in s. 1006.15(3), in any interscholastic athletic competition or engage in any practice, tryout, workout, or other physical activity associated

with the student's candidacy for an interscholastic athletic team until the results of the medical evaluation have been received and approved by the school.

2. Beginning with the 2026-2027 school year, students identified by the FHSAA who participate in interscholastic athletic competition or are candidates for an interscholastic athletic team must receive an electrocardiogram as a part of the student's medical evaluation. The FHSAA shall adopt a schedule to require that, by the 2028-2029 school year, each student who participates in interscholastic athletic competition or is a candidate for an interscholastic athletic team has received at least one electrocardiogram as a part of the student's medical evaluation before participation. The FHSAA bylaws must specify those students who must receive an electrocardiogram in the 2029-2030 school year and thereafter.

(d)1. Notwithstanding ~~the provisions of~~ paragraph (c), a student may participate in interscholastic athletic competition or be a candidate for an interscholastic athletic team if the parent of the student objects in writing to the student undergoing a medical evaluation or receiving an electrocardiogram because such evaluation or electrocardiogram is contrary to his or her religious tenets or practices. However, in such case, there shall be no liability on the part of any person or entity in a position to otherwise rely on the results of such medical evaluation or electrocardiogram for any damages resulting from the student's injury or death arising directly from the student's participation in interscholastic athletics when ~~where~~ an undisclosed medical condition that would have been revealed in the medical evaluation or

electrocardiogram is a proximate cause of the injury or death. If a parent of a student objects in writing to the student receiving an electrocardiogram on the grounds that it is contrary to the parent's or student's religious tenets or practices, the parent must provide a written release of liability prepared by an attorney in good standing with The Florida Bar. Alternatively, a parent may provide a written statement from a practitioner licensed under chapter 458 or chapter 459 and in good standing with the practitioner's regulatory board that the student does not require an electrocardiogram.

2. The FHSAA shall develop a standard form to document exceptions granted under this paragraph.

Section 4. This act shall take effect July 1, 2025.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 12th, 2025

I respectfully request that **Senate Bill #1070**, relating to Electrocardiograms for Student Athletes, be placed on the:

☐ Committee agenda at your earliest possible convenience.

☒ Next committee agenda.

Senator Corey Simon
Florida Senate, District 3

File signed original with committee office

S-020 (03/2004)

Tab 4

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

03/18/2025
Meeting Date

Health Policy
Committee

1070
Bill Number or Topic

Amendment Barcode (if applicable)

Name Bob Harris

Phone 850-222-0720

Address 2618 Centennial Place
Street

Email bharris@lawfla.com

Tallahassee FL 32308
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[ ] I am appearing without compensation or sponsorship.

[X] I am a registered lobbyist, representing: Panhandle Area Educational Consortium

[ ] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3/18/25
Meeting Date

Sen. Health Policy
Committee

SB 1070
Bill Number or Topic

~~SB 1070~~
Amendment Barcode (if applicable)

Name Jerry Stevens Fl. Board of Athletic Training Phone (904)208-0713

Address 4396 Allenwood Ct
Street

Email stevensge duvalschools.org

Jacksonville FL 32258
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3/18/25
Meeting Date

HEALTH POLICY
Committee

SB 1070
Bill Number or Topic

Amendment Barcode (if applicable)

Name PRADEEP VANGUNI

Phone 954-882-9642

Address 10342 LIMA STREET
Street

Email prvangori@gmail.com

COOPER CITY FL 33026
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☑ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

ATHLETIC TRAINERS' ASSOCIATION OF FLORIDA

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1544
INTRODUCER:	Senator Rodriguez
SUBJECT:	Opticianry
DATE:	March 17, 2025
REVISED:	03/20/25

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

I. Summary:

SB 1544 establishes that only a licensed optician may practice opticianry. The bill removes an optician's ability to delegate duties, tasks, and functions to non-licensed supportive personnel who perform such duties, tasks, and functions under the optician's direct supervision. The bill also removes a provision indicating that nothing in the opticianry practice act may be construed to mean that an employee of a licensed physician or a licensed optometrist is required to be licensed as an optician as long as the employee is working exclusively for, and under the direct supervision of, such physician or optometrist and does not hold himself or herself out as an optician.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Eye Care Professions in Florida

The Legislature created the Department of Health (DOH), to protect and promote the health of all residents and visitors in the state.[1] The DOH is charged with the regulation of health practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the boards[2] and professions within the DOH.[3]

[1] Section 20.43, F.S.
[2] Under s. 456.001(1), F.S., "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH MQA.
[3] Section 20.43, F.S.

Florida law recognizes three distinct eye care professions, each with specific roles and regulations:

- Ophthalmologists are either allopathic physicians (M.D.) regulated by the Florida Board of Medicine, or osteopathic physicians (D.O.) regulated by the Florida Board of Osteopathic Medicine, who are trained in medical schools to treat the whole person and who undertake four additional years of specialized training in eye care, diseases of the eye, and surgery.[4]
- Optometrists (O.D.), regulated by the Florida Board of Optometry, conduct comprehensive eye exams, prescribe glasses, contact lenses, and certain medications, and manage common eye conditions, though they may not perform surgery[5] under Florida law.[6]
- Opticians, regulated by the Florida Board of Opticianry[7], are trained to fit, dispense, and adjust eyeglasses and contact lenses based on a prescription issued by an ophthalmologist or optometrist, but cannot perform eye exams or prescribe treatment. Their primary role is to ensure that patients receive properly fitted corrective eyewear that meets their vision needs.

Opticianry

The practice of opticianry in Florida is governed by Chapter 484, Part I, Florida Statutes, and Florida Administrative Code (F.A.C) Rule 64B12.

Scope of Practice [8]

The Florida Statutes define "opticianry" as the preparation, fitting, and dispensing of prescription lenses, eyeglasses, contact lenses, and other optical devices. Opticians must work from a written prescription provided by a licensed optometrist or ophthalmologist and are responsible for ensuring that corrective eyewear is properly fitted to the intended user. While opticians facilitate the selection and sale of frames, these activities are not considered part of opticianry itself. However, an optician must complete the fitting process before transferring physical possession of the optical device to the customer. As part of optical dispensing, opticians interpret but do not alter prescriptions, ensuring that the prescribed optical aids are designed, adapted, and fitted correctly. Opticians may duplicate lenses without a prescription, provided the duplication is accurate in power, and they can also duplicate nonprescription eyewear and its components.

A board-certified optician, who has passed the National Contact Lens Registry Examination and who has completed a board-approved course of 20 contact hours, is authorized to fill, fit, adapt, and dispense soft contact lenses.[9] Additionally, such an optician may handle extended wear and hard contact lenses but only within the specific authorization provided by the prescribing optometrist or physician.[10]

[4] Ophthalmologists are licensed under ch. 458, F.S., relating to the allopathic practice of medicine or ch. 459, F.S., relating to the osteopathic practice of medicine.
[5] Section 463.014(4), F.S.
[6] Optometrists are licensed under ch. 463.
[7] Sections 463.003, 463.004, 463.005, F.S.
[8] Section 484.002(3), F.S.
[9] Section 484.002(6), F.S.
[10] *Id.*

The optician's scope of practice does not include performing eye exams, diagnosing conditions, or modifying prescriptions.[11] An optician's practice is focused on ensuring accurate dispensing, proper fit, and comfort of eyewear, ensuring that patients receive optical aids tailored to their vision needs.

Opticians may delegate certain tasks (e.g., pre-adjusting frames, assisting with eyewear selection) to non-licensed assistants, but they must directly supervise and remain responsible for the final fitting and dispensing.[12] Non-licensed personnel may not measure, fit, or dispense optical devices independently. Licensed opticians may also oversee apprentice opticians who are in training.[13]

Licensing Requirements [14]

To become licensed by examination as an optician in Florida, an optician must successfully pass the Florida Opticianry Licensure Examination, complete a two-hour course on fitting and adjusting, and pay a licensing fee.

An applicant for licensure by examination must submit an Optician Application for Examination form and the examination fee[15], and also meet the following criteria:

- *Is not younger than 18 years of age;*
- *Is a graduate of an accredited high school or possesses a certificate of equivalency of a high school education;*
- *Successfully passed the National Opticianry Competency Examination within three years of application or has current American Board of Opticianry certification;*
- *Successfully passed the Contact Lens Registry Examination within three years of application or has current National Contact Lens Examiners certification; and*
- *Has completed one of the following:*
  - Received an associate degree, or equivalent, in opticianry from an accredited school; or
  - Has registered as an apprentice with the department and completed 6,240 hours of training under their registered sponsor(s).[16]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 484.011, F.S., to delete a provision in current law which authorizes a licensed optician to delegate duties, tasks, and functions within the optician's scope of practice[17] to non-licensed supportive personnel. It also deletes a provision in current law

[11] Section 484.013(3), F.S.
[12] Section 484.011, F.S.
[13] Section 484.007(1)(d), F.S. See also Rule 64B12-16 F.A.C.
[14] Florida Board of Opticianry, *Licensing Requirements* available at https://floridasopticianry.gov/licensing/optician/#tab-requirements (last accessed March 14, 2025.) *See also* s. 484.007, F.S.
[15] Florida Board of Opticianry, *Fees* available at https://floridasopticianry.gov/licensing/optician/#tab-fees (last accessed March 14, 2025.)
[16] The apprenticeship requirements must be met within 5 years after the date of registration. Refer to Rule 64B12-16.003, F.A.C for the training subject areas. *Supra* note 13.
[17] An optician's scope of practice is controlled by the statutory definition of the term "opticianry" in s. 484.002(3), F.S.

which specifies that all such delegated tasks shall be performed under the direct supervision[18] of the licensed optician and that the optician shall be liable for acts performed by the non-licensed person performing acts under the optician's direct supervision.

These changes would establish that only a licensed optician may practice opticianry.

Section 2 of the bill amends s. 484.018, F.S., to delete a provision in current law indicating that nothing in the opticianry practice act may be construed to mean that an employee of a licensed physician or a licensed optometrist is required to be licensed as an optician as long as the employee is working exclusively for, and under the direct supervision of, such physician or optometrist and does not hold himself or herself out to the public generally as an optician.

Section 3 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

[18] "Direct supervision" means supervision where the licensee remains on the premises while all work is being done and gives final approval to any work performed by an employee. Section 484.002(5), F.S.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Section 484.007(1), F.S., requires the Department of Health to administer a licensure examination to applicants who meet certain criteria, including a high school education and an associate degree in opticianry from an approved accrediting agency or who has completed an apprenticeship program after registering with the department. Changes made to s. 484.011, F.S., in Section 1 of the bill, which would prohibit anyone aside from a licensed optician from practicing opticianry, may prohibit apprentices from completing their training program. If this is the case, and if this is unintended, an amendment should be considered to ensure that apprentices may continue their training programs in their pursuit of licensure.

VII. Related Issues:

Staff recommends that an amendment be considered to repeal s. 484.002(5), F.S., and remove the definition of the term "direct supervision" as the term is defined for part I of ch. 484. The changes made by the bill delete the only two uses of the term "direct supervision" within part I of ch. 484, and the term and its definition would no longer be in use if the bill is enacted.

VIII. Statutes Affected:

This bill substantially amends the following sections 484.011 and 484.018 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

885492

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/18/2025	.	
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The Committee on Health Policy (Rodriguez) recommended the following:

Senate Amendment (with title amendment)

Delete lines 12 - 22
and insert:
Section 1. Paragraph (e) of subsection (1) of section 484.007, Florida Statutes, as amended by section 30 of chapter 2024-243, Laws of Florida, is amended to read:
484.007 Licensure of opticians; permitting of optical establishments.—
(1) Any person desiring to practice opticianry shall apply

885492

to the department, upon forms prescribed by it, to take a licensure examination. The department shall examine each applicant who the board certifies meets all of the following criteria:

(e)1. Has received an associate degree, or its equivalent, in opticianry from an educational institution the curriculum of which is accredited by an accrediting agency recognized and approved by the United States Department of Education or the Council on Postsecondary Education or approved by the board; or

2. Has registered as an apprentice with the department and paid a registration fee not to exceed $60, as set by rule of the board. The apprentice shall complete 6,240 hours of training under the supervision of an optician licensed in this state for at least 1 year ~~or of a physician or optometrist licensed under the laws of this state~~. These requirements must be met within 5 years after the date of registration. However, any time spent in a recognized school may be considered as part of the apprenticeship program provided herein. The board may establish administrative processing fees sufficient to cover the cost of administering apprentice rules as promulgated by the board.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete lines 2 - 4

and insert:

An act relating to opticianry; amending s. 484.007, F.S.; revising the supervision requirements for the training of registered apprentices seeking licensure to practice opticianry;

By Senator Rodriguez

40-01185-25 20251544__

A bill to be entitled

An act relating to opticianry; amending s. 484.011, F.S.; deleting the ability of an optician to delegate specified acts to unlicensed supportive personnel; amending s. 484.018, F.S.; deleting an exception to optician licensure requirements for employees working under the direct supervision of a physician or optometrist; providing an effective date.

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

Section 1. Section 484.011, Florida Statutes, is amended to read:

484.011 License required ~~Supportive personnel~~.—Any ~~No~~ person other than a licensed optician may not engage in the practice of opticianry~~, except that a licensed optician may delegate to nonlicensed supportive personnel those duties, tasks, and functions which fall within the purview of s. 484.002(3). All such delegated acts shall be performed under the direct supervision of a licensed optician, who shall be responsible for all such acts performed by persons under her or his supervision~~.

Section 2. Subsection (2) of section 484.018, Florida Statutes, is amended to read:

484.018 Exceptions.—

~~(2) Nothing in this part shall be construed to mean that an employee of a licensed physician or a licensed optometrist shall be required to secure a license under this part, so long as the employee is working exclusively for, and under the direct~~

~~supervision of, the licensed physician or optometrist and does not hold herself or himself out to the public generally as an optician.~~

Section 3. This act shall take effect July 1, 2025.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy;

Subject: Committee Agenda Request

Date: March 6, 2025

I respectfully request that **SB 1544**, relating to Opticianry, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 40

File signed original with committee office

S-020 (03/2004)

Tab 5

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3/18/25
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Tiffany Wiggan Pearce Phone 561-699-7710

Address 96 Mallard Ct Email tpearce0661e gmail.com.
Street

RPB FL 33411
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[ ] I am appearing without compensation or sponsorship.

[ ] I am a registered lobbyist, representing:

[ ] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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18 MAR 25
Meeting Date

HEALTH POLICY
Committee

SB1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name EDWARD MITCHELL JR

Phone 850 758 0474

Address 115 STEEPLECHASE DR
Street

Email Cabanaeyes@gmail

CRESTVIEW FL 32539
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[X] I am appearing without compensation or sponsorship.

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S-001 (08/10/2021)

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3-18-25
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Thomas Neff

Phone 3525364384

Address 13229 Satin Lily Drive
Street

Email ThomasneffFLDO@gmail.com

Riverview FL 33579
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

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3/18/2025
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Laurie Pierce

Phone (813) 853-7433

Address 2401 Bayshore Blvd. #203
Street

Tampa, FL 33629
City State Zip

Email lpierce@hccfl.edu

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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03.18.25
Meeting Date

Health Policy
Committee

SB1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Stacie Hart Sidwell

Phone 321 305 6647

Address 425 Poi Ct.
Street

Email stacie@freedomoptical inc.com

Merritt Island FL 32953
City State Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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3/18/25
Meeting Date

Health Policy
Committee

S31544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Erick Ross

Phone 321-243-5255

Address 331 Melbourne Ave
Street

Indialantic 32903
City State Zip

Email erickross321@icloud.com

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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☐ I am a registered lobbyist, representing:

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3/18/2025
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Leta Chambers

Phone 9546817530

Address 7911 Colony Circle N^th H105
Street

Email iTeachvision2@gmail.com

Tamarac FL 33321
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

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3/18/25
Meeting Date

Health Policy
Committee

SB1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Shirley Melendez

Phone 561-800-4066

Address 2237 SW Edison Cir
Street

Email Shirleymelendez2@gmail.com

Port St. Lucie FL 34953
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[X] I am appearing without compensation or sponsorship.

[ ] I am a registered lobbyist, representing:

[ ] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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3/18/25
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Glenn Broga

Phone 850-445-5045

Address 59 Parkside Cir
Street

Email glenn.broga@gmail.com

Crawfordville FL 32327
City State Zip

Speaking: ☒ For ☐ Against ☐ Information (Questions Only.) **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

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March 18, 2025
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Audrey Lyons

Phone 850-445-4419

Address 1901 Miccosukee Rd
Street

Email alyons@myeyedr.com

Tallahassee FL 32308
City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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S-001 (08/10/2021)

The Florida Senate

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March 18, 2025
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dr. Mark Marciano

Phone (561) 254-0939

Address 10 Speldale Lane
Street

Email drmarciano@gmail.com

Palm Beach Gardens FL 33418
City State Zip

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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☐ I am a registered lobbyist, representing:

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S-001 (08/10/2021)

The Florida Senate

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3/18/2025
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Destynee Turner

Phone 561-401-0902

Address 218 Lyman Pl
Street

Email Destynee@myoptical ekp com

WPB FL 33409
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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☐ I am a registered lobbyist, representing:

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S-001 (08/10/2021)

The Florida Senate

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3/15/25
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Daniel Vonderpool

Phone 850-449-4461

Address 2476 Remington Street
Street

Email DVonderpool22@gmail.com

Jacksonville FL 32205
City State Zip

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

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3/18/25
Meeting Date

Health Policy
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jonathan Styron

Phone 850 324 3425

Address 2976 Remington St
Street

Email RMLOAK6@aol.com

Jacksonville FL 32205
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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S-001 (08/10/2021)

The Florida Senate

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3/18/25
Meeting Date

Health policy
Committee

1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Mackenna Davis

Phone 863-608-6658

Address 2600 Marston Rd
Street

Tallahassee FL 32308
City *State* *Zip*

Email Mackenna@converge public.com

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☒ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Essilor
Luxottica

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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03/18/25
Meeting Date

Health policy committee
Committee

SB 1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Rebecca Moore

Phone 850 491 2284

Address 1840 Cottage Grove Rd
Street

Email MRS.Rebecca.j.moore@gmail.com

Tallahassee FL 32303
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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3/18/2025
Meeting Date

Health Policy
Committee

SB1544
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dee Paee

Phone 8504451288

Address 59 Parkside Circle
Street

Crawford FL 32327
City State Zip

Email dee@pcf.org

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 944
INTRODUCER:	Banking and Insurance Committee and Senator Davis
SUBJECT:	Insurance Overpayment Claims Submitted to Psychologists
DATE:	March 17, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Brown	Brown	HP	**Favorable**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 944 reduces from 30 months to 12 months the timeframe for a health insurer or health maintenance organization (HMO) to submit claims for overpayment to a licensed psychologist. The bill's reduction in the look-back period results in licensed psychologists being subject to the same 12-month look-back period for insurer and HMO overpayments as health care providers licensed under chs. 458 (medical practice), 459 (osteopathic medicine), 460 (chiropractic medicine), 461 (podiatric medicine), or 466 (dentistry), F.S.

The bill provides an effective date of July 1, 2025, and applies to claims for services provided on or after January 1, 2026.

II. Present Situation:

State Regulation of Insurance

The Office of Insurance Regulation (OIR),[1] is responsible for all activities concerning health maintenance organizations (HMOs), health insurers, and other risk-bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided

[1] The OIR is a unit under the Financial Services Commission, which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. Commission members serve as the agency head for purposes of rulemaking under ch. 120, F.S. See s. 20.121(3), F.S.

under the Florida Insurance Code.[2] To transact business in Florida, a health insurer or HMO must obtain a certificate of authority from the OIR.[3] The Agency for Health Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[4] As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[5]

Payment of Health Insurer and HMO Claims

The Florida Insurance Code[6] prescribes the rights and responsibilities of health care providers, health insurers, and HMOs for the payment of claims. Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, in accordance with ss. 627.6131, 627.662, and 641.3155, F.S., respectively.[7] The law prescribes a protocol for specified providers to use for the submission of their claims to an insurer or HMO, as well as a statutory process for insurers or HMOs to use for the payment or denial of the claims.

Generally, if a health insurer or HMO determines it has made an overpayment to a provider, the insurer's or HMO's claim for the overpayment must be submitted to the provider within 30 months after the applicable payment by the insurer or HMO.[8] A provider must pay, deny, or contest the claim for overpayment of a health insurer or HMO within 40 days after receiving the claim.

All contested claims for overpayment must be paid or denied within 120 days after the provider's receipt of the claim.[9] Failure to pay or deny the claim of overpayment within 140 days after receipt creates an uncontestable obligation by the provider to pay the claim.[10] A claim for overpayment is not permitted beyond 30 months after the health insurer's or HMO's applicable payment to the provider, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234, F.S.[11]

Section 627.6131(18), F.S., provides an exception to the period of 30 months for an insurer to submit a claim for overpayment to a provider. Section 641.3155(16), F.S., provides the same requirements for an HMO. All claims for overpayment submitted to a provider licensed under chs. 458 (medical practice), 459 (osteopathic medicine), 460 (chiropractic medicine), 461 (podiatric medicine), or 466 (dentistry), F.S., must be submitted to the provider within 12 months – not 30 months – after the health insurer's or HMO's applicable payment to the

[2] Section 20.121(3)(a), F.S.
[3] Sections 624.401 and 641.49, F.S.
[4] Section 641.495, F.S.
[5] *Id.*
[6] Pursuant to s. 624.01, F.S., chs. 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code."
[7] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S.
[8] Section 627.6131(6), F.S., and s. 641.3155(5) F.S., for HMO provision.
[9] *Id.*
[10] *Id.*
[11] *Id.*

provider. A claim for overpayment may not be permitted after 12 months except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234, F.S.

Division of State Group Insurance Program

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group health insurance program under a cafeteria plan consistent with s. 125, Internal Revenue Code. To administer the state group health insurance program, DMS contracts with third party administrators for self-insured health plans and insured plans, as well as a pharmacy benefits manager for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.

Oversight of the Practice of Psychology in Florida

The Board of Psychology within the Department of Health is the state's regulatory board for the practice of psychology under the Psychological Services Act.[12] The "practice of psychology" means the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health.[13] Chapter 490, F.S., prescribes the requirements for an individual to be licensed as a psychologist.[14]

III. Effect of Proposed Changes:

Section 1 amends s. 627.6131, F.S., relating to the payment of claims, to add a provider licensed under ch. 490, F.S., (psychologists) to the list of health care providers to whom an insurer must submit a claim for overpayment within 12 months instead of 30 months after the insurer's applicable payment to the provider.

Section 2 amends s. 641.3155(16), F.S., relating to payment of claims, to add a provider licensed under ch. 490, F.S., (psychologists) to the list of health care providers to whom a health maintenance organization (HMO) must submit a claim for overpayment within 12 months instead of 30 months after the HMO's applicable payment to the provider.

Section 2 provides that the amendments made by the bill to ss. 627.6131(18), and 641.3155(16), F.S., apply to claims for services provided on or after January 1, 2026.

Section 3 provides an effective date of July 1, 2025.

[12] Sections 490.001 and 490.004, F.S.
[13] Section 490.003(4), F.S.
[14] Section 490.003(7), F.S., defines a psychologist as a person licensed pursuant to s. 490.005(1), F.S., s. 490.006, F.S., or the provision identified as s. 490.013(2), F.S., in s. 1, ch. 81-235, Laws of Florida.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill reduces the look-back period for a health insurer or health maintenance organization to submit claims for overpayments to psychologists from 30 months to 12 months. This may result in a positive fiscal impact for licensed psychologists or less fiscal uncertainty beyond the 12-month period, especially if the bill leads to increased participation by psychologists in insurer or HMO networks.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 627.6131 and 641.3155 of the Florida Statutes.

This bill creates one non-statutory section of the Laws of Florida.

IX. Additional Information:

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

CS by Banking and Insurance on March 10, 2025:
The committee substitute:

- Adds a health care provider licensed under ch. 490, F.S., (psychologists) to the list of health care providers to whom a health maintenance organization (HMO) must submit a claim for overpayment within 12 months instead of 30 months after payment of the claim.
- Revises the implementation date for application of the provisions of the bill to claims for services provided on or after January 1, 2026, instead of July 1, 2025, and adds a conforming change to reference s. 641.3155, F.S., thereby subjecting HMO claims for services to this same requirement.

B. Amendments:

None.

By the Committee on Banking and Insurance; and Senator Davis

597-02252-25 2025944c1

A bill to be entitled

An act relating to insurance overpayment claims submitted to psychologists; amending ss. 627.6131 and 641.3155, F.S.; requiring that insurance overpayment claims submitted to psychologists be submitted within a specified timeframe; providing applicability; providing an effective date.

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

Section 1. Subsection (18) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.—

(18) Notwithstanding the 30-month period provided in subsection (6), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health insurer's payment of the claim. A claim for overpayment may not be permitted beyond 12 months after the health insurer's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

Section 2. Subsection (16) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(16) Notwithstanding the 30-month period provided in subsection (5), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to

the provider within 12 months after the health maintenance organization's payment of the claim. A claim for overpayment may not be permitted beyond 12 months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

Section 3. The amendments made by this act to ss. 627.6131(18) and 641.3155(16), Florida Statutes, apply to claims for services provided on or after January 1, 2026.

Section 4. This act shall take effect July 1, 2025.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 10, 2025

I respectfully request that **Senate Bill # 944**, relating to Insurance Overpayment Claims Submitted to Psychologists, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Thank you for your time and consideration.

Senator Tracie Davis
Florida Senate, District 5

File signed original with committee office

Tab 6

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

March 18, 2025
Meeting Date

Health Policy
Committee

SB 944
Bill Number or Topic

Amendment Barcode (if applicable)

Name Deborah Foote

Phone 850-656-2222

Address PO Box 7416
Street

Email deborah@flapsych.com

Tallahassee FL 32314
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☑ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:
FL Psychological Assn

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 768
INTRODUCER:	Health Policy Committee and Senator Calatayud
SUBJECT:	Controlling Business Interests by Persons with Ties to Foreign Countries of Concern
DATE:	March 19, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.			JU	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 768 revises health care providers' minimum licensure requirements to require licensees to make reasonable efforts to ensure that a person or entity that possesses a direct controlling interest does not directly hold an interest in an entity that has a business relationship with a foreign country of concern or that is subject to the statute prohibiting contracting with scrutinized companies. The bill also removes "any other entity of significant control" (of such foreign country of concern) from the definition of foreign country of concern and engaging in "any other apparatus of business or commerce" from the definition of "business relationship, for purposes of that requirement.

These changes would ease heightened requirements, relating to business interests by persons with ties to foreign countries of concern, for licensees who may not have access to the information that they need to ensure that they satisfy those current minimum licensure requirements.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Health Care Licensing Procedures Act

As of February 21, 2025, the Florida Agency for Health Care Administration (AHCA) regulates 49,823 health care providers.[1] The Health Care Licensing Procedures Act[2] provides a streamlined and consistent set of basic licensing requirements for health care providers that are licensed, registered, or certified by the AHCA.[3] The Act is intended to minimize confusion, standardize terminology, and include issues that are not otherwise addressed in state law pertaining to specific providers.[4] Among other things, it provides certain minimum licensure requirements with which applicants and licensees must comply in order to obtain and maintain a license.[5] The issuance of a license is not a contract or an agreement between the state and the licensee.[6] A license is a privilege that is granted by the state based upon the licensee complying with licensure requirements.[7]

Minimum Licensure Requirements; An Act Relating to the Interests of Foreign Countries

On July 1, 2023, Senate Bill 264 (2023), relating to the Interests of Foreign Countries, became effective, creating additional minimum licensure requirements for health care providers.[8]

One such additional requirement is subsection (15) of s. 408.810, F.S., which requires a licensee to ensure that a person or entity who possesses a *controlling interest* in the licensee does not also hold, either directly or indirectly, regardless of ownership structure, an *interest* in an entity that has a business relationship with a foreign country of concern or that is subject to the statute prohibiting contracting with scrutinized companies.[9]

---

[1] Agency for Health Care Administration, Senate Bill 786 Legislative Analysis (Feb. 19, 2025) (on file with the Senate Committee on Health Policy).
[2] Chapter 408, Part II, F.S. *See also* s. 408.801(1), F.S.
[3] Section 408.801(2), F.S. The act applies to following providers: laboratories authorized to perform testing under the Drug-Free Workplace Act, birth centers, abortion clinics, crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, residential treatment centers for children and adolescents, hospitals, ambulatory surgical centers, nursing homes, assisted living facilities, home health agencies, nurse registries, companion services or homemaker services providers, adult day care centers, hospices, adult family-care homes, homes for special services, transitional living facilities, prescribed pediatric extended care centers, home medical equipment providers, intermediate care facilities for persons with developmental disabilities, health care services pools, health care clinics, organ tissue and eye procurement organizations.
[4] *Id.*
[5] *See generally* s. 408.810, F.S.
[6] *Supra* note 1.
[7] *Supra* note 1.
[8] Chapter 2023-22, s. 10, Laws of Fla.
[9] Section 287.135, F.S.

The term "controlling interest" is defined for the Act (part II of ch. 408, F.S.) in s. 408.803(7), F.S.:

- "Controlling interest" means:
  - *(a) The applicant or licensee;*
  - *(b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or*
  - *(c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider.*

The term does not include a voluntary board member.

For purposes of s. 408.810(15), F.S., the following terms are defined:

- "Business relationship" means engaging in commerce in any form, including, but not limited to, acquiring, developing, maintaining, owning, selling, possessing, leasing, or operating equipment, facilities, personnel, products, services, personal property, real property, military equipment, or any other apparatus of business or commerce.
- "Foreign country of concern" has the same meaning as in s. 692.201(3), F.S., as that term is defined for purposes of the conveyance of property.
  - *"Foreign country of concern" means the People's Republic of China, the Russian Federation, the Islamic Republic of Iran, the Democratic People's Republic of Korea, the Republic of Cuba, the Venezuelan regime of Nicolás Maduro, or the Syrian Arab Republic, including any agency of or any other entity of significant control of such foreign country of concern.*
- "Interest" has the same meaning as in s. 286.101(1), F.S., as that term is defined for purposes of foreign gifts and contracts in business.
  - *"Interest" in an entity means any direct or indirect investment in or loan to the entity valued at 5 percent or more of the entity's net worth or any form of direct or indirect control exerting similar or greater influence on the governance of the entity.*

The onus is on the licensee to ensure that no business relationship exists with foreign countries of concern or that is subject to the statute prohibiting contracting with scrutinized companies.[10]

Pursuant to s. 408.806(5), F.S., which outlines the license application process for the Act, proof of compliance with s. 408.810, F.S., including subsection (15) of that section, must be submitted with an application for licensure and licensure renewal.[11]

In practice, the AHCA processes the background screenings of individual people with a controlling interest (generally 5 percent or more) in the licensee when their names are listed on an application.[12] Licensees may have controlling interests that are business entities with no individual people having been named or disclosed. The AHCA reports that aside from the application process, there is no mechanism by which its staff can verify whether the

[10] *Supra* note 1.
[11] Section 408.806(5), F.S.
[12] Section 408.809(1)(d), F.S.

requirements of subsection (15) are met.[13] The AHCA notes that it is a registered user of the SAVE Program of the U.S. Department of Homeland Security[14] and can determine the status of nonimmigrant aliens with controlling interest in home health agencies, home medical equipment providers, and health care clinics.[15]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 408.810(15), F.S., which provides certain minimum licensure requirements for health care providers relating to foreign countries of concern.[16] The bill adds the phrase "make reasonable efforts to" to subsection (15), so that a licensee would be required to make reasonable efforts to ensure, rather than to absolutely ensure, that a person or entity who possesses a direct controlling interest in the licensee does not also directly hold, regardless of ownership structure, an interest in an entity that has a business relationship with a foreign country of concern or that is subject to the statute prohibiting contracting with scrutinized companies. The bill removes the concept of engaging in "any other apparatus of business or commerce" from the definition of "business relationship", for purposes of this requirement.

Under the bill, a licensee would no longer have to ensure that a person or entity who possesses an *indirect* controlling interest does not have an interest in an entity that has an otherwise forbidden business relationship.

Additionally, the bill defines the term "foreign country of concern" in a similar manner to how it is currently defined in s. 692.201, F.S.[17], but removes the phrase "or any other entity of significant control of" such foreign country of concern.

These changes would ease the heightened requirements on licensees who may not have access to the information they need to ensure that they meet the current requirements of subsection (15).

Section 2 of the bill provides an effective date of July 1, 2025.

[13] *Supra* note 1.
[14] SAVE is an online service for registered federal, state, territorial, tribal, and local government agencies to verify immigration status and naturalized/acquired U.S. citizenship of applicants seeking benefits or licenses. United States Department of Homeland Security, *SAVE, available at* https://www.uscis.gov/save (last accessed Mar. 15, 2025).
[15] *Supra* note 1.
[16] Section 408.802, F.S. (listing regulated providers).
[17] Pursuant to s. 692.201, F.S., "Foreign country of concern" means the People's Republic of China, the Russian Federation, the Islamic Republic of Iran, the Democratic People's Republic of Korea, the Republic of Cuba, the Venezuelan regime of Nicolás Maduro, or the Syrian Arab Republic, including any agency of or any other entity of significant control of such foreign country of concern.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

It is objectively easier to "make reasonable efforts to ensure" rather than "ensure" that certain business relationships do not exist. It is possible that changes made by the bill which ease minimum licensure requirements could encourage additional health care providers to seek licensure and provide health care services in this state.

C. Government Sector Impact:

The AHCA expects this bill to have no fiscal impact on the agency.[18]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The AHCA has noted a lack of clarity as to what it means to make a "reasonable effort" as required by the bill.[19]

[18] *Supra* note 1.
[19] *Supra* note 1.

VIII. Statutes Affected:

This bill substantially amends section 408.810 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on March 18, 2025:
The committee substitute revises the application of the requirement in the underlying bill that a licensee must make a reasonable effort to ensure that a person or entity that possesses a "controlling interest" (as defined in the underlying bill) does not have a specified business relationship. Instead, the CS requires the licensee to ensure that a person or entity that possesses a *direct* controlling interest does not have such a relationship. It also deletes the definition of "controlling interest" which is already defined for the chapter in current law.

The underlying bill required the licensee to ensure that such a person or entity does not directly or indirectly hold a specified business relationship. The CS removes "indirectly" and requires the licensee to ensure that such a person or entity does not directly hold such a relationship.

The CS removes the concept of engaging in "any other apparatus of business or commerce" from the definition of "business relationship," for purposes of the bill's overall requirement.

B. Amendments:

None.

217378

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2025	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 22 - 43

and insert:

that a person or an entity that ~~who~~ possesses a direct controlling interest does not directly hold~~, either directly or indirectly~~, regardless of ownership structure, an interest in an entity that has a business relationship with a foreign country of concern or that is subject to s. 287.135.

(b) For purposes of this subsection, the term:

217378

1. "Business relationship" means engaging in commerce in any form, including~~, but not limited to,~~ acquiring, developing, maintaining, owning, selling, possessing, leasing, or operating equipment, facilities, personnel, products, services, personal property, real property, or military equipment~~, or any other apparatus of business or commerce~~.

2. "Foreign country of concern" means the People's Republic of China, the Russian Federation, the Islamic Republic of Iran, the Democratic People's Republic of Korea, the Republic of Cuba, the Venezuelan regime of Nicolas Maduro, or the Syrian Arab Republic, including any agency of such foreign country of concern ~~has the same meaning as in s. 692.201~~.

3. "Interest" has the same meaning as in s. 286.101(1).

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 6 - 8

and insert:

persons or entities possessing a specified controlling interest in the licensee; revising the definition of the terms "business relationship" and

By Senator Calatayud

38-01085A-25 2025768__

A bill to be entitled

An act relating to controlling business interests by persons with ties to foreign countries of concern; amending s. 408.810, F.S.; revising minimum health care provider licensure requirements relating to persons or entities possessing a controlling interest in the licensee; defining the term "controlling interest"; revising the definition of the term "foreign country of concern"; providing an effective date.

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

Section 1. Subsection (15) of section 408.810, Florida Statutes, is amended to read:

408.810 Minimum licensure requirements.—In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(15)(a) The licensee must make reasonable efforts to ensure that a person or entity who possesses a controlling interest does not hold, either directly or indirectly, regardless of ownership structure, an interest in an entity that has a business relationship with a foreign country of concern or that is subject to s. 287.135.

(b) For purposes of this subsection, the term:

1. "Business relationship" means engaging in commerce in any form, including, but not limited to, acquiring, developing,

maintaining, owning, selling, possessing, leasing, or operating equipment, facilities, personnel, products, services, personal property, real property, military equipment, or any other apparatus of business or commerce.

2. "Controlling interest" has the same meaning as in s. 408.803, but is limited to persons or entities that have a direct controlling interest in the licensee.

3. "Foreign country of concern" means the People's Republic of China, the Russian Federation, the Islamic Republic of Iran, the Democratic People's Republic of Korea, the Republic of Cuba, the Venezuelan regime of Nicolas Maduro, or the Syrian Arab Republic, including any agency of such foreign country of concern ~~has the same meaning as in s. 692.201~~.

4.~~3.~~ "Interest" has the same meaning as in s. 286.101(1).

Section 2. This act shall take effect July 1, 2025.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 2, 2025

I respectfully request that **Senate Bill #768**, relating to Controlling Business Interests by Persons with Ties to Foreign Countries of Concern, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Alexis Calatayud

Senator Alexis Calatayud
Florida Senate, District 38

File signed original with committee office

S-020 (03/2004)

Tab 7

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

3-18-25
Meeting Date

HEALTH POLICY
Committee

SB 768
Bill Number or Topic

Amendment Barcode (if applicable)

Name STEVEN GRIGAS

Phone (850) 228-8244

Address
Street

Email steven.grigas@akerman.com

City State Zip

Speaking: ☑ For ☐ Against ☑ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

HEALTH LAW SECTION OF FLA. BAR.

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1370
INTRODUCER:	Senator Trumbull
SUBJECT:	Ambulatory Surgical Centers
DATE:	March 17, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			AHS	
3.			RC	

I. Summary:

SB 1370 creates and amends numerous sections of the Florida Statutes to remove regulation of ambulatory surgical centers (ASC) from Part I of ch. 395, F.S., which currently houses regulations for both ASCs and hospitals, and create a new ch. 396, F.S., specific to the regulation of ASCs. The bill also specifies that it is the intent of the Legislature to bifurcate all fees and public records exemptions related to ASCs established in ch. 395, F.S., and transfer those fees to, and preserve such public records exemptions under, ch. 396, F.S.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Ambulatory Surgical Centers

An ASC is a licensed health care facility that is not part of a hospital and has the primary purpose of providing elective surgical care. A patient is admitted to and discharged from the facility within 24 hours.[1] ASCs are required to be licensed by the Agency for Health Care Administration (AHCA) and may choose to be Medicare certified and/or accredited.[2]

Licensure

ASCs are licensed and regulated under ch. 395, F.S., by the AHCA under the same regulatory framework as hospitals.[3] Applicants for ASC licensure are required to submit certain information to the AHCA prior to accepting patients for care or treatment, including:

[1] Agency for Health Care Administration, Ambulatory Surgical Center, available at https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/hospital-outpatient-services-unit/ambulatory-surgical-center, (last visited Mar. 13, 2025).
[2] *Id*.
[3] Sections 395.001-395.1065, F.S., and part II, ch. 408, F.S.

- An affidavit of compliance with fictitious name;
- Registration of articles of incorporation; and
- The applicant's zoning certificate or proof of compliance with zoning requirements.[4]

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

- Governing body bylaws, rules, and regulations;
- Medical staff bylaws, rules, and regulations;
- A roster of medical staff members;
- A roster of registered nurses and licensed practical nurses with current license numbers;
- A nursing procedure manual;
- A fire plan; and
- A comprehensive emergency management plan.[5]

The licensure fee is $1,679.82 and the survey/inspection fee is $400.[6] Currently there are 532 licensed ASCs in Florida.[7] In 2023, ASCs were visited by patients for outpatient services 3,205,371 times which equals 53.6 percent of all outpatient visits in Florida.[8]

Accreditation

If an ASC chooses to become accredited by an organization recognized by the AHCA, including the Accreditation Association for Ambulatory Health Care, the QUAD A, the Accreditation Commission for Health Care, or the Joint Commission, the ASC may be deemed to be in compliance with state licensure and certification requirements. Deemed ASCs are not scheduled for routine on-site licensure or recertification surveys, although periodic Life Safety Code inspections are still required. Facilities must provide a complete copy of the most recent survey report indicating continuation as an accredited facility in lieu of inspections. The survey report should include correspondence from the accrediting organization containing:

- The dates of the survey,
- Any citations to which the accreditation organization requires a response,
- A response to each citation,
- The effective date of accreditation,
- Any follow-up reports, and
- Verification of Medicare (CMS) deemed status, if applicable.

Facilities no longer accredited or granted accreditation status other than accredited, or fail to submit the requested documentation, will be scheduled for annual licensure or recertification surveys to be conducted by AHCA field office staff.[9]

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[4] Rule 59A-5.003(4), F.A.C.
[5] Rule 59A-5.003(5), F.A.C.
[6] *Supra* note 1.
[7] Florida Health Finder report, available at https://quality.healthfinder.fl.gov/Facility-Search/FacilityLocateSearch, (last visited Mar. 13, 2025).
[8] Ambulatory (outpatient) Surgery Query Results, Florida Health Finder, available at https://quality.healthfinder.fl.gov/QueryTool/QTResults#, (last visited Mar. 13, 2025).
[9] *Supra* note 1.

Licensure Requirements

Pursuant to s. 395.1055, F.S., the AHCA is authorized to adopt rules for hospitals and ASCs. Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals, but the rules for all hospitals and ASCs are required to include minimum standards for ensuring that:

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

Rule 59A-5 of the Florida Administrative Code (F.A.C.) implements the minimum standards for ASCs. Those rules require policies and procedures to ensure the protection of patient rights.

Staff and Personnel Rules

ASCs are required to have written policies and procedures for surgical services, anesthesia services, nursing services, pharmaceutical services, laboratory services, and radiologic services. In providing these services, ACSs are required to have certain professional staff available, including:

- A qualified person responsible for the daily functioning and maintenance of the surgical suite;
- An anesthesiologist or other physician, or a certified registered nurse anesthetist under the on-site medical direction of a licensed physician, or an anesthesiologist assistant under the direct supervision of an anesthesiologist, who must be in the center during the anesthesia and post-anesthesia recovery period until all patients are cleared for discharge;
- A registered professional nurse who is responsible for coordinating and supervising all nursing services;
- A registered professional circulating nurse for a patient during that patient's surgical procedure; and
- A registered professional nurse who must be in the recovery area at all times when a patient is present.[10]

Infection Control Program

ASCs are required to establish an infection control program involving members of the medical, nursing, and administrative staff. The program must include written policies and procedures reflecting the scope of the infection control program. The written policies and procedures must be reviewed at least every two years by the infection control program members. The infection control program must include:

- Surveillance, prevention, and control of infection among patients and personnel;

[10] Rule 59A-5.0085, F.A.C.

- A system for identifying, reporting, evaluating, and maintaining records of infections;
- Ongoing review and evaluation of aseptic, isolation, and sanitation techniques employed by the ASC; and
- Development and coordination of training programs in infection control for all personnel.[11]

Emergency Management Plan

ASCs are required to develop and adopt a written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency. The ASC must review the plan and update it annually.[12]

Medicare Requirements

ASCs are required to have an agreement with the federal Centers for Medicare & Medicaid Services (CMS) to participate in Medicare. ASCs are also required to comply with specific conditions for coverage. The CMS defines "ASC" as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and for whom the expected duration of services would not exceed 24 hours following an admission.[13]

The CMS may deem an ASC to be in compliance with all of the conditions for coverage if the ASC is accredited by a national accrediting body or licensed by a state agency and if the CMS determines that such accreditation or licensure provides reasonable assurance that the conditions for coverage are met.[14] All CMS conditions for coverage requirements are specifically required in Rule 59A-5, F.A.C., and apply to all ASCs in Florida. The conditions for coverage require ASCs to have a:

- Governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation;
- Quality assessment and performance improvement program;
- Transfer agreement with one or more acute care general hospitals, which will admit any patient referred who requires continuing care;
- Disaster preparedness plan;
- Organized medical staff;
- Fire control plan;
- Sanitary environment;
- Infection control program; and
- Procedure for patient admission, assessment and discharge.

III. Effect of Proposed Changes:

SB 1370 creates ch. 396, F.S., consisting of ss. 396.201-396.225, F.S., entitled "Ambulatory Surgical Centers." The bill duplicates provisions from Part I of ch. 395, F.S., as necessary to create substantively identical requirements for ASCs in the newly created ch. 396, F.S. The bill also amends provisions in part I of ch. 395, F.S., as well as multiple other sections of the Florida

[11] Rule 59A-5.011, F.A.C.
[12] Rule 59A-5.018, F.A.C.
[13] 42 C.F.R. s. 416.2
[14] 42 C.F.R. s. 416.26(a)(1)

Statutes, to remove the regulation of ASCs from Part I of ch. 395, F.S., and make conforming changes.

The bill also specifies that it is the intent of the Legislature to bifurcate all fees applicable to ASCs authorized and imposed under ch. 395, F.S., and transfer them to ch. 396, F.S. The AHCA is authorized to maintain its current fees for ASCs and may adopt rules to codify such fees in rule to conform to changes made by the bill. Additionally, the bill specifies that it is the intent of the Legislature to bifurcate any exemptions from public records and public meetings requirements applicable to ASCs under ch. 395, F.S., and preserve such exemptions under ch. 396, F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

SB 1370 creates a new chapter of the Florida Statutes specific to the regulation of ASCs and removes ASC regulation from ch. 395, F.S., where it is currently housed. As such, many other statutes are required to be amended to make conforming changes to refer to ch. 396, F.S., rather than ch. 395, F.S. As drafted, the bill includes some of the necessary conforming changes but does not amend numerous other statutes that reference ch. 395, F.S., and include both ASCs and hospitals. Such additional statutes should be amended to conform to the changes made by the bill.

Additionally, the AHCA has raised several technical issues with SB 1370 including citing multiple incorrect cross-references and several places in which not cross-referencing ch. 396, F.S., may inadvertently leave out ASCs from exemptions or regulations that are necessary for ASCs.[15]

VII. Related Issues:

None.

VIII. Statutes Affected:

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

This bill creates the following sections of the Florida Statutes: 396.201, 396.225, 396.202, 396.203, 396.204, 396.205, 396.206, 396.207, 396.208, 396.209, 396.211, 396.212, 396.213, 396.214, 396.215, 396.216, 396.217, 396.218, 396.219, 396.221, 396.222, 396.223, and 396.224.

IX. Additional Information:

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

None.

B. Amendments:

None.

[15] Email from Jim Browne, AHCA Legislative Affairs Director, on March 14, 2025. On file with Senate Health Policy Committee staff.

By Senator Trumbull

2-01226-25 20251370__

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.; defining terms; creating s. 396.203, F.S.; providing requirements for issuance, denial, suspension, and revocation of ambulatory surgical center licenses; 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; authorizing the agency to accept surveys or inspections from certain accrediting organizations in lieu of its own periodic inspections, provided certain conditions are met; requiring the agency to develop and adopt by rule certain criteria; requiring an applicant or a licensee to pay certain fees at the time of inspection; requiring the agency to coordinate periodic inspections to minimize costs and disruption of services; 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; providing that such reports be retained for a specified timeframe; prohibiting the distribution of specified records;

requiring a licensed facility to provide a copy of its most recent inspection report to certain parties upon request; providing for a charge for such copies; creating s. 396.208, F.S.; providing that specified provisions govern the design, construction, erection, alteration, modification, repair, and demolition of licensed facilities; requiring the agency to review facility plans and survey the construction of licensed facilities; authorizing the agency to conduct certain inspections and investigations; authorizing the agency to adopt certain rules; requiring the agency to approve or disapprove facility plans and specifications within a specified timeframe; providing an extension under certain circumstances; deeming a facility plan or specification approved if the agency fails to act within the specified timeframe; requiring the agency to set forth in writing its reasons for any disapprovals; authorizing the agency to charge and collect specified fees; creating s. 396.209, F.S.; prohibiting any person from paying or receiving a commission, bonus, kickback, or rebate for referring a patient 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; specifying

requirements for such rules and procedures; providing for the termination of clinical privileges for physician assistants under certain circumstances; requiring a licensed facility to make available specified membership or privileges to physicians under certain circumstances; providing construction; requiring the governing board of a licensed facility to set standards and procedures to be applied in considering and acting upon applications; providing that such standards and procedures must be made available for public inspection; requiring a licensed facility to provide an applicant with reasons for denial within a specified timeframe; providing immunity from monetary liability to certain persons and entities; providing that investigations, proceedings, and records produced or acquired by the governing board or its agent are not subject to discovery or introduction into evidence in certain proceedings under certain circumstances; providing for the award of specified fees and costs; requiring applicants who bring an action against a review team to post a bond or other security in a certain amount, as set by the court; creating s. 396.212, F.S.; providing legislative intent; requiring licensed facilities to provide for peer review of certain physicians and develop procedures to conduct such reviews; providing requirements for such procedures; providing grounds for peer review and reporting requirements; providing immunity from monetary

liability to certain persons and entities; providing construction; providing administrative penalties; providing that certain proceedings and records of peer review panels, committees, and governing boards or agents thereof are exempt from public record requirements and are not subject to discovery or introduction into evidence in certain proceedings; prohibiting persons in attendance at certain meetings from testifying in certain civil or administrative actions; providing construction; providing for the award of specified fees and costs; requiring persons who bring an action against a review team to post a bond or other security in a certain amount, as set by the court; creating s. 396.213, F.S.; requiring licensed facilities to establish an internal risk management program; providing requirements for such program; providing that the governing board of the licensed facility is responsible for the program; requiring licensed facilities to hire a risk manager; providing requirements for such risk manager; encouraging licensed facilities to implement certain innovative approaches; requiring licensed facilities to report specified information annually to the Department of Health; requiring the agency and the department to include certain statistical information in their respective annual reports; requiring the agency to adopt certain rules relating to internal risk management programs; defining the term "adverse incident"; requiring licensed facilities to report

specified information annually to the agency; requiring the agency to review the reported information and make certain determinations; providing that the reported information is exempt from public record requirements and is not discoverable or admissible in civil or administrative actions, with exceptions; requiring licensed facilities to report certain adverse incidents to the agency within a specified timeframe; authorizing the agency to grant extensions to the reporting requirement under certain circumstances and subject to certain conditions; providing that such reports are exempt from public records requirements and are not discoverable or admissible in civil an administrative actions, with exceptions; authorizing the agency to investigate reported adverse incidents and prescribe response measures; requiring the agency to review adverse incidents and make certain determinations; requiring the agency to publish certain reports and summaries within certain timeframes on its website; providing a purpose; providing certain investigative and reporting requirements for internal risk managers relating to the investigation and reporting of allegations of sexual misconduct or sexual abuse at licensed facilities; specifying requirements for witnesses to such allegations; defining the term "sexual abuse"; providing criminal penalties for making a false allegation of sexual misconduct; requiring the agency to require a written plan of correction from the

licensed facility for certain violations; requiring licensed facilities to provide the agency with all access to the facility records it needs for specified purposes; providing that such records obtained by the agency are exempt from public record requirements and are not discoverable or admissible in civil and administrative actions, with exceptions; providing an exemption from public meeting and record requirements for certain meetings of the committees and governing board of a licensed facility; requiring the agency to review the internal risk management program of each licensed facility as part of its licensure review process; providing risk managers with immunity from monetary and civil liability in certain proceedings under certain circumstances; providing immunity from civil liability to risk managers and licensed facilities in certain actions, with an exception; requiring the agency to report certain investigative results to the applicable regulatory board; prohibiting intimidation of a risk manager; providing for civil penalties; 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; providing requirements for such survey; requiring that survey data be submitted to the agency in a certain format;

authorizing licensed facilities to develop an internal action plan for a certain purpose; creating s. 396.216, F.S.; requiring licensed facilities to adopt specified protocols for the treatment of victims of child abuse, abandonment, or neglect; requiring licensed facilities to submit a copy of such protocols to the agency and the Department of Children and Families; providing for administrative penalties; creating s. 396.217, F.S.; providing requirements for notifying patients about adverse incidents; providing construction; creating s. 396.218, F.S.; requiring the agency to adopt specified rules relating to minimum standards for licensed facilities; providing construction; providing that certain licensed facilities have a specified timeframe in which to comply with any newly adopted agency rules; preempting the adoption of certain rules to the Florida Building Commission and the State Fire Marshal; creating s. 396.219, F.S.; providing criminal and administrative penalties; authorizing the agency to impose an immediate moratorium on elective admissions to any licensed facility under certain circumstances; creating s. 396.221, F.S.; providing powers and duties of the agency; creating s. 396.222, 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 that facility websites provide specified information and notify and inform patients or prospective patients of certain information; defining the terms "shoppable health care services" and "standard charge"; 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; specifying requirements for such estimates; 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 civil penalty for failing to provide an estimate of charges to a patient; requiring licensed facilities to provide an itemized statement or bill to a patient or his or her survivor or legal guardian within a specified timeframe upon request and after discharge; specifying requirements for the statement or bill; requiring licensed facilities to make available certain records to the patient within a specified timeframe and in a specified manner; authorizing licensed facilities to charge fees in a specified amount for copies of such records; requiring licensed facilities to establish certain internal processes relating to itemized statements and bills and grievances; requiring licensed facilities to disclose certain information relating to the patient's cost-sharing obligation;

providing an administrative penalty for failure to disclose such information; creating s. 396.223, F.S.; defining the term "extraordinary collection action"; prohibiting certain collection actions by a licensed facility; creating s. 396.224, F.S.; prohibiting the fraudulent alteration, defacement, or falsification of medical records; providing criminal penalties and for disciplinary action; creating s. 396.225, F.S.; providing requirements for appropriate disclosure of patient records; specifying authorized charges for copies of such records; providing for confidentiality of patient records; providing exceptions; authorizing the department to examine certain records for certain purposes; providing criminal penalties; 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; bifurcating fees applicable to ambulatory surgical centers under ch. 395, F.S., and transferring them to ch. 396, F.S.; authorizing the agency to maintain its current fees for ambulatory surgical centers and adopt certain rules; bifurcating public records and public meetings exemptions applicable to ambulatory surgical centers under ch. 395, F.S., and preserving them under ch. 396, F.S.; providing an effective date.

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

Section 1. Chapter 396, Florida Statutes, consisting of ss. 396.201-396.225, Florida Statutes, 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 the 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 whose standards incorporate comparable licensure regulations required by this 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 such facility within 24 hours, and which is not part of a hospital. The term does not include 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, except that that any such facility or office that is certified or seeks certification as a Medicare ambulatory surgical center must be licensed as an ambulatory surgical center under this chapter.

(4) "Biomedical waste" has the same meaning as provided 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 a hospital, 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 who 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. 396.201-396.225 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. 396.201-396.225. 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" 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.

(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 implement 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 must 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 which 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, but not limited to, 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 a 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 of at least $400 per facility.

(b) Inspection for lifesafety only.—A fee of 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 are 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 health care 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 may 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 may 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. Such standards and procedures must be made available for public inspection.

(6) Upon the written request of the applicant, any licensed facility that has denied staff membership or clinical privileges to an applicant specified in subsection (1) or subsection (2) must, 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 may 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 that 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 in 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. 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) 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) A mechanism to identify and avoid conflict of interest on the part of the peer review panel members.

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

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

(g) Focus the peer review process on reviewing 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 must investigate and determine whether grounds for discipline exist with respect to such staff member or physician. The governing board of a 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 or physician.

(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 Medical Quality Assurance of the Department of Health within 30 working days after its initial occurrence, regardless of the pendency of appeals to the governing board of the licensed facility. 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 Medical Quality Assurance 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 which 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 may rise 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 a licensed facility; 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 committee of an ambulatory surgical center, a disciplinary board, or a governing board, or agents thereof with whom there is a specific written contract for that purpose, as described in this section are not 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 that 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 is not permitted and may not be 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 in 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, at a minimum, 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 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 planned procedures 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 the occurrence of such incidents.

(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 the department, 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 a responsible individual who is competent in risk management techniques, such as an insurance coordinator, in the employ of each licensed facility, 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 outcomes:

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 adverse 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 applies.

(c) The report submitted to the agency must also contain the name of the risk manager of the licensed facility, a copy of the policies and procedures governing 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 would be subject to disciplinary action, in which case s. 456.073 applies.

(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 health care 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 which 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 must be given 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 are they discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor are records obtained pursuant to s. 456.071 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 practitioner 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 may 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 is 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 relating to biomedical waste. 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 licensed 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 Cases of child abuse, abandonment, or neglect; 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 of Children and Families, a staff physician to act as a liaison between the licensed facility and the Department of Children and Families office that 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.

Each licensed facility shall provide a copy of its policy to the agency and the department as specified by agency rule. Failure to comply with this section is punishable by a fine not to exceed $1,000, to be fixed, imposed, and collected by the agency. Each day in violation of this section is considered a separate offense.

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. Notifications 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. Such 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. 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 chapter 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 pursuant to federal law or rules adopted pursuant thereto.

(4) Any licensed facility which is in operation at the time of adoption of any applicable rules under this chapter must 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

ambulatory surgical centers.

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 any provision of this chapter, 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 must 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 the provisions of this chapter were 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. 395.1055(1)(g).

Section 20. Section 396.221, Florida Statutes, is created to read:

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

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

(2) Develop a model risk management program for licensed facilities which 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 396.222, Florida Statutes, is created to read:

396.222 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 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 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 fees for providing copies of records as specified in s. 395.3025(1).

(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 396.223, Florida Statutes, is created to read:

396.223 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 396.224, Florida Statutes, is created to read:

396.224 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 a license.

Section 24. Section 396.225, Florida Statutes, is created to read:

396.225 Patient and personnel records; copies; examination.—

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

(g) 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.

(h) If applicable to a licensed facility, 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 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 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 is 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 from 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 (3), (10), (17), (23), and (28) of section 395.002, Florida Statutes, 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 (15) ~~(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 chapter ~~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 (2), (3), and (9) of section 395.1055, Florida Statutes, 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. 395.202 ~~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 do ~~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 does ~~shall~~ not apply to treatment rendered after the patient is stabilized~~,~~ or ~~the~~ treatment that 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 ~~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 ~~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 ~~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 ~~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 ~~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 a ~~an ambulatory surgical center or~~ hospital licensed under chapter 395, an ambulatory surgical center licensed under chapter 396, 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., follow-up ~~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. Follow-up ~~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 may ~~shall~~ not exceed $150,000 per claimant.

(b) Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such practitioners may ~~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. (1) It is the intent of the Legislature to bifurcate all fees applicable to ambulatory surgical centers authorized and imposed under chapter 395, Florida Statutes (2024), and transfer them to chapter 396, Florida Statutes, as

created by this act. The Agency for Health Care Administration may maintain its current fees for ambulatory surgical centers and may adopt rules to codify such fees in rule to conform to changes made by this act.

(2) It is further the intent of the Legislature to bifurcate any exemptions from public records and public meetings requirements applicable to ambulatory surgical centers under chapter 395, Florida Statutes (2024), and preserve such exemptions under chapter 396, Florida Statutes, as created by this act.

Section 78. This act shall take effect July 1, 2025.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Health and Human Services, *Chair*
Appropriations
Appropriations Committee on Higher Education
Community Affairs
Health Policy
Judiciary
Rules

SENATOR JAY TRUMBULL
2nd District

March 10, 2025

Re: SB 1370

Dear Chair Burton,

I respectfully request for Senate Bill 1370, relating to Ambulatory Surgical Centers, be placed on the agenda for the next meeting of the Health Policy Committee.

I appreciate your time and consideration of this request. If you have any questions or concerns, please do not hesitate to contact my office at (850) 487-5002.

Thank you,

Senator Jay Trumbull
District 2

REPLY TO:
❒ 840 West 11th Street, Panama City, Florida 32401 (850) 747-5454
❒ 415 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5002

Senate's Website: *www.flsenate.gov*

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

The Florida Senate

APPEARANCE RECORD

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Take 8

3/18/25
Meeting Date

Health Policy
Committee

1370
Bill Number or Topic

Amendment Barcode (if applicable)

Name Mike Madewell

Phone 8508901407

Address 408 E Beach Dr
Street

Panama City FL 32401
City State Zip

Email mpmadewell@gmail.com

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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3/18/25
Meeting Date

Health Policy
Committee

1370
Bill Number or Topic

Amendment Barcode (if applicable)

Name Robert Haen

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Jax FL 32256
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[X] I am appearing without compensation or sponsorship.

[ ] I am a registered lobbyist, representing:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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3/18/25
Meeting Date

1370
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name EDWARD TENNANT

Phone 813 245-9675

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JAX
City

FL
State

32224
Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1808
INTRODUCER:	Health Policy Committee and Senator Burton
SUBJECT:	Refund of Overpayments Made by Patients
DATE:	March 20, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.			AHS	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1808 requires health care practitioners, facilities, providers, and anyone who accepts payment from insurance for services rendered by health care practitioners, to refund to a patient any overpayment made by the patient no later than 30 days after determining that the patient made an overpayment.

Under the bill, if a health care practitioner fails to timely refund an overpayment after he or she determines that an overpayment was made, the failure constitutes grounds for disciplinary action by the applicable board, or the Department of Health if there is no board.

Under the bill, if a facility or provider licensed by the Agency for Health Care Administration fails to timely refund an overpayment, the agency may impose an administrative penalty of up to $500 on the licensee.

The bill's requirement to timely refund such an overpayment does not apply to overpayments made to providers by health insurers and health maintenance organizations, and the bill instead defers to existing law for such cases.

The bill provides an effective date of January 1, 2026.

II. Present Situation:

Overpayments in Health Care

Circumstances such as miscalculations, duplicate payments, insurance coverage adjustments, and coding errors can create occasional overpayments by patients to health care providers. When this occurs, it is legally required[1] for the provider to return any excess funds to the patient, although there is no statutory requirement that the overpayment be refunded by a certain date.

For example, the following situations could lead to a health care provider collecting an overpayment and subsequently refunding the overpayment to the patient:

Excess Patient Responsibility Collected

In some instances, a patient's insurance benefits or deductibles may be miscalculated by either the patient or the health care provider. For example, a clinic might initially collect a copayment or deductible based on an estimate of services rendered. When the insurance claim is later processed, the insurer might pay more than anticipated, resulting in an overpayment on the patient's account. In such cases, the provider is obligated to refund the excess amount to the patient.

Duplicate Payments

Occasionally, patients or their family members may inadvertently make multiple payments for the same service. This situation can occur when payment is mailed, then followed by an electronic payment or when two different individuals in a household pay the same bill. Once the provider's accounting or billing system detects that the patient's account has been paid more than once for the same service, they may issue a refund of the additional payment.

Insurance Reconciliation Adjustments

After claims are submitted to an insurance company, subsequent policy adjustments or retroactive changes to coverage may alter the final bill. For instance, if an insurance company conducts an internal audit and determines that a greater portion of the claim should have been covered, they might send an additional reimbursement to the provider. This supplemental payment can create a credit on the patient's account, thereby necessitating a refund of any previously collected balance from the patient.

Billing or Coding Errors

In rare circumstances, mistakes in billing codes or modifiers lead to inaccurate charges on a patient's account. Such coding discrepancies may not be apparent until the insurance company or the provider's billing department conducts a review. Upon identifying a coding error—such as a charge for a service that was not actually performed—the provider corrects the billing statement and may refund any overpayment to the patient.

[1] A court order would be required to mandate that a patient's overpayment be refunded to the patient. In common law, restitution for an overpayment aims to prevent unjust enrichment by restoring the claimant to their original position, requiring the recipient to return the benefit received, typically money, due to a mistake or other legal basis. *See also* the Florida Deceptive and Unfair Trade Practices Act in part II of ch. 501. F.S.

Coordination of Benefits Between Multiple Insurers

Patients sometimes have two or more sources of insurance coverage (e.g., primary and secondary insurance plans). If both insurers remit payment and inadvertently exceed the cost of the service, the health care provider may receive funds beyond what is contractually called for. Once this overage is discovered, the overpayment may be refunded directly to the patient or appropriately adjusted between the insurers.

State Regulation of Insurance

The Office of Insurance Regulation (OIR)[2] is responsible for all activities concerning health maintenance organizations (HMOs), health insurers, and other risk-bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Florida Insurance Code.[3] To transact business in Florida, a health insurer or HMO must obtain a certificate of authority from the OIR.[4] The Agency for Health Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[5] As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[6]

Payment of Health Insurer and HMO Claims

The Florida Insurance Code[7] prescribes the rights and responsibilities of health care providers, health insurers, and HMOs for the payment of claims. Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, in accordance with ss. 627.6131, 627.662, and 641.3155, F.S., respectively.[8] The law prescribes a protocol for specified providers to use for the submission of their claims to an insurer or HMO, as well as a statutory process for insurers or HMOs to use for the payment or denial of the claims.

Generally, if a health insurer or HMO determines it has made an overpayment to a provider, the insurer's or HMO's claim for the overpayment must be submitted to the provider within 30 months after the applicable payment by the insurer or HMO.[9] A provider must pay, deny, or contest the claim for overpayment of a health insurer or HMO within 40 days after receiving the claim.

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[2] The OIR is a unit under the Financial Services Commission, which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. Commission members serve as the agency head for purposes of rulemaking under ch. 120, F.S. See s. 20.121(3), F.S.
[3] Section 20.121(3)(a), F.S.
[4] Sections 624.401 and 641.49, F.S.
[5] Section 641.495, F.S.
[6] *Id.*
[7] Pursuant to s. 624.01, F.S., chs. 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code."
[8] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S.
[9] Section 627.6131(6), F.S., and s. 641.3155(5) F.S., for HMO provision.

All contested claims for overpayment must be paid or denied within 120 days after the provider's receipt of the claim.[10] Failure to pay or deny the claim of overpayment within 140 days after receipt creates an uncontestable obligation by the provider to pay the claim.[11] A claim for overpayment is not permitted beyond 30 months after the health insurer's or HMO's applicable payment to the provider, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234, F.S.[12]

Section 627.6131(18), F.S., provides an exception to the period of 30 months for an insurer to submit a claim for overpayment to a provider. Section 641.3155(16), F.S., provides the same requirements for an HMO. All claims for overpayment submitted to a provider licensed under chs. 458 (medical practice), 459 (osteopathic medicine), 460 (chiropractic medicine), 461 (podiatric medicine), or 466 (dentistry), F.S., must be submitted to the provider within 12 months – not 30 months – after the health insurer's or HMO's applicable payment to the provider. A claim for overpayment may not be permitted after 12 months except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234, F.S.

Agency for Health Care Administration; Health Care Licensing Procedures Act

As of February 21, 2025, the Florida Agency for Health Care Administration (AHCA) regulates 49,823 health care providers.[13] The Health Care Licensing Procedures Act[14] (Act) provides a streamlined and consistent set of basic licensing requirements for health care providers that are licensed, registered, or certified by the AHCA, including all of the following:[15]

- Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102, F.S.
- Birth centers, as provided under ch. 383, F.S.
- Abortion clinics, as provided under ch. 390, F.S.
- Crisis stabilization units, as provided under parts I and IV of ch. 394, F.S.
- Short-term residential treatment facilities, as provided under parts I and IV of ch. 394, F.S.
- Residential treatment facilities, as provided under part IV of ch. 394, F.S.
- Residential treatment centers for children and adolescents, as provided under part IV of ch. 394, F.S.
- Hospitals, as provided under part I of ch. 395, F.S.

[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] Agency for Health Care Administration, Senate Bill 786 Legislative Analysis (Feb. 19, 2025) (on file with the Senate Committee on Health Policy).
[14] Chapter 408, Part II, F.S. *See also* s. 408.801(1), F.S.
[15] Section 408.801(2), F.S. The act applies to following providers: laboratories authorized to perform testing under the Drug-Free Workplace Act, birth centers, abortion clinics, crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, residential treatment centers for children and adolescents, hospitals, ambulatory surgical centers, nursing homes, assisted living facilities, home health agencies, nurse registries, companion services or homemaker services providers, adult day care centers, hospices, adult family-care homes, homes for special services, transitional living facilities, prescribed pediatric extended care centers, home medical equipment providers, intermediate care facilities for persons with developmental disabilities, health care services pools, health care clinics, organ tissue and eye procurement organizations.

- Ambulatory surgical centers, as provided under part I of ch. 395, F.S.
- Nursing homes, as provided under part II of ch. 400, F.S.
- Assisted living facilities, as provided under part I of ch. 429, F.S.
- Home health agencies, as provided under part III of ch. 400, F.S.
- Nurse registries, as provided under part III of ch. 400, F.S.
- Companion services or homemaker services providers, as provided under part III of ch. 400, F.S.
- Adult day care centers, as provided under part III of ch. 429, F.S.
- Hospices, as provided under part IV of ch. 400, F.S.
- Adult family-care homes, as provided under part II of ch. 429, F.S.
- Homes for special services, as provided under part V of ch. 400, F.S.
- Transitional living facilities, as provided under part XI of ch. 400, F.S.
- Prescribed pediatric extended care centers, as provided under part VI of ch. 400, F.S.
- Home medical equipment providers, as provided under part VII of ch. 400, F.S.
- Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of ch. 400, F.S.
- Health care services pools, as provided under part IX of ch. 400, F.S.
- Health care clinics, as provided under part X of ch. 400, F.S.
- Organ, tissue, and eye procurement organizations, as provided under part V of ch. 765, F.S.

The Act is intended to minimize confusion, standardize terminology, and include issues that are not otherwise addressed in state law pertaining to specific providers.[16] Among other things, it provides certain minimum licensure requirements with which applicants and licensees must comply in order to obtain and maintain a license.[17]

The Department of Health (DOH)

The Legislature created the DOH to protect and promote the health of all residents and visitors in the state.[18] The DOH is charged with the regulation of health practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the boards[19] and professions within the DOH.[20] The health care practitioners licensed by the DOH include the following:

- Acupuncturists;[21]
- Allopathic physicians, physician assistants, anesthesiologist assistants, and medical assistants;[22]
- Osteopathic physicians, physician assistants, and anesthesiologist assistants;[23]

[16] *Id.*
[17] *See* generally s. 408.810, F.S.
[18] Section 20.43(1), F.S.
[19] Under s. 456.001(1), F.S., "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH MQA.
[20] Section 20.43(3)(g), F.S.
[21] Chapter 457, F.S.
[22] Chapter 458, F.S.
[23] Chapter 459, F.S.

- Chiropractic physicians and physician assistants;[24]
- Podiatric physicians;[25]
- Naturopathic physicians;[26]
- Optometrists;[27]
- Autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses, and certified nursing assistants;[28]
- Pharmacists, pharmacy interns, and pharmacy technicians;[29]
- Dentists, dental hygienists, and dental laboratories;[30]
- Midwives;[31]
- Speech and language pathologists;[32]
- Audiologists;[33]
- Occupational therapists and occupational therapy assistants;[34]
- Respiratory therapists;[35]
- Dieticians and nutritionists;[36]
- Athletic trainers;[37]
- Orthotists, prosthetists, and pedorthists;[38]
- Electrologists;[39]
- Massage therapists;[40]
- Clinical laboratory personnel;[41]
- Medical physicists;[42]
- Genetic counselors;[43]
- Opticians;[44]
- Hearing aid specialists;[45]
- Physical therapists;[46]

[24] Chapter 460, F.S.
[25] Chapter 461, F.S.
[26] Chapter 462, F.S.
[27] Chapter 463, F.S.
[28] Chapter 464, F.S.
[29] Chapter 465, F.S.
[30] Chapter 466, F.S.
[31] Chapter 467, F.S.
[32] Part I, ch. 468, F.S.
[33] *Id.*
[34] Part III, ch. 468, F.S.
[35] Part V, ch. 468, F.S.
[36] Part X, ch. 468, F.S.
[37] Part XIII, ch. 468, F.S.
[38] Part XIV, ch. 468, F.S.
[39] Chapter 478, F.S.
[40] Chapter 480, F.S.
[41] Part I, ch. 483, F.S.
[42] Part II, ch. 483, F.S.
[43] Part III, ch. 483, F.S.
[44] Part I, ch. 484, F.S.
[45] Part II, ch. 484, F.S.
[46] Chapter 486, F.S.

- Psychologists and school psychologists;[47] and
- Clinical social workers, mental health counselors, and marriage and family therapists.[48]

Disciplinary Proceeding under Chapters 456 and 120, F.S.

Section 456.072, F.S., enumerates at least 45 specific acts that constitute grounds for disciplinary action against licensed health care practitioners in Florida. In addition, each health care practitioner's respective practice act contains specific statutory provisions on prohibited acts, disciplinary actions, grounds for discipline, and actions by the applicable board.

The DOH, on behalf of the boards, investigates any complaint that is filed against a health care practitioner if the complaint is:
- In writing;
- Signed by the complainant;[49] and
- Legally sufficient.[50]

A complaint is legally sufficient if it contains allegations of ultimate facts that, if true, show that a regulated practitioner has violated:
- Chapter 456, F.S.;
- His or her practice act; or
- A rule of his or her board or the DOH.[51]

The Consumer Services Unit receives the complaints and refers them to the closest Investigative Services Unit (ISU) office. The ISU investigates complaints against health care practitioners.[52] Complaints that present an immediate threat to public safety are given priority; however, all complaints are investigated as timely as possible. When the complaint is assigned to an investigator, the complainant will be contacted and given the opportunity to provide additional information. A thorough investigation will be conducted. The steps taken in the investigation are determined by the specifics of the allegations, but generally include the following:
- Obtaining medical records, documents, and evidence;
- Locating and interviewing the complainant, the patient, the subject, and any witnesses; and
- Drafting and serving subpoenas for necessary information.[53]

[47] Chapter 490, F.S.
[48] Chapter 491, F.S.
[49] Section 456.073(1), F.S. The DOH may also investigate an anonymous complaint, or that of a confidential informant, if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the DOH has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.
[50] *Id.*
[51] *Id.*
[52] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services*, *available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited March 14, 2025).
[53] *Id.*

The ISU includes a staff of professional investigators and senior pharmacists who conduct interviews, collect documents and evidence, prepare investigative reports for the Prosecution Services Unit (PSU), and serve subpoenas and official orders for the DOH.[54]

The PSU is responsible for providing legal services to the DOH in the regulation of all health care boards and councils.[55] The PSU will review the investigative file and report from ISU and recommend a course of action to the State Surgeon General (when an immediate threat to the health, safety, and welfare of the people of Florida exists), the appropriate board's probable cause panel, or the DOH, if there is no board, which may include:

- Having the file reviewed by an expert;
- Issuing a closing order (CO);
- Filing an administrative complaint (AC); or
- Issuing an emergency order (ERO or ESO).[56]

If the ISU investigative file received by the PSU does not pose an immediate threat to the health, safety, and welfare of the people of Florida, then the PSU attorneys review the file and determine, first, whether expert review is required and, then, whether to recommend to the board's probable cause panel:

- A CO;
- An AC; or
- A Letter of Guidance (LOG).[57,58]

A CO is recommended if the investigation and/or the expert opinion does not support the allegation(s). The subject and the complainant are notified of the results. The complainant may appeal the decision within sixty (60) days of notification by providing additional information for consideration. Cases closed with no finding of probable cause are confidential and are not available through a public records request.[59]

An AC is recommended when the investigation and/or the expert opinion supports the allegation(s). The subject is entitled to a copy of the complete case file prior to the probable cause panel meeting. When an AC is filed with the agency clerk, the subject has the right to choose one of the following options:

- *An Administrative Hearing Involving Disputed Issues of Material Fact* – The subject disputes the facts in the AC and elects to have a hearing before the Division of Administrative Hearings (DOAH). If this occurs, all parties may be asked to testify and the administrative law judge will issue a recommended order that will then go to the board or the DOH for final agency action.

[54] *Id.*
[55] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Prosecution Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited March 14, 2025).
[56] *Id.*
[57] Section 456.073(2), F.S. The DOH may recommend a LOG in lieu of finding probable cause if the subject has not previously been issued a LOG for a related offense.
[58] *Id.*
[59] *Supra* note 57.

- *A Settlement/Stipulation/Consent Agreement* – The subject enters into an agreement to be presented before the board or the DOH. Terms of this agreement may impose penalties negotiated between the subject or the subject's attorney and the DOH's attorney.
- *A Hearing Not Involving Disputed Issues of Material Fact* – The subject of the AC does not dispute the facts. The subject elects to be heard before the board or the DOH. At that time, the subject will be permitted to give oral and/or written evidence in mitigation or in opposition to the recommended action by the DOH.
- *Voluntary Relinquishment of License* – The subject of the AC may elect to surrender his or her license and to cease practice.[60]

Final DOH action, including all of the above, as well as cases where the subject has failed to respond to an AC, are presented before the applicable board, or the DOH if there is no board. The subject may be required to appear. The complainant is notified of the date and location of the hearing and may attend. If the subject is entitled to, and does, appeal the final decision, PSU defends the final order before the appropriate appellate court.[61]

When the applicable board, or the DOH if there is no board, finds a person guilty, it may enter an order imposing a penalty listed in s. 456.072(2), F.S., which includes revocation, suspension, and restriction of license, administrative fines not to exceed $10,000 per offense, reprimand, probation, corrective action, and remedial education. It must also consider what sanctions are necessary to protect the public or compensate the patient.

III. Effect of Proposed Changes:

Section 1 of the bill creates s. 408.812, F.S., to require an AHCA licensee[62] who tenders charges for reimbursement to refund to the patient the amount of any overpayment made by the patient no later than 30 days after the date that the licensee determines that such overpayment was made. The licensee would need to refund the full amount of the overpayment to satisfy this requirement. For purposes of this section of statute, the bill defines the term "tenders charges for reimbursement" to mean the licensee files a claim for reimbursement with any government-sponsored program (including Medicaid, Medicare, and Tricare) or private health insurer or health maintenance organization for services rendered to the patient.

The bill's requirement for timely refund of an overpayment would not apply to overpayments made to providers by commercial health insurers subject to s. 627.6131, F.S., or to health maintenance organizations subject to s. 641.3155, F.S.

A licensee's violation of this new section would be subject to an administrative fine under s. 408.813, as amended in section 2 of the bill.

[60] *Id.*
[61] *Supra* note 54.
[62] *See* "Agency for Health Care Administration; Health Care Licensing Procedures Act" under "Present Situation" in this Bill Analysis for a list of practitioners who would be required to follow new s. 408.812, F.S.

Section 2 of the bill amends s. 408.813, F.S., to add a violation of s. 408.812, F.S., as created in section 1 of the bill, to a list of unclassified violations,[63] for which the AHCA could impose an administrative fine of up to $500.

Section 3 of the bill creates s. 456.0625, F.S., to require a health care practitioner[64] who tenders charges for reimbursement, or any billing department, management company, or group practice that accepts payment for services rendered by the health care practitioner, to refund the amount of any overpayment made to the health care practitioner by a patient no later than 30 days after the date that the health care practitioner determines that the overpayment was made. The health care practitioner would need to refund the full amount of the overpayment to satisfy this requirement. For purposes of this section of statute, the bill defines the term "tenders charges for reimbursement" to mean that the health care practitioner, department, company, or practice files a claim for reimbursement with any government-sponsored program (including Medicaid, Medicare, and Tricare) or private health insurer or health maintenance organization for services rendered to the patient.

The bill's requirement for timely refund of an overpayment would not apply to overpayments made to providers by commercial health insurers subject to s. 627.6131, F.S., or to health maintenance organizations subject to s. 641.3155, F.S.

A violation of s. 456.0625, F.S., would constitute grounds for disciplinary action under the practitioner's practice act and under s. 456.072, F.S., as amended in section 4 of the bill.

Section 4 of the bill amends s. 456.072(1), F.S. to add failure to comply with s. 456.0625, F.S., as created in section 3 of the bill, to the list of grounds for discipline. If the board, or the department when there is no board, finds any person guilty of this new ground for discipline, it may discipline the health care practitioner with disciplinary actions specified in s. 456.072(2), F.S.

Section 5 of the bill provides an effective date of January 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[63] An unclassified violation is a violation listed in s. 408.813, F.S., which is not designated as a class I, class II, class III, or class IV violation.

[64] *See* "The Department of Health" under "Present Situation" in this Bill Analysis for a list of practitioners who would be required to follow new s. 456.0625, F.S.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill may result in a loss of improper revenue for providers who fail to check for or refund overpayments.

C. Government Sector Impact:

The DOH reports that the bill may create a workload demand on the department requiring additional staff. [65] Such demand would depend on a high volume of complaints filed against health care practitioners under the bill's new requirements. Whether such volume materializes is indeterminant.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill creates sections 408.812 and 456.0625 of the Florida Statutes.

The bill substantially amends sections 408.13 and 456.072 of the Florida Statutes.

[65] Department of Health, Senate Bill 1808 Legislative Analysis (Mar. 14, 2025) (on file with the Senate Committee on Health Policy).

IX. Additional Information:

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

CS by Health Policy on March 18, 2025:
The CS expands the number of parties subject to the bill's 30-day requirement to include AHCA licensees, all health care practitioners regulated by DOH, and anyone who accepts payment from insurance for services rendered by health care practitioners, including billing department, management companies, or group practices. Such parties must refund any overpayment made by the patient no later than 30 days after determining that the patient made an overpayment. The CS defines the term "tenders charges for reimbursement." The CS authorizes the AHCA to impose a fine of up to $500 on a licensee who violates the 30-day refund requirement. The CS also removes a provision in the underlying bill extending rulemaking authority to the DOH.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2025	.	
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The Committee on Health Policy (Burton) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 408.12, Florida Statutes, is created to read:

408.12 Patient overpayments; refunds.—

(1) A licensee who tenders charges for reimbursement shall refund to the patient the amount of any overpayment made by the patient to the licensee no later than 30 days after the date

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that the licensee determines that such overpayment was made. For purposes of this section, the term "tenders charges for reimbursement" means the licensee files a claim for reimbursement with any government-sponsored program or private health insurer or health maintenance organization for services rendered to the patient.

(2) This section does not apply to an overpayment subject to s. 627.6131 or s. 641.3155.

(3) A licensee who violates this section is subject to an administrative fine under s. 408.813.

Section 2. Paragraph (g) is added to subsection (3) of section 408.813, Florida Statutes, to read:

408.813 Administrative fines; violations.—As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine.

(3) The agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class IV violation. Unless otherwise specified by law, the amount of the fine may not exceed $500 for each violation. Unclassified violations include:

(g) Failing to refund a patient overpayment pursuant to s. 408.12.

Section 3. Section 456.0625, Florida Statutes, is created to read:

456.0625 Patient overpayments; refunds.—

(1) A health care practitioner who tenders charges for reimbursement, or any billing department, management company, or group practice that accepts payment for services rendered by the health care practitioner, shall refund to the patient the amount

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of any overpayment made by the patient no later than 30 days after the date that it was determined that an overpayment was made. For purposes of this section, the term "tenders charges for reimbursement" means that the health care practitioner, department, company, or practice files a claim for reimbursement with any government-sponsored program or private health insurer or health maintenance organization for services rendered by the health care practitioner to the patient.

(2) This section does not apply to an overpayment subject to s. 627.6131 or s. 641.3155.

(3) A health care practitioner's violation of this section constitutes grounds for disciplinary action under s. 456.072.

Section 4. Paragraph (tt) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(tt) Failure to comply with s. 456.0625, relating to refunding overpayments to patients.

Section 5. This act shall take effect January 1, 2026.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to refund of overpayments made by patients; creating s. 408.12, F.S.; requiring health

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care facility licensees to refund to the patient any overpayment within a specified timeframe; defining the term "tenders charges for reimbursement"; providing applicability; specifying that health care facility licensees who violate certain provisions are subject to administrative fines; amending s. 408.813, F.S.; revising administrative fines for health care practitioners; amending s. 456.0625, F.S.; requiring health care practitioners to refund to the patient any overpayment within a specified timeframe; defining the term "tenders charges for reimbursement"; providing applicability; specifying that health care practitioners who violate certain provisions are subject to disciplinary actions; amending s. 456.072, F.S.; revising the acts that constitute grounds for disciplinary actions for health care practitioners; providing an effective date.

By Senator Burton

12-00994B-25 20251808__

A bill to be entitled

An act relating to refund of overpayments made by patients; creating s. 456.0625, F.S.; requiring certain health care practitioners to refund to the patient any overpayment within a specified timeframe; providing applicability; providing for disciplinary action; authorizing the applicable regulatory board, or the Department of Health if there is no board, to adopt rules; amending s. 456.072, F.S.; subjecting certain health care practitioners to disciplinary action for failing to comply with specified provisions; providing an effective date.

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

Section 1. Section 456.0625, Florida Statutes, is created to read:

456.0625 Patient overpayments; refunds by health care practitioners.—

(1) A health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, chapter 467, chapter 478, chapter 483, part I of chapter 484, chapter 486, chapter 490, or chapter 491 shall refund to the patient the amount of any overpayment made to the health care practitioner no later than 30 days after the date that the health care practitioner determines that the overpayment was made.

(2) This section does not apply to an overpayment subject to s. 627.6131 or s. 641.3155.

(3) A health care practitioner's violation of this section constitutes grounds for disciplinary action under the applicable practice act and under s. 456.072.

(4) The applicable board, or the department if there is no board, may adopt rules to implement this section.

Section 2. Paragraph (tt) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(tt) Failing to comply with s. 456.0625, relating to refunding overpayments to patients.

Section 3. This act shall take effect January 1, 2026.

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Senate Committee on Health Policy **Judge:**

Started: 3/18/2025 3:33:08 PM
Ends: 3/18/2025 5:03:36 PM Length: 01:30:29

3:33:07 PM Call to Order-Chair Burton
3:33:21 PM Roll Call
3:33:25 PM Quorum Present
3:34:17 PM Tab 2 SB 1546
3:34:24 PM Senator Grall
3:35:43 PM Time Waived Read into Record
3:36:12 PM Roll Call for SB 1546
3:36:39 PM Reported Favorably
3:36:49 PM Tab 3 SB 958
3:36:53 PM Senator Bernard
3:37:04 PM Amendment #371944
3:37:15 PM Senator Bernard
3:38:02 PM Senator Passidomo
3:38:30 PM Senator Bernard
3:38:44 PM Amendment Adopted
3:39:14 PM Time Waived Read into Record
3:39:26 PM Senator Osgood
3:40:12 PM Senator Bernard
3:40:37 PM Roll Call for SB 958
3:41:06 PM Reported Favorably
3:41:11 PM Tab 4 SB 1070
3:41:14 PM Senator Simon
3:41:27 PM Amendment #290226
3:41:37 PM Senator Simon
3:42:59 PM Senator Passidomo
3:43:39 PM Senator Simon
3:43:45 PM Senator Passidomo
3:44:02 PM Senator Simon
3:44:17 PM Senator Berman
3:44:43 PM Senator Simon
3:45:20 PM Senator Harrell
3:45:36 PM Senator Simon
3:46:57 PM Senator Harrell
3:47:18 PM Senator Simon
3:48:38 PM Senator Harrell
3:49:31 PM Senator Simon
3:50:13 PM Amendment Adopted
3:50:28 PM Public Testimony
3:50:43 PM Bob Harris, Panhandle Area Educational Consortium
3:53:53 PM Time Waived Read into Record
3:55:06 PM Senator Trumbull
3:56:33 PM Senator Harrell
3:58:18 PM Senator Osgood
3:59:53 PM Senator Gaetz
4:01:08 PM Senator Burton
4:01:29 PM Senator Simon
4:03:21 PM Roll Call for SB 1070
4:04:22 PM Reported Favorably
4:04:52 PM Tab 1 SB 1060
4:04:59 PM Senator Brodeur
4:09:05 PM Senator Harrell
4:10:38 PM Senator Brodeur

4:11:46 PM Senator Passidomo
4:12:11 PM Senator Brodeur
4:12:36 PM Senator Davis
4:13:12 PM Senator Brodeur
4:14:28 PM Senator Davis
4:14:31 PM Senator Brodeur
4:15:24 PM Senator Davis
4:15:28 PM Senator Brodeur
4:16:50 PM Senator Gaetz
4:17:28 PM Senator Brodeur
4:18:42 PM Public Testimony
4:19:35 PM Time Waived Read into Record
4:19:48 PM Senator Harrell
4:20:55 PM Senator Brodeur
4:21:29 PM Roll Call for SB 1060
4:21:33 PM Reported Favorably
4:21:59 PM Tab 6 SB 944
4:22:11 PM Senator Davis
4:23:27 PM Public Testimony
4:23:42 PM Waives Read into Record
4:23:47 PM Roll Call for SB 944
4:24:05 PM Reported Favorably
4:24:28 PM Tab 8 SB 1370
4:24:31 PM Senator Trumbull
4:25:14 PM Public Testimony
4:25:19 PM Mike Madewell
4:25:54 PM Time Waives Read into Record
4:26:12 PM Roll Call for SB 1030
4:26:20 PM Reported Favorably
4:26:37 PM Tab 7 SB 768
4:26:46 PM Senator Calatayud
4:28:43 PM Late Filed Amendment #217378
4:29:43 PM Senator Calatayud
4:31:23 PM Amendment Adopted
4:31:32 PM Senator Berman
4:31:37 PM Senator Calatayud
4:34:00 PM Public Testimony
4:34:07 PM Time Waives Read into Record
4:34:15 PM Senator Berman
4:34:59 PM Senator Calatayud
4:35:29 PM Roll Call for SB 768
4:36:00 PM Reported Favorably
4:36:05 PM Tab 5 SB 1544
4:36:13 PM Senator Rodriguez
4:36:31 PM Senator Berman
4:36:53 PM Senator Rodriguez
4:37:01 PM Senator Berman
4:37:15 PM Senator Rodriguez
4:37:23 PM Senator Gaetz
4:38:24 PM Senator Rodriguez
4:38:51 PM Senator Gaetz
4:39:51 PM Committee Staff Member
4:41:12 PM Senator Gaetz
4:41:33 PM Senator Rodriguez
4:41:57 PM Senator Passidomo
4:42:27 PM Senator Rodriguez
4:43:16 PM Senator Osgood
4:44:12 PM Senator Rodriguez
4:44:30 PM Senator Osgood
4:45:08 PM Senator Rodriguez
4:45:49 PM Chair Burton
4:45:50 PM Senator Gaetz

4:48:23 PM Senator Rodriguez
4:49:06 PM Amendment # 885492
4:49:25 PM Senator Rodriguez
4:49:55 PM Senator Berman
4:50:14 PM Senator Rodriguez
4:50:23 PM Senator Berman
4:51:00 PM Senator Rodriguez
4:51:08 PM Senator Gaetz
4:52:16 PM Senator Rodriguez
4:52:40 PM Amendment Withdrawn by Senator Rodriguez
4:53:21 PM Public Testimony
4:53:37 PM Tiffany Wiggan Pearce
4:55:57 PM SB 1544 Temporarily Postponed by Senator Rodriguez
4:56:45 PM Gavel Given to Senator Harrell
4:57:00 PM Tab 9 SB 1808
4:57:20 PM Late Filed Amendment #736708
4:57:47 PM Senator Burton
4:59:33 PM Senator Berman
5:00:44 PM Senator Burton
5:01:05 PM Amendment Adopted
5:01:55 PM Senator Burton
5:02:06 PM Roll Call for SB 1808
5:02:25 PM Reported Favorably
5:02:45 PM Gavel Given to Senator Burton
5:02:54 PM Recording Votes-Senator Harrell
5:03:10 PM Closing Remarks
5:03:21 PM Adjourned