By the Committees on Appropriations; and Health Policy

576-04629B-19 20197078c1

A bill to be entitled

An act relating to health care; providing legislative intent; creating s. 381.4019, F.S.; establishing the Dental Student Loan Repayment Program to support dentists who practice in public health programs located in certain underserved areas; providing definitions; requiring the Department of Health to establish a dental student loan repayment program for specified purposes; providing for the award of funds; providing the maximum number of years for which funds may be awarded; providing eligibility requirements; requiring the department to adopt rules; specifying that implementation of the program is subject to legislative appropriation; creating s. 381.40195, F.S.; providing a short title; providing definitions; requiring the Department of Health to establish the Donated Dental Services Program to provide comprehensive dental care to certain eligible individuals; requiring the department to contract with a nonprofit organization to implement and administer the program; specifying minimum contractual responsibilities; requiring the department to adopt rules; specifying that implementation of the program is subject to legislative appropriation; amending s. 395.1012, F.S.; requiring a licensed hospital to provide specified information and data relating to patient safety and quality measures to a patient under certain circumstances or to any person upon request; creating s. 395.1052, F.S.; requiring a hospital to

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notify a patient's primary care provider within a specified timeframe after the patient's admission; requiring a hospital to inform a patient, upon admission, of the option to request consultation between the hospital's treating physician and the patient's primary care provider or specialist provider; requiring a hospital to notify a patient's primary care provider of the patient's discharge and provide specified information and records to the primary care provider within a specified timeframe after discharge; amending s. 395.002, F.S.; revising the definition of the term "ambulatory surgical center"; amending s. 395.1055, F.S.; requiring the Agency for Health Care Administration, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, to adopt rules that establish requirements related to the delivery of surgical care to children in ambulatory surgical centers, in accordance with specified standards; specifying that ambulatory surgical centers may provide certain procedures only if authorized by agency rule; authorizing the reimbursement of per diem and travel expenses to members of the pediatric cardiac technical advisory panel, established within the Agency for Health Care Administration; revising panel membership to include certain alternate at-large members; providing term limits for voting members; providing that members of the panel under certain circumstances are agents of the state for a specified purpose;

requiring the Secretary of Health Care Administration to consult the panel for advisory recommendations on certain certificate of need applications; authorizing the secretary to request announced or unannounced site visits to any existing pediatric cardiac surgical center or facility seeking licensure as a pediatric cardiac surgical center through the certificate of need process; providing a process for the appointment of physician experts to a site visit team; requiring each member of a site visit team to submit a report to the panel; requiring the panel to discuss such reports and present an advisory opinion to the secretary; providing requirements for an on-site inspection; requiring the Surgeon General of the Department of Health to provide specified reports to the secretary; 395.301, F.S.; requiring a licensed facility, upon placing a patient on observation status, to immediately notify the patient of such status using a specified form; requiring that such notification be documented in the patient's medical records and discharge papers; creating s. 542.336, F.S.; specifying that certain restrictive covenants entered into with certain physicians are not supported by legitimate business interests; providing legislative findings; providing that such restrictive covenants are void and remain void and unenforceable for a specified period; amending s. 624.27, F.S.; expanding the scope of direct primary care agreements, which are renamed "direct health care agreements"; conforming

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provisions to changes made by the act; creating s. 627.42393, F.S.; prohibiting certain health insurers from employing step-therapy protocols under certain circumstances; defining the term "health coverage plan"; clarifying that a health insurer is not required to take specific actions regarding prescription drugs; amending s. 641.31, F.S.; prohibiting certain health maintenance organizations from employing step-therapy protocols under certain circumstances; defining the term "health coverage plan"; clarifying that a health maintenance organization is not required to take specific actions regarding prescription drugs; requiring the Office of Program Policy Analysis and Government Accountability to submit by a specified date a report and recommendations to the Governor and the Legislature which addresses this state's prospective entrance into the Interstate Medical Licensure Compact as a member state; providing parameters for the report; providing effective dates.

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

Section 1. It is the intent of the Legislature to promote programs and initiatives that help make available preventive and educational dental services for the residents of the state, as well as provide quality dental treatment services. The geographic characteristics among the residents of the state are distinctive and vary from region to region, with such residents

having unique needs regarding access to dental care. The Legislature recognizes that maintaining good oral health is integral to the overall health status of individuals and that the good health of the residents of this state is an important contributing factor in economic development. Better health, including better oral health, increases workplace productivity, reduces the burden of health care costs, and improves the cognitive development of children, resulting in a reduction of missed school days.

Section 2. Section 381.4019, Florida Statutes, is created to read:

381.4019 Dental Student Loan Repayment Program.—The Dental Student Loan Repayment Program is established to promote access to dental care by supporting qualified dentists who treat medically underserved populations in dental health professional shortage areas or medically underserved areas.

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

(a) "Dental health professional shortage area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

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

(c) "Loan program" means the Dental Student Loan Repayment Program.

(d) "Medically underserved area" means a geographic area, an area having a special population, or a facility which is designated by department rule as a health professional shortage area as defined by federal regulation and which has a shortage of dental health professionals who serve Medicaid recipients and

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other low-income patients.

(e) "Public health program" means a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department.

(2) The department shall establish a dental student loan repayment program to benefit Florida-licensed dentists who demonstrate, as required by department rule, active employment in a public health program that serves Medicaid recipients and other low-income patients and is located in a dental health professional shortage area or a medically underserved area.

(3) The department shall award funds from the loan program to repay the student loans of a dentist who meets the requirements of subsection (2).

(a) An award may not exceed $50,000 per year per eligible dentist.

(b) Only loans to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses may be covered.

(c) All repayments are contingent upon continued proof of eligibility and must be made directly to the holder of the loan. The state bears no responsibility for the collection of any interest charges or other remaining balances.

(d) A dentist may receive funds under the loan program for at least 1 year, up to a maximum of 5 years.

(e) The department shall limit the number of new dentists participating in the loan program to not more than 10 per fiscal year.

(4) A dentist is no longer eligible to receive funds under the loan program if the dentist:

(a) Is no longer employed by a public health program that meets the requirements of subsection (2).

(b) Ceases to participate in the Florida Medicaid program.

(c) Has disciplinary action taken against his or her license by the Board of Dentistry for a violation of s. 466.028.

(5) The department shall adopt rules to administer the loan program.

(6) Implementation of the loan program is subject to legislative appropriation.

Section 3. Section 381.40195, Florida Statutes, is created to read:

381.40195 Donated Dental Services Program.—

(1) This act may be cited as the "Donated Dental Services Act."

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

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

(b) "Program" means the Donated Dental Services Program as established pursuant to subsection (3).

(3) The department shall establish the Donated Dental Services Program for the purpose of providing comprehensive dental care through a network of volunteer dentists and other dental providers to needy, disabled, elderly, and medically compromised individuals who cannot afford necessary treatment but are ineligible for public assistance. An eligible individual may receive treatment in a volunteer dentist's or participating dental provider's private office or at any other suitable location. An eligible individual is not required to pay any fee

or cost associated with the treatment he or she receives.

(4) The department shall establish the program. The department shall contract with a nonprofit organization that has experience in providing similar services or administering similar programs. The contract must specify the responsibilities of the nonprofit organization, which may include, but are not limited to:

(a) Maintaining a network of volunteer dentists and other dental providers, including, but not limited to, dental specialists and dental laboratories, to provide comprehensive dental services to eligible individuals.

(b) Maintaining a system to refer eligible individuals to the appropriate volunteer dentist or participating dental provider.

(c) Developing a public awareness and marketing campaign to promote the program and educate eligible individuals about its availability and services.

(d) Providing the necessary administrative and technical support to administer the program.

(e) Submitting an annual report to the department which must include, at a minimum:

1. Financial data relating to administering the program.

2. Demographic data and other information relating to the eligible individuals who are referred to and receive treatment through the program.

3. Demographic data and other information relating to the volunteer dentists and participating dental providers who provide dental services through the program.

4. Any other data or information that the department may

require.

(f) Performing any other program-related duties and responsibilities as required by the department.

(5) The department shall adopt rules to administer the program.

(6) Implementation of the program is subject to legislative appropriation.

Section 4. Subsection (3) is added to section 395.1012, Florida Statutes, to read:

395.1012 Patient safety.—

(3)(a) Each hospital shall provide to any patient upon admission, upon scheduling of nonemergency care, or before treatment, written information on a form created by the agency which contains the following information available for the hospital for the most recent year and the statewide average for all hospitals related to the following quality measures:

1. The rate of hospital-acquired infections;

2. The overall rating of the Hospital Consumer Assessment of Healthcare Providers and Systems survey; and

3. The 15-day readmission rate.

(b) A hospital shall also provide to any person, upon request, the written information specified in paragraph (a).

(c) The information required by this subsection must be presented in a manner that is easily understandable and accessible to the patient and must also include an explanation of the quality measures and the relationship between patient safety and the hospital's data for the quality measures.

Section 5. Section 395.1052, Florida Statutes, is created to read:

395.1052 Patient access to primary care and specialty providers; notification.—A hospital shall:

(1) Notify each patient's primary care provider, if any, within 24 hours after the patient's admission to the hospital.

(2) Inform the patient immediately upon admission that he or she may request to have the hospital's treating physician consult with the patient's primary care provider or specialist provider, if any, when developing the patient's plan of care. Upon the patient's request, the hospital's treating physician shall make reasonable efforts to consult with the patient's primary care provider or specialist provider when developing the patient's plan of care.

(3) Notify the patient's primary care provider, if any, of the patient's discharge from the hospital within 24 hours after the discharge.

(4) Provide the discharge summary and any related information or records to the patient's primary care provider, if any, within 14 days after the patient's discharge from the hospital.

Section 6. Subsection (3) of section 395.002, Florida Statutes, is 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 ~~the same working day and is not permitted to stay overnight~~, 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

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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.

Section 7. Section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, 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

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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 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) All hospitals submit such data as necessary to conduct certificate-of-need reviews required under part I of chapter 408. Such data shall include, but shall not be limited to, patient origin data, hospital utilization data, type of service reporting, and facility staffing data. The agency may not collect data that identifies or could disclose the identity of individual patients. The agency shall utilize existing uniform statewide data sources when available and shall minimize reporting costs to hospitals.

(g) Each hospital has a quality improvement program designed according to standards established by their 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

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

(h) Licensed facilities make available on their Internet websites, no later than October 1, 2004, 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.

(i) All hospitals providing organ transplantation, neonatal intensive care services, inpatient psychiatric services, inpatient substance abuse services, or comprehensive medical rehabilitation meet the minimum licensure requirements adopted by the agency. Such licensure requirements must include quality of care, nurse staffing, physician staffing, physical plant, equipment, emergency transportation, and data reporting standards.

(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)(a) The agency, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, shall adopt rules that establish requirements to ensure the safe and effective delivery of surgical care to children kept past midnight in ambulatory surgical centers. The rules must be consistent with the American College of Surgeons' 2015 standards document entitled "Optimal Resources for Children's Surgical Care" and must establish minimum standards for pediatric patient care in ambulatory surgical centers.

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(b) Ambulatory surgical centers may provide operative procedures that require a length of stay past midnight on the day of surgery for children younger than 18 years of age only if the agency authorizes the performance of such procedures by rule.

(4) ~~(3)~~ The agency shall adopt rules with respect to the care and treatment of patients residing in distinct part nursing units of hospitals which are certified for participation in Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act skilled nursing facility program. Such rules shall take into account the types of patients treated in hospital skilled nursing units, including typical patient acuity levels and the average length of stay in such units, and shall be limited to the appropriate portions of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203) (December 22, 1987), Title IV (Medicare, Medicaid, and Other Health-Related Programs), Subtitle C (Nursing Home Reform), as amended. The agency shall require level 2 background screening as specified in s. 408.809(1)(e) pursuant to s. 408.809 and chapter 435 for personnel of distinct part nursing units.

(5) ~~(4)~~ The agency shall adopt rules with respect to the care and treatment of clients in intensive residential treatment programs for children and adolescents and with respect to the safe and healthful development, operation, and maintenance of such programs.

(6) ~~(5)~~ The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily

admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment.

(7)~~(6)~~ No rule shall be adopted under this part by the agency which would have the effect of denying a license to a facility required to be licensed under this part, solely by reason of the school or system of practice employed or permitted to be employed by physicians therein, provided that such school or system of practice is recognized by the laws of this state. However, nothing in this subsection shall be construed to limit the powers of the agency to provide and require minimum standards for the maintenance and operation of, and for the treatment of patients in, those licensed facilities which receive federal aid, in order to meet minimum standards related to such matters in such licensed facilities which may now or hereafter be required by appropriate federal officers or agencies in pursuance of federal law or promulgated in pursuance of federal law.

(8)~~(7)~~ Any licensed facility which is in operation at the time of promulgation of any applicable rules under this part shall be given a reasonable time, under the particular circumstances, but not to exceed 1 year from the date of such promulgation, within which to comply with such rules.

(9)~~(8)~~ The agency may not adopt any rule governing the design, construction, erection, alteration, modification, repair, or demolition of any public or private hospital, 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, intermediate residential treatment facilities, and ambulatory surgical centers.

(10) ~~(9)~~ The agency shall establish a pediatric cardiac technical advisory panel, pursuant to s. 20.052, to develop procedures and standards for measuring outcomes of pediatric cardiac catheterization programs and pediatric cardiovascular surgery programs.

(a) Members of the panel must have technical expertise in pediatric cardiac medicine, shall serve without compensation, and may ~~not~~ be reimbursed for per diem and travel expenses.

(b) Voting members of the panel shall include: 3 at-large members, and 3 alternate at-large members with different program affiliations, including 1 cardiologist who is board certified in caring for adults with congenital heart disease and 2 board-certified pediatric cardiologists, neither of whom may be employed by any of the hospitals specified in subparagraphs 1.-10. or their affiliates, each of whom is appointed by the Secretary of Health Care Administration, and 10 members, and an alternate for each member, each of whom is a pediatric cardiologist or a pediatric cardiovascular surgeon, each appointed by the chief executive officer of the following hospitals:

1. Johns Hopkins All Children’s Hospital in St. Petersburg.
2. Arnold Palmer Hospital for Children in Orlando.
3. Joe DiMaggio Children’s Hospital in Hollywood.

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4. Nicklaus Children's Hospital in Miami.

5. St. Joseph's Children's Hospital in Tampa.

6. University of Florida Health Shands Hospital in Gainesville.

7. University of Miami Holtz Children's Hospital in Miami.

8. Wolfson Children's Hospital in Jacksonville.

9. Florida Hospital for Children in Orlando.

10. Nemours Children's Hospital in Orlando.

Appointments made under subparagraphs 1.-10. are contingent upon the hospital's maintenance of pediatric certificates of need and the hospital's compliance with this section and rules adopted thereunder, as determined by the Secretary of Health Care Administration. A member appointed under subparagraphs 1.-10. whose hospital fails to maintain such certificates or comply with standards may serve only as a nonvoting member until the hospital restores such certificates or complies with such standards. A voting member may serve a maximum of two 2-year terms and may be reappointed to the panel after being retired from the panel for a full 2-year term.

(c) The Secretary of Health Care Administration may appoint nonvoting members to the panel. Nonvoting members may include:

1. The Secretary of Health Care Administration.

2. The Surgeon General.

3. The Deputy Secretary of Children's Medical Services.

4. Any current or past Division Director of Children's Medical Services.

5. A parent of a child with congenital heart disease.

6. An adult with congenital heart disease.

7. A representative from each of the following organizations: the Florida Chapter of the American Academy of Pediatrics, the Florida Chapter of the American College of Cardiology, the Greater Southeast Affiliate of the American Heart Association, the Adult Congenital Heart Association, the March of Dimes, the Florida Association of Children's Hospitals, and the Florida Society of Thoracic and Cardiovascular Surgeons.

(d) The panel shall meet biannually, or more frequently upon the call of the Secretary of Health Care Administration. Such meetings may be conducted telephonically, or by other electronic means.

(e) The duties of the panel include recommending to the agency standards for quality of care, personnel, physical plant, equipment, emergency transportation, and data reporting for hospitals that provide pediatric cardiac services.

(f) Beginning on January 1, 2020, and annually thereafter, the panel shall submit a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Secretary of Health Care Administration, and the State Surgeon General. The report must summarize the panel's activities during the preceding fiscal year and include data and performance measures on surgical morbidity and mortality for all pediatric cardiac programs.

(g) Panel members are agents of the state for purposes of s. 768.28 throughout the good faith performance of the duties assigned to them by the Secretary of Health Care Administration.

(11) The Secretary of Health Care Administration shall consult the pediatric cardiac technical advisory panel for an advisory recommendation on all certificate of need applications

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to establish pediatric cardiac surgical centers.

(12)~~(10)~~ Based on the recommendations of the pediatric cardiac technical advisory panel ~~in subsection (9)~~, the agency shall adopt rules for pediatric cardiac programs which, at a minimum, include:

(a) Standards for pediatric cardiac catheterization services and pediatric cardiovascular surgery including quality of care, personnel, physical plant, equipment, emergency transportation, data reporting, and appropriate operating hours and timeframes for mobilization for emergency procedures.

(b) Outcome standards consistent with nationally established levels of performance in pediatric cardiac programs.

(c) Specific steps to be taken by the agency and licensed facilities when the facilities do not meet the outcome standards within a specified time, including time required for detailed case reviews and the development and implementation of corrective action plans.

(13)~~(11)~~ A pediatric cardiac program shall:

(a) Have a pediatric cardiology clinic affiliated with a hospital licensed under this chapter.

(b) Have a pediatric cardiac catheterization laboratory and a pediatric cardiovascular surgical program located in the hospital.

(c) Have a risk adjustment surgical procedure protocol following the guidelines established by the Society of Thoracic Surgeons.

(d) Have quality assurance and quality improvement processes in place to enhance clinical operation and patient satisfaction with services.

(e) Participate in the clinical outcome reporting systems operated by the Society of Thoracic Surgeons and the American College of Cardiology.

(14)(a) The Secretary of Health Care Administration may request announced or unannounced site visits to any existing pediatric cardiac surgical center or facility seeking licensure as a pediatric cardiac surgical center through the certificate of need process, to ensure compliance with this section and rules adopted hereunder.

(b) At the request of the Secretary of Health Care Administration, the pediatric cardiac technical advisory panel shall recommend in-state physician experts to conduct an on-site visit. The Secretary may also appoint up to two out-of-state physician experts.

(c) A site visit team shall conduct an on-site inspection of the designated hospital's pediatric medical and surgical programs, and each member shall submit a written report of his or her findings to the panel. The panel shall discuss the written reports and present an advisory opinion to the Secretary of Health Care Administration which includes recommendations and any suggested actions for correction.

(d) Each on-site inspection must include all of the following:

1. An inspection of the program's physical facilities, clinics, and laboratories.

2. Interviews with support staff and hospital administrators.

3. A review of:

a. Randomly selected medical records and reports,

including, but not limited to, advanced cardiac imaging, computed tomography, magnetic resonance imaging, cardiac ultrasound, cardiac catheterization, and surgical operative notes.

b. The program's clinical outcome data submitted to the Society of Thoracic Surgeons and the American College of Cardiology pursuant to s. 408.05(3)(k).

c. Mortality reports from cardiac-related deaths that occurred in the previous year.

d. Program volume data from the preceding year for interventional and electrophysiology catheterizations and surgical procedures.

(15) The Surgeon General shall provide quarterly reports to the Secretary of Health Care Administration consisting of data from the Children's Medical Services' critical congenital heart disease screening program for review by the advisory panel.

(16) ~~(12)~~ The agency may adopt rules to administer the requirements of part II of chapter 408.

Section 8. Subsection (3) of section 395.301, Florida Statutes, is amended to read:

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

(3) If a licensed facility places a patient on observation status rather than inpatient status, the licensed facility must immediately notify the patient of such status using the form adopted under 42 C.F.R. s. 489.20 for Medicare patients or a form adopted by agency rule for non-Medicare patients. Such notification must ~~observation services shall~~ be documented in the patient's medical records and discharge papers. The ~~patient~~

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~~or the~~ patient's survivor or legal guardian must ~~shall~~ be notified of observation services through discharge papers, which may also include brochures, signage, or other forms of communication for this purpose.

Section 9. Section 542.336, Florida Statutes, is created to read:

542.336 Invalid restrictive covenants.—A restrictive covenant entered into with a physician who is licensed under chapter 458 or chapter 459 and who practices a medical specialty in a county wherein one entity employs or contracts with, either directly or through related or affiliated entities, all physicians who practice such specialty in that county is not supported by a legitimate business interest. The Legislature finds that such covenants restrict patient access to physicians, increase costs, and are void and unenforceable under current law. Such restrictive covenants shall remain void and unenforceable for 3 years after the date on which a second entity that employs or contracts with, either directly or through related or affiliated entities, one or more physicians who practice such specialty begins offering such specialty services in that county.

Section 10. Section 624.27, Florida Statutes, is amended to read:

624.27 Direct health ~~primary~~ care agreements; exemption from code.—

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

(a) "Direct health ~~primary~~ care agreement" means a contract between a health ~~primary~~ care provider and a patient, a patient's legal representative, or a patient's employer, which

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meets the requirements of subsection (4) and does not indemnify for services provided by a third party.

(b) "Health ~~Primary~~ care provider" means a health care provider licensed under chapter 458, chapter 459, chapter 460, ~~or~~ chapter 464, or chapter 466, or a health ~~primary~~ care group practice, who provides health ~~primary~~ care services to patients.

(c) "Health ~~Primary~~ care services" means the screening, assessment, diagnosis, and treatment of a patient conducted within the competency and training of the health ~~primary~~ care provider for the purpose of promoting health or detecting and managing disease or injury.

(2) A direct health ~~primary~~ care agreement does not constitute insurance and is not subject to the Florida Insurance Code. The act of entering into a direct health ~~primary~~ care agreement does not constitute the business of insurance and is not subject to the Florida Insurance Code.

(3) A health ~~primary~~ care provider or an agent of a health ~~primary~~ care provider is not required to obtain a certificate of authority or license under the Florida Insurance Code to market, sell, or offer to sell a direct health ~~primary~~ care agreement.

(4) For purposes of this section, a direct health ~~primary~~ care agreement must:

(a) Be in writing.

(b) Be signed by the health ~~primary~~ care provider or an agent of the health ~~primary~~ care provider and the patient, the patient's legal representative, or the patient's employer.

(c) Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The agreement may provide for immediate termination due to a

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violation of the physician-patient relationship or a breach of the terms of the agreement.

(d) Describe the scope of health ~~primary~~ care services that are covered by the monthly fee.

(e) Specify the monthly fee and any fees for health ~~primary~~ care services not covered by the monthly fee.

(f) Specify the duration of the agreement and any automatic renewal provisions.

(g) Offer a refund to the patient, the patient's legal representative, or the patient's employer of monthly fees paid in advance if the health ~~primary~~ care provider ceases to offer health ~~primary~~ care services for any reason.

(h) Contain, in contrasting color and in at least 12-point type, the following statement on the signature page: "This agreement is not health insurance and the health ~~primary~~ care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any health ~~primary~~ care services covered by the agreement. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and Affordable Care Act, 26 U.S.C. s. 5000A. This agreement is not workers' compensation insurance and does not replace an employer's obligations under chapter 440."

Section 11. Effective January 1, 2020, section 627.42393, Florida Statutes, is created to read:

627.42393 Step-therapy protocol.—

(1) A health insurer issuing a major medical individual or group policy may not require a step-therapy protocol under the policy for a covered prescription drug requested by an insured

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if:

(a) The insured has previously been approved to receive the prescription drug through the completion of a step-therapy protocol required by a separate health coverage plan; and

(b) The insured provides documentation originating from the health coverage plan that approved the prescription drug as described in paragraph (a) indicating that the health coverage plan paid for the drug on the insured's behalf during the 90 days immediately before the request.

(2) As used in this section, the term "health coverage plan" means any of the following which is currently or was previously providing major medical or similar comprehensive coverage or benefits to the insured:

(a) A health insurer or health maintenance organization.

(b) A plan established or maintained by an individual employer as provided by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406.

(c) A multiple-employer welfare arrangement as defined in s. 624.437.

(d) A governmental entity providing a plan of self-insurance.

(3) This section does not require a health insurer to add a drug to its prescription drug formulary or to cover a prescription drug that the insurer does not otherwise cover.

Section 12. Effective January 1, 2020, subsection (45) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(45)(a) A health maintenance organization issuing major medical coverage through an individual or group contract may not

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require a step-therapy protocol under the contract for a covered prescription drug requested by a subscriber if:

1. The subscriber has previously been approved to receive the prescription drug through the completion of a step-therapy protocol required by a separate health coverage plan; and

2. The subscriber provides documentation originating from the health coverage plan that approved the prescription drug as described in subparagraph 1. indicating that the health coverage plan paid for the drug on the subscriber's behalf during the 90 days immediately before the request.

(b) As used in this subsection, the term "health coverage plan" means any of the following which previously provided or is currently providing major medical or similar comprehensive coverage or benefits to the subscriber:

1. A health insurer or health maintenance organization;

2. A plan established or maintained by an individual employer as provided by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406;

3. A multiple-employer welfare arrangement as defined in s. 624.437; or

4. A governmental entity providing a plan of self-insurance.

(c) This subsection does not require a health maintenance organization to add a drug to its prescription drug formulary or to cover a prescription drug that the health maintenance organization does not otherwise cover.

Section 13. The Office of Program Policy Analysis and Government Accountability shall research and analyze the Interstate Medical Licensure Compact and the relevant

requirements and provisions of general law and the State Constitution and shall develop a report and recommendations addressing this state's prospective entrance into the compact as a member state while remaining consistent with those requirements and provisions. In conducting such research and analysis, the office may consult with the executive director, other executive staff, or the executive committee of the Interstate Medical Licensure Compact Commission. The office shall submit the report and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by not later than October 1, 2019.

Section 14. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2019.

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