

## **REGULATION OF HEALTH CARE FACILITIES/SERVICES/BUSINESSES**

### **CS/SB 188 — Regulation of Transitional Living Facilities**

by Health Care Committee and Senator Brown-Waite

This bill (Chapter 98-12) amends ss. 400.805, 413.49, and 413.605, F.S., relating to the regulation of transitional living facilities (TLF) for brain-injured and spinal-cord-injured persons and the care provided such persons in transitional living facilities. The bill expressly authorizes the Agency for Health Care Administration (agency or AHCA), the state fire marshal, or a local fire marshal to enter the premises of a licensed TLF to determine compliance with TLF licensure rules and standards. The agency may pursue a temporary or permanent injunction against a licensee or an operator of an unlicensed facility to: 1) enforce licensure requirements, 2) terminate the operation of a facility found in violation of such requirements, or 3) protect facility residents from immediately life-threatening situations. Upon determination that conditions in a facility threaten the health, safety, or welfare of residents, AHCA is authorized to impose a moratorium on admissions to the offending TLF. The law relating to vocational rehabilitation is amended to provide guidelines that: 1) require TLFs to provide, at a minimum, physical, occupational, speech, neuropsychology, independent living skills training, behavior analysis for programs serving brain-injured persons, health education, and recreation therapies; 2) require TLFs to develop an initial treatment plan for each resident within 3 days after the resident's admission and develop a comprehensive plan of treatment and discharge plan no later than 30 days after the resident's admission; 3) require discharge of TLF residents to appropriate discharge sites that are the least restrictive environment in which an individual's health, well-being, and safety are preserved; and 4) provide for appointment of a committee by the Advisory Council on Brain and Spinal Cord Injuries, located administratively under the Division of Vocational Rehabilitation of the Department of Labor and Employment Security, that is to conduct on-site investigations as follow-up to AHCA findings of possible violations relating to the quality of the care that a TLF is giving its residents.

These provisions were approved by the Governor, without his signature, and take effect October 1, 1998.

*Vote: Senate 33-0; House 117-0*

**CS/SB 250 — Certificate of Need/Medicaid Conditions on Nursing Home Beds**  
by Health Care Committee

This bill amends the certificate-of-need (CON) law to modify the procedure for imposing conditions on a CON for a nursing home that was issued in reliance on the applicant's statements to provide a specified number of nursing home beds to Medicaid recipients. The law relating to CON conditions and monitoring is amended to explicitly clarify that a nursing home CON issued in reliance upon an applicant's statement to provide Medicaid nursing home beds must include a statement of such commitment. The CON program is required to notify the Medicaid program and the Department of Elderly Affairs when it imposes Medicaid conditions on a CON for a nursing home that will operate in an area in which a community diversion pilot project is implemented. Additionally, explicit authority is provided for a holder of a CON to apply to the Agency for Health Care Administration for a modification of conditions imposed on its CON. The bill creates an interagency workgroup with participation from private-sector interested parties to study and monitor issues pertaining to ensuring a sufficient supply of Medicaid nursing home beds. The workgroup is required to submit two reports and it is abolished effective January 1, 2000.

The bill revises a provision in the nursing home licensure law by deleting language that pertains to CON regulation. Additionally, the bill exempts certain state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs from CON review when specified conditions are met.

If approved by the Governor, these provisions take effect July 1, 1998.

*Vote: Senate 31-0; House 119-0*

**SB 288 — Rural Hospitals**  
by Senators Thomas and Myers

This act (Chapter 98-14) modifies the definition of the term "rural hospital" to increase the allowable number of licensed beds that a hospital that is designated as a rural hospital may have from 85 to 100. The act revises provisions relating to Medicaid rural hospital disproportionate share funding to provide that any rural hospital designated after July 1, 1998, may not receive disproportionate share or financial assistance payments unless each year additional appropriations are made to prevent any reduction in payments to existing rural hospitals or their successor-in-interest hospitals with respect to the level of funding that the existing rural hospitals currently receive from the disproportionate share program or the financial assistance program for rural hospitals. The act corrects a glitch in the law that inadvertently left out a provision exempting

rural hospitals from certificate-of-need review when such hospitals decide to offer home health services.

These provisions were approved by the Governor, without his signature, and take effect July 1, 1998.

*Vote: Senate 37-0; House 112-0*

### **SB 304 — Organ and Tissue Donation**

by Senator Childers

This bill relates to anatomical gifts, and revises ch. 732, part X, F.S., as follows:

- Adds a definition for the term “death” in the context of organ and tissue donation;
- Specifies persons who may make an anatomical gift, if the decedent has not done so;
- Clarifies the ways by which an anatomical gift may be revoked;
- Revises language which provides immunity from civil and criminal liability for any hospital, or hospital administrator or designee to include any organ procurement organization, eye bank, or tissue bank, when performing organ or tissue donation recovery;
- Modifies the duties of a hospital administrator or his or her designee and organ procurement organizations with regard to organ procurement activities; and
- Authorizes the use of funds in the Florida Organ and Tissue Donor Education and Procurement Trust Fund to establish a statewide organ donor registry and to help develop the statewide organ donor education program.

In addition, the bill modifies several statutory provisions relating to organ and tissue-related trust fund revenue sources to expand the uses of such revenue for purposes of the maintenance of the organ and tissue donor registry and the organ and tissue donor education program.

If approved by the Governor, these provisions take effect upon becoming law, except as otherwise provided.

*Vote: Senate 35-0; House 116-0*

## **CS/SB 314 — Health Care Deregulation and Regulation**

by Health Care Committee and Senator Brown-Waite

The Committee Substitute for Senate Bill 314 abolishes the Health Care Board within the Agency for Health Care Administration (agency or AHCA), revises the duties of the Division of Health Policy and Cost Control within the agency to abolish its duties relating to hospital budget review, abolishes the hospital budget review process, repeals the authority for the Health Care Board to conduct data-based studies and evaluations relating to certain business practices of health care providers, transfers certain duties delegated to the Health Care Board to the agency, authorizes the agency to conduct data-based studies and evaluations relating to certain business practices of health care providers, and retroactively applies the repeal of hospital budget review to hospital budgets for fiscal years that ended during the 1996 calendar year. Additionally, the bill:

- Deregulates certain detached outpatient facilities from state construction and plan review under the hospital and ambulatory surgical center licensure law;
- Limits rulemaking authority relating to hospital and nursing home facility emergency preparedness guidelines for hurricanes and other disasters to facilities constructed after July 1, 1999, and to new wings or floors added to existing facilities after July 1, 1999; additionally, AHCA is required to work with persons affected by the emergency preparedness guidelines and to report to the Governor and Legislature its recommendations for cost-effective renovation standards for existing facilities;
- Amends the Florida Patient's Bill of Rights and Responsibilities to include a requirement that health care providers give patients information on how to file a complaint with the appropriate state agency; clarifies that the Patient's Bill of Rights and Responsibilities applies to, in addition to health care providers treating a patient in an office, hospitals and ambulatory surgical centers that offer emergency and outpatient services, as well as inpatient services; and establishes administrative fines against health care providers for failure to advise patients of their rights and responsibilities;
- Amends peer review procedures that are applicable to hospitals and ambulatory surgical centers to require reporting of any disciplinary actions taken against a health care practitioner within 30 days after its occurrence, to require corrective action by facilities that fail to report, and to authorize fines in cases where facilities fail to take corrective action;
- Amends the internal risk management program requirements applicable to hospitals and ambulatory surgical centers, to require reporting of adverse incidents to a facility's risk manager within 3 days of the occurrence of the incident, to establish requirements for facilities

to report to the agency various categories of adverse incidents, to require corrective action by facilities that fail to report, to authorize fines in cases where facilities fail to take corrective action, and to revise pertinent definitions;

- Provides for transfer of the health care risk manager licensure program from the Department of Insurance to the Agency for Health Care Administration;
- Amends the statutory definition of “medical review committee” or “committee” to include physician-hospital organizations, provider-sponsored organizations, and integrated delivery systems; and
- Appropriates \$100,281 from the Health Care Trust Fund and allocates one full-time position to AHCA for the administration of the health care risk manager licensure program.

If approved by the Governor, these provisions take effect July 1, 1998, except as otherwise provided.

*Vote: Senate 38-0; House 117-0*

**CS/SB 570 — Radiation Therapy Services/Assessments on Health Care Entities**  
by Ways & Means Committee and Senator Dudley

The bill repeals the annual Public Medical Assistance Trust Fund assessment on certain freestanding radiation therapy centers and exempts outpatient radiation therapy services provided by hospitals from the assessment. The bill directs legislative staff to analyze the short and long term public policy and cost implications of implementing an Adult Heart Transplant Program either through the Medicaid program or on a non-Medicaid basis. The report completed by staff based on its analysis of the public policy and cost implications of implementing an Adult Heart Transplant Program must consider all costs for providing the comprehensive array of transplant-related services, and any alternatives for program implementation. The report must be presented to the Social Services Estimating Conference, which must review and certify the cost estimates. The report and the findings of the estimating conference must be presented to the President of the Senate and the Speaker of the House of Representatives leadership by September 1, 1998. The bill authorizes the Agency for Health Care Administration to submit a budget amendment to implement an Adult Heart Transplant Program during FY 1998-99.

If approved by the Governor, these provisions take effect July 1, 1998, except as otherwise provided.

*Vote: Senate 39-0; House 111-0*

## **CS/CS/SB 714 — Health Quality Assurance/HIV Testing**

by Ways & Means Committee, Health Care Committee, and Senators Forman and Klein

The bill revises various provisions of statute relating to human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS). It expands HIV/AIDS course requirements for employees and clients of specific health care facilities and for certain licensed health care professionals. Addressed in the bill are the following issues related to various aspects of HIV testing: (1) streamlining of requirements relating to HIV testing, specifically relating to pre- and post-test counseling requirements; (2) sharing of preliminary test results under certain circumstances; (3) disclosure of test results; (4) informed consent for testing; (5) confidentiality of test results; (6) release of test results under specific, limited circumstances; (7) significant exposure situations involving medical and non-medical personnel; (8) registration of test sites with the Department of Health (DOH); and (9) DOH's model HIV testing protocol.

Employees of health care facilities and facilities that provide services to persons with developmental disabilities or that offer community alcohol, drug abuse, mental health or substance abuse services must be instructed in any protocols and procedures applicable to HIV counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification issues in accordance with law. Informed consent requirements are augmented with a requirement that prior to testing, a person be told that, when a positive HIV test result occurs, such results will be reported to the county health department with sufficient information to identify the test subject and also be told of the location of sites at which anonymous testing is performed. Provision is made for the release of preliminary results from an HIV test to health care providers and the person tested when decisions about medical care or treatment of the person tested cannot await the results of confirmatory testing. However, positive preliminary HIV test results may not be characterized to the patient as a diagnosis of HIV nor may such information be released for purposes of routine identification of HIV-infected individuals or when HIV testing is incidental to the preliminary diagnosis or care of a patient. The use of preliminary HIV test results must be documented in the medical record by the health care provider who ordered the test. Corroborating or confirmatory testing must be conducted as follow-up to a positive preliminary HIV test. A court order may be sought by medical personnel or the employer of such personnel that would direct a person who will not voluntarily submit to HIV testing, when a blood sample is not available, and who was the source of a *significant exposure* of such personnel to submit to HIV testing. The petition for a court order must include a physician's sworn statement attesting that a significant exposure has occurred and that testing is medically necessary to determine the course of treatment, if any. Results of a court-ordered HIV test must be released to the source of the exposure and to the person who experienced the exposure.

Other provisions of the bill provide: background screening requirements for persons (natural and corporate persons) applying to the Agency for Health Care Administration (AHCA) for licensure to operate a health care facility or to register as a utilization review agent; requirements for certain health care entities to conduct employment background screening for all direct-care employees; and requirements for abuse registry screening of certain administrative employees. The background screening requirements take effect July 1, 1998, for initial *and* renewal licenses. The screening requirements are applicable to persons applying to operate: (1) a laboratory used for drug specimen analysis under the Drug-Free Workplace Act; (2) an organ procurement organization, a tissue bank, or an eye bank; (3) a birth center; (4) an abortion clinic; (5) a prescribed pediatric extended care center; (6) an intermediate care facility for the developmentally disabled; (7) a crisis stabilization unit or residential treatment facility that provides community alcohol, drug abuse, or mental health services; (8) a hospital, ambulatory surgical center, or mobile surgical unit; (9) a nursing home facility; (10) an assisted living facility; (11) a home health agency or nurse registry; (12) an adult day care center; (13) a hospice; (14) an adult-family-care home; (15) a home for special services; (16) a transitional living facility; (17) a clinical laboratory; or (18) a multiphasic health testing center. Background screening requirements for operators of adult-family-care homes are revised. Additionally, as pertains to other regulatory requirements, the bill:

- Amends the Drug-Free Workplace Act to authorize use of body hair, excluding hair from the pubic area, as specimens for purposes of drug testing, as provided under the act. This modification of law is applicable to public sector and private sector workplaces;
- Lowers the threshold that triggers the disclosure requirement of a person holding an ownership interest in a corporation that is applying for licensure to operate a mental health facility, nursing home, or assisted living facility from a 10 percent ownership interest to 5 percent;
- Conforms references to reflect the transfer of regulatory authority of mental health facilities and other similar facilities regulated under ch. 394, F.S., from the defunct Department of Health and Rehabilitative Services to AHCA;
- Provides for AHCA to consult with the Department of Children and Family Services, as relates to mental health facilities, crisis stabilization units, residential treatment facilities, or community mental health centers, to: set initial licensure and renewal licensure fees, adopting rules, inspect facilities and records, develop guidelines for the approval of accreditation organizations, petition the court (independently or in conjunction with the department) for receivership of a crisis stabilization unit or a residential treatment facility, and to change the trust fund designated for receipt of moneys AHCA receives through regulation of entities

offering community alcohol, drug abuse, and mental health services in accordance with the requirements of ch. 394, F.S.;

- Provides additional grounds, relating to compliance with background screening requirements, for denial, revocation, or suspension of an assisted living facility, hospice, adult day care center, or adult family care home license;
- Requires the Department of Elderly Affairs to take disciplinary action against an area agency on aging for failure to implement and maintain a department-approved client grievance resolution procedure;
- Repeals licensure of designated health care services providers under s. 455.661, F.S.;
- Allocates three full-time positions to AHCA for the implementation and administration of the exemption program related to the background screening requirements provided in the bill and appropriations \$166,430 from the Health Care Trust Fund for the exemption program;
- Authorizes the Florida Department of Law Enforcement (FDLE) to establish additional job positions in excess of the total authorized positions (presumably, the reference to *authorized positions* is to positions allocated in other legislation or the General Appropriations Act because the bill makes no specific appropriation to FDLE); the additional positions are to be funded from FDLE's Law Enforcement Operating Trust Fund and the positions must be used to process the increased workload of conducting the criminal history records checks authorized by the bill; the positions are to be earmarked by FDLE, and when *no longer needed may be placed in a reserve status for future use*;
- The background screening requirements created in the bill are scheduled for repeal on June 30, 2001, unless reviewed and saved from repeal through reenactment by the Legislature; AHCA is required to convene a workgroup to evaluate the effectiveness of the background screening requirements in preventing persons with specified criminal backgrounds from operating health care programs, and in preventing or deterring health care fraud and abuse; the workgroup's report must be completed and a report submitted to the Legislature by January 1, 2001.
- Makes numerous cross reference, conforming, and other technical revisions.

If approved by the Governor, these provisions take effect July 1, 1998.

*Vote: Senate 39-0; House 118-0*

**CS/HBs 3089 & 171 — Nursing Homes/Employee Background Screening**

by Elder Affairs & Long Term Care Committee, Reps. Brooks, Diaz de la Portilla, Littlefield and others (CS/CS/SB 208 by Ways & Means Committee, Health Care Committee and Senators Brown-Waite, Latvala, Bronson, McKay and Grant)

The Committee Substitute for House Bills 3089 & 171 provides for expedited administrative hearings relating to certain disciplinary actions against a nursing home facility license, background screening of certain nursing home employees, and notification about screening results for employees of certain other specified health care facilities. The bill requires a Division of Administrative Hearings law judge to schedule a hearing within 120 days, unless both parties waive that time period, for consideration of an action by the Agency for Health Care Administration (AHCA or agency) against a nursing home facility's license relating to the health, safety, or welfare of nursing home residents. The administrative law judge must render a decision within 30 days after receipt of a proposed recommended order. Licensure actions relating to the suspension of a facility's license are excluded from the 120-day time frame to preserve a requirement that hearings relating to suspensions be held within 90 days.

The bill requires AHCA to establish and maintain a database of screened employees which includes giving AHCA electronic access to the Central Abuse Registry and Tracking System in the Department of Children and Family Services. The database is to maintain background screening information obtained through level 1 and level 2 screening and abuse registry screening. Level 2 screening is performed by the Florida Department of Law Enforcement and includes a criminal history check of the FBI's databases. The agency is required to establish a fee schedule of charges to cover the costs of level 1 and level 2 screening and abuse registry screening. Nursing homes may reimburse job applicants and employees for their screening costs. The Agency for Health Care Administration is *required*, as allowable, to reimburse nursing facilities for the cost of background screening; the reimbursements are explicitly excluded from the Medicaid reimbursement rate ceilings and payment targets. A nursing home employer or other employer authorized to obtain screening information from the AHCA database is absolved of liability for terminating an employee's employment because of disqualification following screening, even when the employee has applied for an exemption from disqualification. Nursing home facility administrators are authorized to acknowledge to other such administrators receipt of a qualifying or disqualifying screening subject to a requirement of providing the date of the screening report referenced. Also, an employer is authorized to obtain written verification of qualifying screening results for an employee or prospective employee from the previous employer or other entity which caused such screening to be performed.

The Agency for Health Care Administration is authorized to exempt from disqualification from employment an employee or prospective employee who is subject to the bill's screening

requirements and who is not a professional licensed or certified by the Department of Health. Similarly, the Department of Health is authorized to exempt from disqualification from employment an employee or prospective employee who is subject to the bill's screening requirements and who is a professional licensed or certified by the department. Employees and prospective employees who have been screened and qualified for employment, who have not been unemployed for more than 180 days after qualification, and who under penalty of perjury attest to not having been convicted of a disqualifying offense since the completion of screening may not be required to be rescreened. Current law relating to the screening of certified nursing assistants is repealed, as they are subject to the screening requirements of this bill.

If approved by the Governor, these provisions take effect July 1, 1998, except as otherwise provided.

*Vote: Senate 39-0; House 117-0*

### **HB 3231 — Rural Hospitals**

by Reps. Burroughs, Horan, and Melvin (SB 170 by Senator Childers)

This act (Chapter 98-21) modifies the statutory definition of the term "rural hospital" to require population densities used in the definition of that term to be based upon the most recently completed United States census. The act requires a study to be performed by the Agency for Health Care Administration, in consultation with the Department of Health and representatives of the hospital industry, regarding the adequacy of the statutory definition of the term "rural hospital." The Agency for Health Care Administration must submit its findings and recommendations to the Governor, the Speaker of the House of Representatives, and the President of the Senate no later than December 31, 1999.

These provisions became law without the Governor's signature on April 22, 1998.

*Vote: Senate 36-0; House 116-0*

### **CS/HB 3585 — Public Records/Private Corporations Leasing Public Health Care Facilities**

by Governmental Operations Committee, Rep. Peaden and others (CS/CS/SB 1044 by Governmental Reform & Oversight Committee, Health Care Committee, and Senator Williams)

The bill provides for the confidentiality of the records of private corporate entities that lease public hospitals or other public health care facilities. Such records and the meetings of the governing board of the private corporation are also made exempt from the constitutional and statutory Public Records Law and Public Meetings Law requirements when the public lessor complies with certain public finance accountability guidelines relating to the transfer of any public funds to the private lessee (requiring that payments in excess of \$100,000 from the public entity that owns the facility

to its private lessee is subject to the governmental entity's appropriations process) and when the private lessee meets at least three of five criteria. The five criteria are: 1) the public lessor was not the incorporator of the private corporation that leases the public hospital or other health care facility; 2) the public lessor and the private lessee do not commingle any of their funds in any account maintained by either of them, except as specifically authorized for administrative purposes; 3) the private lessee is not allowed to participate in the decision-making process of the public lessor, except as a member of the public or as otherwise provided in law; 4) the lease agreement does not expressly require the lessee to comply with the requirements of the Public Records Law or the Public Meetings Law; or 5) the public lessor is not entitled to receive any revenues from the lessee, except rental or administrative fees due under the lease, and the lessor is not responsible for the debts or other obligations of the lessee. Clarifying language, contained in the bill, provides that the Florida Rules of Civil Procedure and statutory provisions relating to civil actions apply to all records and information made confidential and exempt by enactment of the bill. The provisions of the bill are made to apply retroactively to all existing lease arrangements of public hospitals and other public health care facilities and prospectively to all new lease arrangements that meet the requirements of the bill. A statement of public necessity is provided in conformity with the requirements of s. 24, Art. I, State Constitution.

If approved by the Governor, these provisions take effect upon becoming law.

*Vote: Senate 39-0; House 116-0*

### **HB 3971 — Health Facilities Authorities/Accounts Receivables**

by Reps. Gay and others (CS/SB 1060 by Health Care Committee and Senator Silver)

The bill empowers health facilities authorities established under ch. 154, F.S., to issue bonds and incur other forms of indebtedness on behalf of a health facility (private, not-for-profit corporations organized as hospitals, nursing homes, developmental disabilities facilities, mental health facilities, or providers of life care services under continuing care contracts) or a group of health facilities to use in financing the purchase of accounts receivables acquired from other not-for-profit health facilities, whether or not affiliated with the authority, including out-of-state, not-for-profit health facilities.

The bill amends s. 212.08(7)(o), F.S., to provide a sales tax exemption for a not-for-profit health system foundation which applied for such an exemption from the Department of Revenue in an application filed prior to November 15, 1997, and which application is subsequently approved. The exemption would apply retroactively to any unpaid taxes on purchases made during the period November 14, 1990 to December 31, 1997.

If approved by the Governor, these provisions take effect upon becoming law.

*Vote: Senate 38-0; House 119-0*

**CS/HB 4455 — Mobile Surgical Facilities/Licensure**

by Corrections Committee and Reps. Brooks and Trovillion

The bill authorizes mobile surgical facilities to contract with the Department of Corrections to provide elective surgical services to inmates of the Department of Corrections or private correctional facilities. A descriptive definition of “mobile surgical facility” is added to ch. 395, F.S., which also provides for the regulation of hospitals and ambulatory surgical centers. Mobile surgical facilities are placed under the regulatory jurisdiction of the Agency for Health Care Administration. These facilities are exempted from certificate-of-need requirements. Mobile surgical facilities that operate under contracts entered into on or after July 1, 1998, are made subject to the Public Medical Assistance Trust Fund assessment.

If approved by the Governor, these provisions take effect upon becoming law.

*Vote: Senate 40-0; House 116-0*

**HB 4515 — Health Care Practitioner/Credentials**

by Health Care Standards & Regulatory Reform Committee, Rep. Jones and others (SB 1940 by Senator Myers)

The bill requires the Department of Health, for the purpose of eliminating duplication in the verification of credentials of health care practitioners, to develop standardized forms necessary for the creation of a standardized system as well as guidelines for collecting, verifying, maintaining, storing, and providing core credentials data on health care practitioners through credentials verification entities. The bill requires the department, in consultation with the applicable practitioner licensure board to adopt rules necessary to develop and implement a standardized credentials-verification program. The department must appoint a 13-member Credentials-Verification Advisory Council to assist with development of guidelines for the establishment of the standardized credentials-verification program. The department in consultation with the Credentials Verification Advisory Council must establish the minimum liability insurance requirements for each credentials verification entity doing business in Florida.

The bill requires persons applying for licensure as a medical physician, osteopathic physician, physician assistant, chiropractic physician, or podiatric physician to submit individual initial core credentials data to a credentials verification entity, if the information has not already been submitted to the Department of Health, the appropriate licensing board, or to any other credentials verification entity. The department must maintain all core credentials data. The bill defines “core credentials data” to mean: professional education; professional training; peer references; licensure;

social security number; foreign medical graduate information; board certification; hospital and managed care affiliations; practitioner profiling data; professional liability insurance, claims, suits, judgments, or settlements; Medicare or Medicaid sanctions; civil or criminal law violations; regulatory exemptions not previously reported to the Department of Health; and special conditions of impairment. Before releasing a health care practitioner's core credentials data from its data bank, a designated credentials verification entity other than the Department of Health must provide health care practitioners up to 30 days to review the core credentials data and to make any corrections of fact. Health care entities are prohibited from attempting to collect duplicate core credentials data from individual health care practitioners or from originating sources. Any health care entity that employs, contracts with, or allows health care practitioners to treat its patients must use the credentials verification entity that is designated by a health care practitioner applying for privileges with that entity to obtain core credentials data for the health care practitioner.

The bill requires any credentials verification entity that does business in Florida to meet national standards, as outlined by national accrediting organizations, and to register with the department. Any credentials verification entity that fails to meet the required standards, fails to register with the department, or fails to provide data collected on a health care practitioner may not be selected as the designated credentials verification entity for any health care practitioner. The bill provides that any health care entity will not be liable for any civil, criminal, or administrative actions, if it relies on data obtained from a certified credentials verification entity.

The Secretary of Health must reappoint the health care credentials task force created by s. 103 of ch. 97-261, L.O.F. The task force must develop procedures to expand the standardized credentials verification program and its activities may include site visits.

The bill appropriates \$5,560,000 from the Medical Quality Assurance Trust Fund and seven positions to the Department of Health to implement the standardized credentials verification program.

If approved by the Governor, these provisions take effect July 1, 1999.

*Vote: Senate 38-0; House 110-0*

## **REGULATION OF HEALTH CARE PRACTITIONERS**

### **CS/SB 290 — Paramedics & Emergency Medical Technicians**

by Health Care Committee and Senator Klein

The bill authorizes a paramedic or emergency medical technician to perform health promotion and wellness activities and blood pressure screening in a nonemergency environment within the scope of training of the paramedic or emergency medical technician and under the direction of an emergency medical service's medical director. The bill defines "health promotion and wellness." Under the direction of an emergency medical service's medical director, a paramedic may administer immunizations in a nonemergency environment that is in accord with the protocols, policies, and procedures in a written agreement between the medical director and the county health department located where the paramedic administers immunizations. The bill makes an emergency medical service's medical director liable for any act or omission of any paramedic or emergency medical technician acting under his or her supervision and control when performing blood pressure screening, health promotion and wellness activities or administering immunizations, which is not in the provision of emergency care. The bill modifies the ground for which a paramedic or emergency medical technician may be subject to discipline for unprofessional conduct to include the undertaking of activities that the emergency medical technician or paramedic is not qualified by experience or training to perform. The bill grants rulemaking authority to the Department of Health to enforce the provisions relating to a paramedic's administration of immunizations and the performance of health promotion and wellness activities and blood pressure screening by a paramedic or emergency medical technician in a nonemergency environment.

If approved by the Governor, these provisions take effect upon becoming law.

*Vote: Senate 37-0; House 119-0*

### **CS/SB 776 — Physician Assistant Certification**

by Health Care Committee and Senator Clary

The bill revises alternate physician assistant certification requirements for certain unlicensed physicians who are foreign medical school graduates. The bill exempts the applicants under the alternate physician assistant certification requirements from a practical component of the certification examination. The Department of Health must incorporate any practice competencies into the written physician assistant examination. The bill revises the frequency of the department's administration of the examination so that there is a 1-year interval between the reporting of the scores of the first and subsequent examinations and the administration of the next examination. The bill revises the time frame for requests for the examination to be translated into a foreign language and specifies procedures for applicants to demonstrate their competency to communicate

in basic English. The bill revises the procedures for a supervisory physician to notify the Department of Health of his or her intent to delegate prescriptive authority to a physician assistant and requires the physician to notify the department regarding any change in the prescriptive privileges delegated to a physician assistant. The bill makes conforming changes to reflect the supervision of physician assistants by both medical and osteopathic physicians. The bill changes references to “certified physician assistant” throughout the Florida Statutes to “licensed physician assistant.”

If approved by the Governor, these provisions take effect upon becoming law.

*Vote: Senate 38-0; House 113-3*

### **CS/SB 2128 — Regulation of Professions**

by Health Care Committee and Senator Myers

The bill makes a number of minor substantive changes to ch. 455, F.S., and the various practice acts for professions under the Department of Health and the Department of Business and Professional Regulation, to correct statutory cross-references, references to the appropriate department, and inadvertent substantive glitches in the law resulting from the 1997 division of statutory provisions for the departments into parts I and II of ch. 455, F.S. The bill changes references to “podiatry” to “podiatric medicine” and references to “podiatrist” to “podiatric physician” throughout the Florida Statutes. The bill changes references to “chiropractor” to “chiropractic physician” and references to “chiropractic” to “chiropractic medicine” throughout the Florida Statutes.

The bill revises the disclosure requirements for medical physicians and osteopathic physicians who do not carry medical malpractice insurance so that such physicians must provide their patients with *either* a notice in the form of a prominently displayed sign *or* provide a written statement to any person to whom medical services are being provided. The bill deletes the requirement that a physician obtain a written statement from the patient acknowledging receipt of the disclosure that the physician has no medical malpractice insurance. The bill requires the Department of Health to notify health maintenance organizations of any disciplinary action taken by a licensed health care facility or professional standards review organization against a licensed medical physician or a licensed osteopathic physician.

The bill authorizes the Board of Medicine and the Board of Osteopathic Medicine, respectively, to establish by rule, standards of practice and standards of care for particular practice settings to include but not be limited to, education and training, equipment and supplies, medications including anesthetics, assistance of and delegation to other personnel, transfer agreements, sterilization, records, performance of complex or multiple procedures, informed consent, and policy and procedure manuals. The bill revises requirements for a hospital’s submission of reports on resident physicians, interns, and fellows so that the reports may be submitted on dates

designated by the Board of Medicine and the Board of Osteopathic Medicine, respectively, in consultation with the Department of Health rather than on January 1 or July 1 of each year.

The bill specifies physical requirements for any license issued by the Department of Health to health care professionals so that the license must consist of: a wallet-size identification card; a 3-inch by 5-inch certificate; and an 8½-inch by 13-inch wall certificate, and a wall certificate which may not be smaller than 8½ inches by 14 inches suitable for conspicuous display. The bill requires licensed health care professionals whose licenses are revoked or suspended to surrender the wallet-size identification card and wall certificate to the department and specifies a mechanism for their return to the licensee upon reinstatement of the revoked or suspended license. The bill grants rulemaking authority to the Department of Health or the appropriate board within the department to approve alternative methods of obtaining continuing education credits in risk management. The alternative methods may include attending a board meeting at which a licensee is disciplined, serving as a volunteer expert witness for the department in a disciplinary case, or serving as a member of a probable cause panel following the expiration of a board member's term. The bill grants rulemaking authority to the Department of Health to adopt rules to administer and develop examinations for health care professions and for establishing requirements for a written protocol between athletic trainers and their supervising physicians. The bill extends exemptions to the fictitious name registration requirements to persons licensed by the Department of Health, for the purpose of practicing their licensed profession and the transaction of business ancillary to the practice of the profession. The bill revises health insurance coverage of massage services.

The bill adds dentists and dental hygienists to the definition of health care provider for purposes of extending sovereign immunity to their practice under certain circumstances. The bill allows physicians who hold limited licenses to practice medicine, to work for any approved employer in an area of critical need approved by the Board of Medicine. The physicians holding limited licenses must within 30 days after accepting employment, notify the Board of Medicine of all approved institutions in which the limited license holders practice and of all approved institutions where practice privileges have been denied. The bill allows an individual who is licensed to prescribe medicinal drugs in Florida to dispense up to a 24-hour supply of a medicinal drug to any patient of an emergency department of a hospital that operates a Class II institutional pharmacy, if the physician treating the patient in such hospital's emergency department determines that the medicinal drug is warranted and that community pharmacy services are not readily accessible, geographically or otherwise, to the patient.

The bill deletes the requirement that the chiropractor member of the Council of Athletic Training be certified in the specialty of sports medicine by the Chiropractic Council on Sports Medicine. The bill revises the requirements for the chiropractor member of the Advisory Council of Medical Physicians under the Department of Health to only require the chiropractor member to practice

radiology instead of requiring the chiropractor member to hold board certification from the American Chiropractic Radiology Board or its equivalent.

The bill authorizes the Department of Health to issue a physicist-in-training certificate to a person qualified to practice medical physics under direct supervision and to establish, by rule, requirements for initial certification and renewal of a physicist-in-training certificate. The bill extends the grandfather clause for persons who would be subject to licensure as a medical physicist from October 1, 1997 until October 1, 1998 to allow certain persons who meet specified educational and experience requirements to become licensed as medical physicists.

The bill requires any independent special hospital district with taxing authority which owns two or more hospitals to provide requested medical records within 20 days of the request for the records relevant to any litigation of medical negligence claim or defense, rather than 10 days of the request for the records. The bill repeals s. 455.661, F.S., that subjects entities that furnish clinical laboratory services, diagnostic-imaging services, physical therapy services, comprehensive rehabilitative services, or radiation therapy services to licensure by the Agency for Health Care Administration.

The bill revises alternate medical licensing requirements for certain foreign-trained physicians to become licensed in Florida by deleting a requirement that the licensing examination required for these applicants be in the same form and content and administered in the same manner as the FLEX, a national medical licensing examination. The bill revises the date that the Department of Health must develop an examination for the alternate medical licensing pathway from September 1, 1998 to December 31, 1998. The bill provides an appropriation of \$1.2 million from the Medical Quality Assurance Trust Fund to the Department of Health to have the examination required under the alternate medical licensing pathway developed by contract with the University of South Florida and authorizes the department to charge examinees a fee that, in the aggregate, will reimburse the Medical Quality Assurance Trust Fund for the amount advanced to the department.

The bill provides an alternate path to become a licensed psychologist for persons who have received and submitted to the Board of Psychology, before July 1, 2001, certification of a doctoral-level program that at the time the applicant was enrolled and graduated maintained a standard of education and training comparable to the standard of training of programs accredited by a programmatic agency recognized and approved by the U. S. Dept. of Education. The bill also limits the alternate psychology licensing path to persons who were enrolled in a program that the Board of Psychology determined was comparable to standards of education and training

comparable to the standard of training of programs accredited by a programmatic agency recognized and approved by the U. S. Dept. of Education before October 1, 1995.

If approved by the Governor, these provisions take effect July 1, 1998.

*Vote: Senate 34-3; House 117-0*

### **HB 4365 — Acupuncture/Oriental Medicine**

by Rep. Kelly (CS/SB 2282 by Health Care Committee and Senator Gutman)

The bill redefines the term “acupuncture” to include “modern Oriental medical techniques” and defines “Oriental medicine.” “Oriental medicine” means the use of acupuncture, electro-acupuncture, Qi Gong, oriental massage, herbal therapy, dietary guidelines, and other adjunctive therapies. The bill revises the licensing requirements for acupuncturists under both the 3-year course of study and the 4-year course of study to conform to the change in the definition of acupuncture as revised by the bill to include an academic course in Oriental medicine. The bill increases the five-member Board of Acupuncture to seven by adding two additional acupuncturists to the board. Effective July 1, 2001, applicants for acupuncturist licensure must complete a course on first aid and cardiopulmonary resuscitation. The bill revises continuing education requirements for acupuncturists and eliminates the Board of Acupuncture’s authority to approve criteria for continuing education programs and courses. The bill provides additional prohibitions under the acupuncturist practice act in ch. 457, F.S.

If approved by the Governor, these provisions take effect October 1, 1998.

*Vote: Senate 40-0; House 117-0*

## **CHILDREN’S HEALTH CARE**

### **CS/SB 228 — Health Insurance Coverage for Cleft Lip and Cleft Palate**

by Health Care Committee, Senator Gutman and others

The bill requires an insurance policy that covers a child under age 18 to provide coverage for treatment of cleft lip and cleft palate for the child. Insurers must cover medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by a treating physician or surgeon and such physician or surgeon certifies that such services are medically necessary and consequent to treatment of cleft lip or cleft palate. The bill specifies that terms and conditions applicable to other benefits apply to these coverage requirements, and specifies the inapplicability of the coverage requirement to specified-accident, specified disease, hospital indemnity, limited benefit disability income, or long-term care insurance policies. The bill applies

this coverage requirement to a policy of individual insurance (s. 627.64193, F.S.); group, blanket, or franchise accident or health insurance (s. 627.66911, F.S.), including an out-of-state group health insurance (s. 627.6515(2)(c), F.S.), and small group health insurance (s. 627.6699(12)(b), F.S.); and to a contract issued by a health maintenance organization (s. 641.31(34), F.S.).

The bill provides a statement of public necessity for the coverage requirements, in compliance with constitutional requirements regarding mandates on local governments.

If approved by the Governor, these provisions take effect October 1, 1998, and are applicable to policies and contracts issued or renewed on or after that date.

*Vote: Senate 39-0; House 119-0*

### **CS/HB 3145 — Targeted Outreach for Pregnant Women**

by Health Care Services Committee, Rep. Heyman and others (CS/SB 1258 by Health Care Committee and Senator Harris)

This bill creates s. 381.0045, F.S., and entitles this section as the “Targeted Outreach for Pregnant Women Act of 1998.” The bill establishes a 2-year targeted outreach pilot program for high-risk pregnant women who may not seek proper prenatal care, who suffer from substance abuse, or who are infected with HIV. The pilot counties are Dade, Broward, Palm Beach, Hillsborough, and Orange, and the program is to function through the county health departments in these counties.

The bill specifies duties of the Department of Health, and requires the Department of Health to coordinate the outreach programs through contracts with, grants to, or other working relationships with persons or entities where the target population is likely to be found, to provide services and information to high-risk pregnant women and their infants. The bill requires the Department of Health to compile reports and recommendations regarding the program, to include specific topics.

A series of “whereas” clauses provide background information as to the need for the pilot program.

The bill appropriates \$15.6 million from the Tobacco Settlement Trust Fund and \$1.4 million non-recurring general revenue, to be used in unspecified amounts, for:

- The implementation of the act;
- The replacement of the Department of Health’s Tampa branch laboratory;

- The Healthy Moms and Healthy Babies facility at the University of South Florida;
- The construction/renovation of the Hendry County Health Department; and
- The Center for Urban Transportation Research at the University of South Florida.

The bill also repeals s. 206.606(1)(c), F.S., relating to \$1.5 million per year from the Fuel Tax Collection Trust Fund for transfer to the Board of Regents for the Center for Urban Transportation Research, effective July 1, 1998.

If approved by the Governor, these provisions take effect October 1, 1998, except as otherwise provided.

*Vote: Senate 39-0; House 119-0*

### **HB 3999 — Termination of Pregnancy/Parental Notification**

by Rep. Sindler and others (CS/SB 1814 by Health Care Committee, Senator Harris and others)

House Bill 3999 is designated the “Parental Notice of Abortion Act.” The act requires that a physician who refers a minor for termination of her pregnancy or who plans to perform such a procedure on a minor must first give 48-hours *actual notice* prior to the procedure to one parent of the minor or her legal guardian. If actual notice is not possible after reasonable effort, 48 hours *constructive notice* (thus, certified mail to the last known address of the parent or legal guardian of the minor, with delivery deemed to have occurred 48 hours after the certified notice is mailed) must be given by person or his or her agent. Notice is not required: (1) in instances of a medical emergency, as provided in the bill; (2) when notice is waived in writing by the person who is *entitled* to notice; (3) if the minor is, or has been, married or has had the disability of nonage removed under a state law; (4) if the patient has a minor child dependent on her; or (5) when a court judicially waives notice based upon a petition filed by the minor seeking to terminate her pregnancy, as provided in the bill. A physician who violates the notice requirements established under the bill is subject to disciplinary action under either the medical practice act or the osteopathic medical practice act.

#### ***Judicial Waiver of the Parental Notification Requirement***

The bill provides a procedure for the judicial waiver of parental notice. This procedure requires that a pregnant minor who wants to terminate her pregnancy without notifying at least one of her parents or her legal guardian before the procedure is performed or the termination of pregnancy is induced must file a petition with *any* circuit court for a waiver of the bill’s notice requirements. She is authorized to participate in the proceedings on her own behalf. The petition shall include a

statement that the complainant is pregnant and notice has not been waived. The court may appoint a guardian ad litem for her. The court must advise the minor that she has a right to court-appointed counsel and must provide her with counsel upon her request. However, no county may be obligated to pay the fee, salary, costs, or expenses of any counsel appointed by the court.

The bill makes such court proceedings confidential and requires that the courts ensure the anonymity of the minor, including allowing the minor to use a pseudonym (such as “Jane Doe”) or only her initials. Additionally, the court proceedings shall be sealed. All *documents* relating to the proceedings are given confidential status and are made unavailable to the public.

The courts are directed to give precedence to the proceedings relating to petitions for waiver of notice over *other pending matters to the extent necessary to ensure that the court reaches a decision promptly*. At the hearing on the petition, the court must receive evidence relating to the emotional development, maturity, intellect, and understanding of the minor, and must issue written and specific factual findings and legal conclusions supporting its decision and shall order that a confidential record of the evidence and the judge’s findings and conclusions be maintained. The court must rule, and issue written findings of fact and conclusions of law, within 48 hours *of the time that the petition was filed unless an extension is requested by the minor who submitted the petition*. If the court that is petitioned fails to rule within the 48-hour period and an extension has not been requested, the petition *is deemed to have been granted and the notice requirement is waived*.

A circuit court may waive the notice requirement if it finds, using a clear and convincing evidence standard, that the minor *is sufficiently mature to decide whether to terminate her pregnancy or that there is a pattern of physical, sexual, or emotional abuse of the minor by a parent, guardian, or custodian or that the notification of the parent or guardian is not in the best interest of the complainant*. If the court makes any such finding, it must issue an order authorizing the minor to consent to the performance or inducement of a termination of pregnancy *without notification of a parent or guardian*. If the court does not make at least one of the specified findings, it is required to dismiss the petition, and either the referring physician or the physician to perform or induce the termination of pregnancy must notify at least one of her parents or her legal guardian.

### ***Expedited Appeal of a Petition for Waiver of Notice that is Denied and Court Fees***

If the petition for waiver of parental notification is denied by the circuit court, an *expedited confidential appeal must be available*, as provided by rule of the state Supreme Court. However, an order authorizing waiver of notice is not subject to appeal. No filing fees may be assessed against a minor petitioning for judicial waiver of parental notification at either the trial or appellate levels. The notice requirements and procedures, as provided in the bill, are made available to

minors *whether or not they are residents of Florida*. The state Supreme Court is requested to adopt rules to ensure that proceedings under s. 390.0111, F.S., are handled in an *expeditious and confidential manner and in a manner which will satisfy the requirements of federal courts*.

The provisions of the bill are explicitly made severable.

If approved by the Governor, these provisions take effect July 1, 1999.

*Vote: Senate 31-9; House 92-25*

### **CS/HB 4415 — Children’s Health**

by Health and Human Services Appropriations Committee, Health Care Services Committee, Rep. Albright and others (CS/CS/CS/SB 1228 by Ways & Means Committee, Banking & Insurance Committee, Health Care Committee, Senators Brown-Waite, Myers and others)

The bill implements, in Florida, a children’s health insurance program in conformance with the State Children’s Health Insurance Program provisions (Title XXI) of the federal Balanced Budget Act of 1997 (P.L. 105-33). The bill creates the “Florida Kidcare Act” as ss. 409.810-409.820, F.S., specifies the Florida Kidcare program’s purpose, and defines 27 specific terms used in the act. The Florida Kidcare program is an umbrella children’s health insurance program that includes the following components:

- Medicaid children’s coverage;
- Florida Healthy Kids Program;
- A Medikids component (for children ages 0 to 5), a non-entitlement, Medicaid look-alike program;
- Employer-based health insurance plans (indemnity and HMOs); and
- The Children’s Medical Services network (for children with special health care needs).

The bill indicates that, with the exception of Medicaid, program coverage is not an entitlement and stipulates that there is no cause of action against the state and its agencies for failure to make health care services available under the program.

The bill creates the Medikids program component and specifies: purpose; administration; insurance licensure not required; applicability of Medicaid laws; benefits; eligibility; periodic open enrollment; special enrollment periods; and penalties for voluntary cancellation.

The bill provides for annual enrollment and expenditure ceilings for the non-Medicaid components of the Florida Kidcare program.

The bill directs the Department of Health to contract with the Department of Children and Family Services to provide behavioral health services to non-Medicaid-eligible children with special health care needs. The bill authorizes the Department of Children and Family Services to establish behavioral health services' scope, clinical guidelines, standards, performance and outcome measures, practice guidelines, and rules.

The bill specifies health benefits coverage:

- For Medicaid and Medikids eligibles, the Medicaid benefits are to be provided.
- Establishes the existing Florida Healthy Kids program benefit package, with some modifications, as the benchmark for other coverage to be offered under the program.

The bill provides eligibility guidelines, targeting those children whose family income is at or below 200 percent of the federal poverty level, with no asset test:

- A Medicaid eligible child must be enrolled in Medicaid.
- A child not eligible for Medicaid is eligible for premium assistance for remaining program components to the extent coverage is available in the child's county of residence.
- A child with special health care needs is eligible for subsidized health benefits coverage under the Children's Medical Services network.
- Certain children excluded from eligibility under Title XXI of the Social Security Act are excluded.

The bill authorizes participation, without premium assistance, for children whose family income exceeds 200 percent of the federal poverty level.

The bill provides for a 6-month period of continuous eligibility for all program components, with the exception of children less than age 5 who are eligible for Medicaid, who are granted 12 months of eligibility without a redetermination or reverification of eligibility, effective January 1, 1999.

The bill provides limits on family premium contributions and other cost sharing specific to:

- Medicaid;
- Those with family income at or below 150 percent of the federal poverty level; and
- Those with family income above 150 percent of the federal poverty level.

The bill specifies requirements for health benefits coverage for purposes of such coverage qualifying for premium assistance under the program:

- Be certified by the Department of Insurance as meeting, exceeding, or being actuarially equivalent to the benchmark benefit plan;
- Be guarantee issued;
- Be community rated (for health insurance);
- Have no preexisting condition exclusion (with specific exceptions);
- Comply with applicable premium and cost-sharing limitations;
- Meet quality assurance and access standards; and
- Establish periodic open enrollment periods.

The bill specifies that a health maintenance organization or a health insurer may, at the provider's option, reimburse providers located in rural counties according to the Medicaid fee schedule for services rendered to enrollees in rural counties.

The bill provides for program evaluation, with a collaborative annual report to be submitted to the Legislature by January 1 of each year by the agencies involved in program administration. The evaluation must include an assessment of "crowd-out" and access to health care, as well as a series of additional specified issues.

The bill provides for administration, specifying agency functions for:

- **Department of Children and Family Services** - developing a simplified eligibility application form, establishing and maintaining the eligibility determination process, informing program applicants about eligibility determinations and informing program providers about eligibility, and adopting necessary rules.
- **Department of Health** - designing an eligibility intake process, designing and implementing program outreach activities, chairing a state-level coordinating council relating to program implementation and operation, establishing a toll-free telephone line for the program, and adopting necessary rules.
- **Agency for Health Care Administration** - calculating the premium assistance payment levels, calculating the annual program enrollment ceiling, making premium assistance payments, monitoring compliance with quality assurance and access standards, establishing a mechanism for investigating and resolving complaints and grievances, approving health benefits coverage for program participation, and adopting necessary rules. The agency is designated the lead state agency for Title XXI for purposes of receipt of federal funds, for reporting purposes, and for ensuring compliance with federal and state regulations and rules.
- **Department of Insurance** - certifying that plans (excluding those offered through the Florida Healthy Kids program and the Children's Medical Services network) meet, exceed, or are actuarially equivalent to the benchmark benefit plan, ensuring that such plans will be offered at an approved rate, and adopting necessary rules.
- **The Florida Healthy Kids Program** - maintaining current functions as authorized in s. 624.91, F.S.

The bill authorizes these implementing agencies, after consultation with and approval of the Legislature, to make program modifications necessary to overcome any objections of the federal Department of Health and Human Services in the plan approval process.

The bill gives the Department of Health lead responsibility for program outreach, in conjunction with other agencies, and in so doing specifies the activities to be included, with an emphasis on targeting minority children. (Transfers and renumbers s. 154.508, F.S., as s. 409.819, F.S., and amends that section.)

The bill provides for the development of a minimum set of quality assurance and access standards for the program.

The bill specifies detailed performance-based program budgeting performance measures and outcome standards for the program for FY 1998-99.

The bill directs the Agency for Health Care Administration to conduct a study of extending Medicaid presumptive eligibility to children, with a report to the Legislature no later than December 31, 1998.

The bill establishes an enrollment ceiling of 270,000 children for FY 1998-99 for the non-Medicaid portion of the program.

The bill amends s. 409.904, F.S., to extend optional Medicaid eligibility to children ages 15 to 19 with family income up to 100 percent of the federal poverty level, up from the current 28 percent of the federal poverty level for these children, and to specify 6 months of continuous eligibility for children under the Medicaid program and, effective January 1, 1999, 12 months of continuous eligibility for Medicaid children under age 5.

The bill amends s. 409.906, F.S., to establish as a new optional service under the Medicaid program Healthy Start services, if a federal waiver is approved. The bill directs the Agency for Health Care Administration, working jointly with the Department of Health and the Association of Healthy Start Coalitions, to seek a waiver to secure Medicaid matching funds for Healthy Start services.

The bill completely rewrites ch. 391, F.S., relating to Children's Medical Services. The rewrite addresses: the focus and mission of the program; applicability and scope of services; the insurance, managed care approach; eligibility; benefits; service delivery; program components; and Medicaid versus non-Medicaid issues. The bill transfers the provisions relating to pediatric extended care centers from ch. 391, F.S., to a new part IX of ch. 400, F.S.

The bill revises s. 409.9126, F.S., relating to the Children's Medical Services network, to: make the network available to children with special health care needs who are eligible for the Florida Kidcare program; make capitated reimbursement applicable only to Medicaid-eligible children with special health care needs, effective July 1, 1999; make the Agency for Health Care Administration responsible for determining the number of enrollment slots approved for a managed care plan based on the plan's network capacity to serve children with special health care needs; and delete from statute provisions relating to definitions (which are contained in the ch. 391, F.S., rewrite), provider gatekeeper roles, agency rules, network initiation, network contracting, and network evaluation.

The bill revises s. 624.91, F.S., relating to the Florida Healthy Kids Corporation, to: provide legislative intent; state the non-entitlement, no-cause-of-action nature of the program; and modify the duties of the program. The bill provides for the applicability of the provisions of this act to existing Florida Healthy Kids provider contracts.

The bill establishes thresholds for future legislative review and repeal of the Florida Kidcare program based on specified reductions in the federal matching funding percentage and the state's actual allocation of federal funding.

The bill repeals the following sections of statute:

- Section 391.031, F.S., relating to Children's Medical Services' patient care centers;
- Section 391.056, F.S., relating to the appointment of Children's medical Services district program supervisors; and
- Section 624.92, F.S., as created by s. 9 of ch. 97-260, L.O.F., relating to limitations on the Florida Healthy Kids Corporation enrollment and eligibility duration.

If approved by the Governor, these provisions take effect July 1, 1998.

*Vote: Senate 39-0; House 113-0*

## **MANAGED CARE CONSUMER PROTECTIONS**

### **CS/HB 1005 — Managed Care/Subscriber Grievances**

by Health Care Standards & Regulatory Reform Committee and Rep. Saunders (CS/SB 162 by Banking & Insurance Committee and Senator Brown-Waite)

The bill (Chapter 98-10) amends ss. 408.7056 and 641.511, F.S., to clarify the types of grievances filed by managed care entity subscribers and providers that are within the jurisdiction of the Statewide Provider and Subscriber Assistance Program. The bill establishes general, expedited, and emergency procedures for the review of grievances by the panel, and provides for one or more panels that meet as often as necessary to timely review, consider, and hear grievances and make recommendations to the Agency for Health Care Administration (agency or AHCA) or the Department of Insurance (department) regarding any actions concerning individual cases heard by the panel. The bill provides that the panel must make written findings of fact and written recommendations and establishes a set period of time for the agency or the department to consider the panel's recommendations and findings of fact. The agency or the department may adopt such recommendations or the findings of fact in a proposed order or an emergency order. The agency or department is authorized to issue a proposed order or an emergency order, as provided in ch. 120, F.S., imposing fines or sanctions. The agency and the department's actions are subject to ch. 120, F.S., the Administrative Procedure Act. The bill also provides that if an order only involves the panel's recommendations, the order shall be subject to a summary hearing under s. 120.574, F.S., unless both parties agree otherwise. If the managed care entity does not prevail at the hearing, it

must pay AHCA's or the department's reasonable costs and attorney's fees incurred because of the hearing. The bill appropriates six full-time-equivalent positions and \$308,830 from the Health Care Trust Fund to AHCA for the implementation of the bill's provisions during FY 1998-99.

These provisions became law upon approval by the Governor on December 1, 1998.

*Vote: Senate 38-0; House 107-0*

## **PUBLIC HEALTH AND MEDICAID**

### **CS/CS/SB 484 — Public Assistance/Medicaid and Public Health**

by Ways & Means Committee and Health Care Committee

This bill was initiated as the product of an interim project by the Committee on Health Care relating to Medicaid reform, supervised by Senator Bankhead. The bill was subsequently amended to incorporate several additional issues, which are delineated below.

#### ***Medicaid-General Provisions***

The bill amends s. 409.903, F.S., relating to mandatory payments for eligible persons, to reflect current policies and practices regarding Medicaid eligibility and to clarify the circumstances under which a low-income family with children is considered eligible for Medicaid. Specifically, such family:

- Must include a dependent child living with a caretaker relative.
- Must have an income that does not exceed the gross income test.
- Have a countable income that does not exceed the applicable AFDC or successor WAGES income requirements.

The bill amends s. 409.908, F.S., relating to Medicaid reimbursement, to direct the Agency for Health Care Administration (AHCA) to establish a case-mix reimbursement methodology for nursing homes no earlier than the rate-setting period beginning April 1, 1999, and to specify how AHCA is to develop the case-mix reimbursement methodology. The bill provides an option for AHCA to modify the patient care component of the current nursing home reimbursement methodology if sufficient data are not available to implement the planned case-mix reimbursement

methodology. The bill prescribes guidelines for Medicaid payment of Medicare deductibles and coinsurance for those Medicaid recipients who are dually eligible for both Medicare and Medicaid.

The bill amends s. 409.912, F.S., relating to cost-effective purchasing of services under Medicaid to:

- Authorize the district 6 prepaid mental health pilot project provider entity to be licensed by December 31, 1998, as a prepaid limited health service organization under ch. 636, F.S., in addition to existing licensure options as a health maintenance organization under ch. 641, F.S., or an insurer under ch. 624, F.S.
- Specifically authorize AHCA to include disease management initiatives in its health care utilization review strategies.
- Specifically authorize AHCA to competitively negotiate home health services, including seeking any needed federal waivers.
- Add a requirement that AHCA issue a request for proposals or intent to negotiate for a 3-year outpatient specialty services pilot project in a rural county and in an urban county. Project requirements and objectives are specified. Quality assurance review requirements are specified, as well as data reporting requirements for the projects. AHCA is required to report to the Legislature and the Governor its findings from the projects. The projects are not to conflict with the existing law requiring competitive negotiation of certain Medicaid services.

The bill further amends s. 409.912(3)(d), F.S., effective January 1, 1999, to delete a prohibition on federally qualified health center participation in the Medicaid provider service network demonstration project and eliminate a redundant provision relating to the demonstration project.

The bill amends s. 409.9122, F.S., relating to Medicaid managed care, to:

- Direct AHCA to reimburse county health departments the federal Medicaid share for school based services rendered to those Medicaid-eligible children enrolled in managed care plans or MediPass; and direct Medicaid managed-care contractors to attempt to enter agreements with county health departments for school based services. (This provides county health departments the same opportunity for Medicaid reimbursement for school-based services that local school

districts have when rendering services to comparable children under the certified school-match program.)

- Clarify which state agencies are involved in making Medicaid managed care or MediPass enrollees aware of their managed care enrollment options.
- Specify that Medicaid managed care recipients who do not choose a managed care plan or MediPass will be assigned to managed care plans or provider service networks until equal enrollment of 50 percent in MediPass and provider service networks and 50 percent in managed care plans is achieved, and subsequently such recipients will be assigned so as to maintain equal enrollment in MediPass and managed care plans for FY 1998-99.
- Increase from 60 days to 90 days the time period during which a Medicaid recipient may voluntarily change his or her mind about a selected managed care provider.
- Delete reference to any ratio of commercial enrollees to Medicaid enrollees in managed care plans.

### ***Medicaid-Third-Party Recoveries***

The bill amends s. 409.910, F.S., relating to Medicaid third-party liability, to specify the distribution of recoveries from third-party benefits resulting from recoupment of funds paid by Medicaid following a judgment, award, or settlement. After attorney's fees and taxable costs as defined by the Florida Rules of Civil Procedure, one-half of the remaining recovery shall be paid to AHCA up to the total amount of medical assistance provided by Medicaid, with the remaining recovery paid to the recipient. The fee for services of an attorney retained by the recipient or his or her legal representative is to be calculated at 25 percent of the judgment, award, or settlement. The bill requires that certain third-party benefits received by a Medicaid recipient be remitted to AHCA within 60 days after receipt of settlement proceeds.

The bill amends s. 414.28, F.S., relating to public assistance payments constituting debts of the recipient, to specify that claims made against the estate of a public assistance recipient be considered class 3 claims rather than class 7 claims under s. 733.707, F.S., relating to order of payment of claims under probate proceedings.

The bill amends s. 198.30, F.S., relating to the decedent information that circuit courts must furnish to the Department of Revenue, to require that this same information be submitted to AHCA by the circuit courts.

***General Public Provisions Health***

The bill amends s. 154.504, F.S., relating to eligibility and benefits under the “Primary Care for Children and Families Challenge Grant Act,” to prohibit the use of copayments as compensation by health care providers. (This addresses a concern relating to sovereign immunity and patient provider compensation under the challenge grants.)

The bill creates ss. 381.0022 and 402.115, F.S., to authorize the Department of Health (DOH) and the Department of Children and Family Services to share otherwise confidential and exempt client information for a client served by both agencies.

The bill amends s. 414.028, F.S., relating to local WAGES coalitions, to provide for a representative of a county health department or Healthy Start Coalition to serve as an ex officio, nonvoting member of the local WAGES coalition.

The bill amends s. 766.101, F.S., relating to immunity from liability for medical review committees, to redefine the term “medical review committee” to include a committee of the Department of Health (DOH).

The bill amends s. 383.011, F.S., relating to the administration of maternal and child health programs by DOH, to designate the department as the state agency responsible for receiving federal funds for the federal Child and Adult Food Program, commonly referred to as the Child Care Food Program, and provide the department with rule-making authority for standards and procedures for the child care food program. These rules governing program participation must address: organization participation criteria; investigation of noncompliance; application and renewal requirements; audit requirements; meal pattern requirements; fund management requirements; participant eligibility; food storage and preparation; food service companies; reimbursements; use of commodities; administrative reviews and monitoring; training requirements; recordkeeping requirements; and criteria for imposing sanctions and penalties, including denial, termination, and appeal of program eligibility. (The program was transferred from the Department of Education to the Department of Health via the 1997-98 General Appropriations Act, with no statutory authority and no rules for the program.)

The bill amends s. 383.04, F.S., relating to the required use of a prophylactic for the eyes of infants, to require that the prophylactic used be one recommended by the Committee on Infectious Diseases of the American Academy of Pediatrics.

The bill repeals s. 383.05, F.S., to eliminate a requirement for the Department of Health to prepare the prophylactic solution and provide the solution for free distribution.

***Penalties Relating to HIV and AIDS***

The bill amends s. 381.004(6), F.S., relating to penalty provisions for HIV testing violations, to provide a penalty of a felony of the third degree for maliciously or for material gain sharing information that one knew or should have known identifies a person with a sexually transmissible disease (STD), HIV, or AIDS.

The bill amends s. 384.34, F.S., relating to penalties related to STDs, to: increase the penalty for the malicious dissemination of false information or reports concerning an STD from a misdemeanor of the second degree to a felony of the third degree; provide a penalty of a felony of the first degree for multiple violations relating to the unlawful transmission of HIV; provide a penalty of a felony of the third degree for maliciously or for material gain sharing information that one knew or should have known identifies a person with an STD, HIV, or AIDS.

***Health Care Responsibility Act Revisions***

The bill revises the provisions of ch. 154, part IV, F.S., consisting of ss. 154.301-154.316, F.S., relating to the Health Care Responsibility Act of 1988. The bill clarifies that the Agency for Health Care Administration is administratively responsible for the program; reduces by up to one-half the maximum amount a county may be required to pay to out-of-county hospitals for care provided to qualified indigent residents, provided that the amount not paid has or is being spent for in-county hospital care provided to qualified indigent residents; and incorporates numerous technical, clarifying, and conforming revisions.

***Professional Liability Claims and Reports***

The bill amends s. 627.912, F.S., relating to professional liability claims and actions and reports by insurers, to: no longer require insurers to report to the Department of Insurance claims with a final disposition not resulting in payment on behalf of the insured; and to correct a glitch in the law by requiring any self-insurance program authorized through the Board of Regents that covers professional liability claims for the board, students, and faculty of any university of the State University System, officers and employee, or agents of the board, professional practitioners practicing a profession within, or through their employment with any university of the State University System to report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in

performance of professional services of a medical physician, osteopathic physician, podiatrist, or dentist as an agent of the board.

### ***Transfer of Functions***

The bill provides for a type 2 transfer of the Nursing Student Loan Forgiveness Program, the Nursing Student Loan Forgiveness Trust Fund, and the Nursing Scholarship program from the Department of Health to the Department of Education, and incorporates conforming amendments into ss. 240.4075 and 240.4076, F.S., to reflect this transfer of functions.

### ***Building Designation***

The bill provides for the naming of the Marion County Health Department building under construction for Carl S. Lytle, M.D.

### ***Appropriations***

The bill provides an appropriation of \$2 million from the tobacco settlement revenues to the Grants and Donations Trust Fund of the Agency for Health Care Administration to be matched at an appropriate level with federal Medicaid funds to provide prosthetic and orthotic devices for Medicaid recipients when such devices are prescribed by licensed practitioners participating in the Medicaid program.

If approved by the Governor, these provisions take effect July 1, 1998, except as otherwise provided.

*Vote: Senate 39-1; House 117-0*

### **CS/HB 1213 — Breast and Prostrate Cancer**

by Health Care Services Committee, Rep. Murman and others (CS/CS/SB 94 by Ways & Means Committee, Health Care Committee and Senators Grant, Clary, Sullivan, Casas, Meadows, Kirkpatrick, Campbell and Hargrett)

The bill creates an 18-member Prostate Cancer Task Force within the H. Lee Moffitt Cancer Center and Research Institute at the University of South Florida. The task force, which is to exist for 2 years, is directed to collect research and information on prostate cancer and prepare recommendations for reducing the incidence and the number of deaths related to prostate cancer in the state, and report its findings to the Governor and Legislature by January 15, 2000.

The bill amends s. 240.5121(4)(m), F.S., relating to the duties and functions of the Cancer Control and Research Advisory Council, or C-CRAB, to direct the C-CRAB, to the extent funds are

specifically appropriated, to develop or purchase a standardized, easy-to-understand, written statement regarding prostate cancer treatment alternatives, including the relative advantages, disadvantages, and associated risks of treatment. The pamphlet or booklet is to be made available to treating physicians, updated periodically, and targeted to prostate cancer patients and those men considering prostate cancer screening. The C-CRAB is directed to develop and implement an education program centered around the distribution of the pamphlet and the early detection and treatment of prostate cancer.

The C-CRAB's membership is increased from 32 to 35 members to include a representative of the Cancer Information Service, a member of the Florida A & M University Institute of Public Health, and a member of the Florida Society of Oncology Social Workers. The bill corrects reference to the Nova Southeastern College of Osteopathic Medicine for purposes of council membership.

The bill provides a \$50,000 General Revenue appropriation for FY 1998-99 for the council to produce or purchase and to distribute pamphlets in English and Spanish regarding treatment alternatives for prostate cancer and to develop an educational program.

The bill also provides a \$50,000 General Revenue appropriation for FY 1998-99 for the council to produce or purchase and to distribute pamphlets in English and Spanish regarding treatment alternatives for breast cancer and to develop an educational program.

If approved by the Governor, these provisions take effect July 1, 1998.

*Vote: Senate 36-0; House 116-0*

### **HB 3783 — Cigarette Tax Collection Trust Fund**

by Reps. Tamargo, Bradley and others (CS/SB 1258 by Ways & Means Committee and Senator Harris)

The bill creates s. 210.20(2)(c), F.S., to specify that, beginning January 1, 1999, and continuing for 10 years thereafter, the Division of Alcoholic Beverages and Tobacco of the Department of Business and Professional Regulation shall from month to month certify to the Comptroller the amount derived from the cigarette tax imposed under s. 215.20, F.S., less the general revenue service charge provided in s. 215.20, F.S., and less 0.9 percent of the amount derived from the cigarette tax imposed by s. 210.02, F.S., which shall be deposited into the Alcoholic Beverage and Tobacco Trust Fund, specifying an amount equal to 2.59 percent of the net collections be paid to the Board of Directors of the H. Lee Moffitt Cancer Center and Research Institute. These funds shall be used for financing the construction, furnishing, and equipping of a cancer research facility at the University of South Florida. The bill provides that in FY 1999-2000 and thereafter, with the exception of FY 2008-09, the appropriation to the institute shall not be less than the amount which

would have been paid to the institute for FY 1998-99 had payments been made for the entire fiscal year rather than for a 6-month period.

The bill directs the Board of Directors of the Institute to construct, furnish, equip, and covenant to complete the facility. The bill provides for the use of the transferred funds for securing financing to pay costs related to constructing, furnishing, and equipping the facility, including the issuance of tax-exempt bonds pursuant to ch. 159, parts II and III, F.S. The bill specifies that the cigarette tax dollars pledged for this facility shall be replaced annually by the Legislature from tobacco litigation settlement proceeds.

If approved by the Governor, these provisions take effect July 1, 1998.

*Vote: Senate 38-0; House 118-0*

