Senate Committee on Health, Aging and Long-Term Care

DEPARTMENT OF HEALTH

CS/CS/SB 352 — Women and Heart Disease Task Force

by Fiscal Policy Committee; Health, Aging & Long-Term Care Committee; and Senator King

This bill creates the Women and Heart Disease Task Force within the Department of Health. The task force is comprised of the Secretary of Health or a designee, the Executive Director of the Agency for Health Care Administration or a designee, and the Insurance Commissioner or a designee, and 28 members who are to be appointed by July 15, 2000, by the Governor, the President of the Senate, and the Speaker of the House of Representatives. The bill requires that at least one representative appointed by each appointing entity must be a member of an ethnic or racial minority and at least one-half of the members appointed by each appointing entity must be women. The task force is to meet as often as necessary to carry out its duties and responsibilities and will exist for a 2-year period that ends July 1, 2002.

The task force is charged with identifying where public awareness, public education, research, and coordination regarding women and heart disease is lacking; collecting research and information on heart disease in women; preparing recommendations to establish research on the reasons women suffer more severe first heart attacks than men and the reasons women die more often from heart attacks; and increasing the public's awareness of the importance of identifying the symptoms of, and treating, heart disease in women. The task force is empowered to obtain information and assistance from any state agency and all state agencies are required to give the task force all relevant information and reasonable assistance on matters related to heart disease.

The task force is required to submit a report to the Governor and the Legislature by January 15, 2002, that contains its recommendations and proposed legislation for reducing the incidence and the number of women's deaths related to heart disease in Florida and other specified information. The task force's recommendations must provide a plan for reducing the number of deaths related to heart disease in Florida, a plan for increasing research and appropriate funding at Florida institutions studying heart disease in women, for the development of practice guidelines for addressing heart disease in women, and a program to monitor the implementation and effectiveness of the task force's recommendations.

The bill appropriates $100,000 from the General Revenue Fund to the Department of Health for FY 2000-2001 and FY 2001-2002 for a total appropriation of $200,000 during the existence of the task force. Appropriated funds must be used to produce or purchase and to distribute summaries in English, Spanish, and Creole which inform women patients about their risk of heart disease and about treatment alternatives for heart disease. Additionally, the appropriated funds must be used to develop and implement an educational program that includes the distribution of information specific to women and heart disease.

These provisions were approved by the Governor and take effect July 1, 2000.
Vote: Senate 38-0; House 106-0

CS/SB 1412 — Public Swimming and Bathing Places

by Health, Aging & Long-Term Care Committee and Senators Childers and Latvala

The bill pertains to regulation of water quality of public beaches in Florida. The bill adds coastal and intracoastal waters to the statutory definition of public bathing places and permits the Department of Health to adopt and enforce rules to protect the health of persons using beach waters of the state, including establishment of health standards, procedures, and time frames for bacteriological sampling of beach waters. The bill permits the department to issue health advisories if the quality of beach water fails to meet standards established by the department, and specifies that the issuance of health advisories related to beach water sampling is preempted to the state. “Beach waters” are defined in the bill as waters along the coastal and intracoastal beaches, including both salt and brackish water. The bill exempts coastal and intracoastal beaches from construction and operating permit requirements applicable to other public swimming and bathing facilities. The bill authorizes, subject to a legislative appropriation, a nonrecurring sum of $600,000 to the Department of Health to perform a 3 year study to determine the water quality at beaches throughout the state and to determine which indicator organism and the levels of such organism are best suited with respect to bacteriological sampling to determine the safety of beach waters, and to establish a statewide model to help predict when possible water quality problems will occur.

The bill requires the Department of Health to form an interagency technical advisory committee to oversee the performance of the studies in the bill, and to advise it in rulemaking pertaining to coastal and intracoastal public bathing places. The committee consists of equal numbers of staff of the Department of Health and the Department of Environmental Protection having expertise in the subject matter of the studies. Members are to be appointed by the respective secretaries and the committee is to be chaired by a Department of Health representative.

The bill appropriates $745,000 from the Ecosystem Management and Restoration Trust Fund to the Department of Environmental Protection, Division of Water Resource Management, Beach Management Program to be transferred to the Department of Health. In addition, the sum of $745,000 is appropriated from the County Health Department Trust Fund in the Department of Health for a 2-year "Healthy Beaches" study in the coastal waters of Escambia and Santa Rosa counties and the Tampa Bay area of Pinellas county, to determine which indicator organism is best suited to be used with respect to Florida's waters and establish a statewide model to help predict when possible water-quality problems will occur.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 40-0; House 113-0

CS/SB 2034 — Health Care

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

Department of Health

This bill amends various provisions relating to the jurisdiction of the Department of Health (DOH or department) to better reflect the department's mission and functions. The bill takes care of a number of "glitches" identified by the department. The bill: consolidates certain planning functions into DOH's agency strategic plan; revises provisions to correct glitches resulting from the transfer of the Brain and Spinal Cord Injury Program and clarify DOH's authority over the program; updates provisions regarding the department's oversight of primary care services; authorizes DOH to adopt rules for primary care programs which provide for a definition of income to be used to determine eligibility or sliding fees; specifies that prevention should be a factor in the research conducted by the Biomedical Research Program; grants authority to establish an immunization registry; gives DOH access to medical and related records for cases of reported diseases of public health significance; authorizes the use of preliminary HIV test results in certain additional specified circumstances and revises the definition of "medical personnel" for HIV testing relating to a significant exposure; exempts persons who give group lectures from school health background screening requirements; revises continuing education requirements and other certification requirements for environmental health professionals; and makes numerous technical and conforming changes in the Florida Statutes.

The bill also authorizes the Department of Health to hold copyrights, trademarks, and service marks and enforce its rights with respect thereto, except the department's authority does not extend to any public records relating to the department's responsibilities for health care practitioners regulated under part II, ch. 455, F.S.

Community-Based Support Services

The bill requires the Department of Health, contingent upon a specific appropriation, to study the long-term needs for community-based support and services for individuals who have sustained traumatic brain or spinal cord injuries to prevent inappropriate residential and institutional placement of these individuals, and to promote placement in the most cost effective and least restrictive environment. The department must submit a report which outlines any placement recommendations for these individuals to the Governor and Legislature by December 31, 2000. The department must establish, by rule, a plan to implement long-term community-based supports and services for individuals who have sustained traumatic brain or spinal cord injuries who may be subject to inappropriate residential and institutional placement. The department must create, by rule, procedures to ensure, that in the event the program is unable to directly or indirectly provide such services to all eligible individuals due to lack of funds, those individuals most at risk to suffer the greatest harm from an imminent inappropriate residential or institutional placement are served first. Every applicant of the community-based supports and services program must have been a Florida resident for 1 year before application and be a Florida-resident at the time of application.

Hepatitis A Awareness Program

The Department of Health must develop a hepatitis A awareness program which includes information regarding the availability of hepatitis A vaccine. The department is authorized to work with private businesses and associations in developing the hepatitis A awareness program and in disseminating the information.

Jessie Trice Cancer Prevention Program

The bill establishes the Jessie Trice Cancer Prevention Program to reduce deaths and illness resulting from lung and other cancers among low income African-American and Hispanic populations by increasing access to screening and diagnosis, education, and treatment programs. The program is administratively housed in the Department of Health and will be operated through contracts with community health centers and local community faith-based education programs in low income communities in Dade and Lee Counties. Implementation of these requirements are contingent upon a specific appropriation for this purpose in the General Appropriations Act.

Alzheimer's Disease Day

The bill designates February 6th of each year as Florida Alzheimer's Disease Day.

Health Facilities Authority

The bill authorizes any health facilities authority, despite limitations in current law to the contrary, if it finds that there will be a benefit or a cost savings to a health facility located within its jurisdiction, to issue bonds for such health facility to finance projects for such health facility, or for another not-for-profit corporation under common control with such health facility, located outside the geographical limits of the local agency or outside this state.

Clinical Laboratory Services for Kidney Dialysis Patients Study

The bill extends the time for a study by the Agency for Health Care Administration of clinical laboratory services for kidney dialysis patients and appropriates $230,000 from the Agency for Health Care Administration Tobacco Settlement Trust Fund to the Agency for Health Care Administration to fund a contract with the University of South Florida to conduct a review of the quality and effectiveness of kidney dialysis treatment as well as the utilization and business arrangements related to kidney dialysis centers. A report on the findings must be submitted to the Legislature by February 1, 2001.

Florida Commission on Excellence in Health Care

The bill creates the Florida Commission on Excellence in Health Care and designates the Secretary of Health and the Director of Health Care Administration as co-chairs. The purpose of the commission is to develop a comprehensive statewide strategy for improving health care delivery systems through meaningful reporting standards, data collection and review, and quality measurement. In carrying out its various assigned responsibilities, the commission is required to sponsor public hearings. The bill explicitly prohibits use of information generated through the commission's work to be used for evidentiary purposes in legal or administrative proceedings.

The bill specifies membership and appointments to the 38-member commission which must consist of the Secretary of Health and the Director of Health Care Administration; one representative from each of the following agencies or organizations: the Board of Medicine, the Board of Osteopathic Medicine, the Board of Pharmacy, the Board of Dentistry, the Board of Nursing, the Florida Dental Association, the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Chiropractic Association, the Florida Chiropractic Society, the Florida Podiatric Medical Association, the Florida Nurses Association, the Florida Organization of Nursing Executives, the Florida Pharmacy Association, the Florida Society of Health System Pharmacists, Inc., the Florida Hospital Association, the Association of Community Hospitals and Health Systems of Florida, Inc., the Florida League of Health Systems, the Florida Health Care Risk Management Advisory Council, Inc., the Florida Statutory Teaching Hospital

Council, the Florida Statutory Rural Hospital Council, Inc., the Florida Association of Homes for the Aging, and the Florida Society for Respiratory Care; two health lawyers, appointed by the Secretary of Health; two representatives of the health insurance industry, appointed by the Director of Health Care Administration; five consumer advocates, including a representative of the Association for Responsible Medicine, two appointed by the Governor, one appointed by the President of the Senate and one appointed by the Speaker of the House of Representatives; two legislators; and one representative of a Florida medical school.

The commission is required to submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 2001; but, is to continue to exist until its termination date of June 1, 2001, for purposes of assisting the Department of Health, the Agency for Health Care Administration, and the regulatory boards in their drafting of proposed legislation and rules to implement the commission's recommendations and for purposes of providing information to the health care industry about its recommendations. An appropriation of $91,000 is made to the Department of Health from the General Revenue Fund to cover costs of travel and related expenses of staff and consumer members and for copying and distributing commission documents.

Medicaid Drug Spending Controls

The bill modifies Medicaid requirements relating to cost-effective purchasing of health care in order to implement a spending reduction in the proposed 2000-2001 General Appropriations Act. Because the reductions made within this program are recurring in nature and affect the base upon which future budgets will be built, permanent changes to the law are necessary. The bill requires the Agency for Health Care Administration (AHCA) to implement a Medicaid prescribed drug spending control program. Under the program, adult Medicaid beneficiaries not residing in nursing homes or other institutions will be limited to four brand-name prescription drugs per month per recipient and to no more than a 34-day supply. The agency is authorized to grant exceptions to the brand-name drug restrictions under certain circumstances. Children, institutionalized adults, anti-retroviral agents, and certain medications used to treat mental illnesses are exempt from this restriction. The bill requires the reimbursement level to pharmacies for Medicaid prescribed drugs to be set at the average wholesale price minus 13.25 percent. The bill also requires manufacturers of generic drugs prescribed to Medicaid patients to guarantee the state a rebate of at least 15.1 percent of the total Medicaid payment for their generic products. The bill requires AHCA to establish a process to manage the drug therapies of Medicaid recipients who require a significant number of prescribed medications each month, authorizes AHCA to limit the size of its pharmacy network, and requires AHCA to establish a program that requires Medicaid practitioners prescribing

drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency may contract for any or all portions of the program.

The bill creates a Medicaid Pharmaceutical and Therapeutics Committee to develop and implement a voluntary Medicaid preferred, prescribed drug designation program. The membership and appointing authorities are specified. Staff support for the committee is to be provided by the Agency for Health Care Administration.

Real Property Contracts

The bill requires each state agency to include in its standard contract document a requirement that any state funds provided for the purchase of or improvements to real property are contingent upon the contractor or political subdivision granting to the state a security interest in the property at least to the amount of state funds provided for at least 5 years from the date of purchase or the completion of the improvements or as further required by law.

Certificate of Need

The bill provides that, notwithstanding the provisions of CS/HB 2339 which was enacted earlier in the 2000 Regular Session of the Legislature, the establishment of a specialty hospital offering a range of medical services restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county, is not exempt from the requirements for a certificate of need under s. 408.036(1), F.S.

Long-Term Care Ombudsman Program

The bill makes changes to the State Long-Term Care Ombudsman program. The bill requires the State Long-Term Care Ombudsman to prepare an annual budget request, enter into cooperative agreements with the human rights advocacy committees and the office of state government responsible for investigating Medicaid fraud. The bill requires the Department of Elderly Affairs (DOEA) to meet the costs of providing administrative support to the ombudsman from appropriated funds; specifies that DOEA should capture these costs when preparing its Legislative Budget Request; and caps the percentage of federal program funds which can be diverted from the ombudsman program by the department. The bill revises the procedure for appointments to the State Long-Term Care Ombudsman Council and provides that the decision of the ombudsman is final when determining whether a member's three consecutive unexcused absences were without cause for purposes of determining if a vacancy exists. The bill limits membership on the State Council to two three-year terms. The bill provides for an appropriation for training

of newly appointed state and local ombudsmen and an appropriation for materials for public education and awareness training.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 38-0; House 112-0

CS/SB 2628 — Department of Health; Rule Authorizing Bill
by Health, Aging & Long-Term Care Committee and Senator Myers

The Department of Health (DOH) reported 203 rules, or portions thereof, to the Joint Administrative Procedures Committee, pursuant to s. 120.536(2)(b), F.S., as exceeding DOH's statutory rulemaking authority. This section requires the Legislature to determine whether specific legislation should be enacted to authorize the rules, or portions thereof, identified by the agency. This bill provides specific statutory authority to authorize the rules reported by DOH.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 39-0; House 119-0

AGENCY FOR HEALTH CARE ADMINISTRATION / MEDICAID

SB 212 — Health Care Assistance for Children
by Committee on Health, Aging and Long-Term Care, Senators Clary and Dawson

This bill modifies the Florida Kidcare program and provisions relating to subsidized child care.

Kidcare provisions

The bill requires the Social Services Estimating Conference to develop projections for the Florida Kidcare program; moves coverage for children 0-1 year of age from Medikids to Medicaid; removes the applicability of Medicaid third-party liability requirements to the Medikids program; allows mandatory assignment in the Medikids program; requires collection and analysis of data by the agencies that administer Kidcare program components; authorizes presumptive eligibility for Medicaid-eligible children; accelerates enrollment in other Kidcare program components; clarifies that, in the Children's Medical Services program component, a complete application includes a medical or behavioral health screening; requires that applicants be provided notice of changes in eligibility and that the program components cooperate to ensure continuity of health care coverage; adds a dental benefit to Kidcare; revises Kidcare evaluation requirements; directs the

Department of Children and Family Services to develop a redetermination process which enables a family to easily update changes in circumstances which could affect eligibility; prohibits linking a child's eligibility for Medicaid to eligibility determinations for other programs; and requires the Division of State Group Insurance and the Healthy Kids Corporation to study the feasibility of providing a subsidy, comparable to that of the Healthy Kids Corporation, through the state employee health insurance program for children of state employees who meet the eligibility requirements for the Healthy Kids Program.

Subsidized child care provisions

The bill modifies provisions relating to child care and early intervention to add: a requirement that child care agencies assist families in identifying, evaluating and choosing summer recreation and day camp programs; an extension of eligibility for subsidized child care to children whose family income does not exceed 200 percent of the Federal Poverty Level; an authorization for the Department of Children and Family Services to contract and adopt rules for administration of a scholarship program for personnel involved in child care; an increase in the age of children applying to the number of children served in large family child care homes from 12 to 13 years; procedures for level III assessments in the developmental assessment program for subsidized child care; a definition of "child enrichment service providers" and standards for such providers; inclusion of large-family child care homes in licensing standards for child care facilities; and a workgroup, contingent on an appropriation, to develop recommendations for improving health and safety of summer camp programs. The bill also deletes restrictions on the use of child care purchasing pool funds supplanting existing funds.

If approved by the Governor, these provisions take effect July 1, 2000.
Votes: Senate 39-0; House 118-0

CS/CS/SB 940 — Prescription Drugs for Medicare Participants

by Fiscal Policy Committee; Health, Aging & Long-Term Care Committee; and Senators Lee, Brown-Waite, Silver, Clary, Latvala, Saunders, Kurth, and Cowin.

The title of the bill is the "Prescription Affordability Act for Seniors." The bill creates a pharmaceutical expense assistance program for individuals who qualify for limited assistance under Medicaid as a result of being dually eligible for both Medicaid and Medicare and whose limited assistance or Medicare coverage does not include pharmacy benefits. Eligible individuals are Florida residents 65 years of age or older, who have incomes between 90 and 120 percent of the federal poverty level, are not enrolled in a Medicare Health Maintenance Organization that provides a pharmacy benefit, and request to be enrolled in the program. Medications covered under this program are those covered

under the Medicaid program. Monthly benefit payments are limited to $80 per program participant. Participants are required to make a 10 percent coinsurance payment for each prescription purchased through the program.

The program is to be administered by the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs. A single page application is to be developed for the program. The agency is required, by rule, to establish eligibility requirements, limits on participation, benefit limitations, a requirement for generic drug substitution and other program parameters comparable to those of the Medicaid program.

The bill requires an annual report, by January 1 of each year, to the Legislature on the operation and impact of the program. The bill states that the program is not an entitlement. In order for a drug product to be covered under the program, the product's manufacturer must provide a rebate equal to the rebate required by Medicaid and make the drug available to the program for the best price the manufacturer makes the drug available in the Medicaid program. Reimbursements to pharmacies under the program are to be equivalent to reimbursements under the Medicaid program.

The bill requires that, as a condition of participation in the Medicaid program or the pharmaceutical expense assistance program, a pharmacy must agree to charge any Medicare beneficiary who presents a Medicare card when they present a prescription a price no greater than the cost of ingredients equal to the average wholesale price minus 9 percent, and a dispensing fee of $4.50. In lieu of this requirement, and as a condition of participation in the Medicaid program or the pharmaceutical expense assistance program, a pharmacy must agree to provide a private, voluntary prescription discount program to state residents who are Medicare beneficiaries or accept a private voluntary discount prescription program from state residents who are Medicare beneficiaries. This discount must be at least as great as the discounts described above.

The bill appropriates $15 million from the General Revenue Fund to the Agency for Health Care Administration to implement the pharmaceutical expense assistance program effective January 1, 2001. Additionally, $250,000 is appropriated from the General Revenue Fund to the agency to administer the program. Rebates collected under for this program are to be used to help finance the program.

If approved by the Governor, these provisions take effect July 1, 2000
Vote: Senate 39-0; House 118-0

CS/HB 1129 — Medicaid Managed Behavioral Health Care

by Health and Human Services Appropriations Committee; Children & Families Committee; Rep. Murman and others (CS/SB 1046 by Health, Aging & Long-Term Care Committee and Senators Silver and Kirkpatrick)

The bill modifies the Agency for Health Care Administration's (AHCA) procurement of capitated inpatient and outpatient mental health services to: broaden the scope of services covered to include all mental health and substance abuse services available to Medicaid recipients; require that entities under contract posses the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients; require the Secretary of the Department of Children and Families to approve provisions of procurements related to children in the department's care and custody prior to enrolling such children in a prepaid behavioral health plan; require that contracts be competitively procured; require the agency to develop and implement a plan to ensure compliance with s. 394.4574, F.S., concerning care of persons in assisted living facilities holding limited mental health licenses; ensure choice of at least two managed behavioral health care plans; and allow the agency to reimburse substance abuse services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

The bill requires existing contracts in Hillsborough, Highlands, Hardee, Manatee, and Polk counties to be modified by January 1, 2001, to include substance abuse treatment services. The agency is required to contract by December 31, 2001 with entities providing comprehensive behavioral health care services to Medicaid recipients through prepaid arrangements in Charlotte, Collier, DeSoto, Escambia, Glades, Hendry, Lee, Okaloosa, Pasco, Pinellas, Santa Rosa, Sarasota, and Walton Counties. The bill permits the agency to contract for these services through capitated, prepaid arrangements in Alachua County, and allows the agency to determine if Sarasota County is to be included as a separate catchment area or included in any other agency geographic area.

The bill excludes children residing in a Department of Juvenile Justice residential program which has been approved as a Medicaid behavioral health overlay services provider from inclusion in a behavioral health care prepaid health plan.

In converting to a prepaid system of delivery, the agency, in its procurement document, shall require an entity providing comprehensive behavioral health care services to prevent the displacement of indigent patients by enrollees in the Medicaid behavioral health plan from facilities receiving state funding to provide indigent behavioral health care to facilities licensed under ch. 395 which do not receive state funding, or to reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent patient.

The bill requires traditional community and inpatient mental health providers to be offered the opportunity to accept or decline a contract to participate in a provider network for prepaid behavioral health care services.

The bill allows the agency to contract for comprehensive behavioral health care services with an entity which provides such services through an administrative services organization agreement.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 38-0; House 114-0

HB 2037 — Health Care; Reorganization of the Agency for Health Care Administration by Reps. Farkas and Bloom (CS/SB 2132 by Health, Aging & Long-Term Care Committee and Senator Lee)

This bill establishes the Public Cord Blood Tissue Bank as a statewide nonprofit collaborative consortium comprised of the University of Florida, the University of South Florida, the University of Miami, and the Mayo Clinic in Jacksonville. The consortium is encouraged to conduct outreach and research for Hispanics, African Americans, Native Americans, and other ethnic and racial minorities. Each consortium member is required to work with community resources such as regional blood banks, hospitals, and other health care providers to develop local and regional coalitions to collect, screen for infectious and genetic diseases, perform tissue typing, cryopreserve, and store umbilical cord blood as a resource to the public. To fund the Public Cord Blood Tissue Bank, consortium participants, the Agency for Health Care Administration, and the Department of Health must seek private or federal funds to initiate program actions for FY 2000-2001.

The Agency for Health Care Administration and the Department of Health are required to encourage health care providers, including, but not limited to, hospitals, birthing facilities, county health departments, physicians, midwives, and nurses, to disseminate information about the Public Cord Blood Tissue Bank. It is clarified, however, that no requirement is being imposed on a health care or services program that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices the tenet that blood transfer is contrary to the moral principles the denomination considers to be an essential part of its beliefs. A collector of umbilical cord blood that is remunerated for the collection is required to give written disclosure about such remuneration to any woman postpartum or parent of a newborn from whom the umbilical cord blood is collected prior to harvesting it. Hospitals and birthing facilities are explicitly authorized to offer a woman admitted to such facilities the opportunity to donate umbilical cord blood to the Public Cord Blood Tissue Bank, but a woman may not be required to make such a donation. The consortium is authorized to charge reasonable rates and fees to recipients of cord blood tissue bank products.

The Agency for Health Care Administration was created in s. 20.42, F.S., in 1992 and placed, for organizational purposes only, under what is now the Department of Business and Professional Regulation. The Director of Health Care Administration, the head of the agency, is not required to answer to the secretary of the department nor was the agency subject to the administrative supervision of the department.

The bill re-creates the Agency for Health Care Administration as a department that will be known by the same name. The head of the new department is the secretary, who is subject to Senate confirmation. The department is designated the chief health policy and planning entity for the state. The internal structure of the department, currently established in statute, is repealed and replaced with explicit delegation of the department's responsibilities, which include: health facility licensure, inspection, and regulatory enforcement; investigation of consumer complaints related to health care facilities and managed care plans; the implementation of the certificate-of-need program; the operation of the State Center for Health Statistics; the administration of the Medicaid program; the administration of the contracts with the Florida Healthy Kids Corporation; the quality-of-care certification of health maintenance organizations and prepaid health clinics; and any other duties prescribed by statute or agreement.

The provision of law that established the Florida Health Care Purchasing Cooperative is repealed effective December 31, 2000, or upon dissolution of the Cooperative, whichever occurs first.

If approved by the Governor, these provisions take effect October 1, 2000.
Vote: Senate 40-0; House 119-0

CS/HB 2329 — Health Care

by Health Care Services Committee, Rep. Peaden and others (CS/SB 2242 by Health, Aging and Long-Term Care Committee and Senator Saunders)

This bill modifies a number of provisions of law relating to the Medicaid program.

Medicaid Fraud Control Unit

The bill provides express exemptions for the Medicaid Fraud Control Unit of the Department of Legal Affairs in several confidential medical records provisions contained in the Florida Statutes. The bill also provides that investigators employed by the Medicaid Fraud Control Unit have the authority to apply for, serve, and execute "...other process" throughout the state pertaining to Medicaid fraud.

Optional State Supplementation

The bill increases the optional state supplementation rate by the federal cost-of-living adjustment provided the average state optional supplementation contribution does not increase.

Medicaid eligibility rule-making authority

The bill restores rule making authority to the Department of Children and Family Services with respect to Medicaid eligibility determinations and clarifies responsibilities relating to this function.

Transfer of General Revenue funds between agencies

The bill authorizes the transfer of specified funds to the Agency for Health Care Administration (AHCA) from the Department of Children and Family Services to provide additional state match for targeted case management services and from the Department of Elderly Affairs unexpended funds for the Assisted Living for the Elderly Medicaid waiver to fund Medicaid-reimbursed nursing home care.

Medicaid provider enrollment

The bill broadens the ability of AHCA to designate other agencies to perform onsite inspections of Medicaid providers and to expand the maximum amount of a surety bond the agency may require of a prospective or currently participating provider which is reimbursed on a fee-for-service basis or fee schedule basis which is not cost-based from $50,000 to the total amount billed by the provider during the current or most recent calendar year, whichever is greater. For providers who are new to the program, the agency may base the surety bond on the provider's estimate of its first year billings. In the instance that the provider's actual first year billings exceed these estimates, the agency may require the provider to acquire an additional bond in an amount such that the aggregate amount of the surety bonds equals the amount billed by the provider. A provider's bond shall not exceed $50,000 if a physician or physician group licensed under ch. 458, 459, or 460 has a 50 percent or greater ownership interest in the provider, or if the provider is an assisted living facility licensed under ch. 400, part III.

The bill expands the grounds on which the agency may deny a provider's application to become a Medicaid provider to include if the agency finds that, for any reason, the provider's participation could affect the efficient and effective administration of the program, including the current availability of medical care, taking into consideration geographic location and reasonable travel time.

Medicaid reimbursement changes

The bill increases the annual adult hospital outpatient services cap under the Medicaid program from $1,000 to $1,500 per state fiscal year per recipient.

The bill imposes conditions on the inclusion of nursing home liability insurance costs in the calculation of nursing home interim rate adjustments under Medicaid. The agency is required to report on the cost of liability insurance for Florida nursing homes for fiscal years 1999 and 2000 and the extent to which these costs are not being compensated by the Medicaid program. Medicaid-participating nursing homes are required to report to the agency information necessary to compile the report.

The bill provides findings that there has been confusion regarding Medicaid reimbursement for services rendered to dually eligible Medicare beneficiaries, and clarifies that it has always been the intent of the Legislature, before and after 1991, to reimburse physician services at the lesser of physician billings or the Medicaid maximum fee, and that it has never been the intent of the Legislature that Medicaid be required to provide payment in excess of the state Medicaid plan for such services.

The bill requires the agency to develop and implement a disproportionate share program for hospitals licensed as specialty hospitals for children as of January 1, 2000. Counties are exempt from contributing toward the cost of this special reimbursement. The bill establishes a formula for calculating the additional payment for hospitals participating in the program; requires that hospitals must be in full compliance with applicable rules of the agency to receive payments under the section; and specifies that a hospital that is not in compliance for two or more consecutive quarters may not receive its share of the funds, which are redistributed to the remaining participating hospitals that are in compliance.

The bill authorizes AHCA, at its discretion, to renew its contract or contracts for fiscal intermediary services one or more times for such periods as AHCA may decide, provided such renewals not combine to exceed the term of the initial contract.

The bill authorizes university laboratory schools to participate in Medicaid certified school match funding.

The bill directs the agency to seek a federal waiver for a demonstration project for a system of care for ventilator-dependent patients over age 21. The waiver must be submitted by September 1, 2000.

Long-Term Care Community Diversion Pilot Projects

The bill modifies the authority of the Department of Elderly Affairs in contracting for long-term care community diversion services by providing a definition of "other qualified provider" as an entity licensed under chapter 400 that demonstrates a long-term care continuum, posts a $500,000 performance bond and meets all the financial and quality assurance requirements for a provider services network as specified in s. 409.912, F.S., and all requirements pursuant to an interagency agreement between AHCA and the Department of Elderly Affairs (DOEA)

The bill authorizes DOEA to contract, on a prepaid basis, with other qualified providers (as defined above) to provide long-term care within community diversion pilot project areas and directs AHCA to evaluate and report quarterly to DOEA the compliance by other qualified providers with all financial and quality assurance requirements of the contract.

Florida Alzheimer's day

The bill designates February 6th of each year as Florida Alzheimer's Disease Day.

Prepaid Health Plans

The bill repeals s. 409.912(4)(b), F.S., relating to AHCA's ability to contract for prepaid health care services with entities that provide only Medicaid services on a prepaid basis, and which are exempt from part I of ch. 641, F.S.

Graduate Medical Education Funding

The bill amends "The Community Hospital Education Act," to: emphasize primary care training as opposed to family practice program training; provide additional detail as to eligibility for funding based on training slots, the timing of the creation of training slots, and accreditation status; provide a means to seek available federal matching funds for graduate medical education purposes; specify primary care specialties; provide for a Program for Graduate Medical Education Innovation, to the extent funded, designed to provide funds on a grant or formula basis to achieve state health care workforce policy objectives; specify that the Board of Regents quarterly certify to AHCA those hospitals eligible for matching funds; and specify the committee on graduate medical education (GME) as part of the Community Hospital Education Act, the purpose of which is to provide an annual report on GME funding.

The bill amends the definition of "teaching hospital," in s. 408.07(44), F.S., to make the definition specific to Florida hospitals and medical schools, specify the accreditation

entity, base resident slots on full-time equivalent positions, and specify that AHCA determine the hospitals that meet the definition.

The bill revises Medicaid limitations for hospital inpatient services to provide exceptions for: raising reimbursement caps, recognition of the costs associated with graduate medical education, and other methodologies provided in the General Appropriations Act. The bill authorizes AHCA to receive funds from certain entities for these reimbursements and provides an exception from county contribution requirements for such reimbursements.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 38-0; House 117-0

REGULATION OF HEALTH CARE PRACTIONERS, FACILITIES, SERVICES AND BUSINESSES

CS/HB 399 — Newborn Hearing Screening

by Health Care Services Committee, Rep. Prieguez and others (CS/SB 1428 by Health, Aging & Long-Term Care Committee and Senator Dawson)

The bill establishes a statewide program of universal hearing impairment screening, identification, and follow-up care for newborns and infants. The bill requires licensed hospitals or other state-licensed birthing facilities to provide for universal hearing screening for all newborns, prior to discharge from the facility. Licensed birth centers are required to refer all newborns, prior to discharge, for hearing screening. In the instance of a home birth, the health care provider in attendance is responsible for referral for the hearing screening. The bill requires the initial screening procedure and any medically necessary follow-up reevaluations leading to diagnosis to be a covered benefit under Medicaid. Health insurance policies and health maintenance organizations are required to compensate providers for "the covered benefit at the contracted rate." The bill requires that non-insured persons who cannot afford the testing must be given a list of newborn hearing screening providers who will provide the testing free of charge.

If approved by the Governor, these provisions take effect July 1, 2000
Vote: Senate 40-0; House 113-0

CS/CS/HB 591 — Health Care

by Governmental Rules & Regulations Committee; Health Care Licensing & Regulation Committee; Rep. Minton and others (CS/SB 420 by Health, Aging & Long-Term Care Committee and Senator Clary)

Unlicensed Assisted Living Facilities

The bill requires each local field office of the Agency for Health Care Administration (AHCA) to establish a local coordinating workgroup which includes representatives of local law enforcement agencies, state attorneys, local fire authorities, the Department of Children and Family Services, the district long-term care ombudsman council, and the district human rights advocacy committee to assist in identifying the operation of unlicensed assisted living facilities (ALFs) and to develop and implement a plan to ensure effective enforcement of state laws relating to unlicensed ALF's to prevent the operation of such facilities. The workgroups are required to report their respective findings, actions, and recommendations semi-annually to the Director of Health Facility Regulation at AHCA.

The bill requires a health care practitioner, when aware of the operation of an unlicensed ALF, to report it to AHCA. The bill provides for sanctioning, by reporting to the health care practitioner's licensing board, for failure to report an unlicensed ALF or ALF that the practitioner knows, or has reasonable cause to suspect, is unlicensed. A hospital or community mental health center may be sanctioned by AHCA for knowingly discharging a patient or client to an ALF that the hospital or community mental health center *knows* to be unlicensed. Additionally, the bill adds paramedics, emergency medical technicians, and employees of the Department of Business and Professional Regulation who conduct inspections of certain public lodging establishments to the list of persons who must report abuse, neglect, or exploitation of disabled adults or elderly persons.

Certificate-of-Need Regulation

This bill amends the certificate-of-need (CON) law by moving certain projects from *comparative* (full) review to *expedited* review. These projects include conversion of mental health services beds or hospital-based distinct part skilled nursing unit beds to acute care beds, conversion between or among the categories of mental health services beds and conversion of acute care beds to mental health services beds.

Additionally, certain projects that are currently subject to expedited review are made subject to the minimal level of review under CON regulation, that is, *exemption* review. These include combination within one nursing home of the beds authorized by two or more CONs within the same planning subdistrict; division into two or more nursing

homes in the same planning subdistrict of the beds authorized by a CON. The bill, also, creates some new exemption-level review projects:

1. Addition of hospital beds in a number not to exceed 10 beds or 10 percent of the licensed capacity of the service being expanded, except beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, and provided there was a prior 12-month occupancy of at least 80 percent in that service or at least 96 percent for hospital-based distinct part skilled nursing units.

2. Addition of temporary acute care hospital beds, as authorized by AHCA's administrative rules that are consistent with the hospital licensure law, in a number not exceeding 10 beds or 10 percent of the licensed bed capacity, whichever is greater, in a hospital that has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.

3. Addition of nursing home beds in a number not exceeding 10 beds or 10 percent of the licensed capacity of beds at the nursing home, whichever is greater, provided that the facility has been designated a Gold Seal nursing home, pursuant to s. 400.235, F.S., and there was a prior 12-month occupancy of at least 96 percent.

Certificate-of-need regulation is removed from the following services and projects:

1. Respite care.

2. Expenditures for outpatient services.

3. Medicare-certified home health agencies.

4. Acquisitions.

5. Cost overruns.

Exemption requests are subject to a $250 fee. Certain sheltered beds designated for inpatient hospice care that are operated by continuing care residential communities are excluded from a 5-year limit on the use of such beds in providing hospice services.

The bill creates a CON workgroup consisting of 30 members, including representatives from health care provider organizations, health care facilities, individual health care practitioners, local health councils, consumer organizations, and persons with health care

market expertise as a private-sector consultant. The workgroup is to study issues pertaining to the CON program, including the impact of trends in health care delivery and financing. The workgroup is to submit an interim report by December 31, 2001, and a final report by December 31, 2002. It is abolished effective July 1, 2003.

Clinical Laboratory Services for Kidney Dialysis Patients Study

The bill extends the time for a study by the Agency for Health Care Administration of clinical laboratory services for kidney dialysis patients and appropriates $230,000 from the Agency for Health Care Administration Tobacco Settlement Trust Fund to the Agency for Health Care Administration to fund a contract with the University of South Florida to conduct a review of the quality and effectiveness of kidney dialysis treatment as well as the utilization and business arrangements related to kidney dialysis centers. A report on the findings must be submitted to the Legislature by February 1, 2001.

Department of Health Regulation of Professions

The bill revises licensing procedures for the Department of Health and authorizes the department to process a licensure application for a person who is not a citizen or resident of this country, and therefore, does not have a social security number at the time of initial licensure application but is otherwise qualified for licensure. The department may issue a temporary license for 30 days so that the applicant may obtain a social security number. The temporary license expires automatically after 30 days unless a social security number is obtained and given to the department in writing. Upon receipt of the social security number, the department must issue a regular license to the applicant. The department may require the submission of supplemental licensure application materials in a non-electronic format and the department is required to make its licensure applications available on the World Wide Web and is authorized to accept electronically submitted applications, beginning July 1, 2001. Duplicate fingerprinting submissions by health care practitioners to other state agencies is eliminated. Licensees may change licensure status at any time.

The bill revises the grounds for which a licensed health professional is subject to discipline to add being unable to practice with reasonable skill and safety to patients by reason of impairment and testing positive for any drug, as defined in s. 112.0455, F.S., on any confirmed preemployment or employer-ordered drug screening when the practitioner does not have a lawful prescription and legitimate medical reason. The board, or department when there is no board, must assess a fine and issue citations for first-time violations of unprofessional conduct as the term is defined for the discipline of nurses, midwives, respiratory care practitioners, and electrologists when no actual harm to the patient occurred. The provisions providing for the Impaired Practitioners Committee are repealed and minor technical changes are made regarding the role of the consultant for treatment programs of impaired practitioners. The appropriate regulatory board, or the

Department of Health when there is no board, may grant an exemption from disqualification from employment or contracting as provided in s. 435.07, F.S.

Unlicensed Practice of a Health Care Profession

The bill expands the enforcement efforts against the unlicensed practice of health care professions regulated by the Department of Health or the appropriate board. Legislative intent for, and minor technical revisions are made, relating to funding and enforcement of prohibitions against unlicensed activity. The bill creates criminal offenses for the unlicensed practice of a health care profession and requires a minimum mandatory sentence of imprisonment and a monetary fine. An exemption to the criminal penalties applicable to unlicensed practice of a health care profession is provided for persons selling dietary supplements. This act may not be construed to prohibit anyone from seeking medical information via the Internet.

Medical Physician Licensure

The Department of Health is authorized to issue a maximum of 10 temporary medical education certificates, annually, to qualified international medical graduates to practice under the direct supervision of a Florida-licensed physician in conjunction with a course of study at each National Cancer Institute (NCI)-designated cancer center in Florida. Each education and training course offered by an NCI-designated cancer center must be approved and certified to the Board of Medicine by the cancer center. The holder of such a temporary certificate must practice under the supervision of a Florida-licensed physician. Medical faculty certificates may be issued by the Department of Health to Florida State University.

The application fees and all licensure fees are waived for persons applying for a temporary certificate to practice medicine in Florida in an area of critical need if the applicants submit an affidavit from their employing agency or institution stating that they will not receive compensation for any services involving the practice of medicine. The medical practice act and the osteopathic practice act are amended to authorize any person who desires to practice as a resident physician, assistant resident physician, house physician, intern or fellow in fellowship training in a teaching hospital to register without having to train in a program which leads to a subspecialty board certification. The Board of Medicine and the Board of Osteopathic Medicine are given rulemaking authority to implement these registration provisions. The Council on Physician Assistants is allowed to enter an order to refuse to certify or place restrictions on the licensure of physician assistants.

Laser or Light-based Hair Removal

All persons who are not a licensed medical physician or licensed osteopathic physician using laser or light-based hair removal or reduction are required to do so pursuant to a protocol under direct supervision of a licensed medical physician or osteopathic physician.

Ophthalmology

The bill provides requirements for a primary care physician who contracts with a managed care organization to refer a patient to an ophthalmologist if that physician and the managed care organization determine the examination is medically necessary and is a covered service.

Clinical Laboratory Personnel

The bill revises the clinical laboratory personnel licensing requirements to make clinical laboratory directors with a doctoral degree maintain national certification requirements equal to those required by the federal Health Care Financing Administration.

Alzheimer's Disease Day

The bill designates February 6th of each year as Florida Alzheimer's Disease Day.

Acupuncture

The definition of "acupuncture" is revised to include the use of electroacupuncture, Qi Gong, oriental massage, herbal therapy, dietary guidelines, and other adjunctive therapies, as defined by the Board of Acupuncture by rule. The acupuncture licensure requirements are modified to require applicants to be at least 21 years of age or older, to have good moral character, and to be able to communicate in English by passage of a national written examination in English. Acupuncture licensure renewal fees are reduced from $700 to $500.

Exceptions to CS/HB 2339

This bill being the later enacted act of the Legislature, relative to CS/HB 2339, during the 2000 Regular Session of the Legislature shall be considered to control, as to any changes in law, as described below.

Effective upon this bill becoming a law:

1. Any funds appropriated in CS/HB 2339, enacted *prior to this bill during* the 2000 Regular Session of the Legislature, for the purpose of a review of current mandated health coverages shall revert to the fund from which appropriated, and such review may not be conducted.

2. Notwithstanding any provision to the contrary contained in CS/HB 2339, enacted *prior to this bill during* the 2000 Regular Session of the Legislature, the establishment of a specialty hospital offering a range of medical services restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county, is *not exempt* from the provisions of s. 408.036(1), F.S.

Employee Health Care Access Act

The current Employee Health Care Access Act in s. 627.6699, F.S., requires insurers in the small group market to guarantee the issue of coverage to any small employer with 1 to 50 employees, including sole proprietors and self-employed individuals, regardless of their health condition. Rates for such policies must be established on a "modified community rating" basis, which prohibits consideration of health status or claims experience, and allows only age, gender, geographic location, tobacco usage, and family composition (size) to be used as rating factors.

This bill makes the following changes:

1. Eliminates the prohibition that rates not be based on the health status or claims experience of any individual or group and allows limited use of such factors. Small group carriers are allowed to adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium may be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these additional factors.

2. Deletes the guaranteed-issue requirements for employers with one employee, sole proprietors, and self-employed individuals and, instead, provides for an annual open enrollment period for such persons, during the month of August. Coverage would begin on October 1, unless the insurer and the policyholder agree to a different date. Any one-person small employer getting coverage must not be formed primarily for the purposes of buying health insurance and if an individual hires his or her spouse and dependent children as employees, the entire family unit would be considered a one-person group, unless both spouses

are working full-time. (Although this bill delays the implementation of this provision until August 2001, and continues to provide for guaranteed-issued of one life groups until such time, another bill, CS/HB 2339, provides for the 1-month open enrollment to begin in August 2000. Since this bill was enacted after CS/HB 2339, it was the last act of the Legislature relating to this issue and shall be considered to govern which would have the effect of continuing the guaranteed-issued of one life groups until August 2001.)

3. Allows small group carriers to provide a credit to reflect the administrative and acquisition expense savings resulting from the size of the group. This is expected to result in about a 3 to 5 percent credit for larger groups (for example, 25 to 50 employees), and be transferred as an overall cost increase to the smaller groups.

4. Prohibits small group carriers from using "composite rating" for employers with fewer than 10 employees, which would prohibit a premium statement to an employer that averages the rates for all employees and, instead, would require the carrier to list the rate applicable to each employee based on that employee's age and gender. (But, the total premium remains unchanged.)

5. Specifies certain family-size categories that a small group carrier may use.

6. Clarifies the applicability of additional rate filing procedures and standards for insurers and HMOs, respectively.

Changes to Regulatory Requirements for Health Maintenance Organizations

The bill revises several provisions relating to the regulation of HMOs. It clarifies that certain provisions of the Insurance Code apply to HMOs; provides that the Department of Insurance may terminate an HMO contract if the contract is with an entity that is not licensed under state law, if such license is required, or is not in good standing with the applicable regulatory agency; authorizes HMOs to pay contracted examiners directly; provides for application of federal solvency requirements to provider-sponsored organizations; makes it a third-degree felony for an officer or director of an HMO to accept new or renewal subscriber contracts if the HMO is insolvent or impaired; and applies insurance holding company provisions to HMOs.

Appropriation for a Systematic Review of Proposed Mandated Health Coverages

The bill appropriates $200,000 from the Insurance Commissioner's Regulatory Trust Fund to the Office of Legislative Services to implement the legislative intent to conduct a systematic review of proposed mandated health coverages or mandatorily offered health

coverages, as provided in s. 624.215(1), F.S. The review will be used by the Legislature in determining whether mandating a particular coverage is in the public interest based on legislative recognition, as expressed in s. 624.215(1), F.S., that many such benefits provide beneficial social and health consequences which may be in the public interest but most of them contribute to the increasing cost of health insurance premiums.

The review must be conducted by certified actuaries and other appropriate professionals and shall consist of an assessment of the impact, including, but not limited to, the costs and benefits, of mandated health coverages using guidelines specified in s. 624.215(2), F.S. The review must establish the aggregate cost of proposed mandated health coverages. Health care providers are explicitly excluded from the meaning of the term "mandated health coverages" as that term is used in the bill.

Indigent Care and Trauma Center Surtax

The bill revises the requirements of the indigent health surtax to also fund a trauma center and directs the clerk of the court of the county with a population of at least 800,000 residents that has levied the indigent care surtax to annually disburse $6.5 million to fund a hospital in the county's jurisdiction that has a Level I trauma center or to annually disburse $3.5 million to fund a hospital in the county's jurisdiction that has a Level I trauma center if that county enacts a hospital lien law in accordance with ch. 1998-499, L.O.F., (a special law limited to Hillsborough County that authorizes the Hillsborough County Commission to adopt an ordinance for liens in favor of all operators of hospitals in Hillsborough County and in favor of Hillsborough County, when the county pays for medical care, treatment, or maintenance of qualifying residents of the county, upon all causes of action which the injured person or his legal representative may assert, as well as the proceeds of any settlements or judgments arising from the cause of action that required hospitalization and medical treatment).

Nursing

This bill transfers the regulatory and rulemaking authority that the Department of Health has over certified nursing assistants (CNAs) to the Board of Nursing within the department. The bill splits chapter 464, F.S., relating to nursing into two parts by creating ch. 464, part I, F.S., for the regulation of the practice of nursing and ch. 464, part II, F.S., for the regulation of CNAs. The bill creates a five-member Council on Certified Nursing Assistants and specifies its duties. The bill adds advanced registered nurse practitioners to the list of professionals who may participate in the credentialing program administered by the Department of Health. Advanced registered nurse practitioners must comply with the requirements of the practitioner profiling program through electronic submission, except for fingerprints, only if otherwise required by law. The bill revises requirements for CNA certification and application procedures. The appropriate regulatory board within the

Department of Health or department itself when there is no board is authorized to grant an exemption from disqualification to an employee or prospective employee who has received a professional license or certification from the Department of Health or a regulatory board within that department and who is subject to criminal background screening as a condition of employment or contract with a nursing home, home health agency, nurse registry, or as a companion or homemaker.

The regulation of professions must be financed solely by fee revenues and deposited into the Medical Quality Assurance Trust Fund. An exception is made to the funding of professional regulation, to require the Board of Nursing to pay for the costs incurred in regulation of certified nursing assistants. To implement the provisions of this act relating to the transfer of certified nursing assistants and the publishing of profiles of advanced registered nurse practitioners, $280,000 is appropriated from the Medical Quality Assurance Trust Fund to the Department of Health.

Changes to Licensure Regulation of Home Health Agencies and Nurse Registries, Changes to Registration Requirements for Companion Services and Homemaker Services, and Changes to the Regulation of Home Health Aides

The bill authorizes AHCA, in addition to any other penalties imposed as authorized by law, to assess costs, against a home health agency, nurse registry, companion service provider, or homemaker service provider, related to an investigation that results in a successful prosecution, excluding costs associated with an attorney's time. As pertains to nurse registries, companion service providers, and homemaker service providers, if AHCA imposes such an assessment of costs and the assessment is not paid, and if challenged is not the subject of a pending appeal, prior to the renewal of the license or registration, AHCA is prohibited from issuing the renewal license or renewal registration until the assessment is paid or arrangements for payment of the assessment are made.

The bill requires that services provided by a home health agency be covered by an agreement between the home health agency and the patient or the patient's legal representative and must specify the home health services to be provided, the rates or charges for services paid with private funds, and the method of payment. Current law requiring that the attending physician for a patient who is to receive skilled care must establish treatment orders is modified to impose such a requirement only when required by the nurse practice act; the speech-language pathology and audiology practice act, the occupational therapy practice act, the respiratory therapy practice act; or physical therapy practice act. Home health agencies will be required to arrange for supervisory visits by a registered nurse to the home of a patient receiving home health aide services in accordance with the patient's direction and approval in place of the current requirement that the home health agency establish a service provision plan and maintain a record of the services provided by home health aides.

The Agency for Health Care Administration is required to create, by rule, the home health aide competency test. The agency must adopt rules to allow a home health aide who passes the competency test to substitute such passage for statutorily required training or training required by administrative rule. Additionally, AHCA is required to adopt rules that provide *criteria* for the frequency of onsite licensure surveys. The bill deletes statutory requirements for rules providing for: establishing the qualifications, minimum training requirements and supervision requirements of all home health agency personnel; AHCA to establish guidelines for background screening of prospective employees and contractors of home health agencies; administration of home health agencies; procedures for administering drugs and biologicals; ensuring that home health services are provided in accordance with the treatment orders established for each patient for whom physician orders are required; and standards for contractual arrangements for the provision of home health services by providers not employed by the home health agency to whom the patient has been admitted.

Background screening requirements for home health agency personnel, nurse registry personnel, companions, and homemakers are modified by requiring AHCA to conduct a search for any report of confirmed abuse and, for purposes of compliance with statutory employment screening requirements, AHCA must search for any criminal record from the Department of Law Enforcement. Current law requires that certain identifying information obtained from a prospective administrator or managing employee for a home health agency be submitted to the Department of Children and Family Services abuse hotline for state processing or the central abuse registry and tracking system and the Department of Law Enforcement is required to conduct the criminal record check. The statutory requirement that home health agencies, nurse registries, companion service providers, and homemaker service providers bear the cost of searches of the Department of Children and Family Services central abuse hotline is deleted.

The bill extends immunity from monetary liability and precludes a cause of action for damages against a home health agency's employee for reasonable and good faith communication of his or her honest opinions, if the home health agency is asked about the person, relating to the job performance of a person who was employed by or contracted with the home health agency as a caregiver. The protection provided to such an employee of a home health agency is explicitly made inapplicable to the official immunity of an officer or employee of a public corporation.

Notice of Medical Malpractice Litigation

The bill revises requirements for a medical malpractice claimant to file a presuit notice of an intent to file a medical malpractice claim with the Department of Health for its review to determine whether it involved conduct by a licensed health care professional which is potentially subject to disciplinary action. In lieu of filing, with the Department of Health,

a notice of intent to file a medical malpractice claim and other specified information (the name and address of the claimant, the full name and addresses of any prospective defendants who are licensed health care providers, the date and summary of the occurrence giving rise to the claim, and a description of the injury to the claimant), a medical malpractice claimant must provide a copy of the complaint to the Department of Health following the initiation of a suit alleging medical malpractice with a court of competent jurisdiction and service of the complaint upon the defendant.

Division of Sponsored Research

The bill amends s. 240.241, F.S., to revise accounting procedures for units within the Division of Sponsored Research at the University of Florida which includes sponsored research programs of the Institute of Food and Agricultural Sciences, the University of Florida Health Science Center, and the engineering and industrial experiment station, to allow indirect cost reimbursements of all grants deposited in the Division of Sponsored Research to be distributed directly to the above units in direct proportion to the amounts earned by each unit.

Ticket to Work and Work Incentives Act of 1999 Study

The bill requires the Agency for Health Care Administration to conduct a cost and feasibility study regarding the implementation of the federal “Ticket to Work and Work Incentives Act of “1999" in Florida and to report its findings to the Speaker of the House of Representatives and the President of the Senate by December 1, 2000.

HIV/AIDS Prepaid Health Plans

The Agency for Health Care Administration is authorized to contract with specialty prepaid health plans and pay them on a prepaid capitated basis to provide Medicaid benefits to Medicaid-eligible recipients who have HIV/AIDS. The agency must apply for and is authorized to implement federal waivers or other necessary federal authorization to implement the specialty prepaid health plans. The agency must procure the specialty prepaid health plans through a competitive procurement and in awarding a contract to a managed care plan, the agency must consider specified criteria. The agency may bid the HIV/AIDS specialty plans on a county, regional, or statewide basis. Each qualified plan must be licensed under ch. 641, F.S. The agency must monitor and evaluate the implementation of this waiver program if it is approved by the federal government and must report on its status to the President of the Senate and the Speaker of the House of Representatives by February 1, 2001.

If approved by the Governor, these provisions take effect on July 1, 2000, except as otherwise provided.
Vote: Senate 37-0; House 113-5

HB 729 — Board of Dentistry

by Rep. Bense (SB 1014 by Senator Saunders)

This bill (ch. 2000-115, L.O.F.) revises the conditions of appointment to the Board of Dentistry for dentists or persons who are connected with any dental college or community college. The bill deletes a requirement for dentists appointed to the Board of Dentistry to have their principal source of income come from direct patient care and authorizes the appointment of persons to the board who are connected with a dental college or community college, as long as their principal income is not derived from their connection with the college. The bill applies to appointments to the Board of Dentistry made on or after the effective date of this bill.

These provisions were approved by the Governor and take effect July 1, 2000.
Vote: Senate 34-0; House 115-0

CS/CS/SB 1890 — End-of-Life Care

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

This bill clarifies the scope of a pre-hospital do-not-resuscitate order (DNRO) in the hospital setting and the authority of a physician to issue a DNRO. As relates to DNROs, the bill extends authority to withhold or withdraw cardiopulmonary resuscitation based on a pre-hospital DNRO that was executed for paramedics and emergency medical technicians to honor and extends immunity from liability for hospital personnel who act in conformity with the instructions provided in a pre-hospital DNRO. Current law is clarified with a statement that a physician *is not precluded* from withholding or withdrawing cardiopulmonary resuscitation from a hospitalized patient, nursing home resident, a resident of an assisted living facility, or hospice patient, due to the absence of a pre-hospital DNRO so long as it is done as otherwise permitted by law.

Requirements pertaining to execution of a valid pre-hospital DNRO, which an emergency medical technician or paramedic is authorized to honor, are stated more explicitly. Specifically, the DNRO must be executed on the Department of Health's standard DNRO form which must be signed by the patient's physician and the patient, or the patient's health care surrogate, proxy, or court-appointed guardian, or attorney in fact pursuant to a durable power of attorney. A court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient so that such person's signature, in lieu of the patient's, will not invalidate the pre-hospital DNRO.

The bill prescribes requirements relating to pain management or palliative care. It requires specified health care facilities, health care providers, and health care practitioners to comply, when appropriate, with a request for pain management or palliative care by a patient or an incapacitated patient's health care surrogate, proxy, court-appointed guardian, or attorney in fact under a durable power of attorney.

The contents of the statutory suggested form for designation of a health care surrogate are modified to add language to the suggested form stating that authority for a surrogate to make health care decisions does not include the decision to donate organs, unless a separate declaration is executed. This is consistent with the definition for "health care decisions" which includes the decision to make an anatomical gift. The anatomical gift law conditions the authority of a health care surrogate to make an anatomical gift on the existence of some specific declaration by the principal regarding an anatomical gift. This declaration may be indicated in a written agreement, an organ and tissue donor card, a living will, other advance directive, or a driver's license. Also, the bill addresses the procedure for a physician's determination of a principal's incapacity to make health care decisions. It clarifies that the health care facility must notify the designated health care surrogate or attorney in fact with specified authority under the durable power of attorney that a determination of incapacity has been made by a physician. Provisions contained in the suggested statutory form for a living will are also modified to replace the term "mentally and physically incapacitated" with "incapacitated" and the same change is made to provisions of law relating to the procedure to forego treatment in the absence of a living will and the procedure for determining whether a patient has a terminal condition, an end-stage condition, or is in a persistent vegetative state or otherwise has a medical condition or limitation provided in a health care advance directive.

Furthermore, the bill eliminates the provisions relating to the conditions under which a proxy may exercise authority to withhold or withdraw life-prolonging procedures on behalf of a patient. In its place, proxies must comply with the same provisions applicable to health care surrogates when making this particular decision but it must still be based on clear and convincing evidence that the decision would have been one that the patient would have made if the patient had been competent.

Continuing educational requirements are revised to permit health care professionals licensed or certified as physicians, nurses, dentists, midwives, psychologists, or as providers of clinical and psychotherapy services to elect to complete an end-of-life care and palliative health care course in lieu of a domestic violence course for licensure and licensure renewal, provided the health care professional has completed a domestic violence course in the immediately preceding biennium. Additionally, the bill clarifies legislative intent that the procedure for planning for one's own later incapacity may be made either by executing a document or *orally designating* another person to direct the course of his or her medical treatment upon his or her incapacity. It adds legislative

recognition for the need to educate health care professionals about end-of-life care and palliative health care. It also encourages professional regulatory boards to adopt appropriate standards and guidelines regarding end-of-life care and pain management and educational institutions who train health care professionals and allied health professionals to implement curricula on end-of-life care, including pain management and palliative care. The Department of Elderly Affairs, the Agency for Health Care Administration, and the Department of Health are required to conduct a joint campaign on end-of-life care to educate the public. The campaign should include culturally sensitive programs to improve understanding of end-of-life care issues in minority communities.

An 18-member End-of-Life Care Workgroup is created within the Department of Elderly Affairs. The workgroup is required to: (1) Examine reimbursement methodologies for end-of-life care, (2) Identify end-of-life care standards for purposes of developing a health care delivery system for end-of-life care, and (3) Develop recommendations for incentives for appropriate end-of-life care. The workgroup must submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2000. The Department of Elderly Affairs is required to provide staff support to the workgroup within its existing resources. Members of the workgroup must serve without compensation. The workgroup expires on May 1, 2001.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 39-0; House 116-0

CS/HB 1991 — Trauma Services

by Governmental Rules and Regulations Committee and Reps. Casey and Fasano (CS/SB 2624 by Health, Aging & Long-Term Care Committee and Senator Myers)

The bill provides for an inclusive statewide trauma system, revises the requirements for trauma transport protocols, and provides for certain uniform protocols.

The bill removes definitions from s. 395.401, F.S., and creates a new s. 395.4001, F.S., of definitions that apply to all of part II, ch. 395, F.S., relating to trauma. New definitions created are for "interfacility trauma transfer" and "trauma transport protocol," which are currently used in substantive language without definition. It revises definitions for "trauma center," "level I trauma center," and "level II trauma center."

This bill requires that state and local level trauma planning address the transportation of trauma victims to improve access to trauma care when this care is not available locally. The bill requires the department to use the state trauma system plan as a basis for implementing an inclusive trauma system.

The bill requires each emergency medical services provider licensed under chapter 401, F.S., to transport victims to hospitals approved as trauma centers, except as provided for in either the trauma transport protocol approved for the provider or the protocol approved for the trauma agency responsible for the geographical area in which the provider operates. The bill allows a trauma agency to develop a uniform trauma transport protocol that is applicable to the licensed emergency medical services provider operating within the agency's geographical area.

Also, the bill provides that the scoring system through which trauma alert victims are identified must include an adult or pediatric assessment as specified in rule. The Department of Health will establish by rule the minimum criteria related to prehospital trauma transport, trauma center or hospital destination determinations, and interfacility transport. Prior to an interfacility transport, the emergency medical services provider's medical director (or his designee) must agree that the staff of the transport vehicle has the skills, equipment and resources to provide the care the patient is anticipated to need, and allows the medical director or designee to require appropriate staffing, equipment and resources to ensure proper patient care and safety during transfer. The bill provides that rules pertaining to air transportation of trauma victims will, at a minimum, be consistent with Federal Aviation Administration guidelines. In the instance in which there is no department-approved trauma agency trauma transport protocol for an area in which an emergency medical services provider applicant operates, the applicant must submit and obtain department approval of a trauma transport protocol prior to the department granting a license.

The bill provides that the medical director of an emergency medical services provider will have medical responsibility and accountability for all trauma victims during an interfacility transfer. It grants authority to the department to adopt and enforce rules necessary to administer the provisions of the act.

The bill establishes an advisory 16 member Emergency Services Task Force to study and make recommendations regarding several issues related to the provision and financing of emergency medical care services.

If approved by the Governor, these provisions take effect October 1, 2000, except for the section creating the Emergency Services Task Force which takes effect July 1, 2000.
Vote: Senate 40-0; House 112-0

HB 1993 — Task Force on the Availability and Affordability of Long-term Care

by Rep. Russell and others (CS/SB 1222 by Fiscal Policy Committee and Senator McKay)

The bill establishes the Task Force on the Availability and Affordability of Long-term Care, to study issues related to the provision of long-term care to the elderly in nursing homes and alternatives to nursing homes and to make recommendations to the Governor and the Legislature. The task force is charged to study long-term care issues in terms of the availability of alternative housing and care settings and community based care arrangements, the role of family members in caring for elderly relatives and ways quality family care can be encouraged, the adequacy of reimbursement arrangements in both nursing home and alternative care arrangements, the availability and affordability of long-term care insurance, the role of the certificate-of-need process in the development of long-term care systems, issues related to the economic stability and quality of long-term care facilities as influenced by market forces, lawsuits against nursing homes, the cost and availability of liability insurance for long-term care providers, the causes for recent bankruptcies in the nursing home industry, the costs to Medicaid, Medicare, and the family when a patient is admitted to a hospital for a preventable condition, other states innovations in alternative and home based care, the difference between the quality of care provided by for-profit and not-for-profit skilled nursing facilities, and an evaluation of the quality of care in Florida long-term care facilities compared to facilities in other states.

The task force is comprised of 19 members, including the Lieutenant Governor, who is the chair; the Secretary of Elderly Affairs; the state Medicaid director; a member of the Florida Bar; one representative each from the Florida Assisted Living Association and the Florida Association of Homes for the Aging; a representative of the insurance industry who has experience in insurance markets affecting long-term care; a member representing private sponsors of housing financed through the U.S. Department of Housing and Urban Development; an investment banker who has experience in long-term-care economics; an academic gerontologist; and a geriatric physician who is experienced in treating people with memory-related disorders, a Florida member of the American Association of Retired persons who has experience in administering a long-term care facility, an individual experienced with periodic review of nursing homes and other long-term care facilities, a representative of the Florida Health Care Association, a local volunteer ombudsman, two consumer representatives, and two members of the Legislature.

The task force is located at the University of South Florida for administrative purposes. The Florida Policy Exchange Center on Aging is to provide staff and support services to the task force.

The members of the task force may not delegate attendance or voting power to designees. Appointments to the task force must be completed within one month after the effective date of the act and the task force must hold its first meeting within 45 days after the effective date of the act. The task force is required to submit a report of its recommendations to the Governor, the President of the Senate and the Speaker of the House of Representatives by January 1, 2001. The task force shall expire on March 1, 2001.

The non-recurring sum of $200,000 is appropriated to the University of South Florida for the purposes of implementing the bill.

If approved by the Governor, the bill takes effect upon becoming a law.
Vote: Senate 38-0; House 118-0

HB 2319 — Rural Hospitals

by Health Care Services Committee and Reps. Peaden and Casey (SB 2422 by Senators Clary, Mitchell, Rossin, Thomas, Childers, Saunders, Latvala, Myers, and Dawson)

This bill implements the recommendations of the Rural Hospital Statutory Redefinition Advisory Group which was created by the 1998 Florida Legislature. The bill revises the definition of "rural hospital" in ss. 395.602 and 408.07, F.S., by: eliminating the requirement that a rural hospital be located in an area defined as rural by the United States census; adding a criterion for a sub-county rural hospital service area based on ZIP codes that account for 75 percent of the hospital's discharges for the most recent 5-year period; and adding a criterion for a hospital designated by the Department of Health as a critical access hospital in accordance with federal regulations and state requirements. The bill revises the applicability of the disproportionate share program and financial assistance program for rural hospitals to permit certain rural hospitals that were funded prior to July 1, 1998, to continue to receive funding without having to seek additional appropriations.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 39-0; House 118-0

FSU COLLEGE OF MEDICINE

HB 1121 — The Florida State University College of Medicine

by Rep. Peaden and others (SB 1692 by Senators King, McKay, Childers, Clary, Horne, Thomas, Geller, Campbell, Mitchell, Holzendorf, Saunders, Dawson, and Bronson)

This bill creates the Florida State University College of Medicine, a 4-year allopathic medical school within the Florida State University. The medical college must have a principal focus on recruiting and training medical professionals to meet the state's primary health care needs, especially the needs of the state's elderly, rural, minority, and other underserved citizens. The bill provides legislative intent for, specifies the purpose of, and addresses the transition to, organizational structure of, and admissions process of the proposed College of Medicine.

The bill specifies curricula and insurance requirements. The initial preclinical 2-year curriculum is to draw on the Program in Medical Sciences' experience at the Florida State University and national trends in basic science instruction and the use of technology for distributed and distance learning. First-year instruction will include a lecture mode and problem-based learning and the second-year, a small-group, problem-based learning approach will provide more advanced treatment of each academic subject in a patient-centered context. Short-term clinical exposures will be programmed throughout the pre-clinical years, including rural, geriatric, minority health, and contemporary practice patterns in these areas. During the third and fourth years, the curriculum will follow a distributed, community-based model with a special emphasis on rural health. The bill authorizes Florida State University, for and on behalf of the Board of Regents, to negotiate and purchase policies of insurance to indemnify from any liability those individuals or entities providing sponsorship or training to the students of the medical school, professionals employed by the medical school, and students of the medical school.

The proposed College of Medicine must develop a comprehensive program that ensures training in the medical needs of the elderly, rural and underserved populations of the state. The bill specifies the partner organizations for clinical instruction and graduate programs. To provide broad-based clinical instruction in both rural and urban settings, the College of Medicine must seek affiliation agreements with health care systems and organizations, local hospitals, and military health care facilities in the following targeted communities: Pensacola, Tallahassee, Orlando, Sarasota, Jacksonville, and rural areas of the state. Selected hospitals in the target communities are, but are not limited to: Baptist Health Care, Sacred Heart Health System, and West Florida Regional Medical Center in Pensacola, Lee Memorial Health System in Fort Myers, Tallahassee Memorial Healthcare in Tallahassee, Florida Hospital Health System in Orlando, Sarasota Memorial Health Care System in Sarasota, Mayo Clinic in Jacksonville, and rural hospitals in the state. The

bill requires the College of Medicine to increase participation of under represented groups and socially and economically disadvantaged youth in science and medical programs. The bill shall be implemented as provided in the General Appropriations Act.

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