

HEALTH CARE PRACTITIONER REGULATION

HB 103 — Medicinal Drug Prescriptions

by Rep. Quinones and others (SB 132 by Senator Fasano)

The bill (Chapter 2004-8, L.O.F.) requires a prescription written by a practitioner who is authorized under the laws of Florida to write prescriptions for drugs that are not controlled substances but who is not eligible for a federal drug enforcement administration number to include that practitioner's name and professional license number. The pharmacist or dispensing practitioner must include the practitioner's name on the container of the drug that is dispensed. A pharmacist must be permitted, upon verification by the prescriber, to document any required information.

A prescription written by a Florida-licensed advanced registered nurse practitioner or physician assistant for a drug that is not a controlled substance is presumed, subject to rebuttal, to be valid and within the parameters of the prescriptive authority delegated to the advanced registered nurse practitioner or physician assistant who is prescribing the drug. For purposes of the presumption, the prescriptive authority must be delegated to the advanced registered nurse practitioner by a Florida-licensed medical physician, osteopathic physician, or dentist, and in the case of a physician assistant, the prescriptive authority must be delegated by the physician assistant's supervising physician.

These provisions were approved by the Governor and take effect July 1, 2004.

Vote: Senate 40-0; House 119-0

CS/SB 476 — Respiratory Therapy Regulation

by Health, Aging, and Long-Term Care Committee and Senator Saunders

The bill revises the regulation of the practice of respiratory care or respiratory therapy. In lieu of respiratory care licensure by examination procedures administered by the Florida Department of Health, the bill requires Florida respiratory care licensure applicants to be registered as a Registered Respiratory Therapist (entry level) or certified as a Certified Respiratory Therapist (advanced level) by the National Board for Respiratory Care. Florida licensure requirements for respiratory care therapists will conform to the standards set by the National Board for Respiratory Care under the bill. The Florida Board of Respiratory Care will no longer approve educational programs for respiratory care.

Definitions relating to respiratory care are revised to expand the scope of practice of respiratory care therapists to include additional modalities, such as: evaluation and disease management;

administration of drugs as duly ordered or prescribed by a Florida-licensed allopathic or osteopathic physician and in accordance with protocols, policies, and procedures established by a hospital or other health care provider or the Board of Respiratory Care; cardiopulmonary resuscitation, advanced cardiac life support, neonatal resuscitation, and pediatric advanced life support or equivalent functions; education; and initiation and management of hyperbaric oxygen.

The bill eliminates the board's authority to issue temporary licenses to practice respiratory care in Florida to persons who are already licensed in another state as a respiratory care practitioner or respiratory therapist or who are eligible graduates of respiratory care programs.

The bill substantially revises the exemptions to the respiratory care practice act by: restricting an exemption for health care professionals to only those who are licensed; eliminating an exemption for graduates of respiratory care education programs who hold temporary licenses; and restricting an exemption for the delivery, assembly, setup, testing, and demonstration of oxygen aerosol, and intermittent positive pressure breathing equipment to an individual employed to deliver, assemble, set up, or test equipment for use in the home. An exemption to the respiratory care practice act is created for individuals credentialed in hyperbaric medicine by the Underseas Hyperbaric Society or its equivalent as determined by the Board of Respiratory Care.

The bill, effective January 1, 2005, repeals s. 468.356, F.S., which provides requirements for the approval of respiratory care therapy educational programs and repeals s. 468.357, F.S., which specifies procedures for the licensure by examination of persons wishing to practice as certified respiratory therapists.

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

Vote: Senate 40-0; House 115-0

CS/SB 490 — Dental Licensure

by Appropriations Committee and Senator Fasano

The bill authorizes students in the final year of attendance at an accredited dental school who have successfully completed the National Board of Dental Examiners examination within 10 years before the date of application to sit for state dental examinations. Before any dental student in his or her final year may sit for the examination, the student must have successfully completed all the coursework necessary to prepare him or her to perform the clinical and didactic procedures required to pass the examination. If the student obtains a passing score on the state dental examination, the examination score is valid for 180 days after the date the examination was completed. The student must have graduated before he or she may be certified for licensure.

The bill requires accredited dental schools in Florida to seek the approval of the Florida Board of Dentistry to offer regional licensure examinations to students in the final year of attendance at an

accredited dental school for the sole purpose of facilitating the student's licensing in other jurisdictions. To obtain board approval to do so, the dental school must meet requirements specified in the bill.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 40-0; House 114-0

CS/CS/CS/CS/SB 506 — Genetic Counseling Practice Act

by Appropriations Committee; Finance and Taxation Committee; Governmental Oversight and Productivity Committee; Health, Aging, and Long-Term Care Committee; and Senator Cowin

The bill provides for the regulation of genetic counseling in Florida by the Board of Genetic Counselors in the Department of Health. The practice of genetic counseling means, for remuneration, the communication process that deals with the human problems associated with the occurrence, or the risk of occurrence, of a genetic disorder in a family, including the provision of services to help an individual or family:

- Comprehend the medical facts;
- Appreciate the way heredity contributes to the disorder;
- Choose the course of action which seems appropriate and act in accordance with that decision; and
- Make the best possible psychosocial adjustment.

In providing for the regulation of genetic counseling, the bill provides legislative intent, definitions, requirements for licensure, exemptions, rulemaking authority for the newly-created 5-member Board of Genetic Counselors, requirements for membership and appointment to the board, and fees. The bill establishes criminal penalties for certain prohibited acts, including the making of false or fraudulent statements to the Board of Genetic Counselors, the practice of genetic counseling without the required licensure or exemption thereto, and the use of the title "genetic counselor" without a license. The bill establishes grounds for which genetic counselors may be disciplined for failure to adhere to specified standards of practice by their board.

The bill adds the Board of Genetic Counselors in s. 20.43, F.S., under the responsibilities of the Division of Medical Quality Assurance in the Department of Health. The bill redefines "health care practitioner" in ch. 456, F.S., the general regulatory provisions for health care professions under the Department of Health, to include genetic counselors.

If approved by the Governor, these provisions take effect October 1, 2004.

Vote: Senate 40-0; House 116-0

CS/CS/SB 532 — Good Samaritan Act

by Comprehensive Planning Committee; Health, Aging, and Long-Term Care Committee; and Senators Crist and Bullard

The bill extends immunity from civil liability, under the Good Samaritan Act, to a person who gratuitously provides care, treatment, or service during emergency response activities in connection with a community emergency response team, local emergency management agencies, the Division of Emergency Management of the Department of Community Affairs, or the Federal Emergency Management Agency. The immunity also protects a person from civil liability for damages caused by an act or a failure to act to arrange further care, treatment, or services if such person acts as a reasonably prudent person would have acted under the same or similar circumstances.

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

Vote: Senate 38-0; House 98-0

CS/SB 626 — Anesthesiologist Assistants

by Health, Aging, and Long-Term Care Committee and Senators Fasano, Peaden, Klein, and Jones

The bill provides for the licensure of anesthesiologist assistants under the regulatory jurisdiction of the Board of Medicine or the Board of Osteopathic Medicine, and for joint rulemaking by these boards for aspects of the practice of this profession. The regulation would allow an anesthesiologist assistant to practice within the framework of a protocol under the direct supervision of a supervising anesthesiologist or group of anesthesiologists. “Direct supervision” is defined to mean the on-site, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed.

The bill provides definitions and standards of practice and performance for anesthesiologist assistants and anesthesiologists. The Board of Medicine and the Board of Osteopathic Medicine are given rulemaking authority to implement the provisions of the bill regulating anesthesiology providers, including anesthesiologists and the anesthesiologist assistants that such physician specialists may supervise.

The bill specifies requirements for education and training of anesthesiologist assistants and other licensure requirements, including the expanded duties of the Board of Medicine and the Board of Osteopathic Medicine over this profession. The bill creates a criminal offense punishable as a third-degree felony for any person who falsely holds himself or herself out as an anesthesiologist assistant. A supervising anesthesiologist is liable for any act or omission of an anesthesiologist

assistant acting under the anesthesiologist's supervision and control. The bill requires the Board of Medicine and the Board of Osteopathic Medicine by rule, to require all anesthesiologist assistants licensed in Florida, to maintain medical malpractice insurance or provide proof of financial responsibility. The grounds for which an allopathic or osteopathic physician may be subject to discipline for failure to adequately supervise certain health care practitioners is revised to include anesthesiologist assistants.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 28-12; House 74-39

CS/CS/SB 1294 — Automated Pharmacy Systems

by Criminal Justice Committee; Health, Aging, and Long-Term Care Committee; and Senators Fasano, Peaden, Aronberg, and Lynn

The bill authorizes a pharmacy to provide pharmacy services to a long-term care facility or hospice licensed under ch. 400, F.S., or a state correctional institution operated under ch. 944, F.S., through the use of an automated pharmacy system that need not be located at the same location as the pharmacy. Medicinal drugs stored in bulk or unit of use in an automated pharmacy system servicing a long-term care facility, hospice, or state correctional institution are part of the inventory of the pharmacy providing pharmacy services to that facility or institution, and drugs dispensed from the automated pharmacy system are considered to have been dispensed by that pharmacy. The operation of an automated pharmacy system must be under the supervision of a Florida-licensed pharmacist who must develop and implement policies and procedures designed to verify that the medicinal drugs delivered by the automated dispensing system are accurate and valid and that the machine is properly restocked.

The Board of Pharmacy must adopt rules governing the use of an automated pharmacy system by January 1, 2005. The rules must specify requirements for recordkeeping, security, and labeling. The label requirements must permit the use of unit-dose medications if the facility, hospice, or institution maintains medication-administration records that include directions for the use of the medication and the automated pharmacy system identifies the dispensing pharmacy, the prescription number, the name of the patient, and the name of the prescribing practitioner.

The bill allows a community pharmacy to transfer a prescription for a Schedule II controlled substance under specified conditions. The pharmacy receiving the prescription may ship, mail, or deliver into Florida, in any manner, the dispensed Schedule II medicinal drug under the following conditions: the pharmacy receiving and dispensing the transferred prescription maintains a valid unexpired license, permit, or registration to operate the pharmacy in compliance with the laws of the state in which the pharmacy is located and from which the medicinal drugs are dispensed; the community pharmacy and receiving pharmacy are owned and operated by the same person and share a centralized database; and the community pharmacy assures its compliance with federal law and certain state pharmacy laws.

The bill creates a first degree misdemeanor offense for any person, firm, or corporation that is not licensed as a pharmacy or pharmacist in Florida, which holds himself or herself out to be licensed to practice pharmacy in Florida or uses in a trade name, sign, letter, or advertisement, certain protected terms which imply that the person, firm, or corporation is licensed or registered to practice pharmacy in Florida. A person, firm, or corporation which violates the misdemeanor offense may be punished with jail time up to 1 year and the imposition of a fine up to \$1,000.

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

Vote: Senate 37-0; House 117-0

CS/CS/CS/CS/SB 1372 — Internet Pharmacies

by Appropriations Committee; Finance and Taxation Committee; Criminal Justice Committee; Health, Aging, and Long-Term Care Committee; and Senator Saunders

The bill requires an “Internet pharmacy” to receive a permit in order to sell medicinal drugs to persons in Florida. The bill requires any person who desires to operate an Internet pharmacy to apply to the Florida Department of Health (DOH) for an Internet pharmacy permit. The bill defines “Internet pharmacy” to include locations not otherwise licensed or issued a pharmacy permit, within or outside Florida, which use the Internet to communicate with or obtain information from consumers in Florida and use such communication or information to fill or refill prescriptions or to dispense, distribute, or otherwise engage in the practice of pharmacy in Florida. Such acts constitute the practice of pharmacy as defined in the pharmacy practice act. The bill provides requirements for Internet pharmacies. A permit may not be issued to an “Internet pharmacy” unless a licensed pharmacist is designated as the prescription department manager for dispensing medicinal drugs to persons in Florida. The bill requires the Internet pharmacy and the pharmacist designated by that pharmacy to serve as prescription department manager or its equivalent to be licensed in the state of location in order to dispense drugs in Florida.

The bill makes a pharmacist subject to disciplinary action for dispensing any medicinal drug based upon a communication that purports to be a prescription when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship. A pharmacy is subject to disciplinary action for dispensing any medicinal drug based upon a communication that purports to be a prescription when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation.

The bill creates a criminal offense that prohibits an Internet pharmacy from distributing a medicinal drug to any person in Florida without being permitted as a pharmacy in Florida. A violation of this prohibition is a second degree felony punishable by imprisonment of up to 15 years and the imposition of a fine of up to \$10,000. The bill adds the newly created criminal

offense to the racketeering provisions so that the offense may be prosecuted as racketeering in appropriate cases, thereby allowing harsher sentencing for the criminal conduct and the further use of civil racketeering sanctions.

The bill makes minor technical changes to provisions that specify requirements for the issuance of special pharmacy permits by the Florida DOH to conform to an existing definition of “special pharmacy” in the pharmacy practice act.

The bill revises requirements for pharmacists to display the expiration date on the outside of the container of each medicinal drug dispensed. A pharmacist is given the option of providing the purchaser either the expiration date when provided by the manufacturer, repackager, or other distributor of the drug, or an earlier beyond-use date for expiration of up to 1 year from the date of dispensing. The dispensing pharmacist or practitioner must provide information concerning the expiration date to the purchaser upon request and must provide appropriate instructions regarding the proper use and storage of the drug.

The bill authorizes a community pharmacy to transfer a prescription for a Schedule II controlled substance under specified conditions. The pharmacy receiving the prescription may ship, mail, or deliver into Florida, in any manner, the dispensed Schedule II medicinal drug under the following conditions: the pharmacy receiving and dispensing the transferred prescription maintains a valid unexpired license, permit, or registration to operate the pharmacy in compliance with the laws of the state in which the pharmacy is located and from which the medicinal drugs are dispensed; the community pharmacy and receiving pharmacy are owned and operated by the same person and share a centralized database; and the community pharmacy assures its compliance with federal law and certain state pharmacy laws.

The bill creates exceptions to the recordkeeping requirements for prescription drug distribution applicable to chain drug entities, including at least 50 retail pharmacies, warehouses, and repackagers which are members of the same affiliated group, if the affiliated group: discloses to DOH the names of all its members; and agrees in writing to provide records on prescription drug purchases by members of the affiliated group no later than 48 hours after the department requests such records, regardless of the location where the records are stored. The recordkeeping requirements expire on July 1, 2006.

The bill appropriates \$590,051 from the Medical Quality Assurance Trust Fund to DOH, and nine full-time equivalent positions are authorized for FY 2004-2005, to implement the bill.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 37-0; House 115-0

SB 1430 — Law Enforcement and Correctional Officers

by Senator Crist

The bill adds certified advanced registered nurse practitioners to the list of health care providers who may conduct physical examinations of applicants seeking employment or appointment as a law enforcement or correctional officer.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 39-0; House 112-0

HEALTH CARE FACILITY AND HEALTH INSURANCE REGULATION

SB 182 — Certificates of Need/Projects Involving Percutaneous Coronary Intervention

by Senators Atwater and Klein

Exemption from Certificate-of-Need Review for Percutaneous Coronary Intervention Services

This bill provides an exemption from certificate-of-need (CON) review for the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital that does not have an approved adult open-heart surgery program. In addition to any other documentation required by the Agency for Health Care Administration (AHCA), a request for an exemption submitted under this paragraph must comply with the following:

- The applicant must certify that it will meet and continuously maintain the requirements adopted by AHCA for the provision of these services. These licensure requirements must be adopted by rule pursuant to ss. 120.536(1) and 120.54, F.S., and must be consistent with the guidelines published by the American College of Cardiology and the American Heart Association for the provision of percutaneous coronary interventions in hospitals without adult open-heart services.
- The applicant must certify that it will use the patient-selection criteria for the performance of primary angioplasty at hospitals without adult open-heart surgery programs issued by the American College of Cardiology and the American Heart Association.
- The applicant must agree to submit quarterly reports to AHCA regarding patient characteristics, treatment, and outcomes.

Licensure of Adult Interventional Cardiology Services and Burn Units

The bill requires AHCA to adopt rules for licensure standards for adult interventional cardiology services and burn units and provides minimum criteria for inclusion in the rules. Existing providers, any provider with an exemption for open-heart surgery, and any provider with a notice of intent to grant a CON or a final order of the agency granting a CON for adult interventional cardiology services or burn units will be exempt from complying with the rules for 3 years following the date of their next license renewal; these existing providers must meet the licensure standards thereafter.

The bill provides criteria for the two levels of licensure for adult cardiology services:

- Level I programs will perform percutaneous cardiac intervention without on-site cardiac surgery. A hospital seeking a Level I program must demonstrate that, for the most recent 12-month period as report to AHCA, it has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or has transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease and that it has a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure the safe and efficient transfer of a patient within 60 minutes.
- Level II programs will perform percutaneous cardiac intervention with on-site cardiac surgery. A hospital seeking a Level II program must demonstrate that, for the most recent 12-month period as reported to AHCA, it has performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations, or, for the most recent 12-month period, has discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

Advisory Groups

The bill requires the appointment of three advisory bodies, as follows:

- AHCA must establish a technical advisory panel to develop procedures and standards for measuring outcomes of interventional cardiac programs.
- The Secretary of Health Care Administration must appoint an advisory group to study the issue of replacing CON review of organ transplant programs operating under ch. 408, F.S., with licensure regulation of organ transplant programs under ch. 395, F.S., and the advisory group must submit a report to the Governor, the Secretary of Health Care Administration, and the Legislature by July 1, 2005.
- The Secretary of Health Care Administration must appoint a work group to study CON regulations and changing market conditions related to the supply and distribution of

hospital beds, and the work group must submit a report to the Secretary and the Legislature by January 1, 2005.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 37-0; House 109-7

HB 329 — Open Heart Surgery/Certificates of Need

by Rep. Harrell and others (CS/CS/SB 2606 by Appropriations Committee; Health, Aging, and Long-Term Care Committee; and Senators Pruitt, Klein, and Alexander)

The Certificate-of-Need Program

This bill revises various provisions relating to the certificate-of-need (CON) program in ch. 408, F.S., to decrease the regulation of certain health care services. Significant changes include allowing most hospitals to add acute care beds without CON review and making adult cardiac services a licensed activity not subject to CON review.

The bill prohibits the Agency for Health Care Administration (AHCA or agency) from issuing or renewing a hospital license if 65 percent or more of the hospital's patients receive care and treatment classified in diagnosis-related groups that include cardiac-related diseases and disorders, orthopedic-related diseases and disorders, cancer-related diseases and disorders, or any combination of discharges in those groups. Also, a hospital may not be licensed, or have its license renewed, if it restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties. The bill provides certain exemptions and authorizes AHCA to adopt rules to implement the requirement.

The bill requires AHCA to establish a nursing-home-bed-need methodology that has a goal of maintaining a subdistrict average occupancy rate of 94 percent.

The bill revises health-care-related projects that are subject to the CON comparative review process. The following projects *no longer will be subject to comparative review*:

- The addition of beds by new construction or alteration in health care facilities other than community nursing homes, and intermediate care facilities for the developmentally disabled;
- A replacement facility that is not on the same site, but is within 1 mile, if the number of beds in each licensed bed category does not increase;
- An increase in the total licensed bed capacity of a health care facility, other than a community nursing home or intermediate care facility for the developmentally disabled;

- The establishment of inpatient health services by a health care facility, or a substantial change in such services; and
- An increase in the number of beds for acute care, specialty burn units, neonatal intensive care units, mental health services, or hospital-based distinct part skilled nursing units, or at a long-term care hospital, with one exception for the addition of acute care beds in a hospital that is in a low-growth county. Until July 1, 2009, a hospital in a low growth county, as defined by the bill, is subject to comparative review for the addition of acute care beds.

The bill revises health-care-related projects that are subject to an expedited CON review. Projects that would *no longer be subject to expedited review* include:

- Research, education, and training programs;
- Shared services contracts or projects;
- A 50 percent increase in nursing home beds for a specific facility;
- Replacement of a health care facility when the proposed project site is located in the same district and within a 1-mile radius of the replaced health care facility; and
- Certain conversions of hospital mental health services beds or hospital-based distinct part skilled nursing unit beds or general acute care beds.

Under certain circumstances, replacement of a nursing home or relocation of a portion of a nursing home's licensed beds within the same district is subject to expedited review.

The bill revises the list of projects that may be exempt from the CON process. The following projects are made *eligible for an exemption from CON review* by this bill:

- The addition of licensed hospital beds for comprehensive rehabilitation in a number that may not exceed 10 total beds or 10 percent of the licensed capacity, whichever is greater;
- The addition of mental health services or beds if the applicant commits to provide services for Medicaid or charity patients at a level equal to or greater than the district average;
- The replacement of a licensed nursing home on the same site or within 3 miles of the same site if the number of licensed beds does not increase;

- The consolidation or combination of licensed nursing homes or transfer of beds between licensed nursing homes within the same planning subdistrict, by providers that operate multiple nursing homes within that planning subdistrict, if there is no increase in the planning subdistrict total number of nursing home beds and the site of the relocation is not more than 30 miles from the original location;
- Beds in state mental health treatment facilities operated under s. 394.455(30), F.S., and state mental health forensic facilities operated under s. 916.106(8), F.S.;
- Beds in state developmental services institutions as defined in s. 393.063, F.S.;
- The addition of nursing home beds licensed under ch. 400, F.S., at a facility that has been designated as a Gold Seal nursing home under s. 400.235, F.S., in a number not exceeding 20 total beds or 10 percent of the number of licensed beds in the facility being expanded;
- The establishment of Level II and III neonatal intensive care unit (NICU) beds, provided: the applicant facility demonstrates it has had 1,500 annual births (for Level II) or 3,500 annual births and has operated a 10-bed Level II unit (for Level III); the applicant meets specified quality criteria; and the facility commits to providing services to Medicaid and charity care patients equal to or above the district average; and
- The provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital that does not have an approved adult open-heart surgery program.

The following projects are removed from the list of exemptions:

- On-site replacement facilities;
- Termination of inpatient health services;
- Delicensure of beds;
- Addition of hospital beds, both permanent and temporary, for any purpose except comprehensive rehabilitation;
- The provision of adult inpatient diagnostic cardiac catheterization services in a hospital; and
- Other exemptions that are outdated.

Exceptions to the moratorium on CON approval for nursing homes are established under the following circumstances:

- For a proposed nursing home in a county in which there are no community nursing home beds and all nursing home beds that were licensed on July 1, 2001, have subsequently

closed; and

- For the addition of beds in a nursing home in a county of fewer than 50,000 residents in a number not exceeding 10 beds or 10 percent of the number of beds licensed in the facility, whichever is greater.

The fees for CON applications are increased. The current range for CON fees—from \$5,000 to \$22,000—is increased to a range of from \$10,000 to \$50,000.

The bill directs the Secretary of Health Care Administration to appoint an advisory group to study the issue of replacing CON review of organ transplant programs operating under ch. 408, F.S., with licensure regulation of organ transplant programs under ch. 395, F.S., and requires the advisory group to submit a report to the Governor, the Secretary of Health Care Administration, and the Legislature by July 1, 2005. The bill also directs the Secretary of Health Care Administration to appoint a work group to study certificate-of-need regulations and changing market conditions related to the supply and distribution of hospital beds and requires the work group to submit a report to the Secretary and the Legislature by January 1, 2005.

Licensure for Adult Interventional Cardiology Programs

The bill requires AHCA to adopt rules for licensure standards for adult interventional cardiology services and burn units and provides minimum criteria for inclusion in the rules. Existing providers, any provider with an exemption for open-heart surgery, and any provider with a notice of intent to grant a certificate-of-need or a final order of the agency granting a certificate of need for adult interventional cardiology services or burn units will be exempt from complying with the rules for 3 years following the date of their next license renewal; these existing providers must meet the licensure standards thereafter.

The bill requires AHCA to license two levels of treatment for adult interventional cardiology services and provides criteria for the two levels of licensure:

- Level I programs will perform percutaneous cardiac intervention for emergency patients without on-site cardiac surgery. A hospital seeking a Level I program must demonstrate that, for the most recent 12-month period as report to AHCA, it has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or has transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease and that it has a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure the safe and efficient transfer of a patient within 60 minutes.
- Level II programs will perform percutaneous cardiac intervention with on-site cardiac surgery. A hospital seeking a Level II program must demonstrate that, for the most recent

12-month period as reported to AHCA, it has discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

Local Health Councils

The bill moves oversight responsibility for local health councils from AHCA to the Department of Health and removes local health councils from involvement in the CON process. The bill provides for the costs of operating a local health council to come from assessments imposed on selected health care facilities, adds health care clinics to the facilities being assessed, and eliminates CON fees as a source of funding for local health councils. The Department of Health must enter into contracts with the local health councils for certain services.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 37-0; House 112-4

CS/SB 1088 - Health Maintenance Organization Provider Contracts

by Banking and Insurance Committee and Senators Cowin and Campbell

This bill requires a health maintenance organization (HMO) that has a contract with a health care provider to disclose to the provider the complete schedule of all reimbursements for which the HMO and the provider of health care services have contracted, including any deviations from the contracted schedule of reimbursements requested by the HMO and agreed upon by the provider of the health care services. The bill:

- Establishes two ways that an HMO may provide the schedule of reimbursements to providers—by electronic means or in writing.
- Clarifies that the schedule of reimbursements is subject to the nondisclosure provisions of the contract, and the provider must maintain the confidentiality of the schedule.
- Defines provider to mean a physician licensed under ch. 458, 459, 460, 461, or 466, F.S.

If approved by the Governor, these provisions take effect January 1, 2005.

Vote: Senate 38-0; House 115-0

CS/SB 1062 — Health Care Facilities

by Health, Aging, and Long-Term Care Committee and Senators Bennett and Cowin

Nursing Homes

The bill creates a procedure for the issuance of an inactive license for a nursing home to permit a home to maintain its license under two circumstances: during a period when it is temporarily not

serving residents but will resume doing so, or when the nursing home will use a contiguous portion of its facility for other services to meet the long-term care needs of elderly residents.

Nursing home regulation is changed in several ways that affect nursing home operations:

- Certain registered nurses, other than the director of nursing, may sign a resident care plan in a nursing home.
- The Agency for Health Care Administration's (AHCA's) publication of data regarding nursing homes must reflect the most current agency actions.
- AHCA must adopt by rule a nursing home bed need methodology that has a goal of maintaining a district average occupancy rate of 94 percent.
- For the Gold Seal program, nursing homes operated by the state or federal government (VA homes) will be deemed to be financially stable and will not be required to provide further proof of financial stability.

The bill revises certificate-of-need (CON) requirements for nursing homes to provide expedited review of a proposed replacement nursing home or a project to relocate a portion of the beds of a nursing home under specified circumstances. Exemptions from CON review are created for replacing a nursing home on the same site, or within three miles of the site, and for combining or consolidating nursing homes or transferring licensed nursing home beds within the same planning subdistrict. The number of beds that a Gold Seal nursing home facility may add without CON review is increased from 10 to 20, or 10 percent of the number of beds licensed in the facility, whichever is greater.

Exceptions to the moratorium on CON approval for nursing homes are established for a proposed nursing home in a county in which there are no community nursing home beds and all nursing home beds that were licensed on July 1, 2001, have subsequently closed and for the addition of beds in a nursing home in a county of fewer than 50,000 residents.

Health Care Clinics

The bill revises licensure requirements for health care clinics to exempt the following entities from licensure:

- End-stage renal disease providers;
- Therapy providers (speech, occupational, and physical) which are Medicare-certified;
- Birth centers;
- Clinical laboratories;
- Charitable clinics - 501(c)(3) or (4);

- Entities owned or operated by the federal or state government;
- Hospitals and entities they own;
- A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered under s. 627.419, F.S. (includes dentists, optometrists, podiatrists; chiropractors, physicians);
- Entities that provide only oncology or radiation therapy services by physicians; and
- Entities that provide neonatal or pediatric hospital-based healthcare services.

Mobile clinics and portable equipment providers are included in the definition of clinic. The date for filing a clinic license application with AHCA is changed to July 1, 2004, from March 1, 2004. If AHCA issues a notice of intent to deny a clinic license application after a temporary license has been issued, the temporary license expires on the date of the notice and may not be extended during any administrative or judicial review.

The bill provides that any person or entity defined as a clinic is not in violation of the Health Care Clinic Act due to failure to apply for a clinic license by March 1, 2004, and payment to such person or entity by an insurer or other entity liable for payment may not be denied on the grounds that the person or entity failed to apply for or obtain a clinic license before March 1, 2004.

A chief financial officer of a health care clinic is defined as an individual with a bachelor's degree in finance, accounting, or a related field. In an MRI clinic that bills less than 15 percent of its scans to personal injury protection insurance, the chief financial officer can ensure that the billings are not fraudulent.

AHCA may charge an applicant for a certificate of exemption \$100 or the actual cost of processing the certificate, whichever is less. AHCA must refund a portion of a licensure fee that was paid by an applicant that subsequently was exempted from licensure requirements by this bill. The bill sets up a tiered structure for such refunds. AHCA will:

- Refund 75 percent of the fee if a temporary license has not been issued;
- Refund 50 percent of the application fee if the temporary license has been issued but the inspection has not been completed; and
- Make no refund if the inspection has been completed.

Assisted Living Facilities

The amendment requires assisted living facilities to conduct resident elopement-prevention drills at least two times per year.

Long-Term Care Community Diversion Pilot Projects

The bill gives AHCA the authority to seek federal approval in advance of the approval of its formal waiver application to limit the diversion provider network by freezing enrollment of providers at current levels when an area already has three or more providers or, in an expansion area, when enrollment reaches a level of three providers.

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

Vote: Senate 39-0; House 115-1

CS/SB 1590 - Primary and Comprehensive Stroke Centers

by Health, Aging, and Long-Term Care Committee and Senators Fasano, Miller, Margolis, Atwater, Siplin, Haridopolos, Lynn, and Wasserman Schultz

This bill directs the Agency for Health Care Administration (AHCA) to create a list of primary and comprehensive stroke centers and make the list available on its website and to the Department of Health (DOH). AHCA is authorized to adopt rules establishing criteria for these two types of centers. The agency rules establishing criteria for a primary stroke center must be substantially similar to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification standards for primary stroke centers. If JCAHO establishes criteria for a comprehensive stroke center, AHCA must establish criteria for a comprehensive stroke center that are substantially similar to JCAHO's criteria.

By February 15, 2005, AHCA must notify all hospitals in Florida that the agency is compiling a list of primary stroke centers and comprehensive stroke centers in the state. The notice must include an explanation of the criteria necessary for designation as a primary stroke center and the criteria necessary for designation as a comprehensive stroke center. The notice must also advise hospitals of the process by which a hospital might be added to the list of primary or comprehensive stroke centers. The bill prohibits a person from advertising to the public that a hospital is a primary or comprehensive stroke center unless the hospital has provided notice to AHCA as required by the bill.

The bill requires DOH to distribute the list of primary and comprehensive stroke centers to the medical director of each licensed emergency medical services (EMS) provider in Florida and to develop a sample stroke-triage assessment tool. Licensed EMS providers must, by July 1, 2005, use a stroke-triage assessment tool that is substantially similar to the DOH sample tool, and they must develop and use assessment, treatment, and transportation-destination protocols for stroke patients.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 39-0; House 116-0

HB 1629 — Affordable Health Care

by Rep. Farkas and others (CS/CS/CS/SB 2910 by Appropriations Committee; Banking and Insurance Committee; Health, Aging, and Long-Term Care Committee; and Senator Peaden)

This legislation may be referred to as “The 2004 Affordable Health Care for Floridians Act.” The purpose of the act is to address the underlying cause of the double-digit increases in health insurance premiums by mitigating the overall growth in health care costs. The bill includes provisions to improve the availability of affordable health insurance, to provide access to health information regarding costs, and to increase patient safety.

Availability of Health Information (“Transparency”)

The bill requires health care facilities not operated by the state, to:

- Make available on their websites a description of and a link to the performance outcome and financial data that is published by the Agency for Health Care Administration (AHCA); and
- Provide a written estimate of reasonably anticipated charges for nonemergency medical services, within 7 business days of a written request of a prospective patient.

Health care facilities must make available to a patient, in the facility’s offices, all records necessary for verification of the accuracy of the patient’s bill, and must establish a method for responding within 30 days to questions concerning the itemized bill. Health care facilities, providers, and health insurers must submit data to AHCA, and AHCA must make performance outcome and financial data available to consumers, including retail prices for the 50 most frequently prescribed medicines for licensed pharmacies, and patient charge and outcome data for inpatient and outpatient procedures provided in facilities. Pharmacies must make available on their websites a link to the financial data published by AHCA and to post notice of such information where prescriptions are filled.

Florida Health Insurance Plan

The bill creates the Florida Health Insurance Plan (plan) as the high risk pool for uninsurable medical risks, to replace the Florida Comprehensive Health Association (FCHA). The plan must be approved by the Financial Services Commission but the plan cannot be implemented, other than administration of coverage for persons insured by the FCHA and entering into a contract for an actuarial study, until funds are appropriated for start-up costs and any projected deficits.

A 9-member Board of Directors will supervise the plan, chaired by the Director of the Office of Insurance Regulation (OIR), plus 5 members appointed by the Governor, 1 member appointed by the Chief Financial Officer, 1 member by the Senate President, and 1 by the Speaker of the House of Representatives. By December 1, 2004, the board must submit an actuarial study to

determine the impact the creation of the plan will have on the small group market, the number of individuals the pool could reasonably cover at various funding levels, a recommendation as to the best source of funding for anticipated deficits, and the effect on the individual and small group market by including persons eligible for coverage under s. 627.6487, F.S. (i.e., persons eligible under HIPAA for guaranteed issuance of coverage).

Individuals who are residents of Florida for at least 6 months are eligible for coverage if evidence is provided that: 1) the person received notices of rejection or refusal to issue substantially similar insurance for health reasons from two or more health insurers; or 2) the person is enrolled in the FCHA as of the date the plan is implemented.

Persons are not eligible for the plan if they are eligible for health insurance coverage that is substantially similar or more comprehensive, or eligible for Medicaid, Medicare, the state's children's health insurance program, or any other federal, state, or local government program that provides health benefits.

The plan must offer the standard and basic benefit plans required to be offered to small employers and an option of alternative coverage such as catastrophic coverage with a minimum level of primary care coverage and a high deductible plan that meets the federal requirements of a health savings account.

Funding of the high risk pool is provided by premiums capped at 300 percent of standard risk rate, but notwithstanding this limit, the board may approve a sliding scale surcharge based on the insured's income. Additional revenue for any deficit shall be primarily funded through amounts appropriated by the Legislature from general revenue sources, including a portion of the annual growth in premium taxes. The board must operate the plan so that the estimated cost will not exceed total income and to limit plan enrollment accordingly.

Upon the implementation of the plan, the FCHA is abolished and subsumed under the board of the plan. "Implementation" is defined as the effective date after the first meeting of the board when legal authority and administrative ability exist for the board to subsume the transfer of all statutory powers and duties (etc.) of the FCHA. FCHA insureds must convert to the new benefits of the plan by January 1, 2005. For such individuals, for operating losses incurred on or after July 1, 2004, each insurer shall be annually assessed in the same proportion as its statewide market share for earned premiums for health insurance, up to 1 percent of premiums.

Other Health Insurance Issues

- Expands the Health Flex Program statewide.
- Makes the requirement that small group carriers guarantee-issue policies to one-life groups conditional upon the absence of enrollment availability in the Florida Health

Insurance Plan.

- Requires small group carriers to offer a high deductible plan that meets the federal requirements of a health savings account plan or health reimbursement arrangement.
- Creates the “Small Employers Access Program” that authorizes OIR to select an insurer, through competitive bidding, to provide coverage to small employers with 25 or fewer employees within established geographical areas.
- Requires persons who provide access to any discounted medical services to be licensed by OIR.
- Requires health insurers and HMOs to provide for a rebate of premiums when the majority of members of a health plan have maintained participation in a wellness program.
- Reduces from 5 percent to 4 percent the maximum aggregate increased premiums that may be charged to all policyholders by a small group carrier, over a 6-month period, due to the application of health-related rating factors (which generally allows rates to be adjusted by plus or minus 15 percent for a single employer).
- Requires health insurers and HMOs to provide on their websites information regarding appropriate utilization of emergency care services which shall include a list of alternative urgent care contracted providers, and to develop community emergency department diversion programs, which may include enlisting providers to be on call after hours and certain other programs. It allows health insurers and HMOs to require higher copayments for nonemergency use of emergency departments and for use of out-of-network emergency departments.
- Authorizes HMOs that offer point-of-service riders to offer such riders to employers for employees living and working outside the HMO’s approved geographic service area, without having to obtain a health care provider certificate, as long as the master group contract is issued to an employer that maintains its primary place of business within the HMO service area.

Patient Safety

This bill creates the Florida Patient Safety Corporation as a not-for-profit corporation to assist health care providers to improve the quality and safety of health care that is rendered and to reduce harm to patients. In the fulfillment of its purpose, the corporation must work with a consortium of patient safety centers and other patient safety programs in universities in Florida.

The bill specifies the duties of the corporation, the membership of a board of directors, and the advisory committees the corporation must establish. AHCA must assist the corporation in its organizational activities. The corporation is required to seek private funding and apply for grants to accomplish its goals and duties.

By December 1, 2004, the corporation must submit a report on its initial activities to the Governor, the President of the Senate, and the Speaker of the House of Representatives, and must submit an annual report thereafter.

The Office of Program Policy and Government Accountability (OPPAGA) must develop performance standards by which to measure the implementation and activities of the corporation and must conduct a performance audit of the corporation, using the performance standards, during 2006. OPPAGA must submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2007.

Other Provisions

The comprehensive and community-based health promotion and wellness program, known as the Healthy Communities, Healthy People Program, is modified to require the Department of Health to make available on its Internet website and in a hard-copy format a listing of age-specific, disease-specific, and community-specific health promotion, preventive care, and wellness programs offered and established under the Healthy Communities, Healthy People Program. The website must also provide information related to behavior risk factors and healthy lifestyle.

AHCA must develop and implement a strategy for the adoption and use of electronic health records and must report to the Governor and the Legislature with recommendations for legislation necessary to protect the confidentiality of electronic health records.

Hospitals and federally quality health centers are authorized to develop emergency room diversion programs and a “Fast Track” program for nonemergency patients to be treated at alternative sites. The duties of the federally qualified health centers are expanded to include urgent care services and emergency room diversion programs. Health insurers and health maintenance organizations must also develop community emergency department diversion programs.

The Statewide Provider and Subscriber Assistance Program is renamed as the Subscriber Assistance Program. The bill limits the program to hearing grievances filed by subscribers of managed care plans, requires managed care entities to provide certain grievance records, and provides greater flexibility in the composition of the panel.

The bill requires a written contract before an insurance agent may receive any fee or commission for examining any group health insurance or any group health benefit plan for the purpose of

giving or offering advice, counsel, recommendation, or information in respect to terms, conditions, benefits, coverage, or premium of any such policy or contract.

The bill provides appropriations to fund various provisions in the bill.

If approved by the Governor, and except as otherwise provided in the bill, these provisions take effect July 1, 2004.

Vote: Senate 40-0; House 116-0

LONG-TERM CARE

CS/SB 1226 — Long-Term Care Service Delivery

by Health, Aging, and Long-Term Care Committee and Senator Fasano

The bill implements the recommendations contained in Senate Interim Project Report 2004-144, “Model Long-Term Care System/Analyzing Long-Term Care Initiatives in Florida.” The bill makes changes to the long-term care service delivery system administered through the Department of Elderly Affairs (DOEA) and the Agency for Health Care Administration (AHCA).

The bill requires assisted living facilities to conduct a minimum of two resident elopement drills each year. All administrators and direct care staff must participate in the drills and facilities must document the drills.

The bill gives AHCA the authority, in consultation with DOEA, to contract for any function or activity of the Comprehensive Assessment and Review of Long-Term Care Services (CARES) program. CARES staff are required to assess a sample of individuals whose nursing home stay is expected to exceed 20 days regardless of the initial funding source for nursing home placement. This requirement does not apply to continuing care facilities licensed under ch. 651, F.S., and retirement communities that provide a combination of nursing home, independent living, and other long-term care services. DOEA is required to track individuals over time, who are assessed under the CARES program and who are diverted from nursing home placement, and submit to the Legislature and the Office of Long-Term Care Policy each year, a longitudinal study of the individuals who are diverted from nursing home placement. The bill requires CARES staff to review at least 20 percent of Medicaid nursing home resident case files annually to determine whether these residents can be transitioned to a less restrictive setting.

DOEA is required to submit an annual report to the Governor and the Legislature summarizing the results of the department’s monitoring of the activities of each area agency on aging (AAA). The bill revises the requirements under which DOEA can take action against an AAA to include: if the AAA exceeds its authority related to its contract with DOEA or has exceeded its authority, or otherwise failed to adhere to the provisions specifically provided by statute or rule adopted by

DOEA; and if the AAA has failed to properly determine client eligibility or efficiently manage program budgets.

The bill makes changes to the Office of Long-Term Care Policy including:

- Locating the Office of Long-Term Care policy in DOEA for administrative purposes only;
- Providing that the office and its director shall not be subject to control, supervision, or direction by DOEA;
- Replacing the advisory council with an inter-agency staff coordinating team; and
- Requiring the Office to submit a report to the Governor and the Legislature by December 31 of each year of its activities and progress made in improving the long-term care continuum.

The bill redefines the terms “community care service system” and “lead agency,” for purposes of community care for the elderly and requires a single lead agency to provide the array of services to functionally impaired elderly persons. This lead agency can provide any combination of those services.

The bill requires DOEA and AHCA to develop an integrated long-term care service delivery system, phasing in implementation of the integrated system over a three-year period. During FY 2004-2005:

- AHCA is required to develop an implementation plan to integrate the Frail Elder Option into the Nursing Home Diversion pilot project and each program’s funds into one capitated program serving the aged. Beginning July 1, 2004, AHCA may not enroll additional individuals in the Frail Elder Option.
- AHCA is required to integrate the Aged and Disabled Adult Medicaid waiver program and the Assisted Living for the Elderly Medicaid waiver program and each program’s funds into one fee-for-service Medicaid waiver program serving the aged and disabled. AHCA and DOEA must reimburse providers for case management services on a capitated basis and develop uniform standards for case management in this fee-for-service Medicaid waiver program. The coordination of acute and chronic medical services for individuals shall be included in the capitated rate for case management services.
- DOEA is required to develop a demonstration project in which existing Community Care for the Elderly lead agencies are assisted in transferring their business model to enable

assumption over a period of time, of full risk as a community diversion pilot project contractor providing long-term care services in the areas of operation. DOEA must develop an implementation plan for no more than three lead agencies by October 31, 2004.

- DOEA must study the integration of the database systems for the CARES program and the Client Information and Referral Tracking System (CIRTS) and develop a plan for database integration. DOEA must submit the plan to the Governor and the Legislature by December 31, 2004.
- AHCA must work with the fiscal agent for the Medicaid program to develop a service utilization reporting system that operates through the fiscal agent for the Medicaid capitated plans.

During FY 2005-2006:

- AHCA is required to monitor the newly integrated programs and report on the progress of those programs to the Governor and the Legislature by June 30, 2006. The report must include an initial evaluation of the programs in their early stages following the evaluation plan developed by DOEA, in consultation with AHCA and the selected contractor.
- DOEA is required to monitor the pilot projects for resource centers on aging and report on the progress of those projects to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2006.
- DOEA must integrate the CARES and CIRTS database systems into a single operating assessment information system by June 30, 2006.
- AHCA is required to integrate the Frail Elder Option into the Nursing Home Diversion pilot project and each program's funds into one capitated program serving the aged.

During FY 2006-2007:

- AHCA is required to evaluate the Alzheimer's Disease waiver program and the Adult Day Health Care waiver to determine if they should be merged with the comprehensive fee-for-service or capitated programs.
- AHCA is required to begin discussions with the federal government regarding the inclusion of Medicare into the integrated long-term care system. By December 31, 2006, AHCA must submit a plan for including Medicare in the integrated long-term care system to the Governor and the Legislature.

The bill authorizes DOEA to develop pilot projects for aging resource centers to serve as the single point of entry for individuals 60 and older seeking services through specified programs. DOEA is required to submit an implementation plan to the Legislature by October 31, 2004. Each AAA must submit to DOEA a proposal to become an aging resource center by December 31 2004. OPPAGA and the Auditor General are to monitor DOEA's process and the quality of technical assistance provided to the AAAs. A report is to be submitted by February 1, 2005, and periodic reports are to be submitted March and September 1 of each year until full transition has been completed statewide. Staff of DOEA's CARES nursing home screening program, as well as staff from the Department of Children and Families, Economic Self-Sufficiency Services Program Office are to be integrated to determine financial eligibility for all persons age 60 and older seeking Medicaid services, Supplemental Security Income, and food stamps. The bill requires that the aging resource center provide an initial screening of each client who requests services to determine whether the person would be most appropriately served through state programs, federal programs, volunteer services, or by privately paying for the services. Services in these programs are not to be reimbursed except through the aging resource center.

The bill adds a Memory Disorder Clinic at Morton Plant Hospital in Pinellas County.

The bill makes the following changes to the Long-Term Care Community Diversion Pilot Projects:

- Revises the definition of "Other Qualified Provider," deleting language that required the posting of a \$500,000 performance bond and that required an other qualified provider to meet all of the financial and quality standards for a provider service network.
- Gives AHCA the authority to seek federal approval in advance of approval of its formal waiver application to limit the diversion provider network by freezing enrollment of providers at current levels when an area already has three or more providers or, in an expansion area, when enrollment reaches a level of three providers.
- Requires AHCA to annually reevaluate and recertify the capitation rates for the diversion pilot projects.
- DOEA and AHCA are required to allow enrollment of Medicaid beneficiaries on the date that eligibility for the community diversion pilot project is approved. The provider must receive a prorated capitated rate for those enrollees who are enrolled after the first of each month.
- DOEA is required to select providers that have a plan administrator who is dedicated to the diversion pilot project and project staff who perform the necessary project administrative functions, including data collection, reporting, and analysis. Diversion providers must meet certain financial, claims payment, data collection technology, and service provider contracting capabilities.

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

Vote: Senate 39-0; House 114-2

CS/CS/CS/SB 1748 — Multiservice Senior Centers

by Appropriations Committee; Judiciary Committee; Health, Aging, and Long-Term Care Committee; and Senators Jones and Lynn

The bill redefines the term “multiservice senior center” as a community facility that organizes and provides a broad spectrum of services, including health, mental health, social, nutritional, and educational services and recreational activities and facilities for persons 60 years of age or older.

The bill also appropriates \$240,000 from the Administrative Trust Fund to the Department of Elderly Affairs (DOEA) to purchase automated external defibrillators (AED) for placement in multiservice senior centers. A multiservice senior center may purchase an AED from DOEA for half of the cost of the AED. A multiservice senior center located in a rural community may request a free AED from DOEA. Senior centers having an AED are required to ensure that their personnel are trained to use the device. The location of the AED must be registered with the local emergency medical services medical director. The bill extends immunity under the Good Samaritan Act and the Cardiac Arrest Survival Act from civil liability to an employee or volunteer of a senior center who uses an AED.

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

Vote: Senate 39-0; House 113-0

CS/SB 1782 — Guardianship

by Health, Aging, and Long-Term Care Committee and Senator Saunders

This bill creates the “Joining Forces for Public Guardianship” grant program to be administered by the Statewide Public Guardianship Office within the Department of Elderly Affairs. The purpose of the program is to provide start-up funding to encourage communities to develop and administer locally funded and supported public guardianship programs to address the needs of indigent and incapacitated residents. The bill specifies the duties and responsibilities of the Statewide Public Guardianship Office related to the grant program, the application process, application requirements, and proposal review criteria, and establishes eligibility. The bill provides that the grant application must contain, among other things, an agreement or confirmation from a local funding source, such as a county, municipality, or any other public or private organization, that the local funding source will contribute matching funds to the public guardianship program totaling not less than \$1 for every \$1 of grant funds awarded. In-kind contributions may be counted as part or all of the matching funds required.

The bill places limits on how much each county may receive in grant funds and specifies that awards made to counties in successive years shall reduce in value according to a determined scale. Emergency grant funds may be awarded if there is a public need. The bill specifies that grant funds must be used for direct services to wards.

The bill revises the definition of the term “guardian advocate” and provides that guardian advocates are exempt from annual accounting provisions if the court determines the ward receives income only from Social Security benefits and the guardian is the ward’s representative payee for the benefits.

Clerks of court are required to forward the results of a credit or criminal investigation of any public or professional guardian to the Statewide Public Guardianship Office. The executive director of the Statewide Public Guardianship Office may deny registration to a professional guardian if the director determines that the proposed registration, including the guardian’s credit or criminal investigations, indicates that registering the professional guardian would violate any provision of ch. 744, F.S., relating to guardianship.

Circuit courts are authorized to appoint a guardian advocate, without an adjudication of incapacity, for a person with developmental disabilities if the person lacks the capacity to do some, but not all, of the tasks necessary to care for his or her person, property, or estate, or if the person has voluntarily petitioned for the appointment of a guardian advocate.

The bill makes numerous substantive changes related to a direct-support organization (DSO) under ch. 744, F.S. The bill defines “direct support organization” as an organization whose sole purpose is supporting the Statewide Public Guardianship Office and requires the DSO to operate under a written contract with the Statewide Office of Public Guardianship. The bill provides that any moneys may be held in a separate depository account in the name of the DSO and that expenditures of the DSO shall be expressly used to support the Statewide Public Guardianship Office. The bill also requires an annual audit of the DSO and provides for the dissolution of entities improperly using their DSO status.

If approved by the Governor, except as otherwise expressly provided, these provisions take effect July 1, 2004.

Vote: Senate 37-0; House 119-0

PUBLIC HEALTH

HB 333 — Limitation of Civil Liability

by Rep. Simmons and others (CS/SB 1394 by Health, Aging, and Long-Term Care Committee and Senators Smith and Crist)

The bill bars a claim for damages arising from personal injury or wrongful death against a manufacturer, distributor, or seller of foods or nonalcoholic beverages if the claim is premised upon a person's weight gain or obesity, or a health condition related to weight gain or obesity, resulting from long-term consumption of such foods or nonalcoholic beverages. "Long-term" is defined to mean the cumulative effect of multiple instances over a period of time and not the effect of a single or isolated instance. The limitation on such claims does not bar a claim otherwise available under law against a manufacturer, distributor, or seller of foods or nonalcoholic beverages if such person failed to disclose statutorily required nutritional content information or provided materially false or misleading information to the public.

If approved by the Governor, these provisions take effect upon becoming law and shall apply to all claims filed on or after that date.

Vote: Senate 39-0; House 112-1

HB 1121 — Health Care Providers

by Rep. Green and others (CS/SB 1374 by Health, Aging, and Long-Term Care Committee and Senators Saunders and Margolis)

The bill amends the Access to Health Care Act, which extends sovereign immunity to health care providers who execute a contract with a governmental contractor and who provide volunteer, uncompensated health care services to low-income individuals as an agent of the state. The definition of "contract" is revised to provide that for a service to qualify as a volunteer, uncompensated service, the health care provider may not receive any compensation from the governmental contractor for any service rendered to low-income persons and the provider may not bill or accept any compensation from the recipient or any third-party payor for services rendered under the contract. The definition of "health care provider" is revised to include a "free clinic" that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients. The bill requires the Department of Health to adopt rules that specify required methods for determination and approval of patient eligibility and referral and contractual conditions under which a health care provider may perform the patient eligibility and referral process on behalf of the department. These rules must include, but need not be limited to, requirements that:

- The provider must accept all patients referred by the department; however, the number that must be accepted may be limited by the contract;

- The provider must comply with department rules regarding the determination and approval of patient eligibility and referral; and
- The provider must complete training conducted by the Department of Health regarding compliance with the approved methods for determination and approval of patient eligibility and referral.

The bill extends a waiver of biennial license renewal fees and fulfillment of a maximum of 25 percent of continuing education hours to health care practitioners who participate as a health care provider under the Access to Health Care Act. “Health care practitioner” is defined to mean a Florida-licensed allopathic or osteopathic physician or physician assistant, chiropractic physician, podiatric physician, advanced registered nurse practitioner, registered nurse, licensed practical nurse, dentist, dental hygienist, or midwife who participates as a health care provider under the Access to Health Care Act.

The bill amends the “Public School Volunteer Health Care Practitioner Act,” to add Florida-licensed dietitians/nutritionists to the list of health care practitioners who may participate in the volunteer program.

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

Vote: Senate 40-0; House 117-0

CS/CS/SB 1178 — Healthy People 2010 Program

by Appropriations Committee; Health, Aging, and Long-Term Care Committee; and Senators Miller, Lawson, Dawson, Hill, Saunders, Bullard, Siplin, Wilson, Bennett, and Klein

This bill requires the Department of Health to monitor and report, within existing resources, on Florida’s status on the Florida Healthy People 2010 Program goals and objectives. The federal Healthy People 2010 Program goals are to help individuals of all ages increase life expectancy and improve their quality of life; and eliminate health disparities among different segments of the population. The department is required to:

- Report to the Legislature by December 31 of each year on the status of the disparities in health among minorities and nonminorities, using health indicators that are identified in the federal program;
- Work with minority physician networks to develop programs to educate health care professionals about the importance of culture in health status. Programs must include but are not limited to:
 - The education of health care providers about the prevalence of specific health conditions among certain minority groups;
 - The training of clinicians to be sensitive to cultural diversity among patients;

- The creation of initiatives that educate private-sector health care and managed care organizations about the importance of cross-cultural training of health care professionals; and
- The fostering of increased use of interpreter services in health care settings.
- Work with and promote the establishment of public and private partnerships with charitable organizations, hospitals, and minority physician networks to increase the proportion of health care professionals from minority backgrounds; and
- Work with and promote research on methods by which to reduce disparities in health care at colleges and universities that have historically large minority enrollments, including centers of excellence in the state identified by the National Center on Minority Health and Health Disparities, by working with colleges, universities, and community representatives to encourage minority college students to pursue professions in health care.

The bill requires the Agency for Health Care Administration (AHCA) to contract with minority physician networks that provide services to historically underserved minority patients. “Minority physician network” is defined as a network of primary care physicians with experience managing Medicaid or Medicare recipients that is predominantly owned by minorities as defined in s. 288.703, F.S., which may have a collaborative partnership with a public college or university and a tax-exempt charitable corporation. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.

The bill requires AHCA to provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules. Any savings must be split with the minority physician network pursuant to the contract. AHCA is to conduct actuarially sound audits to ensure cost-effectiveness of services, publish the audit results on its Internet website, and submit the results annually to the Governor and the Legislature no later than December 31. If established contracts are not cost-effective, they may not be renewed.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 40-0; House 116-0

CS/SB 1762 — Trauma Care

by Health, Aging, and Long-Term Care Committee and Senators Saunders and Cowin

Local Surtax to Fund Trauma

The bill authorizes counties with a population of less than 800,000 residents to levy, by ordinance, subject to approval by a majority of the electors of the county voting in a referendum, a discretionary sales surtax that may not exceed 0.25 percent for the sole purpose of funding trauma services provided by a trauma center. A surtax imposed under this provision expires 4 years after the effective date of the surtax, unless reenacted by ordinance approved by a majority of the electors. A county may not levy certain local option sales surtaxes in excess of a combined rate of 1 percent.

Definition of Charity Care

The bill revises the definition of “charity care” or “uncompensated care,” for purposes of trauma care, to provide that restricted or unrestricted revenues provided to a hospital by local governments or tax districts for a patient whose family income is less than or equal to 200 percent of the federal poverty level do not qualify as compensation. The definition of “charity care” is revised to conform to the definition of “charity care” that is in ch. 409, F.S., which relates to the Medicaid program.

Update/Assessment of Trauma System

The bill requires the Department of Health (DOH) to update the state trauma system plan by February 2005 and annually thereafter. The DOH is required to complete an assessment of the trauma system in Florida and report its findings to the Governor, the President of the Senate, the Speaker of the House of Representatives and the substantive legislative committees by February 1, 2005. The department must review the existing trauma system and determine whether it is effective in providing trauma care uniformly throughout Florida. The department’s comprehensive assessment must include specified elements including:

- Considering aligning trauma service areas within the trauma region boundaries as established in July 2004;
- Reviewing the number and level of trauma centers needed for each trauma service area to provide a statewide integrated trauma system;
- Establishing criteria for determining the number and level of trauma centers needed to serve the population in a defined trauma service area or region;
- Considering the inclusion of criteria within trauma center verification standards based upon the number of trauma victims served within a service area;

- Reviewing the Regional Domestic Security Task Force structure and determining whether integrating the trauma system planning with interagency regional emergency and disaster planning efforts is feasible and identifying any duplication of efforts between the two entities;
- Making recommendations regarding a continued revenue source which must include a local participation requirement; and
- Making recommendations regarding a formula for the distribution of funds identified for trauma centers.

The DOH, in conducting the comprehensive assessment of the existing trauma system and subsequent annual reviews, must consider the recommendations submitted by regional trauma agencies, stakeholder recommendations, the geographical composition of an area to ensure rapid access to trauma care by patients, historical patterns of patient referral and transfer in an area, inventories of available trauma care resources, population growth characteristics, transportation capabilities, medically appropriate ground and air travel times, recommendations of the regional domestic security task force, the actual number of trauma victims currently being served by each trauma center, and other appropriate criteria.

Boundaries of Trauma Regions

The bill requires the boundaries of trauma regions administered by DOH to be coterminous with the boundaries of the regional domestic security task forces established within the Florida Department of Law Enforcement. Exceptions are provided for the delivery of trauma services by or in coordination with a trauma agency established before July 1, 2004, which may continue in accordance with public and private agreements and operational procedures entered into as provided in s. 395.401, F.S.

Technical Clean-up

The bill makes various technical changes and deletes obsolete language and dates from ch. 395, part II, F.S., relating to trauma care.

Trauma Center Applications

The bill provides that until DOH has conducted the assessment of the trauma system that only hospitals located in trauma service areas where there is no existing trauma center may apply.

Trauma Funding Formula

The bill requires DOH, effective July 1, 2004, to make one-time payments from the Administrative Trust Fund to trauma centers and a hospital with a pending application for Level I trauma center. Payments must be in equal amounts for trauma centers approved as of July 1 of the fiscal year in which funding is appropriated, with lesser amounts for the hospital with an application pending for a Level I trauma center at DOH as of April 1, 2004. Trauma centers that are eligible to receive these funds may request that such funds be used as intergovernmental transfer funds in the Medicaid program. The obsolete funding formula currently in the law is deleted.

Trauma Funding

The bill appropriates \$300,000 from the General Revenue Fund to the Administrative Trust Fund for DOH to contract with a state university to conduct the assessment of the trauma system. The sum of \$20.7 million is appropriated from the General Revenue Fund to the Administrative Trust Fund for DOH to provide \$1 million for each existing trauma center as of July 1, 2004, and \$700,000 for a hospital with a Level I trauma center application pending with DOH as of April 1, 2004.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 40-0; House 118-0

CS/SB 1824 — Veterinary Prescription Drugs

by Health, Aging, and Long-Term Care Committee and Senator Fasano

The bill defines “veterinary prescription drug wholesaler,” for purposes of the Florida Drug and Cosmetic Act, to mean any person engaged in wholesale distribution of veterinary prescription drugs in or into Florida. The bill creates a new permit and annual permit fee for veterinary prescription drug wholesalers.

Veterinary prescription drug wholesalers that also distribute prescription drugs subject to, defined by, or described by s. 503(b) of the Federal Food, Drug, and Cosmetic Act which the wholesaler did not manufacture must obtain a permit as a prescription drug wholesaler or out-of-state prescription drug wholesaler instead of the veterinary prescription drug wholesaler permit. A veterinary prescription drug wholesaler must comply with the requirements for wholesale distributors under s. 499.0121, F.S., except the pedigree paper requirements, and the due diligence requirements for suppliers, which under the bill are limited to prescription drug wholesalers, out-of-state prescription drug wholesalers, or prescription drug repackagers.

The Department of Health’s authority to inspect specified establishments under its jurisdiction is revised to include veterinary prescription drug wholesale establishments. Such wholesalers are

subject to immediate closure and their products may be immediately seized, if the department determines that an imminent danger to the public health exists.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 39-0; House 115-4

CS/SB 2138 — Jessie Trice Cancer Prevention Program

by Health, Aging, and Long-Term Care Committee and Senators Wilson and Bullard

The bill gives the Department of Health the authority to expand the Jessie Trice Cancer Prevention Program, which operates pilot programs in Miami-Dade and Lee Counties, statewide. The bill specifies that funding may be provided to develop contracts with community health centers and local community faith-based education programs to provide cancer screening, diagnosis, education, and treatment services to low-income populations.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 38-0; House 117-0

CS/SB 2306 — Radiologists Performing Mammograms

by Judiciary Committee and Senator Lynn

The bill expresses a legislative finding regarding the importance of the availability of quality mammography services and other diagnostic tools to detect and treat breast cancer. The bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) and the Department of Health (DOH) to study issues relating to the availability, utilization, quality and cost of mammography services. OPPAGA must complete and submit its study to the Legislature by December 15, 2004.

The bill also creates the Workgroup on Mammography Accessibility, to be staffed by DOH, to study the availability, quality of care, and accessibility of mammography in this state; the need for research and educational facilities; availability of resources; and patient wait times for screening and diagnostic mammography. The thirteen-member workgroup will be chaired by the Secretary of Health or his or her designee, and the Governor, the President of the Senate, and the Speaker of the House of Representatives must each appoint four members. DOH must submit a report of the findings and recommendations of the workgroup to the Governor, Senate President, House Speaker, and the substantive legislative committees by December 15, 2004.

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

Vote: Senate 38-0; House 118-0

CS/CS/SB 2372 — Physical Fitness and Health

by Governmental Oversight and Productivity Committee; Health, Aging, and Long-Term Care Committee; and Senators Clary and Margolis

The bill requires the Department of Health, subject to an appropriation in the General Appropriations Act, to promote healthy lifestyles to reduce the prevalence of overweight and obesity in Florida by implementing appropriate physical activity and nutrition programs that target Floridians by:

- Using all appropriate media to promote maximum public awareness of the latest research on healthy lifestyles and chronic diseases and disseminating relevant information through a statewide clearinghouse relating to wellness, physical activity, and nutrition and their impact on chronic diseases and disabling conditions;
- Providing technical assistance, training, and resources on healthy lifestyles and chronic diseases to the public, county health departments, health care providers, school districts, and other persons or entities, including faith-based organizations;
- Developing, implementing, and using all available research methods to collect data, including, but not limited to, population-specific data, and track the incidence and effects of weight-gain, obesity, and related chronic diseases;
- Partnering with the Department of Education, local communities, school districts, and other entities to encourage Florida schools to promote activities during and after school to help students meet a minimum goal of 60 minutes of activity per day;
- Partnering with the Department of Education, school districts, and the Florida Sports Foundation to develop a program that recognizes schools whose students demonstrate excellent physical fitness or fitness improvement; and
- Maximizing all local, state, and federal funding sources, including grants, public-private partnerships, and other mechanisms, to strengthen the department's current physical activity and nutrition programs and to enhance similar county health department programs.

The bill expands the purposes for which the Florida Professional Sports Team License Plate proceeds are to be used by authorizing proceeds to be used to promote education programs in Florida schools that provide an awareness of the benefits of physical activity and nutrition standards and to partner with the Department of Education and the Department of Health to develop a program that recognizes schools whose students demonstrate excellent physical fitness or fitness improvement.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 38-0; House 119-0

CS/SB 2448 - Public Health

by Health, Aging, and Long-Term Care Committee and Senator Saunders

This bill makes numerous revisions to statutes under the purview of the Department of Health (DOH). Most of the revisions are technical and clarifying in nature. Other revisions provide necessary authority for DOH to carry out its public health and regulatory mission efficiently and effectively, and to respond to changing programmatic and funding requirements.

Department Administration

The bill changes the Division of Emergency Medical Services and Community Health Resources to the Division of Emergency Medical Operations; the Division of Information Resource Management to the Division of Information Technology; and the Division of Health Awareness and Tobacco to the Division of Health Access and Tobacco. The Division of Disability Determinations is established within DOH. Positions within DOH which are funded by the United States Trust Fund are excluded from the limitation on the number of authorized positions in the department.

Statewide Research

The bill authorizes DOH to disburse funds from the Tobacco Settlement Clearing Trust Fund to the Biomedical Research Trust Fund in DOH. The bill creates the Institutional Review Board within DOH to review all biomedical and behavioral research on human subjects funded or authorized by DOH and authorizes the board to charge fees to cover research review costs.

Officer of Women's Health Strategy

The bill establishes the Officer of Women's Health Strategy within DOH. The Officer is required to ensure that Florida's policies and programs are responsive to sex and gender differences and to women's health needs. Women's health issues must be taken into consideration in the annual budget planning of DOH, the Agency for Health Care Administration (AHCA), and the Department of Elderly Affairs (DOEA). The inclusion of gender considerations and differential impact must be considered in the criteria for choosing state-funded research and demonstration proposals. Boards or advisory bodies which fall under the purview of DOH, AHCA, and DOEA are encouraged to seek equal representation of women and men and the inclusion of persons who are knowledgeable and sensitive to gender and diversity issues. The Officer is required to submit to the Governor and the Legislature an annual report with policy recommendations.

Minority Health

The Office of Minority Health is established within DOH. The bill requires DOH to include oral health care programs in the department's *Reducing Racial and Ethnic Health Disparities: Closing the Gap* grant program.

Environmental Health

The bill includes elevated blood-lead-level investigations as a service under the environmental health program.

The Onsite Sewage Treatment and Disposal Systems Program is authorized to use the most current products derived from U.S. Geological Survey. The \$5 fee on new sewage system construction permits to support onsite sewage treatment and disposal system research, demonstration, and training projects is continued. The DOH Technical Review and Advisory Panel is required to review and advise the Legislature on the need and structure of a disciplinary board for the onsite sewage industry and must submit a report to the Legislature by January 2, 2005.

The bill requires that septic tank contractors have three years of qualifying work experience immediately preceding the date of application. DOH is authorized to develop rules regarding inactive status and the late filing of renewal applications for septic tank contractors. The bill allows a master septic tank contractor to revert to registered septic tank contractor status any time during the period of registration. DOH is given the authority to deny an application for renewal of a septic tank contractor certificate for failure to pay an administrative penalty.

The bill eliminates a requirement that bars and lounges have a certified food manager and clarifies that public and private school food services are exempt from having a certified food manager if operated by school employees.

The bill clarifies the time frames for performing mandatory radon testing in public and private buildings. The revisions allow one full year to complete and report the initial radon measurements. Follow up testing must be performed after the building has been occupied for 5 years, and the results must be reported to DOH by the first day of the 6th year of occupancy.

Newborns and Children

The bill adds language that allows DOH to release newborn hearing and metabolic tests or screening results to the newborn's primary care physician. The bill requires newborns to be tested for phenylketonuria prior to becoming 1 week of age, rather than 2 weeks of age, and clarifies that newborns do not have to be born in Florida to be screened. The number of members on the Genetics and Newborn Screening Advisory Council is increased from 12 to 15 to include a representative from the Florida Hospital Association, an audiologist, and an individual experienced in newborn screening programs.

The Child Abuse Death Review Team and local review committees are authorized to review all deaths resulting from verified child abuse and neglect, not just those with a report to the central abuse hotline.

The bill revises the definition of “children with special health care needs” to conform to the federal definition. The Children’s Medical Services (CMS) program is authorized to reimburse physicians licensed in other states who provide care to CMS clients under specified circumstances and clarifies CMS eligibility. The bill requires that any newborn found to have an abnormal screening result identified through the newborn screening program be referred to the CMS Network.

The bill creates the Infants and Toddlers Early Intervention Program, authorizing DOH to implement and administer Part C of the federal Individuals with Disabilities Education Act. DOH and DOE are required to prepare a grant proposal each year to the U.S. Department of Education for funding early intervention services for infants and toddlers with disabilities, from birth through 36 months years of age and their parents. The grant proposal must include a reading initiative for infants and toddlers.

Health Care Clinics

The bill revises licensure requirements for health care clinics to exempt the following entities from licensure:

- End-stage renal disease providers;
- Therapy providers (speech, occupational, and physical) which are Medicare-certified;
- Birth centers;
- Clinical laboratories;
- Charitable clinics – 501(c)(3) or (4);
- Entities owned or operated by the federal or state government;
- Hospitals and entities they own;
- A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered under s. 627.419, F.S. (includes dentists, optometrists, podiatrists; chiropractors, physicians);
- A sole proprietorship, group practice, partnership, or corporation that provides health care services under ch. 480, F.S., massage practice, which are wholly owned by one or more licensed health care practitioners;
- Entities that provide only oncology or radiation therapy services by physicians; and
- Entities that provide neonatal or pediatric hospital-based healthcare services.

Mobile clinics and portable equipment providers are included in the definition of clinic. The date for filing a clinic license application with AHCA is changed to July 1, 2004, from March 1, 2004. If AHCA issues a notice of intent to deny a clinic license application after a temporary license has been issued, the temporary license expires on the date of the notice and may not be extended during any administrative or judicial review.

The bill provides that any person or entity defined as a clinic is not in violation of the Health Care Clinic Act due to failure to apply for a clinic license by March 1, 2004, and payment to such person or entity by an insurer or other entity liable for payment may not be denied on the grounds that the person or entity failed to apply for or obtain a clinic license before March 1, 2004.

A chief financial officer of a health care clinic is defined as an individual with a bachelor's degree in finance, accounting, or a related field, and is the person responsible for the preparation of clinic billing. In an MRI clinic that bills less than 15 percent of its scans to personal injury protection insurance, the chief financial officer can ensure that the billings are not fraudulent.

AHCA may charge an applicant for a certificate of exemption \$100 or the actual cost of processing the certificate, whichever is less. AHCA must refund 90 percent of the licensure fee that was paid by an applicant that subsequently was exempted from licensure requirements by this bill.

Injury Prevention Program

The bill establishes an injury-prevention program within DOH. The program is responsible for coordinating and expanding injury prevention activities statewide. DOH duties include data collection, surveillance, education, and intervention promotion. DOH is given the authority to provide expertise and guidance to communities, county health departments, and state agencies; apply for, receive, and spend funds from grants, donations, or contributions, from public and private sources on program activities; and develop a state plan for injury prevention.

Radiologic Testing

The bill clarifies that the prohibition on uncertified operators applies to the "practice of radiologic technology" and not just the application of radiation. The bill specifies the restricted circumstances and additional training under which a nuclear medicine technologist can apply x-radiation from a combination nuclear medicine-computed tomography device. The changes allow the nuclear medicine technologist to operate the devices in a way that protects public safety after additional training has been received.

The bill makes technical changes to certificate issuance and expiration dates under the radiologic testing statutes, specifying the duration and expiration date of the initial certificate as well as the duration and expiration date for an applicant who becomes certified in a new category while holding an active certificate in a different category.

The bill gives DOH explicit authority to investigate and determine whether violations of existing radiologic technology statutes have occurred, and allows DOH to take disciplinary action against technologists who are acted against by national registries or national boards recognized by the

DOH. The bill authorizes DOH to discipline a technologist who tests positive for drugs in the workplace.

The bill provides grounds for discipline for committing a list of crimes established in other statutes governing employee background screening. The bill provides grounds for discipline for a suspected impaired technologist who is referred, or self refers, to DOH's impaired practitioner program, but then fails to comply with the program's recommendations for treatment, evaluation or monitoring. The bill provides that the final disciplinary action against the technologist's license in another jurisdiction would be sufficient justification to begin disciplinary proceedings in Florida, and gives DOH the authority to discipline those who improperly provide continuing education courses to radiologic technologists.

Miscellaneous

The bill modifies the licensure fees for tanning facilities by removing the minimum fee per tanning device, but maintaining the maximum fee per tanning device, and authorizing DOH to set the maximum total fee per individual tanning facility by rule.

The bill requires AHCA to report to the Legislature by December 31, 2004, recommending whether it is in the public interest to allow a hospital to license or operate an emergency department located off the premises of the hospital. A 1-year moratorium on CONs for off-site emergency departments is established.

The bill requires licensed facilities to release patient information to regional poison control centers for patient case management. The bill requires acute care hospitals, upon request, to report trauma registry data to DOH and clarifies reporting requirements for trauma centers, pediatric trauma referral centers, and acute care hospitals to the brain and spinal cord injury central registry.

The bill increases the penalties for battery and assault on persons employed by DOH or its direct service providers. These protections will apply to Environmental Health regulatory staff, A.G. Holley nursing staff, STD investigative staff and all other DOH employees and the employees of DOH's service providers. The increased criminal penalty will authorize law enforcement to take offenders into custody following assault or battery against a DOH employee.

Hospitals licensed under ch. 395, F.S., are required to implement immunization programs to offer immunizations against influenza and pneumococcal bacteria to people aged 65 and older in accordance with the federal Centers for Disease Control and Prevention guidelines.

The bill allows federally qualified health centers to be reimbursed retroactively by the Medicaid program from the date they submit their application to the date the application is approved.

The bill provides that, notwithstanding any other law or local ordinance to the contrary, the regulation, identification, and packaging of meat, poultry, and fish is preempted to the state and the Department of Agriculture and Consumer Services.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 40-0; House 118-0

MEDICAID

CS/CS/SB 1064 — Medicaid Fraud

by Appropriations Committee; Health, Aging, and Long-Term Care Committee; and Senators Saunders, Aronberg, Fasano, Lynn, and Bullard

The bill implements the recommendations from the Senate Select Subcommittee on Medicaid Prescription Drug Over-Prescribing. The bill makes several statutory changes broadening the authority of the Agency for Health Care Administration (AHCA) related to combating fraud and abuse in the Medicaid program, particularly focused on prescribed drugs. The bill also makes several statutory changes giving the Medicaid Fraud Control Unit (MFCU) in the Department of Legal Affairs broader authority to pursue entities that try to defraud the Medicaid program.

The bill requires Medicaid applicants, as a condition of eligibility and subject to federal approval, to agree in writing to forfeit their entitlement to goods and services in the Medicaid program if they are found to have committed fraud, through administrative or judicial determination, 2 times in a period of 5 years. The provision applies only to the Medicaid recipient found to have committed or participated in the fraud and does not apply to any family member of the recipient who was not involved in fraud.

The bill gives AHCA the authority to require a confirmation or second physician's opinion of the correct diagnosis before authorizing future services under the Medicaid program. Access to emergency services or poststabilization care services as defined in 42 C.F.R., part 438.114, are not restricted under this requirement. AHCA is authorized to mandate prior authorization, drug therapy management, or disease management for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud.

The bill requires AHCA and the Drug Utilization Review Board to consult with the Department of Health under the practice pattern identification program.

AHCA is required to mandate a recipient's participation in a provider lock-in program, when appropriate, if a recipient is found by the agency to have used Medicaid goods or services at a frequency or amount not medically necessary, limiting the receipt of goods or services to medically necessary providers, for a period of not less than 1 year. The lock-in programs must include, but are not limited to, pharmacies, medical doctors, and infusion clinics. The limitation

does not apply to emergency services and care provided to the recipient in a hospital emergency department. AHCA is authorized to mandate prior authorization, drug therapy management, or disease management participation for certain Medicaid beneficiaries, and is required to enroll Medicaid recipients in the drug benefit management program if they meet certain criteria and are not enrolled in a Medicaid health maintenance organization.

AHCA must seek a federal waiver for permission to terminate the eligibility of a Medicaid recipient who has been found to have committed fraud, through judicial or administrative determination, two times in a period of five years.

The bill requires AHCA to conduct a study on implementing an electronic verification system for Medicaid recipients and requires AHCA to recommend to the Legislature a plan to implement such a system for Medicaid recipients by January 31, 2005.

The bill specifies that a provider is not entitled to enrollment in the Medicaid provider network and that AHCA may implement fee for service provider network controls, including, but not limited to, competitive procurement and provider credentialing. If a credentialing process is used, AHCA may limit its provider network based upon the following considerations: beneficiary access to care, provider availability, provider quality standards and quality assurance processes, cultural competency, demographic characteristics of beneficiaries, practice standards, service wait times, provider turnover, provider licensure and accreditation history, program integrity history, peer review, Medicaid policy and billing compliance records, clinical and medical record audit findings, and such other areas that are considered necessary by the agency to ensure the integrity of the program.

The bill specifies that AHCA can conduct or contract for prepayment review of provider claims to ensure that billing by a provider is in accordance with applicable Medicaid rules, regulations, handbooks, and policies and in accordance with all state and federal laws, and to ensure that appropriate care is rendered to Medicaid recipients. The bill establishes limitations on such prepayment reviews.

The bill specifies a provider's obligation with regard to submitting claims to the Medicaid program by providing that AHCA shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program. This requirement does not apply:

- In instances involving bona fide emergency medical conditions as determined by the agency;
- To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or outpatient setting, or nursing home;
- To bona fide pro bono services by preapproved non-Medicaid providers as determined by the agency;

- To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program;
- To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program;
- To other physicians who are not enrolled in the Medicaid program but who provide a medically necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician; or
- In instances where the agency cannot practically notify a pharmacy at the point of sale that a prescription will be approved for processing under the previous exemptions. This provision expires July 1, 2005.

AHCA is authorized to seek any remedy provided by law when false or a pattern of erroneous claims are submitted, deleting the requirement that the claims must result in overpayments to a provider or exceed those to which the provider was entitled under the Medicaid program.

Current law authorizes AHCA to terminate certain practitioners from the Medicaid program. The bill clarifies that suspension or termination from the Medicaid program precludes participation in Medicaid during that period, which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

The bill authorizes AHCA to withhold payment to a provider upon receipt of evidence of fraud, willful misrepresentation, or abuse under Medicaid, or a crime committed while rendering goods or services to Medicaid recipients, regardless of whether there are ongoing legal proceedings related to that evidence. AHCA is also authorized to deny payments or require repayments where the goods or services were furnished, supervised, or caused to be furnished by a provider terminated or suspended from the Medicaid or Medicare program by the Federal government or any state.

AHCA is authorized to implement amnesty programs that encourage voluntary repayment of overpayments.

The bill authorizes AHCA and MFCU to review a provider's non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

The bill authorizes AHCA to limit the number of Schedule II and Schedule III refill prescription claims submitted from pharmacy providers if AHCA or MFCU determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted, or was not prescribed by the recipient's medical provider or physician.

The bill requires the Office of Program Policy Analysis and Government Accountability to provide a report to the Legislature on a biennial basis on AHCA's efforts to prevent, detect, and deter fraud and abuse in the Medicaid program.

The bill clarifies that the peer review process for determining an overpayment is triggered by medical necessity, appropriateness, or quality of care determinations and that peer review will be used, in cases involving determination of medical necessity, to determine whether the documentation in the physician's records is adequate.

The bill requires Medicaid provider cost reports submitted to AHCA to include a statement of understanding relating to the laws and regulations of the provision of health services under the Medicaid program.

The bill redefines the term "knowingly" for purposes of Medicaid provider criminal violations, as an act done voluntarily and intentionally and not because of mistake or accident. "Knowingly" also includes the word "willfully" or "willful." The bill makes it unlawful to knowingly use or endeavor to use a Medicaid provider's or recipient's identification number or cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed under the Medicaid program. The bill defines property "paid for" to include all property furnished to or intended to be furnished to any recipient of benefits under the Medicaid program, regardless of whether reimbursement is ever actually made by the program.

The bill specifies that a Medicaid participating physician is required to make available to MFCU any accounts or records relevant to investigations of alleged abuse or neglect of patients, or to investigations of alleged misappropriation of patients' private funds.

The bill provides an additional ground, relating to patterns of inappropriate prescribing under which a health care practitioner who prescribes medicinal drugs or controlled substances may be subject to discipline by the Department of Health or the appropriate board having jurisdiction over the health care practitioner.

The bill requires that AHCA give pharmacists at least 1 week's notice prior to an initial audit for each audit cycle. The pharmacy audit criteria applies only to audits of claims submitted for payment subsequent to July 11, 2003. AHCA is required to not use the accounting practice of extrapolation in calculating penalties for Medicaid audits. The pharmacy audit criteria do not apply to any investigative audit conducted by AHCA when AHCA has reliable evidence that the claim that is the subject of the audit involves fraud, willful misrepresentation, or abuse under the Medicaid program.

MFCU is included in the AHCA local coordinating workgroups for identifying unlicensed assisted living facilities and MFCU is given the authority to enter and inspect these facilities.

The bill authorizes the Office of Statewide Prosecution to investigate and prosecute any criminal violation of s. 409.920 or s. 409.9201, F.S., which relate to Medicaid fraud. The bill establishes new criminal violations relating to Medicaid fraud and dealing in property paid for by the Medicaid program and expands the definition of “racketeering activity” to include crimes committed under s. 409.9201, F.S., relating to Medicaid recipient fraud. The bill expands the definition of “contraband article,” to include property acquired through Medicaid fraud, and requires that proceeds collected under the Contraband Forfeiture Act be deposited in the Department of Legal Affairs Grants and Donations Trust Fund.

The Statewide Grand Jury’s jurisdiction is expanded to include any criminal violation of s. 409.920 or s. 409.9201, F.S., relating to Medicaid fraud.

AHCA is required to report to the Legislature, by January 1, 2005, on the feasibility of creating a database of valid prescriber information for the purpose of notifying pharmacies of prescribers qualified to write prescriptions for Medicaid beneficiaries, or in the alternative, of prescribers not qualified to write prescriptions for Medicaid beneficiaries. The report must include information on the system changes necessary to implement a database.

The bill provides an appropriation of \$262,087 to the Department of Health from the Medical Quality Assurance Trust Fund for four full-time equivalent positions for the purpose of implementing the provisions of this act during FY 2004-2005.

If approved by the Governor, these provisions take effect July 1, 2004.

Vote: Senate 40-0; House 115-0

PUBLIC RECORDS AND MEETINGS EXEMPTIONS

CS/CS/SB 464 — Public Records Exemption/Medical Facilities

by Governmental Oversight and Productivity Committee and Health, Aging, and Long-Term Care Committee

Pursuant to a review under the Open Government Sunset Review Act of 1995, this bill re-enacts and narrows the public records exemption for public hospitals for the home addresses, telephone numbers, photographs, and names and locations of children’s schools and day care facilities of employees who provide direct patient care or security services, and for employees who do not provide direct patient care or security services but who have reason to believe, based upon specific circumstances that have been reported, that release of the information could be used to threaten, or harm them or their families. The home addresses, telephone numbers, and places of employment of the spouses and children of those employees’ are also exempt. This exemption protects personal information of employees held in public hospitals’ personnel records.

If approved by the Governor, these provisions take effect October 1, 2004.

Vote: Senate 38-0; House 114-0

CS/SB 466 — Public Records Exemption/Statewide Public Guardianship Office

by Health, Aging, and Long-Term Care Committee and Senator Lynn

Pursuant to a review under the Open Government Sunset Review Act of 1995, this bill reenacts s. 744.7081, F.S., which provides an exemption from ch. 119, F.S., the Public Records Law, and s. 24(a), Art. I, State Constitution for all records held by the Statewide Public Guardianship Office relating to the medical, financial, or mental health of vulnerable adults as defined in ch. 415, F.S., persons with a developmental disability as defined in ch. 393, F.S., or persons with a mental illness as defined in ch. 394, F.S.

If approved by the Governor, these provisions take effect October 1, 2004.

Vote: Senate 38-0; House 118-0

SB 468 — Public Meetings Exemption/Hospital Board Meetings

by Health, Aging, and Long-Term Care Committee

Pursuant to a review under the Open Government Sunset Review Act of 1995, this bill re-enacts the public meetings exemption for those portions of a public hospital board meeting at which one or more written strategic plans that are confidential under s. 395.3035(2), F.S., are discussed, modified, or approved by the governing board. The exemption permits public hospitals to plan in a way that does not put them at a disadvantage vis-à-vis private hospitals.

If approved by the Governor, these provisions take effect October 1, 2004.

Vote: Senate 38-0; House 113-0

SB 674 — Public Records Exemption/Home Medical Equipment Providers

by Health, Aging, and Long-Term Care Committee

Pursuant to a review under the Open Government Sunset Review Act of 1995, this bill reenacts the public records exemption for medical and personal identifying information about patients of home medical equipment providers that is held by the Agency for Health Care Administration in complaint files. The bill makes one change in the wording in s. 400.945, F.S., to clarify that it is medical and personal identifying information that is exempt.

If approved by the Governor, these provisions take effect October 1, 2004.

Vote: Senate 38-0; House 116-0

CS/SB 702 — Patient Safety Data/Public Records and Meetings Exemptions
by Governmental Oversight and Productivity Committee and Senator Saunders

The bill creates exemptions from the public records and meetings laws for certain information contained in patient safety data held by the Florida Patient Safety Corporation as created in s. 18 of HB 1629. Information that identifies a patient, a person or entity that reports patient safety data to the corporation, and a health care practitioner or health care facility is confidential and exempt from the public records law. Such information may be disclosed only with the express written consent of the person or entity involved, by court order upon a showing of good cause, or to a health research entity under specified conditions. Any portion of a meeting held by the Florida Patient Safety Corporation during which such information is discussed is exempt from the public meetings law.

The bill provides a statement of public necessity for the exemptions and makes the exemptions subject to the Open Government Sunset Review Act of 1995. The exemptions will be repealed on October 2, 2009, unless reviewed and saved from repeal by the Legislature.

If approved by the Governor, these provisions take effect July 1, 2004, contingent upon HB 1629 becoming a law.

Vote: Senate 33-5; House 80-38

PROPOSED CONSTITUTIONAL AMENDMENT

**HJR 1 — Proposed Constitutional Amendment for Parental Notification
Prior to Termination of the Pregnancy of a Minor**

by Rep. Byrd and others (CS/CS/SJR 2178 by Judiciary Committee; Health, Aging, and Long-Term Care Committee; and Senator Diaz de la Portilla)

This joint resolution proposes the creation of s. 22 of Art. X of the State Constitution to authorize the Legislature to require notice to the parent or guardian of a pregnant minor before a termination of the minor's pregnancy. This amendment authorizes the Legislature to require notice notwithstanding a minor's right of privacy provided in s. 23, Art. I of the State Constitution. The joint resolution prohibits the Legislature from limiting or denying the privacy rights of a minor under the United States Constitution as interpreted by the United States Supreme Court. The Legislature must provide exceptions and shall create a process for judicial bypass.

As required by s. 101.161, F.S., the bill provides a statement for the ballot.

The proposed Constitutional amendment will be submitted to the voters for approval or rejection at the general election to be held in November 2004.

Vote: Senate 27-13; House 93-24

