Senate Committee on Health, Aging and Long-Term Care

DEPARTMENT OF HEALTH

HB 811 — Child Protection Team Services

by Rep. Brown and others (CS/SB 2118 by Health, Aging & Long-Term Care Committee and Senator Dawson-White)

This bill revises the law providing for the confidentiality of and exemption from public disclosure, under the Public Records Law, of records and reports of child protection teams relating to child abuse or neglect. The bill authorizes the Department of Health to release to HMOs and other health plan payors, upon request, limited information needed for insurance reimbursement purposes.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate 40-0; House 114-0

CS/CS/SB 890 — Rural Hospital Capital Improvement

by Fiscal Policy Committee; Health, Aging & Long-Term Care Committee; and Senators Mitchell, Geller, Childers, Cowin, Thomas, Kirkpatrick, Jones and Rossin

The bill creates the rural hospital capital improvement grant program and provides a mechanism for a rural hospital to apply for a grant from the Department of Health. Each rural hospital as defined in s. 395.602, F.S., must receive a minimum of $100,000 annually, subject to legislative appropriation, upon application to the Department of Health, for projects to acquire, repair, improve, or upgrade systems, facilities, or equipment. The Department of Health must establish, by rule, criteria for awarding grants for any remaining funds, which must be used exclusively for the support and assistance of rural hospitals, including criteria relating to the level of uncompensated care rendered by the hospital, the participation of the hospital in a rural health network, and the proposed use of the grant by the rural hospital to resolve a specific problem. The department must consider any information that rural hospitals submit in a grant application, and in determination of the hospital's eligibility for and the amount of the grant. The Department of Health must ensure that the funds are used solely for the purpose specified in the bill.

The bill amends s. 395.602, F.S., to revise the definition of "rural hospital" to include a hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was

directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to ch. 125, F.S., and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid in-patient utilization rate greater than 15 percent.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate: 40-0; House 111-0

HB 931 — Public Swimming Pools

by Rep. Miller and others (SB 1212 by Senator Bronson)

The bill amends s. 514.0115, F.S., 1998 Supp., to state that a pool serving a residential child care facility which is exempt from licensure pursuant to s. 409.176, F.S., is exempt from supervision or regulation of construction standards as a public pool. The exemption applies only if the pool is for the exclusive use of the facility's residents and is not open to the public.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 39-0; House 117-0

CS/SB 1356 — School Health Services

by Education Committee and Senators Klein, Clary, Silver, Brown-Waite, Kurth and Myers

The bill revises the School Health Services Act to provide sovereign immunity to any health care entity or entity that provides school health services under contract with the Department of Health pursuant to a school health services plan and as part of a school nurse services public-private partnership. The limitations on tort actions contained in s. 768.28(5), F.S., apply to any action against the health care entity or entity with respect to the provision of school health services, if the entity is acting within the scope of and pursuant to guidelines established in the contract or by rule of the Department of Health. The bill provides that the contract must require the entity to obtain general liability insurance coverage. The bill provides legislative intent that the insurance purchased by the health care entity or entity cover all liability claims, and under no circumstances shall the State of Florida or the Department of Health be responsible for payment of any claims or defense costs for claims brought against the entity or its subcontractor for services performed under the contract with the department.

The bill requires schools to make *adequate* physical facilities available for school health services. The bill requires every person who provides services under a school health services plan to complete a Level 2 screening under ch. 435, F.S. Persons who provide services under a school health services plan shall be on probationary status pending the

results of the background screening. The individual being screened, or his or her employer, must pay the cost of the background screening to the Department of Health. The Department of Health must establish a schedule of fees to cover the costs of the Level 2 screening and the abuse registry check.

The Department of Health is directed to work with the federal Department of Health and Human Services to determine a means through which local units of government, other than county health departments, could be designated as Title V (Maternal and Child Health Block Grant) agencies. Any money earned from Medicaid by such a designated entity would have to be reinvested in school health services.

The Secretary of the Department of Health is required to appoint a study group relating to the training requirements for nurses providing school health services. Two representatives must be appointed to represent each of the following: the Department of Health, the Department of Education, the Florida Nurses Association, the State University System, and the Board of Nursing. The Department of Health must report the group's findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 2000.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate: 39-0; House 116-0

HB 2125 — Health Care

by Health Care Services Committee and Rep. Peaden and others (CS/SB 2220 by Health, Aging and Long-Term Care Committee and Senator Clary)

General Public Health Provisions

The bill makes numerous changes in the statutes relating to the administration of the Department of Health (DOH) and its programs. The bill gives DOH specific authority for certain existing administrative rules, updates statutory references to DOH and makes changes to comply with changes in federal law.

Significant provisions of the bill: modify DOH's authority to use incentives and promotional items in disease prevention and health education; revise and rename divisions within the department; authorize DOH to adopt rules for certain group-care facilities and to impose fines for violation of its rules; revise the requirements and the membership of the Diabetes Advisory Council; update career service exemptions; impose additional requirements on co-payments made pursuant to primary care challenge grants; revise requirements for DOH to hold formal hearings for disqualification reviews of certified nurse assistants; allow nursing homes to administer medical oxygen to their residents without getting a pharmacy license; authorize DOH to contract with the Department of

Children and Family Services to conduct administrative hearings for matters relating to the Special Supplemental Nutrition Program for Women, Infants and Children, the Child Care Food Program, and the Children's Medical Services Program; permit DOH to purchase automobiles for use by county health departments; eliminate DOH's responsibility for monitoring the transportation of radioactive materials; revise requirements for the performance of an HIV test on persons who die during treatment; authorize DOH to adopt rules for family planning; revise the membership and responsibilities of the Health Information Systems Council; define multi-family water system; revise DOH procedures for birth records in the Office of Vital Statistics and authorize the department to retain fees paid to that office for birth certificates in lieu of being transferred into the General Revenue Fund; eliminate requirements for DOH to reimburse hospitals for costs of furnishing data for the cancer registry; revise penalties for certain violations of the Florida Drug and Cosmetic Act, and authorize federal, state, and local government employees to possess prescription drug samples when acting within the scope of their employment; prohibit the distribution of a legend device to a patient without a prescription or order from a licensed practitioner; authorize DOH to use earned dollars to improve the A.G. Holley Hospital through a legislative budget request and to establish an advisory body for the facility; name buildings; authorize DOH to apply for and become a National Environmental Laboratory Accreditation program accrediting authority; and develop and implement a statewide HIV and AIDS prevention campaign that is directed towards minorities who are at risk of HIV infection, including a statewide Black Leadership Conference on HIV and AIDS by January 2000.

Emergency Medical Services

The bill grants DOH specific statutory authority to approve training programs for emergency medical technicians and paramedics, to impose minimum requirements on permitted emergency medical vehicles, to require licensees to provide receiving hospitals with a copy of an individual patient care record for each patient transported to the hospital, and to establish requirements for recertification training for emergency medical technicians and paramedics. The bill requires documents to be submitted by emergency medical licensees and emergency medical certification applicants to the department under oath.

Recreational Sport Diving

Beginning January 1, 2000, DOH must adopt standards for contaminants in compressed air that is used for recreational sport diving. The department must consider the levels of contaminants allowed by the Grade "E" Recreational Diving Standards of the Compressed Gas Association. The bill requires persons providing compressed air for compensation to ensure that samples of air to be sold are tested quarterly by a laboratory certified by the American Industrial Hygiene Association or the American Association for Laboratory

Accreditation. The results of these tests must be provided to the department, which will issue a certificate to the vendor stating that the submitted test samples of compressed air meet standards, or issue a notification that test samples failed to meet the standards. The certificate must be posted in a location where it may be readily seen by any person purchasing the compressed air.

Autism/Secretin

The bill requires the Division of Children's Medical Services of DOH to contract with a private nonprofit provider that is affiliated with a teaching hospital to conduct clinical trials on the use of the drug Secretin to treat autism. The bill requires the private nonprofit provider conducting the clinical trials to report its findings and provides an appropriation of $50,000 to the Division of Children Medical Services from the General Revenue Fund for implementing the bill.

Blood-Borne Infections

The bill provides that any person licensed by DOH and any other person employed by a health care facility who contracts a blood-borne infection shall have a rebuttable presumption that the illness was contracted in the course and scope of his or her employment when the person reports one or more specific significant exposures to the infection as defined in s. 381.004, F.S. The employer may rebut the presumption by the preponderance of evidence. Except as expressly provided in this bill, there shall be no presumption that such infection is a job-related illness.

Trauma

The bill makes provisions for the coordination of activities of DOH, the Boards of Medicine and Nursing, the Agency for Health Care Administration and other providers who have resources to assist a trauma victim in establishing and regulating an inclusive trauma system in Florida. The bill amends the law pertaining to trauma to incorporate the concept of an inclusive trauma system; rename, from patients to trauma victims, persons who suffer trauma and who do not have a provider/patient relationship yet established; establish a five-year time frame for updates of trauma agency plans; clarify that Level I and II trauma centers should each be capable of treating 1,000 and 500 patients, respectively, with an injury severity score of 9 or greater; clarify that transportation requirements apply to trauma alert victims; and require DOH to periodically review the assignment of counties to trauma service areas as currently specified in s. 395.402, F.S.

Medicaid

The bill requires the Department of Children and Family Services and the Agency for Health Care Administration to develop a system to issue a Medicaid number to unborn children. The number is to be used for billing purposes and for monitoring care provided to the child starting at birth. The bill delays and revises the implementation of a plan to reimburse providers on a capitated basis through the Children's Medical Services network for services provided to Medicaid eligible children with special health care needs.

The bill amends the section of statute relating to the Healthy Start waiver, to enable the Agency for Health Care Administration to pursue a certified match program to use local and state Healthy Start funding to draw down federal matching funds in the event that the federal government does not approve the pending Healthy Start waiver request.

The bill requires that, in the instance that health insurers and health maintenance organizations who are liable for Medicaid costs and require tape or electronic billing, the entities must, at their own expense, develop the means to use the standard tape or electronic format of the Medicare program. Entities which cannot use the tape or electronic billing format are required to accept paper claims in the Medicare format.

The bill creates the "Medicaid Estate Recovery Act," which codifies into statute Medicaid's estate recovery process. The provisions are applicable only to estates of those deceased Medicaid recipients who received Medicaid-reimbursed services after reaching the age of 55, and the agency is expressly prohibited from enforcing a claim against any homestead of a deceased Medicaid recipient. The bill requires notification of the Medicaid program of the administration of an estate by the personal representative of a deceased Medicaid recipient and creates a claim and interest in the estate on the part of the state in the amount of Medicaid assistance received by a recipient after the age of 55. The bill creates exemptions from the estate recovery process for homestead property, as well as, in the instance of a surviving spouse, a child under the age of 21 or a disabled child living in the home, a waiver provision if enforcement of the estate recovery process would create a hardship. The bill provides for a Medicaid claim against a settlement due from a third party and provides for the disposal of real property which has value exceeding the cost of its sale, and makes the agency a reasonably ascertainable creditor where a deceased recipient has received Medicaid assistance after the age of 55.

The bill amends the section of statute relating to Medicaid provider service network demonstration projects as a cost-effective means of purchasing, to delete the requirement that one of the four demonstration projects be conducted in Orange County. The bill requires the Agency for Health Care Administration to enter into agreements with not-for-profit organizations based in Florida to provide vision screening.

The bill modifies the agency's program integrity authority to allow Medicaid to withhold payments based on reliable evidence that a provider is engaged in fraud or abuse of the Medicaid program or a crime is being committed while rendering goods or services to Medicaid recipients.

The bill requires the agency, when preforming reviews of medical necessity for physician services, to use physicians of the same specialty as the physician under review to the extent possible. The agency is required to give advance notice to a physician when it wants to conduct onsite record reviews, use valid and accepted statistical models, and refer claims it believes are overpayments for peer review. The bill requires the agency to study its current statistical model used to calculate overpayments and advise the Legislature of any needed changes.

Professional Regulation

The bill makes numerous revisions to the professional regulatory provisions for health care professions within DOH. Significant provisions in the bill include the following:

- DOH, or the appropriate regulatory board having jurisdiction over the health care professional, is authorized to impose an administrative fine when the health care provider fails to make available to patients a summary of their rights. Initial nonwillful violations shall be subject to corrective action and shall not be subject to an administrative fine.

- The definition of "health care practitioner" in pt. II of ch. 455, F.S., relating to the general regulatory provisions for health care professions under DOH, is revised to include certified nursing assistants, midwives, nursing home administrators, athletic trainers, orthotists, prosthetists, pedorthists, electrologists, clinical laboratory personnel, and medical physicists.

- The Board of Medicine, the Board of Osteopathic Medicine, the Board of Chiropractic Medicine, and the Board of Podiatric Medicine are authorized to require by rule that up to 1 hour of the 40 or more hours of continuing education be in the area of risk management or cost containment for licensure renewal. The bill provides that this rulemaking authority may not be interpreted to limit the number of hours that a licensee may obtain in risk management or cost containment which may be used to satisfy the continuing education requirements or be construed to require the boards to impose any requirement on licensees except for the completion of at least 40 hours of continuing education every 2 years.

- Other boards within the Division of Medical Quality Assurance, or DOH, if there is no board, are authorized to adopt rules granting continuing education hours in risk management for attending a board meeting at which another licensee is disciplined, serving as a volunteer expert witness for the department in a disciplinary case, or serving as a member of a probable cause panel following the expiration of a board member's term. The bill authorizes the department to adopt rules for the professions under its jurisdiction: to provide for the use of approved videocassette courses and the criteria for and content of such courses; and to establish criteria for continuing education courses.

- DOH is prohibited from releasing hospital disciplinary action in physician profiles and the practitioner profiling requirements are revised to exempt resident physicians who must register with the department from submitting information that will be compiled into the practitioner profiles.

- Examination fees for radiological certification are revised to require applicants to pay the actual per-applicant cost to DOH for the purchase of the national examination.

- An alternate licensing path for foreign-licensed physicians under s. 458.3115, F.S., to become licensed to practice in Florida, is revised to change the period of time that the applicants may sit for and pass the required combination of medical licensure examinations from the year 2000 to 2002. The requirements are revised to allow the applicants to document no less than 2 years of the active practice of medicine in any jurisdiction rather than another jurisdiction. Effective upon becoming a law, revises the fee that DOH may charge the examinees under this alternate licensure path for foreign-licensed physicians from the actual cost of the examination to a fee that does not exceed 25 percent of the actual costs of the first examination administered pursuant to s. 458.3115, F.S., 1998 Supp., and a fee not to exceed 75 percent of the actual costs for any subsequent examination.

- The application period is extended from December 31, 1998, to December 31, 2000, for an alternate licensing path for foreign-licensed physicians under s. 458.3124, F.S.

- DOH's responsibilities for implementing a standardized credentialing program are revised so that it will no longer serve as a credentials verification organization for all health care practitioners in Florida. The department will maintain a depository for core credentials data for those health care entities authorized by the health care practitioner to receive the data. The bill requires DOH to establish by rule, procedures, guidelines, and fees for credentialing in consultation with the Credentials Advisory Council. Beginning July 1, 2002, the bill prohibits state

agencies that credential health care practitioners from collecting duplicate core credentials data from individual health care practitioners. Any credentials verification organization that does business in Florida must be fully accredited or certified as a credentials verification organization by a national accrediting organization, rather than having to meet national standards for its credentialing procedures. The bill provides that the core credentials data maintained by DOH that is otherwise confidential or exempt from the Public Records Law will be released to any person authorized by the health care practitioner to receive the data.

- Sexual misconduct in the practice of a health care profession is defined to mean violation of the professional relationship through which the health care practitioner uses the relationship to engage or attempt to engage the patient or client, or an immediate family member of the patient or client in, or induce or attempt to induce such person to engage in, verbal or physical sexual activity outside the scope of the professional practice of such health care profession. The bill prohibits sexual misconduct in the practice of a health care profession.

- DOH's requirement to provide procedures for applicants who fail an examination developed by the department or a contracted vendor to review their examination questions, answers, papers, grades, and grading key is limited to only the applicant's examination questions, answers, papers, grades, and grading key for the questions the candidate answered incorrectly or, if not feasible, to only the parts of the examination the applicant failed.

- Health care professionals are made subject to discipline for: failing to comply with requirements to provide patients with information about their patient rights and how to file a patient complaint; engaging or attempting to engage a patient or client in verbal or physical sexual activity; failing to comply with profiling and credentialing requirements; failing to report to the board, or the department if there is no board, in writing within 30 days after the licensee has been convicted or found guilty of, or entered a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction; or using information about people involved in motor vehicle accidents which has been derived from accident reports made by law enforcement officers or persons involved in accidents, or using information published in a newspaper or other news publication or broadcast that has used such reports, for the purposes of commercial or any other solicitation of people involved in such accidents. The amount of the administrative fine is increased from $5,000 to $10,000 that the department may impose on health care professionals for disciplinary violations.

- DOH, or appropriate board, is authorized to consider sanctions necessary to protect the public or to compensate the patient. The department or boards may consider and include requirements to rehabilitate the practitioner only after those sanctions have been imposed. Any costs associated with compliance with disciplinary orders are the obligation of the practitioner. The bill authorizes the department and the boards to assess attorney's fees in addition to costs for prosecution and investigation of disciplinary cases. If the ground for disciplinary action is the first-time failure of the licensee to satisfy continuing education requirements, the disciplinary sanction is limited to a citation for minor violations and assessment of a fine, as determined by the board or department rule. For each hour of continuing education not completed or completed late, the board or department may require the licensee to take an additional hour of continuing education.

- A civil cause of action and recovery of reasonable attorney fees and costs is provided to any person who has been injured by a disclosure of confidential information maintained by an officer, employee, or person under contract with the Department of Health or regulatory board therein, for the enforcement of regulation of health care professionals under the department's jurisdiction, if the disclosure is willfully made.

- The required disclosure by health care providers of free or discounted health services is extended to pharmacists, midwives, electrologists, medical physicists, clinical laboratory personnel, opticians, hearing aid specialists, psychologists, school psychologists, clinical social workers, mental health counselors, and marriage and family therapists.

- DOH's authority to obtain patient records and insurance information based on the investigation of a disciplinary complaint alleging inadequate medical care based on termination of insurance is revised to authorize DOH to obtain patient records, billing records, insurance information, provider contracts, and all attachments thereto pursuant to subpoena without written authorization from the patient, if the department and probable cause panel of the appropriate board find reasonable cause to believe that a health care practitioner has submitted fraudulent insurance claims, used information from a written automobile report to solicit or obtain patients personally or through an agent regardless of whether the information is from another person, solicited patients fraudulently, received a kickback, violated the patient brokering laws, or presented a false or fraudulent insurance claim, and also find that patient authorization cannot be obtained. The bill deletes the exemption to the Public Records Law making confidential patient records and insurance information obtained by DOH for the purpose of disciplinary proceedings. Requirements for a health care practitioner or records owner

furnishing copies of reports or records of a patient examination are revised to include the making of such reports or records available for digital scanning.

- DOH is authorized to suspend or restrict the license of any health care practitioner who tests positive for any drug on any government or private-sector preemployment or employer ordered confirmed drug test when the practitioner does not have a lawful prescription and legitimate medical reason for using such drug. The practitioner must be given 48 hours, after being notified of the confirmed drug test result, to produce a lawful prescription for the drug before an emergency order is issued.

- Midwives are required to maintain medical malpractice insurance or provide proof of financial responsibility in an amount and in a manner determined by DOH by rule.

- Business establishments regulated by the Division of Medical Quality Assurance are required to obtain an active status license before providing regulated services and the business establishments are made subject to the disciplinary violations that may imposed on licensed health care professionals.

- Definitions under the acupuncture practice act are revised to define "prescriptive rights" to mean the prescription, administration, and use of needles and devices, restricted devices, and prescription devices that are used in the practice of acupuncture and oriental medicine.

- The Board of Medicine and the Board of Osteopathic Medicine's authority to adopt rules is revised, to require physicians who perform level 2 procedures lasting more than 5 minutes and all level 3 surgical procedures in an office setting to register the office with DOH unless that office is licensed as a hospital or ambulatory surgical center. The department shall inspect the physician's office annually unless the office is accredited by a nationally recognized accrediting agency or an accrediting organization subsequently approved by the board. The actual costs for registration and inspection or accreditation must be paid by the person seeking to register and operate the office setting in which office surgery is performed.

- Any medical physician, osteopathic physician, or physician assistant is required to notify DOH of any adverse incident that involved the physician or physician assistant which occurred on or after January 1, 2000, in any office maintained by the physician for the practice of medicine that is not licensed under chapter 395, F.S., relating to licensure for hospitals and ambulatory surgical centers. Any medical physician, osteopathic physician, or physician assistant must also notify the

department in writing and by certified mail of any adverse incident within 15 days after the adverse incident occurred. The bill requires DOH to review each adverse incident and determine whether the incident potentially involved conduct by a health care professional who is subject to disciplinary action.

- The medical licensure by examination requirements are revised to limit acceptance of an applicant's passing score on a combination of the examination of the Federation of State Medical Boards of the United States, the United States Medical Licensing Examination (USMLE), or the examination of the National Board of Medical Examiners to the period up to the year 2000.

- An applicant who has graduated from an approved program and who expects to take the first national licensure examination to become a physician assistant may be granted a temporary license that expires 30 days after receipt of scores from that examination.

- Chiropractic students enrolled in a accredited chiropractic college and participating in a community-based internship under the direct supervision of the faculty of that college are exempted from chiropractic licensing requirements and the administrative fines are increased from $2,000 to $10,000 that the Board of Chiropractic may impose on chiropractic physicians.

- Chiropractic physician's assistants are authorized to perform services under the indirect supervision of a chiropractic physician as defined by rule of the Board of Chiropractic and on calls outside of the office of the chiropractic physician to whom she or he is assigned. The duties of certified chiropractic physician's assistants are expanded to include supervision of registered chiropractic assistants.

- The podiatric licensure by examination requirements are revised to require applicants who have not completed a residency in 4 or more years from the filing of their application and who have not practiced for ten continuous years to meet specified requirements. The administrative fines are increased from $5,000 to $10,000 that the Board of Podiatric Medicine may impose on physicians and certified podiatric X-ray assistants are exempted from the regulatory provisions for radiologic technicians.

- The number of times an applicant is permitted to take the nursing licensure examination is limited to 3 consecutive times and remedial training approved by the Board of Nursing is required before any subsequent examination. The bill prohibits the use of the title "nurse" unless the person is duly licensed or certified as a nurse.

- The definition of the practice of the profession of pharmacy is revised to include other pharmaceutical services. A ground for which a pharmacist is subject to discipline, for placing in the stock of any pharmacy any part of any prescription compounded or dispensed which is returned by a patient, is revised to exclude prescription drugs returned for reuse in a correctional facility in which unit-dose medication is dispensed to inpatients. The administrative fines are increased from $1,000 to $5,000 that the Board of Pharmacy may impose on pharmacists.

- The Board of Dentistry is authorized to prescribe by rule the form of written work orders dentists are required to use when they use the services of any unlicensed person for certain services.

- DOH is authorized to grant a provisional license to practice speech-language pathology and audiology to applicants who hold either a master's or a doctoral degree with a major emphasis in the appropriate field.

- The nine-member Board of Athletic Training is created, in lieu of the existing Council of Athletic Training. The bill adds a consumer member and an additional athletic trainer member to the newly-created board. The bill staggers the terms of appointment for the initial members of the board and provides that all parts of part II of chapter 455, F.S., relating to activities of the board shall apply. The bill provides that rules relating to the regulation of athletic trainers in force before October 1, 1999, shall remain in effect until the newly-created board adopts administrative rules which supersede the earlier rules. The bill provides that the Council of Athletic Training and the terms of all council members are terminated on October 1, 1999.

- Any applicant who successfully completed prior to March 1, 1998, at least one-half of the examination required for national certification and successfully completed the remaining portion of the examination and became certified before July 1, 1998, for purposes of the practice of orthotics and prosthetics licensure requirements shall be considered as nationally certified by March 1, 1998.

- The definition of "electrolysis or electrology" is revised to mean the permanent removal of hair by destroying the hair-producing cells using equipment and devices approved by the Board of Medicine and cleared by and registered with the United States Food and Drug Administration.

- The Board of Clinical Laboratory Personnel is authorized to by rule designate a national certification examination that may be accepted in lieu of the state examination for clinical laboratory personnel or public health scientists. The definition of "clinical laboratory" is revised. Clinical laboratories in Florida are

authorized to accept work from a duly licensed practitioner from another state licensed under similar statutes who orders examinations on materials or specimens for non residents of Florida, but who reside in the same state as the requesting practitioner. DOH is authorized to license applicants at the director level in the category of public health to qualify for clinical laboratory director licensure.

- The Board of Clinical Laboratory Personnel is authorized to adopt rules to provide for continuing education or retraining requirements for candidates failing an examination two or more times. The bill provides additional disciplinary violations for clinical laboratory personnel which include: violating a previous order of the Board of Clinical Laboratory Personnel; failing to report violations under the regulations; making or filing a false report; paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split fee arrangement with a physician, organization, agency, or person, for patients referred to providers of health care goods and services; exercising influence on a patient or client for exploitation of the patient or client or for financial gain; practicing or offering to practice beyond the scope permitted by law or rule, or accepting or performing professional services or responsibilities which the licensee knows that he or she is not competent to perform; improperly interfering with an investigation or any disciplinary proceeding; or engaging or attempting to engage in sexual misconduct, causing undue embarrassment or using disparaging language of a sexual nature towards a patient, exploiting superior/subordinate, professional/patient, instructor/student relationships for personal gain, sexual gratification, or advantage.

- DOH's authority to issue a temporary license to medical physicists applicants pending completion of the application process for board certification is eliminated.

- The requirements for the supervision of an apprentice are revised to require the optician who supervises an apprentice to be a Florida-licensed optician who has been licensed for at least one year.

- Hearing aid specialists are required to provide a refund to consumers within 30 days of the return or attempted return of a hearing aid and the penalty for certain prohibited acts is increased from a second-degree misdemeanor punishable by jail time up to 60 days and a $500 fine to a third-degree felony punishable by up to 5 years in prison and a fine of $5,000.

- DOH's authority to issue a temporary permit to practice physical therapy for licensure applicants pending the results of their licensure examination is eliminated.

- An alternate path to become a licensed psychologist that limited the pathway to persons who were enrolled in a program that the board determined was comparable to standards of education and training comparable to the standard of training of programs accredited by a programmatic agency recognized and approved by the U.S. Department of Education before October 1, 1995, is revised. Under the revision, the time that the applicant must submit the certification of the doctoral-level training to the board has been extended from July 1, 2001 to August 31, 2001. The applicant must also meet training requirements that are certified as comparable by the program director of a doctoral-level psychology program accredited by a programmatic agency recognized and approved by the U.S. Department of Education rather than have the comparability of the training be determined by the Board of Psychological Examiners before 1995.

- DOH is required to license a psychologist who otherwise meets licensure requirements and holds a doctoral degree in psychology and who has at least 20 years of experience as a licensee in any jurisdiction of the United States within 25 years preceding the date of application.

- Any clinical social work, marriage and family therapy, and mental health counseling applicant who registers as an intern on or before December 31, 2001, and who otherwise meets the education requirements in effect on December 31, 2000, is deemed to have met the educational requirements for licensure for the profession for which he or she has applied.

- Applicants applying for licensure by examination or endorsement who have met minimum education requirements by holding an earned graduate degree in social work, marriage and family therapy, mental health counseling, or a closely related field are authorized to practice with a provisional license while satisfying additional coursework or examination requirements for licensure.

- Effective January 1, 2001, the bill amends s. 491.005, F.S., as amended by s. 13 of ch. 97-198, L.O.F., and s. 205 of ch. 97-264, L.O.F., relating to clinical social work, marriage and family therapy, and mental health counseling licensure by examination requirements, to provide that the additional educational requirements will change graduate coursework hours for mental health counseling requirements from 36 semester hours to 33 semester hours and from 48 quarter hours to 44 quarter hours.

- The laws and rules courses for licensure and continuing education, and their providers must be approved by DOH or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, to conform to the

department's objective to allow such providers to test the applicants for the courses offered.

- The definition of "wholesale distribution" of prescription drugs for purposes of ch. 499, F.S., the Florida Drug and Cosmetic Act, is revised to exempt the sale, purchase, trade, or other transfer of a prescription drug from or for a federal, state, or local government agency or any entity eligible to purchase prescription drugs at public health services prices under the Veteran's Health Care Act, to a contract provider or its subcontractor for eligible patients of the entity under specified conditions. The agency or entity must obtain written authorization for the sale, purchase, trade, or other transfer of a prescription drug from the Secretary of the Department of Health.

- The Board of Respiratory Care is created. The bill staggers the terms of appointment for the initial members of the board and provides that all parts of part II of ch. 455, F.S., relating to activities of the board shall apply.

- DOH is required to regulate the practice of certified nursing assistants in Florida under a newly created part XV of ch. 468, F.S. The bill also requires DOH to maintain a certified nursing assistant registry.

Studies/Task Forces

The bill creates a Task Force for the Study of Collaborative Drug Therapy Management within DOH to determine the states in which collaborative drug therapy management has been enacted, receive testimony of interested parties, and determine the efficacy of collaborative drug therapy management in improving health care outcomes of patients. The task force must hold its first meeting no later than August 1, 1999, and submit its report to the Legislature no later than December 31, 1999.

The bill creates the Task Force on Telehealth to be appointed by the Secretary of DOH. The task force must submit a report of its findings and recommendations to the Governor, and the Legislature by January 1, 2000.

The Agency for Health Care Administration is required to conduct a detailed study and analysis of clinical laboratory services for kidney dialysis patients in Florida. The study, must among other things, include an analysis of utilization rates of clinical laboratory services for dialysis patients, and financial arrangements among kidney dialysis centers, their medical directors, and any business relationships and affiliations with clinical laboratories. The agency must report its findings to the Legislature no later than February 1, 2000.

The bill creates a seven-member task force to review sources of funds deposited into the Public Medical Assistance Trust Fund. The task force must consider: whether the law needs revision; whether the annual assessments imposed on the various health care entities are imposed equitably; whether additional exemptions from the annual assessments are justified and any other changes that could result in increased revenue for the trust fund. The Agency for Health Care Administration must provide the necessary staff support and technical assistance to the task force. The task force must convene by August 1, 1999 and must submit its finding to the Legislature and the Governor by December 1, 1999.

The bill creates the Minority HIV and AIDS Task Force within DOH to provide recommendations on ways to strengthen HIV and AIDS prevention programs and early intervention and treatment efforts in the state's black, Hispanic, and other minority communities, as well as ways to address the many needs of the state's minorities infected with AIDS and their families. The task force must submit a report by February 1, 2001, and is abolished on July 1, 2001.

Area Agencies on Aging

Area agencies on aging are made subject to the requirements of Public Records Law under ch. 119, F.S., and when considering any contracts requiring expenditures of funds, are made subject to the Public Meetings Law requirements under ss. 286.011- 286.012, F.S.

If approved by the Governor, these provisions take effect July 1, 1999 except as otherwise expressly provided in the bill.
Vote: Senate 36-0; House 114-0

REGULATION OF HEALTH CARE PRACTITIONERS

SB 248 — Orthotics/Prosthetics/Pedorthics

by Senator Kurth

The bill extends the deadline for licensure application established in s. 468.805 (1), F.S., from March 1, 1998, to July 1, 1999, to allow a person who has met the experience requirements to practice orthotics, prosthetics, or pedorthics before March 1, 1998, to apply for licensure, based on the person's experience and educational preparation, without meeting the statutory educational requirements for licensure.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 39-0; House 115-0

HB 699 — Athletic Trainers

by Health Care Licensing & Regulation Committee and Rep. Fasano (SB 1020 by Senator Latvala)

The bill creates the nine-member Board of Athletic Training in lieu of the existing Council of Athletic Training. The bill adds a consumer member and an additional athletic trainer member to the newly-created board. The bill staggers the terms of appointment for the initial members of the board and provides that all parts of part II of ch. 455, F.S., relating to activities of the board shall apply. The bill provides that rules relating to the regulation of athletic trainers in force before October 1, 1999, shall remain in effect until the newly-created board adopts administrative rules which supersede the earlier rules. The bill provides that the Council of Athletic Training and the terms of all council members are terminated on October 1, 1999. The bill makes other minor and conforming changes relating to the creation of the Board of Athletic Training.

If approved by the Governor, these provisions take effect October 1, 1999.
Vote: Senate 39-0; House 114-0

HB 981 — Dentistry

by Rep. Morroni (SB 1378 by Senators Saunders, Bronson, Carlton, Jones, Forman, Sebesta, Dawson-White and Brown-Waite)

The bill revises the conditions of appointment to the Board of Dentistry to require each member of the board who is a licensed dentist in Florida to be actively engaged in the clinical practice of dentistry in Florida, to obtain his or her primary source of income from direct patient care, and to have been actively engaged in the practice of dentistry primarily as a clinical practitioner for at least five years immediately preceding the date of her or his appointment to the board. The bill provides that any person who is connected in any way with a dental college or community college may be appointed to the board so long as that connection does not result in a relationship wherein such college provides more than five percent of the person's income. The bill's revisions to the conditions of appointment to the Board of Dentistry apply to appointments to that board made on or after July 1, 1999.

The bill authorizes the Board of Dentistry to prescribe by rule the form of written work orders dentists are required to use when they use the services of any unlicensed person for certain services. The bill deletes the requirement that the work order forms be provided to dentists, at cost, by the Department of Health.

The bill revises the requirements for dentists to hold themselves out as specialists or advertise as specialists. The bill requires any dentist who lacks membership in or certification, diplomate status, or other similar credentials from an accrediting organization approved as bona fide by either the American Dental Association or the Florida Board of

Dentistry or whose area of practice is officially recognized by an organization that the dentist wants to acknowledge or otherwise reference in an announcement, solicitation, or advertisement that is not approved as bona fide by either the American Dental Association or the Florida Board of Dentistry to provide a disclaimer. The bill revises legislative intent and provides legislative findings with respect to dental specialty advertising.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate 38-0; House 114-0

HB 989 — Physician Assistants Licensure

by Rep. C. Green (SB 1500 by Senator Saunders)

The bill allows any person who has completed all the course requirements of the Master of Medical Science Physician Assistant Program offered through the Florida College of Physician's Assistants prior to its closure in August of 1996, to be eligible for licensure as a physician assistant in Florida under the alternate licensing requirements for certain foreign medical graduates in s. 458.347, F.S., 1998 Supp.

Before taking the required examination, such applicant must successfully complete any clinical rotations that were not completed under the Master of Medical Science Physician Assistant Program offered through the Florida College of Physician's Assistants Program and any additional clinical rotations with an appropriate physician assistant preceptor, not to exceed 6 months, that are determined necessary by the Council on Physician Assistants. The Board of Medicine and the Board of Osteopathic Medicine will determine, based on recommendations from the Council of Physician Assistants, the facilities where such clinical rotations may be completed by the applicant, and determine what constitutes successful completion. The requirements for clinical rotations must be comparable to those established by an accredited physician assistant program.

The alternate licensing requirements for persons who have completed all the course requirements of the Master of Medical Science Physician Assistant Program offered through the Florida College of Physician's Assistants prior to its closure in August of 1996, is repealed on July 1, 2001.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate 40-0; House 114-0

HB 1031 — Physician Assistants

by Rep. Goode and others (CS/SB 1068 by Health, Aging & Long-Term Care Committee and Senator Sullivan)

The bill authorizes a physician assistant licensed under ch. 458, F.S., or ch. 459, F.S., to perform a medical examination of a child who is the subject of reported child abuse, abandonment, or neglect and who has been referred for diagnosis to a licensed physician or an emergency department in a hospital by the person required to investigate suspected child abuse, abandonment or neglect, without the consent of the child's parents, caregiver, or legal custodian. The bill adds physician assistants to the list of licensed health care professionals who may authorize a radiological examination to be performed on a child without the consent of the child's parent, caregiver, or legal custodian, if the health care professional has reasonable cause to suspect that an injury was the result of child abuse, abandonment, or neglect.

The bill requires the appointment of all members of the formulary committee for an initial term beginning July 1, 1999. The bill requires formulary committee members to be appointed for terms of four years, but staggers the initial terms of members. The formulary committee must meet at least quarterly to establish a formulary of medicinal drugs that a fully licensed physician assistant may prescribe. The Board of Medicine and the Board of Osteopathic Medicine must adopt the formulary and each subsequent change at the next regular board meeting following receipt of the formulary from the formulary committee.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate 35-0; House 116-0

REGULATION OF HEALTH CARE FACILITIES/SERVICES/BUSINESSES

CS/SB 276 — Home Medical Equipment Provider Regulation

by Health, Aging & Long-Term Care Committee and Senator Brown-Waite

The bill creates ch. 400, part X, F.S., to regulate home medical equipment (HME) providers. The Agency for Health Care Administration (agency or AHCA) must license HME providers and establish basic standards to ensure the provision of quality equipment, products, and services by such providers. Home medical equipment providers are persons or entities, except for certain exempted entities, that provide incidental services for and sell or rent the following to consumers: (1) oxygen and related respiratory equipment, (2) customized wheelchairs and related seating and positioning equipment, or (3) any products reimbursed under Medicare Part B Durable Medical Equipment benefits or the

Florida Medicaid durable medical equipment program. Home medical equipment services include equipment management and consumer instruction. Prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner are explicitly excluded from HME provider regulation.

Licensure as an HME provider is required of any person or entity that holds itself out to the public as providing such equipment and related services or that accepts physician orders for such equipment and services. A separate license is required for each premise at which a provider operates even if all locations operate under the same management. The bill exempts several entities from licensure, *unless* such an otherwise exempted entity has 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. The exempted entities are: (1) providers operated by the federal government; (2) state-licensed nursing homes; (3) state-licensed assisted living facilities when they are providing services to their residents; (4) state-licensed home health agencies; (5) state-licensed hospices; (6) state-licensed intermediate care facilities; (7) homes for special services; (8) transitional living facilities; (9) state-licensed hospitals and ambulatory surgical centers; (10) manufacturers and wholesale distributors, when not selling directly to consumers; (11) licensed health care practitioners who utilize HME in the course of their practice, but who do not sell or rent HME to their patients; and (12) state-licensed pharmacies.

The bill requires HME providers in existence when the law takes effect to submit an application and fees for licensure by December 31, 1999. The agency, until it acts to deny or grant the initial licensure application, must deem as meeting licensure requirements an existing HME provider that submits an application and the appropriate fees prior to December 31, 1999. However, an existing provider that submits an application for licensure *after* December 31, 1999, must discontinue operations until AHCA approves its application and the applicant obtains its license.

To obtain licensure, an HME provider must: (1) provide at least one category of equipment directly, filling orders from its own inventory; (2) maintain and repair directly, or through a service contract with another company, items rented to consumers; (3) at the time of the initial delivery, set up an appropriate follow-up HME service schedule as needed for such times as, but not limited to, periodic maintenance, supply delivery, and other related activities; (4) accept returns of substandard or unsuitable items from consumers; and (5) upon request by the consumer or as otherwise required by state or federal laws, rules, and regulations, assist consumers with meeting the necessary filing requirements to obtain third-party payment to which a consumer may be entitled. An HME provider must comply with state and federal laws relating to prohibited patient referrals and rebates.

To become licensed, the general manager and financial officer of each applicant requesting licensure as an HME provider must submit to level two background screening pursuant to ch. 435, F.S. Additionally, AHCA is authorized to require background screening for a member of an applicant's or licensee's board of directors or an officer or an individual owning five percent or more of the licensee *if AHCA has probable cause to believe that such individual has been convicted of an offense prohibited under level 2 standards for screening* under ch. 435, F.S. However, an applicant or licensee is exempted from the screening requirement upon submitting proof of compliance with level two background screening requirements under any other state health care licensure requirements within the previous five years. If an applicant has been excluded, permanently suspended, or terminated from the Medicare or Medicaid program, the applicant must submit a description and explanation of such actions along with its application, except that submission of proof of compliance with ownership disclosure and control interest requirements of the Medicare or Medicaid program exempts an applicant from the need to submit such documentation. A similar requirement is made relating to the conviction of an offense prohibited under level two standards of ch. 435, F.S., by a member of the applicant's board of directors, its officers, or any individual owning five percent or more of the applicant, except for certain persons associated with not-for-profit organizations. An applicant for licensure renewal is required to submit to AHCA, under penalty of perjury, an affidavit of compliance with background screening requirements. The agency may not grant a license to an applicant who fails to meet the level two screening standards, unless an exemption from disqualification has been granted by the agency under ch. 435, F.S. The agency is also authorized to deny a license to, or revoke the license of, any potential licensee if the applicant has falsely represented a material fact or has omitted a material fact from its application or has previously been excluded, permanently suspended, or terminated from the Medicaid or Medicare program.

All HME provider *personnel* are required to undergo level 1 employment screening in accordance with ch. 435, F.S. An exemption from employment disqualification may be granted by AHCA. The general manager of each HME provider must annually sign an affidavit, under penalty of perjury, attesting that all personnel hired on or after July 1, 1999, who enter the home of a patient in the capacity of their employment have been screened and all other personnel have worked for the HME provider continuously since before July 1, 1999. However, AHCA is required to accept proof of compliance with the screening requirements relating to state employment, licensure as a nurse, or employment in certain specified health care or social services facilities or for the provision of certain specified services in lieu of employment screening under this section, if the person has been continuously employed in the same type of occupation for which he or she is seeking employment without a breach in service of no more than 180 days, the proof of compliance is not more than two years old, and the person has been screened by FDLE and through the central abuse registry and tracking system maintained by the Department of Children and Family Services. Home medical equipment personnel hired

subsequent to July 1, 1999, must be placed on probationary status pending determination of compliance with minimum standards for good moral character. Home medical equipment providers must automatically terminate the employment of personnel found in noncompliance with the minimum standards for good moral character, unless such employees have been exempted from disqualification.

Employers and contractors are required to *directly* provide proof of compliance with screening requirements to other employers and contractors. A potential employer or contractor may not accept proof of compliance from the person who is subject to screening. A licensed HME provider who terminates an employee's employment due to receipt of notice of a confirmed report of adult abuse, neglect, or exploitation is immunized from liability. The cost of screening is the responsibility of the HME provider or the screened person, at the provider's discretion. Certain misuse of information obtained through the screening process or operating or attempting to operate a licensed HME provider with personnel who do not meet the minimum standards for good moral character, as required under this section, are designated a first degree misdemeanor and misuse of information obtained from juvenile records is designated a third degree felony.

An approved licensure applicant must be issued a provisional license by AHCA that remains in effect for 90 days pending receipt of the FBI's background screening and during which period AHCA must conduct an inspection survey to further determine that the applicant is in substantial compliance with licensure requirements. If substantial compliance is demonstrated, AHCA is required to issue a standard license that expires two years after the effective date of the provisional license. The bill also provides other requirements and standards pertaining to licensure renewal, change of ownership, and change of general managers. A provisional license may be issued to an HME provider against whom a proceeding for revocation or suspension, or for denial of a renewal application is pending at the time of licensure renewal. Such a provisional license is to remain in effect until final disposition of such proceedings by AHCA. If judicial relief from AHCA's final disposition is sought, the court may issue a temporary permit for the duration of the judicial proceeding.

The agency is required to make or cause to be made, as it considers necessary, licensure inspections, inspections directed by the federal Health Care Financing Administration, and licensure complaint investigations. In lieu of its own periodic inspections for licensure, AHCA is required to accept the survey or inspection of an accrediting organization if the accreditation is not provisional and the HME provider authorizes release of, and AHCA receives the report of, the accrediting organization or a copy of a valid medical oxygen retail establishment permit issued by the Department of Health under ch. 499, F.S.

The bill makes it is unlawful for any person to advertise or offer HME and HME services to the public, unless the person has a valid license or is exempted from licensure and it is

unlawful for a licensee to advertise or indicate to the public that it holds an HME provider license other than the one it has been issued. To do so, subjects the person or licensee to injunctive proceedings that AHCA is authorized to initiate and such conduct is designated a violation of the Florida Deceptive and Unfair Trade Practices Act. Additionally, a first occurrence of such conduct is designated as a second degree misdemeanor while a second, and any subsequent, violation is designated a first degree misdemeanor.

Home medical equipment providers are required to maintain, for each patient, a patient record that includes HME and HME services the HME provider has provided. Specifically, the records must contain: any physician's order or certificate of medical necessity, if the equipment was ordered by a physician; signed and dated delivery slips verifying delivery; notes reflecting all services and maintenance performed, and any equipment exchanges; the date on which rental equipment was retrieved; and such other information as is appropriate to specific patients in light of the particular equipment provided to them. Home medical equipment providers are required to retain and maintain patient records for five years following termination of services. If a patient transfers to another HME provider, a copy of his or her record must be provided to the other HME provider, upon request.

A consumer and the consumer's immediate family, if appropriate, must be informed of the right to report abusive, neglectful, or exploitative practices on or before the first day HME is delivered by a state licensed HME provider. Home medical equipment providers are required to establish appropriate policies and procedures for notifying consumers of this right. Additionally, consumers must be provided, in a clearly legible manner, the statewide toll-free telephone number for the central abuse registry with language that states: *"To report abuse, neglect, or exploitation, please call toll-free 1-800-962-2873."*

Operation of an unlicensed HME provider is sanctionable as follows: 1) a third degree felony; 2) AHCA fraud referral to the appropriate government reimbursement program that has paid for services; and 3) if concurrently operating licensed and unlicensed premises, an AHCA-imposed moratorium on accepting new patients or revocation of existing licenses until the unlicensed premises are licensed. A provider that is found to be operating without a license may apply for licensure, but must cease operations until a license *is awarded by AHCA.* Furthermore, AHCA is authorized to institute injunctive proceedings when it determines that an HME provider has violated a provision under ch. 400, part IX, F.S., as created in this bill, or applicable administrative rules. The violation must constitute an emergency affecting the immediate health and safety of a patient or consumer.

A licensure fee of up to $300 and an inspection fee of up to $400 is required of all applicants. Initial licensure applicants must demonstrate financial ability to operate, which may be accomplished by submission of a $50,000 surety bond to AHCA. Applicants for licensure renewal that have demonstrated financial *inability* to operate must, also, demonstrate financial ability to operate. Also, an HME provider must obtain and maintain professional and commercial liability insurance of a minimum of $250,000 per claim, and must submit proof of such coverage with the licensure application. Subcontractors of an HME provider are required to have a minimum of $250,000 per claim liability insurance coverage as well. Additionally, HME providers are made subject to administrative fines of up to $5,000 per violation, per day for violating licensure requirements. An appropriation of $701,370 and 13 full-time-equivalent positions are provided for in the bill.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate 40-0; House 116-0

HB 357 — Hospital Meetings and Records; Exemptions from Disclosure

by Rep. Fasano (CS/SB 1012 by Health, Aging & Long-Term Care Committee and Senator Carlton)

This bill amends the law that provides for the confidentiality and exemption of hospital records and meetings from the Public Records Law and the Public Meetings Law, respectively, as these laws apply to hospital strategic plans. The term "strategic plan" is defined to mean any *record* which describes actions or activities to produce any of the following nine results: (1) initiate or acquire a new health service; (2) materially expand an existing health service; (3) acquire additional facilities by purchase or by lease; (4) materially expand existing facilities; (5) change all or a material part of the use of an existing facility or a newly acquired facility; (6) acquire another health care facility or health care provider; (7) merge or consolidate with another health care facility when the surviving entity is an entity that is subject to the State constitutional Public Records Law and Public Meetings Law provisions; (8) enter into a shared service arrangement with another health care provider; or (9) any combination of (1) through (8). Additionally, the bill states that certain records are expressly excluded from the meaning of the term "strategic plan." Records excluded from classification as a strategic plan are those that describe the existing operations of a hospital or other health care facility which implement or execute the provisions of a strategic plan, unless disclosure of any such document would divulge any part of a strategic plan which has not been fully implemented or is a record that is otherwise exempt from the Public Records Law. Such existing operations include, without limitation, hiring of employees, the purchase of equipment, the placement

of advertisements, and the entering into contracts with physicians to perform medical services. Records that describe operations are not exempt from the Public Records or Public Meetings Laws, except as specifically provided.

Confidentiality and a public records exemption are applied to the records and information comprising strategic plans of *any* hospital that is subject to the Public Records Law as provided in the *State Constitution* and as codified in law under ch. 119, F.S. The confidential status and the public records exemption are applied to such a plan when the plan is *not otherwise known or otherwise legally obtainable by a competitor*, and if disclosure of such plan would be *reasonably likely to be used by the competitor* to gain a competitive advantage. Specific reference to marketing of services is deleted. Also, an exemption from the Public Meetings Law, as codified in law under ch. 286, F.S., and provided in the *State Constitution*, is provided for that portion of a hospital governing board meeting during which one or more *written* strategic plans are *discussed, reported on, modified, or approved by the governing board*. This exemption is scheduled for repeal October 2, 2004, unless reenacted by the Legislature following Sunset review prior to the repeal date.

The bill revises the confidential status and the public meetings exemption that prohibits disclosure of a transcript of a closed hospital governing board meeting. Closed meetings are explicitly restricted to discussion, reports, modification, or approval of a written strategic plan. Such a plan is subject to an earlier expiration of confidentiality and public meetings exemption than the otherwise applicable three-year time limit based on the governing board's determination that the strategic plan discussed, reported on, modified, or approved at the meeting has been implemented, to the extent that confidentiality of the strategic plan is no longer necessary. When a discrete part of a strategic plan has been publicly disclosed by the hospital or has been implemented to the extent that confidentiality of that portion of the plan is no longer necessary, the hospital must redact the transcript and release only that part which records discussion of nonconfidential parts of the strategic plan, unless such disclosure would divulge confidential parts of the plan. Clarifying language contained in the bill expressly states that provisions of the bill do not allow the boards of two separate public entities to meet together in a closed meeting to discuss, report on, modify, or approve the implementation of a strategic plan that affects both entities.

If a governing board of a hospital closes a portion of a governing board meeting to discuss a written strategic plan before placing the strategic plan or any portion of such a plan into operation, as authorized by the bill, it is required to give notice of an open meeting in accordance with the Public Meetings Law and conduct the meeting to inform the public, generally, of the business activity to be implemented. Furthermore, if a strategic plan involves a *substantial reduction in the level of medical services provided to the public*,

30-days prior notice must be given of an open meeting at which the governing board considers the decision to implement the strategic plan. A hospital governing board is prohibited from approving a binding agreement to implement a strategic plan at *any* closed meeting of the board. An public meeting that has been noticed as required under the Public Meetings Law is the only authorized forum for approval a binding agreement. The bill also contains a statement of public necessity relating to the Public Records Law and Public Meetings Law exemptions created and modified in the bill.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 40-0; House 114-0

HB 489 — Body-piercing Salons

by Rep. Valdes and others (CS/CS/SB 980 by Governmental Oversight & Productivity Committee; Health Aging & Long-Term Care Committee; and Senator Lee)

The bill creates s. 381.0075, F. S., requiring the Department of Health to license permanent and temporary body-piercing salons, and to adopt rules to regulate such facilities. The bill establishes licensing procedures, fees, rulemaking authority, and enforcement mechanisms. The bill provides requirements for sterilization of body-piercing equipment, the use of infection control procedures, standards for jewelry to be inserted, aftercare, and staff training. Written, notarized parental consent for body piercing of minors is required. Additionally, minors under the age of 16 must be accompanied by their parents during body piercing. The department is required to conduct an annual inspection of salons.

The bill provides exemptions for the practice of any health care practitioner under the regulatory jurisdiction of the department as long as the person does not hold himself out as a body-piercing establishment. Felony penalties are provided for owning, operating or soliciting business as a body-piercing salon without the required license or obtaining or attempting to obtain a license by means of fraud, misrepresentation or concealment. Misdemeanor penalties are provided for failing to keep required records, falsifying records or failure to adhere to the requirements regarding minors. The department is authorized to issue citations and levy administrative fines not to exceed $1,000 per violation per day.

If approved by the Governor, these provisions take effect October 1, 1999.
Vote: Senate 40-0; House 113-2

CS/HB 645 — Assisted Living Facilities/Unlicensed Facilities

by Elder Affairs & Long-Term Care Committee and Rep. Prieguez and others (CS/SB 2354 by Children & Families Committee and Senator Forman)

This bill revises penalty provisions applicable to the operation of an unlicensed assisted living facility to provide, in part, that each day of continued operation of an unlicensed facility, whether a first or subsequent offense, constitutes a separate felony offense. Application for licensure within 10 working days, which under current law is an affirmative defense to a first offense, is no longer provided. Any unlicensed facility continuing to operate after agency notification is subject to a $1,000 fine. Each day beyond five working days (reduced from 20 days) after agency notification constitutes a separate violation and the facility is subject to a fine of $500 per day. The language which allowed continuing operation, if an unlicensed facility had applied for a license within ten days of agency notification, is deleted.

This bill also provides for the establishment, by the State Fire Marshal, of uniform fire safety standards in adult family-care homes and authorizes the organization of a work group to identify and report on additional steps that may be taken to discourage the operation of unlicensed assisted living facilities.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate 40-0; House 114-1

HB 735 — Health Facilities Authorities Law

by Rep. Farkas and others (SB 1108 by Senator Silver)

The bill revises provisions that empower health facilities authorities established under ch. 154, F.S., to issue bonds and incur other forms of indebtedness on behalf of a health facility (private, not-for-profit corporations organized as hospitals, nursing homes, developmental disabilities facilities, mental health facilities, or providers of life care services under continuing care contracts) or a group of health facilities to use in financing the purchase of accounts receivables. The bill authorizes the purchase of accounts receivables acquired from other not-for-profit health care corporations rather than other not-for-profit health facilities, whether or not the corporations are affiliated with the health facility and regardless of whether or not the corporations are located inside or outside this state.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 40-0; House 118-0

HB 1081 — Hospitals, Ambulatory Surgical Centers, and Mobile Surgical Facilities; Public Records

by Rep. Goodlette (CS/SB 1498 by Health, Aging & Long-Term Care Committee and Senator Saunders)

The bill creates and provides for confidentiality and a narrow Public Records Law exemption relating to personal information about employees of any hospital, ambulatory surgical center, or mobile surgical facility, collectively referred to in the bill as *licensed facilities*. The exemption is limited to the home addresses, telephone numbers, social security numbers, and photographs of employees of such licensed facilities who provide direct patient care or security services; their spouses, additionally exempting the place of employment of spouses; and their children, additionally exempting the names and locations of schools and day care facilities attended by the children. The exemption is subject to availability of the otherwise exempted information to state and federal agencies in the furtherance of their statutory responsibilities. The exemption is repealed effective October 2, 2004, unless saved from repeal through reenactment by the Legislature following Sunset review.

Additionally, the bill provides for confidentiality and a more limited public records exemption to employees of licensed facilities who have a *reasonable belief* that release of their home addresses, telephone numbers, social security numbers, and photographs may be used to threaten, intimidate, harass, inflict violence upon, or defraud the employee or any member of the employee's family, subject to the employee submitting a written request for confidentiality and subject to availability of the otherwise exempted information to state and federal agencies in the furtherance of their statutory responsibilities. The exemption is repealed effective October 2, 2004, unless saved from repeal through reenactment by the Legislature following Sunset review.

The bill provides a statement of public necessity for the public records exemptions. Among other salient points, this statement asserts that the exemptions created in the bill are consistent with the long-standing policy of the State relating to exempting the same type of personal information about certain active and former employees of state and local government, and judges in the judicial branch of government.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate 38-0; House 118-0

CS/HB's 1927 & 961 — Managed Health Care

by Health Care Services Committee and Rep. Eggelletion and others (CS/SB's 2472 & 1892 by Health, Aging & Long-Term Care Committee and Senators Clary and Saunders)

The bill clarifies that the Statewide Provider and Subscriber Assistance Panel may not hear a grievance that is part of an internal grievance in a Medicare managed care entity or a grievance that is limited to the incidental expenses of accrued interest on unpaid balances, court costs, and transportation costs associated with a grievance procedure. The bill increases the number of participants on the Panel to include a consumer and a physician, appointed by the Governor, and physicians with relevant expertise to review subscriber cases on a rotating basis.

Existing law relating to preferred provider organizations (PPO) is modified to provide that a policy issued by a PPO that does not provide direct patient access to a dermatologist must conform to the requirements imposed on exclusive provider organizations. It is expressly stated, however, that such a requirement is not to be construed to affect the amount the insured or patient must pay as a deductible or coinsurance amount.

The bill amends the law governing health maintenance organization (HMO) contracts to authorize an HMO to offer a point-of-service benefit through a point-of-service rider to its contract providing comprehensive health care services, if it meets three conditions: (1) is licensed to do business in Florida, (2) has been licensed to do business in Florida for a minimum of 3 years, and (3) maintains a minimum surplus of $5 million, inclusive of current surplus requirements, at all times that it has riders in effect. This benefit will enable an HMO subscriber, or other covered person, to choose to receive services from, at the time of covered service, a health care provider with whom the HMO does not contract for services. The rider may not require a referral from the HMO for point-of-service benefits. In addition to the surplus requirement, HMOs are restricted in the volume of business that they may generate through point-of-service riders to 15 percent of total premiums for all health plan products sold by the HMO offering the rider. If rider premium volume exceeds the 15 percent ceiling, the HMO must notify the Department of Insurance (DOI) and immediately cease, once it is known, offering the point-of-service rider until it returns to a state of compliance.

Despite restrictions on deductibles and copayments in the HMO regulatory law, an HMO that offers a point-of-service rider is authorized to require a subscriber to pay a reasonable copayment per visit for services provided by a noncontracted provider chosen at the time of the service by the subscriber. The copayment may either be a specific dollar amount or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider at the time that the subscriber receives the services. Additionally, the point-of-service rider may require a reasonable

annual deductible for the expenses associated with the rider and may include a lifetime maximum benefit amount.

A point-of-service rider must disclose any specific methodology, such as usual and customary charges, reasonable and customary charges, or charges based upon the prevailing rate in the community, used in the payment of claims. Also, such riders must comply with copayment and deductible limits provided under the state insurance code and be filed with and approved by DOI. Riders authorized under this section are explicitly exempted from: (1) the protection of HMO subscribers from liability for payment to providers of health care services for services covered by the HMO and (2) the prohibition against a provider collecting, attempting to collect, or suing a subscriber to collect money owed for services covered by the subscriber's HMO. Clarifying language provides that an HMO may not use the term "point of service" except with riders permitted under the provisions of this bill or with forms approved by DOI pertaining to a point-of-service product that the HMO offers with an indemnity insurer.

The bill amends the law relating to HMO provider contracts and payment of provider claims, to require that an HMO must reconcile to specific claims any retroactive reductions on payments or demands for refund of overpayments resulting from retroactive review of coverage decisions or payment levels, unless the parties to the contract agree to other reconciliation methods and terms. Also, a provider must reconcile to specific claims any retroactive demands for payment resulting from underpayment or nonpayment for covered services, unless the parties agree to other reconciliation methods and terms. The look-back period for such retroactive reconciliations may be specified by the terms of the contract.

The AHCA Director is required to establish an 8-member advisory group charged with studying and making recommendations relating to:

- trends and issues pertaining to timely and accurate submission and payment of health claims regulated under the HMO law, including legislative, regulatory, or private-sector solutions for submission and payment of such health claims;

- development of electronic billing and claims processing for providers and health care facilities that provide for electronic processing of eligibility requests; benefit verifications; authorizations; pre-certifications; business expensing of assets, including software, used for electronic billing and claims processing; and electronic monitoring of claims status, including use of models such as those compatible with federal billing systems;

- the form and content of claims; and

- measures to reduce fraud and abuse relating to submission and payment of claims.

The advisory group must be appointed and convened by July 1, 1999, and must present its recommendations by January 1, 2000. All meetings of the advisory group must be held in Tallahassee. Neither *per diem* nor travel expenses may be reimbursed.

The list of access and quality-of-care indicators for which HMOs must submit data to AHCA is expanded to require measures of management of chronic disease, preventive health care for adults and children, prenatal care measures, and child health checkup measures. The requirement that HMOs, individually, conduct standardized consumer satisfaction surveys of their membership is repealed. The bill authorizes AHCA's use of revenues collected through annual regulatory assessments on health maintenance organizations and deposited into the Health Care Trust Fund to conduct annual subscriber satisfaction surveys and payment of OPS contracted physician consultants for the Statewide Provider and Subscriber Assistance Program.

Additionally, the bill: (1) requires AHCA to publish HMO report cards; (2) contains clarifying and remedial language, effective retroactive to October 1, 1990, pertaining to the State's Medicaid tobacco litigation that applies to all causes of action arising after October 1, 1990, under the Medicaid third-party liability law, to *exempt from the guidelines for distribution of funds remaining* from a recovery or other collection of monies from a responsible liable party on behalf of a Medicaid-eligible person, after all expenses are paid to reimburse the state and the federal government, the requirement that the remainder of such funds be distributed to the Medicaid recipient; (3) limits the right of an insurance company or HMO to retroactively cancel a group health insurance policy due to nonpayment of premium by the employer or group contract holder and protects the employee's right to elect a conversion health insurance policy if cancellation occurs under such circumstances; (4) subjects Area Agencies on Aging to the Public Records Law and, when considering any contracts requiring the expenditure of funds, the Open Meetings Laws adopted in the *State Constitution* and codified in ch. 119 of the *Florida Statutes*; (5) modifies budget implementing language related to reductions taken in the 1999-2000 General Appropriations Act in the Medicaid pharmacy program to achieve the budget reductions reflected in the Act, requires the President of the Senate, the Speaker of the House of Representatives, and the Governor to each make three appointments to a panel of health care professionals to advise AHCA on this issue, and AHCA is authorized to determine which practitioners who are prescribing inappropriately or inefficiently must have their prescribing of certain drugs subject to prior authorization; and (6) appropriates $1,439,000 from the Health Care Trust Fund to AHCA for FY 1999-2000.

If approved by the Governor, these provisions take effect upon becoming a law.
Vote: Senate 37-1; House 118-0

SB 1396 — Registration of Drugs, Devices, and Cosmetics

by Senator Burt

The bill exempts any manufacturer of medical devices that is registered with the federal Food and Drug Administration from Florida's device registration requirements and fees if: the manufacturer's devices are approved for marketing by, or listed with the federal Food and Drug Administration for commercial distribution in accordance with federal law; or the manufacturer acts as a subcontractor for another medical devices manufacturer to manufacture components. The bill requires manufacturers permitted in Florida to update any information previously submitted for the exemption to the medical device registration requirements at the renewal of their permit.

If approved by the Governor, these provisions take effect July 1, 1999.
Vote: Senate 39-0; House 118-0

SB 1514 — Hospices

by Senator Clary

The bill (Chapter 99-139, L.O.F.) amends ss. 400.605, 400.6085, and 400.609, F.S., expanding the Department of Elderly Affairs' rulemaking authority regarding hospice standards and procedures. The bill authorizes the department to address, by rule, hospice standards and procedures relating to: license requirements; administrative management of a hospice; components of a patient plan of care; advanced directives and do-not-resuscitate orders; the provision of hospice care in alternative residential settings; physical plant standards for hospice residential units; disaster preparedness plans; quality assurance and utilization review committees; and the collection of hospice data.

The bill allows hospices to provide physician services directly or through contract. Home health aide services may be provided directly or the hospice may arrange for the provision of such services. Hospices are allowed to use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances.

The bill adds adult family care homes as a venue in which hospice care can be provided in addition to a person's own home. The bill expressly establishes that hospice patients residing in other regulated environments are hospice patients, and that the hospice is responsible for the provision of hospice services.

These provisions were approved by the Governor and will take effect July 1, 1999.
Vote: Senate 39-0; House 116-0

HB 1971 — Nursing Home Facility Regulation

by Elder Affairs & Long-Term Care Committee and Rep. Argenziano and Crist (CS/CS/SB's 834, 1140, & 1612 by Fiscal Policy Committee; Health, Aging & Long-Term Care Committee; and Senators Brown-Waite, Meek and Campbell)

Consumer Satisfaction and Information

This bill requires the Office of the State Long-Term Care Ombudsman to establish a statewide toll-free telephone number to enable nursing home residents, their families or friends, nursing home employees, or any member of the public to submit complaints concerning nursing home facilities. The Agency for Health Care Administration (agency or AHCA), or its contractor, is required, in consultation with the nursing home industry and consumer representatives, to: (1) develop an easy-to-use consumer satisfaction survey for nursing home residents to express their reaction to the services and the care they receive in the facility in which they reside, (2) ensure that all licensed nursing homes participate in assessing consumer satisfaction, and (3) establish procedures to ensure that, at least annually, a representative sample of residents of each facility is selected to participate in the survey. The agency is required to report survey results in the consumer information materials it prepares and distributes. It must provide additional consumer information and distribute this information in electronic and printed formats and at certain specified sites to assist consumers and their families in comparing and evaluating nursing home facilities. Examples of the consumer information that AHCA is expressly required to provide and distribute include: (1) a list by name and address of all nursing home facilities in Florida; (2) whether the listed nursing home facilities are proprietary or nonproprietary; (3) each facility's licensure status and rating history for the past 5 years; (4) the name of the owner or owners of each facility and whether the facility is a part of a corporation owning or operating more than one nursing facility in Florida; (5) performance, regulatory, and enforcement information about the corporation, as well as the facility; (6) the total number of beds in each facility; (7) the number of private and semiprivate rooms in each facility; (8) the religious affiliation, if any, of each facility; (9) the language spoken by the administrator and staff of each facility; (9) certain information obtained from the federal Minimum Data Set or maintained on the federal Online Survey Certification and Reporting (OSCAR) system relating to Medicare or Medicaid-certified facilities, and for noncertified facilities certain comparable state regulatory information; and (10) the Internet address for the site where more detailed information can be seen.

Transfer and Discharge of Residents

Section 400.0255, F.S., relating to transfer and discharge of nursing home residents, is amended to define the terms "discharge" and "transfer." The law is also amended to require nursing homes to permit the district ombudsman council to review a notice of discharge or transfer given to a nursing home resident, when requested by the resident,

and to comply with the residents' rights requirements relating to discharge or transfer when deciding to discharge or transfer a resident.

When requested by a nursing home resident, the district ombudsman council must review a notice of discharge or transfer within seven days after receipt of such request. The nursing home administrator, or the administrator's designee, must forward a request for review contained in the notice within 24 hours after such requested is submitted. Failure to forward such a request within 24 hours after its receipt delays the running of the 30-day advance notice period until the request has been forwarded. A district ombudsman, when requested, must review an emergency discharge or transfer within 24 hours after receipt of the request.

Following receipt of a notice of discharge or transfer by a district ombudsman council, the council may request a private informal conversation with a resident to whom the notice is directed, and a family member, if known, or the resident's legal guardian or designee to ensure the nursing home is lawfully proceeding with the discharge or transfer. If requested, the district ombudsman council must assist a resident with filing an appeal of the proposed discharge or transfer.

A licensed nursing home administrator, or an individual employed by the nursing home who is designated by the nursing home administrator, must sign the notice of discharge or transfer, unless the facility is citing a medical reason for the transfer or discharge. When a medical reason is the basis of a discharge or transfer, the resident's personal physician or the facility's medical director must sign the notice. The bill makes it grounds for disciplinary action against a nursing home administrator to discharge or transfer a resident for a reason other than a reason specifically authorized under the residents' rights law or the law governing discharges and transfers of nursing home residents.

Each nursing facility must notify AHCA of any proposed discharge or transfer that results from changes in the facility's physical plant that make the facility unsafe for residents. The agency, must then conduct an onsite inspection of the facility to verify the necessity of the discharge or transfer. A facility that has been reimbursed for reserving a bed and, for reasons other than those permitted under the law relating to discharge or transfer, refuses to readmit a resident within the prescribed time frame must refund the bed reservation payment.

The agency is required to develop a standard document for use by all nursing home facilities for notifying residents of a discharge or transfer. The form must include pertinent information regarding the discharge or transfer process, information necessary for the resident to contact the district long-term care ombudsman, and must clearly describe the resident's appeal rights and the procedures for filing an appeal, including the right to request the district ombudsman council to review the notice of discharge or transfer.

Regulatory Changes

An "early warning system" is established to detect conditions in nursing facilities that could be detrimental to the health, safety, and welfare of residents. The agency must employ quality-of-care monitors in each AHCA area to make regular, unannounced, and periodic visits to all nursing homes in the area. Monitoring visits must be prioritized based on a facility's history of patient care deficiencies. The monitors must be registered nurses who are trained and experienced in nursing home facility regulation, standards of practice in long-term care, and evaluation of patient care. They must observe the care and services provided residents at the facility and must include as a part of assessment visits formal and informal interviews with residents, family members, facility staff, resident guests, volunteers, other regulatory staff, and representatives of a long-term care ombudsman council or human rights advocacy committee. The monitors may not be deployed by the agency as a part of an inspection survey team that conducts routine, scheduled facility surveys.

A monitor's findings, both positive and negative, must be provided orally and in writing to the facility administrator, the administrator on duty, or the director of nursing. Monitors may collaborate with the facility administrator about procedural and policy changes or staff training, as needed. Conditions observed during a monitoring visit by a monitor which threaten the health or safety of residents must be reported immediately to the local AHCA area office supervisor for appropriate regulatory action and to law enforcement, adult protective services, or other responsible agencies, as appropriate or required by law. The written or oral records and communications generated from a monitoring visit are expressly excluded from discovery or introduction into evidence in a civil or administrative action, and a person present at a monitoring visit or evaluation may not be permitted or required to testify in a civil or administrative action, except that such exclusion is inapplicable when a quality-of-care monitor makes a report to the appropriate authorities regarding a threat to the health or safety of a resident. Information, documents, or records otherwise available from original sources remain accessible for purposes of civil or administrative actions.

Additionally, AHCA is directed to create *rapid response teams* to visit facilities identified through the early warning system. These teams may visit facilities that request AHCA's assistance, but the teams may not be deployed to help a facility prepare for an inspection.

The bill creates the "Gold Seal" Program for recognition of nursing home facilities demonstrating excellence in long-term care. It establishes a Panel on Excellence in Long-Term Care under the Executive Office of the Governor that is empowered to, applying criteria established in the bill, designate a nursing home facility as a Gold Seal facility. Once recognized as a Gold Seal facility, a nursing home facility qualifies for biennial

relicensure, instead of annual relicensure, and AHCA may give a certificate-of-need (CON) application for additional beds in an existing Gold Seal facility preferential review using new CON criteria created in the bill for that purpose.

The nursing home rating system is repealed and the Nursing Home Advisory Committee is abolished. Nursing home facilities are made subject to the following: (1) mandatory staffing increases, beyond the minimum required by law, when AHCA administratively sanctions the facility for care-related deficiencies that are directly attributable to insufficient staff, in which case, the facility may request an interim rate increase from Medicaid to cover costs of the additional staff, and it is subject to a $500 per day fine for each day staffing remains below the level required by AHCA; (2) applications for nursing home facility licensure must be accompanied by copies of any civil verdict or judgment relating to medical negligence, violation of residents' rights, or wrongful death involving the applicant that was rendered within the preceding 10 years and copies of any new verdict or judgment involving the applicant relating to such matters within 30 days after filing with the clerk of the court and such information must be maintained in the facility's licensure file and an AHCA database that is available to the public; (3) as a condition of licensure, applicants must agree to participate in the consumer satisfaction measurement process; (4) appointment of a Florida-licensed physician as medical director; (5) provide for residents to use a community pharmacy, as provided for under the residents' rights law; (6) allow residents to have their bulk prescription medications repackaged and relabeled by a Florida-licensed registered pharmacist into a unit dose system compatible with the nursing home facility's system for residents having such a benefit under a certain specified pension plan or retirement plan, subject to a reasonable fee by participating pharmacists for costs of providing such services; (7) public display of a poster provided by AHCA containing information for contacting the state's abuse hotline, the State Long-Term Care Ombudsman, AHCA's consumer hotline, the Advocacy Center for Persons with Disabilities, the Statewide Human Rights Advocacy Committee, and the Medicaid Fraud Control Unit, with a clear description of the assistance to be expected from each, (8) at the request of a resident, mark the resident's personal property with the resident's name or another type of identification; (9) employment of an applicant for employment on a probationary basis upon the applicant's attestation to certain facts about his or her background; and (10) changes in the regulatory system that reflect repeal of the nursing home rating system licensure classifications, including increased administrative penalty caps relating to regulatory deficiencies.

The agency is required to: (1) within 60 days after receipt of a complaint made by a nursing home resident or the resident's representative, complete its investigation and

provide to the complainant its findings and resolution; (2) provide, within 45 days of this provision becoming law, direct-access electronic screening capability to all nursing home facilities that enroll or agencies required by law to restrict employment to only an applicant who does not have a disqualifying report in the central abuse registry and tracking system; (3) adopt rules providing for minimum staffing requirements for nursing homes; and (4) allow properly trained staff of a nursing home facility, in addition to certified nursing assistants and licensed nurses, to assist residents with eating.

Additionally, the bill: (1) makes it unlawful for any person, long-term care facility, or other entity to willfully interfere with an unannounced licensure inspection by alerting or advising a facility of the actual or approximate date of such inspection and making such an act a *per se* violation of this prohibition; (2) authorizes AHCA to implement a teaching nursing home pilot project providing for a comprehensive multidisciplinary program of geriatric education and research; (3) creates a panel on Medicaid reimbursement to study the state's Medicaid reimbursement plan for nursing home facilities and to recommend changes to accomplish certain specified objectives; (4) directs the Department of Elderly Affairs to study the major factors affecting the recruitment, training, employment, and retention of qualified certified nursing assistants within the nursing home industry; (5) appropriates funding from the General Revenue Fund and the Medical Care Trust Fund to AHCA for recruitment and retention of qualified nursing home staff and to provide appropriate care and appropriates funding from the General Revenue Fund to the Department of Elderly Affairs for expenses of the Office of State Long-Term Care Ombudsman, including the statewide toll-free telephone number; (6) authorizes a memory disorder clinic at Sarasota Memorial Hospital in Sarasota County; and (7) authorizes the Department of Elderly Affairs and the Department of Children and Family Services to initiate demonstration projects on the effectiveness of comprehensive day treatment services to seniors and the developmentally disabled as a diversion from nursing home care enabling them to remain in their homes or communities.

If approved by the Governor, these provisions take effect July 1, 1999, except for section 16, relating to personnel screening, which will take effect upon the bill becoming a law. *Vote: Senate 39-0; House 118-0*

HB 2231 — Patient Self-Referral Act of 1992; Referrals for Diagnostic Imaging Services

by Health Care Services Committee and Rep. Peaden and others (CS/SB 2438 by Health, Aging & Long-Term Care Committee and Senator Latvala)

The bill amends the Patient Self-Referral Act of 1992 and addresses issues raised in the court opinion, *Agency for Health Care Administration v. Wingo*, 697 So.2d 1231 (1st DCA June 1997). Specifically, the bill amends the "Patient Self-Referral Act of 1992" to:

- Add definitions for: "diagnostic imaging services," "direct supervision," "outside referral for diagnostic imaging services," "patient of a group practice" or "patient of a sole provider," "present in the office suite," and "sole provider," and substantially modifies the definition of the term "referral."

- Authorize referrals to sole providers and group practices for diagnostic imaging services, excluding radiation therapy services, under certain circumstances, effective July 1, 1999. In order to accept such referrals, the sole provider or group practice must bill both the technical and the professional fee for or on behalf of the patient, if the referring physician has no investment interest in the practice. The diagnostic imaging service referred must be a diagnostic imaging service normally provided within the scope of practice of the sole provider or group practice. Such sole providers and group practices may accept no more than 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.

- Establish conditions for sole providers and group practices to accept outside referrals for diagnostic imaging services relating to practice employment, equity ownership, practice management, billing, Medicaid service delivery, and annual report requirements.

- Impose penalties for those sole providers and group practices that violate the conditions placed on accepting referrals for diagnostic imaging services or the percentage requirements set above, consistent with existing penalty provisions under the Act.

- Require the submission of an annual attestation by each managing physician member of a group practice and each sole provider to the Agency for Health Care Administration (AHCA) confirming compliance with referral limitations.

The bill requires group practices providing diagnostic imaging services to register with AHCA, specifies registration information to be included, and requires registration to be completed by December 31, 1999.

The bill modifies the contingent effective date enacted in 1998, for the removal of the Public Medical Assistance Trust Fund assessment on outpatient radiation therapy services and freestanding radiation therapy centers. If the Health Care Financing Administration notifies AHCA, in writing, between April 15, 1999, and November 15, 1999, that the removal of the assessment violates Federal regulations, then the removal of the assessment is repealed. The repeal will take effect upon the date that the Secretary of State receives notification from AHCA of the Federal determination.

The bill requires AHCA, in conjunction with other agencies as appropriate, to conduct a detailed study and analysis of clinical laboratory services for kidney dialysis patients in Florida; certain issues are specified for study; and AHCA must report its findings to the Legislature by February 1, 2000.

Certificate-of-need rules and AHCA rules are applied to all providers of adult inpatient diagnostic cardiac catheterization programs, including certain national professional guidelines relating to such services.

The law relating to the sale or lease of a public hospital to a private entity is clarified to specify that the transaction, unless otherwise expressly stated in the lease documents, does not subject the private entity to the Public Records Law or the Public Meetings Law. Also, a private lessee operating under a lease may not be construed to be *acting on behalf of* the public lessor.

The bill allows a person to sue for treble damages, reasonable attorney's fees, and costs for *willful* disclosure of certain confidential information protected under s. 455.651, F.S.

The bill contains clarifying and remedial language, effective retroactively to October 1, 1990, pertaining to the State's Medicaid tobacco litigation that applies to all causes of action arising after October 1, 1990, under the Medicaid third-party liability law, to *exempt from the guidelines for distribution of funds remaining* from a recovery or other collection of monies from a responsible liable party on behalf of a Medicaid-eligible person, after all expenses are paid to reimburse the state and the federal government, the requirement that the remainder of such funds be distributed to the Medicaid recipient.

The bill creates the Florida Community Health Protection Act to establish community health pilot projects in certain specified low-income rural and urban communities in Pinellas, Escambia, Hillsborough, Pasco, Manatee, Palm Beach, and Broward Counties, and the City of St. Petersburg; under the Act, certain duties are delegated to the Department of Health, including preparation of a report to be submitted, by January 1, 2001, to the President of the Senate, the Speaker of the House of Representatives, and the Governor presenting findings, accomplishments, and recommendations of the pilot projects.

The bill requires exclusive provider organizations (EPO) and health maintenance organizations (HMO) to allow direct access for their female subscribers to a contracted obstetrician/gynecologist for one annual visit and medically necessary follow-up care detected during the annual visit, but authorizes EPOs and HMOs to require an obstetrician/gynecologist treating a covered patient to coordinate the medical care provided through the patient's primary care physician, if applicable.

If approved by the Governor, these provisions take effect July 1, 1999, except that sections 10 and 11, relating to establishment of the community health pilot projects, are effective October 1, 1999, and this effective date applies to contracts issued or renewed on or after that date.
Vote: Senate 40-0; House 117-0

CS/SB 2360 — Home Health Agency Regulation

by Health, Aging & Long-Term Care Committee and Senator Thomas

The bill substantially revises provisions relating to licensure of home health agencies and nurse registries, and registration requirements for homemaker, companion, and sitter service providers. Generally, the bill amends ch. 400, part IV, F.S., to: (1) create several new definitions, many containing substantive language, and revise several existing definitions; (2) authorize continuing care facilities or certain residential facilities serving retired military personnel to request one home health agency license for provision of services to their residents and for provision of non-Medicare reimbursed home health services to persons in one or more counties within the Agency for Health Care Administration (AHCA) service district in which the facility has been licensed to provide home health services to its residents; (3) revise the list of entities and professionals exempted from home health agency licensure; (4) revise licensure application requirements relating to documentation; (5) delineate regulatory deficiencies within a classification structure with a class I deficiency designated the most egregious and a class IV the least egregious; (6) revise requirements relating to patient care plans, distinguishing between patients receiving skilled care and those who are not receiving that level of care; (7) add authority for an unlicensed person to assist patients with self-administration of certain medications under specified circumstances; (8) provide supervision requirements for all home health agency personnel and authorize AHCA to establish the curriculum and instructor qualifications for home health aide training and permit home health agencies to provide such training; (9) require nurse registries to license each operational site, unless there is more than one such site within a county, and authorize nurse registries to refer home health aides who meet certain training requirements under the same circumstances and limitations that nurse registries refer certified nursing assistants; (10) exempt domestic maid services and sitter services from registration requirements while retaining the registration requirement for homemaker and companion services providers; (11) delete sitters from employment screening requirements, require contractor screening, and establish alternative proofs of compliance with employment screening requirements; and (12) create a task force on home health agency licensure that is to submit its report to the Legislature by December 31, 1999.

Additionally, the bill: (1) authorizes AHCA to adopt rules providing for cooling standards in nursing homes and the Department of Elderly Affairs to adopt rules providing for cooling standards in assisted living facilities, and (2) provides for physician licensure of

certain persons who received their medical education in a country other than the United States and limits the amount that the Department of Health is authorized to charge foreign-licensed physicians as a fee to cover the cost of administering the licensure examination.

If approved by the Governor, these provisions take effect October 1, 1999.
Vote: Senate 38-0; House 119-0

AUTHORIZATION FOR MEDICAL TREATMENT AND CARE

CS/HB 213 — Guardianship

by Real Property & Probate Committee and Rep. Crow (CS/SB 702 by Health, Aging & Long-Term Care Committee and Senator Forman)

The bill modifies several provisions of the state's guardianship law. It extends from 15 to 30 days the time within which a circuit court must review the annual guardianship report and authorizes the circuit courts, in their review of guardianship reports, to require an appointed general or special master to conduct random field audits. Guidelines providing reasons for removing a guardian are modified to allow for removal of the guardian upon a showing that the guardian is not related to the ward or that removal is in the best interest of the ward *by a person who is related to the ward, as specified in law*, and who has not previously been rejected by the court as a guardian irrespective of whether or not that person can show that he or she did not receive notice of the petition for adjudication of incapacity of the ward, as is currently required.

The circuit court in the circuit in which a guardian serves may require a nonprofessional guardian and must require a professional or public guardian to submit, at the guardian's own expense, to a credit history and criminal background check. The clerk of the circuit court in which the guardian serves is required to obtain fingerprint cards from the Federal Bureau of Investigation and make them available to guardians who are required to submit their fingerprints. The guardian must forward the completed card to the Florida Department of Law Enforcement for processing; professional guardians are required to accompany their card with a $5 fee for handling and processing. The clerk of the circuit court in the circuit in which the guardian will serve is designated to receive the results of the federal and state fingerprint background checks on affected guardians and must maintain the results in a guardian file and make the results available to the circuit court. When a guardian is required to submit to a credit or criminal background investigation, the court must consider the results of such investigations in appointing the guardian.

The bill creates the Statewide Public Guardianship Office (Office) within the Department of Elderly Affairs (department or DOEA), and transfers all powers, duties, functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds relating to the public guardianship program from the circuit court budget entity within the judicial branch in the General Appropriations Act to DOEA. The Office is headed by an executive director who is appointed by the Governor, and serves at the pleasure of and reports to the Governor. The department is required to provide administrative support and service to the Office to the extent requested by the executive director within the available resources of the department, however, the Office is *not* subject to the control, supervision, or direction by DOEA in the performance of its duties. The Office may request the assistance of the department's Inspector General in providing auditing services, and the department's Office of General Counsel is authorized to assist in rulemaking and other matters as needed to assist the Office.

The Statewide Public Guardianship Office is delegated oversight responsibilities for all public guardians within available resources as well as rulemaking authority. In meeting its responsibilities, the Office: (1) must review the current public guardian program in Florida and other states; (2) in consultation with local guardianship offices, must develop statewide performance measures and standards; (3) must review the various methods of funding guardianship programs, the kinds of services being provided by such programs, and the demographics of the wards; (4) must review and make recommendations regarding the feasibility of recovering a portion or all of the costs of providing public guardianship services from the assets or income of the wards; (5) no later than October 1, 2000, must submit an interim report describing the progress of the Office in meeting its statutorily specified goals; (6) no later than October 1, 2001, and annually afterward provide a status report containing further recommendations relating to the need for public guardianship services and related issues, and submit a proposed public guardianship plan that includes alternatives for meeting the state's guardianship needs and must provide cost estimates for each alternative; (7) may assist local governments and entities in pursuing grant opportunities, must review and make recommendations in the annual report on the availability and efficacy of seeking Medicaid matching funds, and must diligently seek ways to use existing programs and services to meet the needs of public wards; (8) must develop a guardianship training program that may be offered to public or private guardians. Additionally, the Office is authorized to conduct or contract for demonstration projects to determine the feasibility or desirability of new concepts of organization, administration, financing, or service delivery designed to preserve the civil and constitutional rights of persons of marginal or diminished capacity using funds appropriated or through gifts, grants, or contributions for such purposes any of which, if received, must be deposited into the department's Administrative Trust Fund.

The executive director may, after consultation with the chief judge of the affected judicial circuit and other circuit judges within that circuit and other specified groups, individuals,

and organizations, establish an office of public guardian within a judicial circuit and if established, create a list of persons best qualified to serve as the public guardian, and appoint or contract with a person from that list to serve as the public guardian for the affected circuit, subject to the person submitting to credit and criminal background review. Following appointment or contracting with the person selected to serve as the public guardian of the affected judicial circuit, the executive director must notify, in writing, the chief judge of the judicial circuit and the Chief Justice of the Supreme Court of the appointment. Provision is made for "grandfathering in" public guardians currently serving, but transferring oversight of all public guardians to the Office at the time the bill becomes law, with clarification that the executive director is responsible for all future appointments of public guardians.

The term of office for a public guardian is four years, after which the executive director must review the appointment and may reappointment the public guardian for another term of up to four years. The executive director is delegated authority to suspend a public guardian with or without the request of the chief judge of the judicial circuit, and, under such circumstances, must appoint an acting public guardian as soon as possible to serve until such time as a permanent replacement is selected. Only the executive director is given authority to remove a public guardian from office. In removing a public guardian during the term of office, however, the executive director is required to consult with and consider a recommendation for removal of the chief judge of the judicial circuit before the removal.

Each local public guardian is required to prepare a budget for operation of the local office to be submitted to the Office, whether funding comes, in whole or in part, from local sources, grants, any other source, or whether funded, in whole or in part, by the state. Such information will be submitted by the Office, as appropriate, and included in DOEA's legislative budget request. Additionally, the judicial circuits may increase the $10 civil court filing fee cap to $15 and increase the $200 cap on the sum of all service charges and fees permitted on civil trial and appellate cases initiated in the judicial circuits to $210 to be used in establishing, maintaining, or supplementing local public guardian offices.

If approved by the Governor, these provisions take effect October 1, 1999, except that section two of the bill relating to removal of guardians takes effect upon the bill becoming a law.
Vote: Senate 39-0; House 117-0

CS/SB 1598 — Parental Notice of Abortion

by Judiciary Committee and Senators Bronson, Cowin, Brown-Waite, Sullivan, Grant, Lee and Webster

The bill creates s. 390.01115, F.S., the "Parental Notice of Abortion Act". The act requires a physician who refers a minor for termination of her pregnancy or who plans to perform such a procedure on a minor to first give 48 hours actual notice to one parent or her legal guardian prior to the procedure. If actual notice is not possible after reasonable effort has been made, 48 hours constructive notice must be given. The bill provides for waiver of the notice requirement: (1) in instances of a medical emergency; (2) when notice is waived in writing by the person who is entitled to notice; (3) if the minor is or has been married or has had the disability of nonage removed under s. 743.015, F.S., or a similar law of other states; (4) if the minor has a minor child dependent on her; or (5) when a circuit court judicially waives the notice requirement. The bill specifies the procedure for the judicial waiver of notice. The bill makes violations of the notice requirements subject to the disciplinary provisions of the medical and osteopathic medical practice acts.

If approved by the Governor, the act takes effect July 1, 1999.
Vote: Senate 27-12; House 91-27

CS/CS/SB 2228 — End-of-Life Care

by Judiciary Committee; Health, Aging & Long-Term Care Committee; and Senator Klein

The bill provides legislative findings related to end-of-life care, including pain management and palliative care. Laws governing advance directives and anatomical gifts are revised to incorporate findings and recommendations of the Panel for the Study of End-of-Life Care. The bill also provides for demonstration projects and studies.

Living Wills, Other Advance Directives, and Documents

The law relating to advance directives is modified to more equally emphasize the mental and the physical condition of a person in determining whether an advance directive may be acted upon or, in the absence of an advance directive or a health care surrogate, under what circumstances a proxy or a health care facility may authorize the withholding or withdrawing of life-prolonging procedures. The requisite underlying physical conditions on which a decision to honor an advance directive or authorize the withholding or withdrawing of life-prolonging procedures may be based, when there is no advance directive or health care surrogate, are expanded in the bill to include, in addition to a terminal condition: (1) an end-stage condition or (2) a persistent vegetative state.

Health care providers and health care facilities are explicitly prohibited from requiring a patient to execute an advance directive, or to use the facility's or provider's forms. The

bill requires a patient's advance directive to be made a part of the patient's medical record. Additionally, the bill modifies existing law to require a health care provider or facility that refuses to comply with *a patient's advance directive* to make reasonable efforts to transfer the patient to another health care provider or facility that will comply with the directive or treatment decision ***and***, if refusal to comply with the directive *or the treatment decision of the patient's surrogate* is based on moral or ethical beliefs, to transfer the patient or comply with the directive or surrogate's treatment decision within seven days, as currently required by law. The bill clarifies that the law relating to advance directives is inapplicable to a person who *never had capacity* to designate a health care surrogate or to execute a living will.

The bill revises the procedure for making a living will to authorize any competent adult to make a living will or written declaration to direct the provision, withholding, or withdrawal of life-prolonging procedures when the person has either a terminal condition, an end-stage condition, or is in a persistent vegetative state. The *suggested* statutory living will form is modified to add, as the triple triggers for acting on an executed living will, determination that the executor is *both mentally and physically incapacitated*, has either a terminal condition, an end-stage condition, *or* is in a persistent vegetative state, ***and*** the determination by the person's attending or treating physician and another consulting physician that there is no *reasonable* medical probability of the person's recovery. The bill explicitly authorizes a person to amend his or her advance directive or designation of a health care surrogate, in addition to already existing authority to revoke such documents, and subjects any person who falsifies, forges, or who willfully conceals, cancels, or destroys another's advance directive or amendment of such a document to criminal penalties.

The Department of Health (DOH), in consultation with the Department of Elderly Affairs, and the Agency for Health Care Administration, is directed to develop a standardized do-not-resuscitate-order (DNRO) identification system with devices that indicate that a patient has a DNRO. The Department of Health may charge a fee to cover the cost of producing and distributing such devices.

The bill amends numerous provisions of existing law to immunize health care professionals, staff working in various health care facilities, and health care providers operating health care facilities from liability relating to honoring do-not-resuscitate orders. The bill explicitly authorizes health care professionals and health care providers to withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate that has been executed in accordance with Florida law and protects such professionals and providers when working in the following settings or operating as follows: (1) hospitals, (2) nursing homes, (3) assisted living facilities, (4) home health agencies, (5) hospices, and (6) adult family-care homes.

Consent

The law governing authority for a health care surrogate, a health care professional, or proxy to act according to instructions contained in an advance directive requires that the principal *does not have the capacity* to make necessary decisions about health care needs or to give informed consent for necessary medical care *contemporaneously* with needing therapeutic medical care for treatment of a health need that is not considered to be life ending or with having a terminal condition, end-stage condition, or being in a persistent vegetative state as well as, in the case of a proxy, no designation of a surrogate. The bill adds a requirement to law that the physician, after concluding that the principal lacks the capacity to make health care decisions or to give informed consent, must enter such an evaluation in the principal's medical record, in addition to the current requirement that such an evaluation be entered into the principal's clinical record. Additionally, before a health care surrogate or a health care professional may act on instructions contained in a living will, two conditions must be satisfied: (1) there is no reasonable *medical* probability that the principal will recover *capacity* to make medical decisions or provide informed consent for himself or herself and (2) the principal has a terminal condition, an end-stage condition, or is in a persistent vegetative state.

Health care surrogates are empowered to act on behalf of their principals under terms of an advance directive, which may be only the designation of the surrogate. A surrogate's authority to act on behalf of his or her principal is expanded to allow surrogates to authorize the discharge of the principal to or from a health care facility or other facility or program licensed under the state's law regulating long-term care providers (i.e., nursing homes, assisted living facilities, home health, adult family-care homes, adult day care centers, hospice, and transitional living facilities). When there is no living will, the standard that a surrogate must apply to forego medical treatment on behalf of his or her principal is revised to require that the surrogate be *satisfied* that: (1) there is no *medical* probability that the principal will recover *capacity* to make medical decisions or to provide informed consent ***and*** (2) that the principal is both *mentally and physically incapacitated with no reasonable medical probability of recovery, the patient has an end-stage condition, the patient is in a persistent vegetative state,* or that the patient's physical condition is terminal.

The bill amends the law governing health care proxies, to require a proxy's decision to withhold or withdraw life-prolonging procedures *be supported by a written declaration* or, *if there is no written declaration, the patient must have a terminal condition, an end-stage condition, or be in a persistent vegetative state*. A new provision of law is created for situations in which a decision is under consideration to withhold or withdraw life-prolonging procedures for a person in a persistent vegetative state and when the person has no advance directive, has provided no evidence indicating what the person would have wanted under the circumstances, and for whom, after reasonably diligent inquiry, no

family or friends are available or willing to serve as the person's proxy to make health care decisions for him or her. Decisions to withhold or withdraw life-prolonging procedures may be made under the following conditions: (1) a judicially appointed guardian, with authority to consent to medical treatment, is appointed to represent such person's best interest; and (2) the guardian and the person's attending physician, in consultation with the medical ethics committee of the facility, or the medical ethics committee of another facility or with a community-based ethics committee approved by the Florida Bio-ethics Network, where the person is located, conclude that the condition is permanent and that there is no reasonable medical probability for recovery and the withholding or withdrawing of life-prolonging procedures is in the best interest of the patient. Individual ethics committee members and the facility associated with the ethics committee may not be held liable in any civil action related to the performance of any duties required in making such a decision as provided in law.

Anatomical Gifts

The bill revises the law relating to regulation of anatomical gifts to provide that a person's surrogate, designated under state law, *may* donate all or any part of the deceased person's body as an anatomical gift when the person who has not signed an organ and tissue donor card, expressed his or her wish to donate in a living will or advance directive, or signified his or her intent to donate on his or her driver's license, or in some other written form has indicated his or her wish to make an anatomical gift. The procedure for obtaining an anatomical gift from a deceased person who has not executed a written agreement or designated a surrogate that provides for a list of classes of persons to consent to such a gift is modified to add a precondition that such classes of persons may authorize a gift of all or any part of the deceased person's body in the priority that they are listed *in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class*. Existing law is also revised to require hospital administrators to request consent for an organ or tissue donation from the deceased person's health care surrogate or, if the decedent has not designated a health care surrogate or the surrogate is not reasonably available, a person listed in the priority list of persons who may consent to an anatomical gift under state law, when the decedent has not executed a donor card or document.

Studies and Projects

The bill provides for several studies and for on-going educational enhancements relating to end-of-life care for the public and health care professionals. These include:

- The Secretary of DOH is authorized to develop and implement up to two demonstration projects to evaluate strategies recommended by the Panel. The department is authorized to apply for grants, and accept donations. The Secretary

will report the results of the demonstration projects to the Legislature no later than January 30 of each year.

- The Chancellor of the State University System is requested to convene a working group to review available curricula for end-of-life care and make recommendations through the respective boards for content and materials to be included in the curriculum of each medical, social work, and allied health discipline's school.

- The Department of Elderly Affairs is directed to convene a workgroup to develop model advance directive forms and to make the forms available to the public, and authorizes the department to reconvene the workgroup as necessary.

If approved by the Governor, these provisions take effect October 1, 1999, except that advance directives made prior to October 1, 1999, must be given effect *as executed*, provided such directive was legally effective when written.
Vote: Senate 37-0; House 116-0