STORAGE NAME: h2231z.hcs ****FINAL ACTION****
DATE: July 21, 1999 ****SEE FINAL ACTION STATUS SECTION****

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH CARE SERVICES
FINAL ANALYSIS

BILL #: HB 2231 (PCB HCS 99-08)

RELATING TO: Health Care Services

SPONSOR(S): Committee on Health Care Services and Representative Peaden & Others

COMPANION BILL(S): SB 562 (c), HB 953 (c), HB 1413 (c), SB 1554 (c), SB 2352 (c), and SB 2438 (c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 17 NAYS 1
(2) GOVERNMENTAL OPERATIONS YEAS 6 NAYS 0

I. FINAL ACTION STATUS:

06/11/99 Approved by Governor; Chapter No. 99-356

II. SUMMARY:

HB 2231 addresses several health care issues. Specifically, the bill:

- Amends the “Patient Self-Referral Act of 1992" to: add definitions for 6 specific terms; authorize referrals to sole providers and group practices for diagnostic imaging services, excluding radiation therapy services, effective July 1, 1999, under specified circumstances relating to billing for services, investment interest, and service delivery; authorize sole providers and group practices to accept outside referrals for diagnostic imaging services provided certain conditions are met relating to practice employment, equity ownership, practice management, billing, Medicaid service delivery, and annual report requirements, and provided such outside referrals do not constitute more than 15 percent of the providers’ patients receiving diagnostic imaging services, excluding radiation therapy services; impose penalty provisions for those sole providers and group practices that violate this percentage requirement, consistent with existing penalty provisions; require the submission of an annual attestation by each managing physician member of a group practice and each sole provider to AHCA confirming compliance with referral limitations; and require group practices providing diagnostic imaging services to register specific information with AHCA by December 31, 1999.

- Modifies the contingent effective date enacted in 1998, for the removal of the Public Medical Assistance Trust Fund (PMATF) assessment on specific radiation therapy services.

- Requires AHCA, in conjunction with others, to conduct a study of clinical laboratory services for kidney dialysis patients in Florida, with a report to the Legislature by February 1, 2000.

- Applies certificate-of-need statutes and AHCA rules relating to inpatient adult diagnostic cardiac catheterization programs, including specified national guidelines, to all providers of such services.

- Modifies existing law relating to the sale or lease of a public hospital to a private entity relative to the Public Records Law or the Public Meetings Law requirements; and specifies that, under such a transaction, the private lessee may not be construed to be “acting on behalf of” the public lessor.

- Provides the basis for a lawsuit for willful disclosure of a person’s confidential medical information.

- Contains retroactive clarifying and remedial language pertaining to the guidelines for distribution of funds from the state’s Medicaid tobacco litigation.

- Creates the Florida Community Health Protection Act, including specific pilot projects and a required report by January 1, 2001.

- Requires exclusive provider organizations and health maintenance organizations to allow access for their female subscribers to a contracted obstetrician/gynecologist for certain services.

- Provides for a July 1, 1999, effective date, with specified exceptions.

III. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

The Patient Self-Referral Act of 1992

Section 455.654, F.S., short-titled the "Patient Self-Referral Act of 1992," was created to address issues involved in the referral of a patient by a health care provider for a service or treatment when the health care provider has a financial interest in the service or treatment. The statute prohibits any health care provider from referring a patient for the provision of a designated health service to an entity in which the health care provider is an investor. A designated health service is defined as a clinical laboratory service, a physical therapy service, a comprehensive rehabilitation service, a diagnostic imaging service, or certain radiation therapy services.

In addition, health care providers are prevented from referring a patient for any service or item in which the health care provider is an investor unless: the investment interest is in registered securities issued by a publicly held corporation of a specified size; or if no more than 50 percent of the value of the investment interests are held by investors who are in a position to make referrals, and the terms under which the investment interest is offered meet specified conditions.

Certain investment interests are permitted, including an investment interest in: a health service in a rural area; certain debt service instruments; real property resulting in a landlord-tenant relationship; and ownership or lease of a hospital or nursing home.

Certain types of referrals are permitted, as well, including a referral by: a radiologist for diagnostic imaging services; a physician specializing in radiation therapy services for such services; a medical oncologist for drugs, solutions, and supplies to be administered to his patients; a cardiologist for cardiac catheterization services; a pathologist for laboratory tests and pathological examination services; a provider when treating his/her own patients or patients from his/her group practice, when the provider actually provides or supervises the service; a surgeon for professional surgical services of his/her own patients or his group's patients at an ambulatory surgical center; a health care provider for clinical laboratory services related to renal dialysis; or a urologist for lithotripsy services.

Since Florida's Patient Self-Referral Act was passed, there has been some question as to whether providers outside a group practice could refer patients to the group practice without violating the group practice exception. The group practice exception states that orders, recommendations, or plans of care "by a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice" does not constitute a referral by a health care provider (s. 455.654(3)(k)3.f., F.S.).

The 1st DCA Wingo Decision

In June 1997, the First District Court of Appeal (DCA) narrowly construed the group practice exception in an opinion titled Agency for Health Care Administration v. Wingo, 697 So.2d 1231 (Fla. 1st DCA 1997). In Wingo, the DCA held that a group practice that allows any outside referrals to the group's equipment or facilities loses its privilege to the group practice exception under the Patient Self-Referral Act.

In reaching its decision, the DCA reviewed a declaratory statement made by the Florida Board of Medicine regarding a group practice that had purchased a magnetic resonance imaging system (MRI) to be used by the patients of the practice. The practice expected some patient referrals for MRIs from physicians outside of the group practice who had no investment interest in the clinic. The board ruled that the group practice could accept MRI referrals from non-group physicians to supplement utilization and still maintain the group practice exception to the Self-Referral Act for its own referrals. In forming its decision, the board agreed with the assertion of the group practice that it should be treated differently under the statute because it was *accepting* patients rather than *referring* them.

The Agency for Health Care Administration (AHCA) appealed to the First District Court of Appeal, contending that the practice forfeited its group practice exception by providing MRI services to patients referred from outside physicians. In its analysis of the group practice exception, the court focused on language which states that group practice referred services must be "provided solely for such referring health care provider's or group practice's own patients..." (s. 455.654(3)(k)3.f., F.S.).

In overruling the board, the DCA held that the group practice may not allow providers outside of the group to refer patients to the practice for MRI services, and any outside referrals would prohibit the group from referring its own patients to the practice for MRI services and destroy the group practice exception entirely. The court concluded that a group practice could lawfully provide MRI services to its own patients only if it prohibited referrals from physicians outside the group practice.

Prior to the Wingo decision, a health care provider who did not have the equipment to perform certain designated health services could send his patient to an outside group practice that performed those designated health services for the sole purpose of those services. The patient remained under the care of the health care provider and did not become a patient of the group practice performing the designated health services.

As a result of the Wingo decision, a group practice is prohibited from performing designated health care services for an outside health care provider's patients. If a group practice does provide such services for other health care providers' patients, the group will no longer be able to perform those designated health services on its own patients. The Patient Self-Referral Act defines "designated health services" to mean "clinical laboratory services, physical therapy services, comprehensive rehabilitative services, diagnostic-imaging services, and radiation therapy services" (s. 455.654(3)(c), F.S.).

The referral process from primary care and family practice physicians for more disease-specific diagnostic evaluation is inherent in the practice of medicine. According to the Wingo decision, if a patient is not an established patient of a group practice but is referred to the group practice from an outside physician who has no investment in that practice for the purposes of diagnostic-imaging, the group practice becomes a diagnostic imaging center. As a diagnostic-imaging center, the group practice could no longer perform diagnostic-imaging on its own patients because it would be considered a self-referral.

The intent behind the Patient Self-Referral Act was "to provide guidance to health care providers regarding prohibited patient referrals between health care providers and entities providing health care services and to protect the people of Florida from unnecessary and costly health care expenditures" (s. 455.654(2), F.S.). The DCA's interpretation of the statute may put restrictions on a group that might not have been intended to be restricted by the act: group practices that receive referrals from health care providers who have no financial investment in the practice and who will not gain financially in the referral process.

Public Medical Assistance Trust Fund Assessments

Chapter 409, F.S., relates to various state social and economic assistance programs. Sections 409.901-409.9205, F.S., provide the statutory basis for Florida's Medicaid Program. Section 409.918, F.S., authorizes the Public Medical Assistance Trust Fund, as created in 1984. This section provides legislative findings and intent, provides for deposit of revenue into the trust fund, and use of such trust fund revenue.

Chapter 395, F.S., relates to hospital licensing and regulation. Part IV of ch. 395, F.S., relates to the Public Medical Assistance Trust Fund. Section 395.701, F.S., 1998 Supplement, imposes an assessment of 1.5 percent on the net operating revenue for each hospital, as determined by the Agency for Health Care Administration (AHCA), based on the actual audited data of the hospital as reported to AHCA.

Section 395.7015, F.S., 1998 Supplement, imposes an annual assessment of 1.5 percent on the net operating revenues of certain health care entities. The assessment is imposed on the following entities: ambulatory surgical centers and mobile surgical facilities licensed under s. 395.003; clinical laboratories licensed under s. 483.091 (with certain exclusions); freestanding radiation therapy centers providing treatment through the use of radiation therapy machines that are registered under s. 404.22, F.S., and

rules 10D-91.902, 10D-91.903, and 10D-91.904 of the Florida Administrative Code; and diagnostic-imaging centers that provide specialized services for the identification or determination of diseases through examinations, and also provide sophisticated radiological services rendered by physicians licensed under s. 458.311, 458.313, 458.317, 459.006, 459.007, or 459.0075, F.S.

Chapter 98-192, L.O.F., provided an exemption from the assessment on hospital net operating revenues for outpatient radiation therapy services provided by a hospital, and provided for the elimination of the assessment on freestanding radiation therapy centers. The exemption and elimination were made contingent upon AHCA receiving written confirmation from the federal Health Care Financing Administration (HCFA) that the changes would not adversely affect the use of the remaining assessments as state matches for the Medicaid Program. On July 7, 1998, AHCA submitted a letter to HCFA requesting that they confirm that the provisions of chapter 98-192, L.O.F., would have no impact on the permissibility under federal rules of the remaining assessments. On December 17, 1998, HCFA requested additional information from the agency. The agency is evaluating HCFA's request to determine how best to obtain the data that the agency does not now have, or how to otherwise approximate the requested information. Because HCFA confirmation has not been received, the assessments are still in place. (NOTE: See COMMENTS section.)

In addition to the assessments noted above derived from assessments on the net operating revenues of hospitals and non-hospital health care entities, there are several other sources of revenues for the trust fund. Most notable as a major source of funding is the cigarette tax revenue, as authorized in s. 210.20, F.S. In addition, authorization also exists for certain health care regulatory enforcement fine amounts to be deposited into the trust fund: s. 395.1041, F.S., relating to hospital emergency room access violation fines; s. 408.040, F.S., relating to certificate-of-need violation fines; and s. 408.08, F.S., relating to hospital cost containment violation fines.

All assessments collected under ss. 395.701 and 395.7015, F.S., 1998 Supplement, are deposited into the Public Medical Assistance Trust Fund. The assessments, combined with the projected revenues from cigarette taxes and interest earnings, are fully utilized each year in the General Appropriations Act.

The Social Services Estimating Conference met on February 16, 1999, and adopted the following estimates for the Public Medical Assistance Trust Fund for FY 1999-2000:

Estimated revenues:	
Assessments on hospitals	$253,300,000
Assessments on other health care entities	19,200,000
Cigarette tax distribution to PMATF	118,300,000
Interest	3,000,000
Total estimated revenues	$393,800,000
Estimated expenditures:	
Hospital inpatient services	$393,600,000
Administration	200,000
Total estimated expenditures	$393,800,000
Estimated ending cash balance	$0

Clinical Laboratory Services for Kidney Dialysis Patients

Currently, vertically integrated corporate entities that have dialysis clinics also have clinical laboratories that perform laboratory procedures on dialysis patients concomitant to the dialysis services. There are differing opinions regarding whether such arrangements should be allowed to operate this way, or whether there should be a divestiture of one service from the other within a single corporate entity. The Florida Legislature has not made a public policy decision regarding this issue. There are no data as to the extent to which this dual function is occurring, and what benefit or detriment may exist for dialysis patients from such arrangements.

Under current law, a nephrologist, when referring for renal dialysis services and supplies, is included as one of a limited number of practitioners and services that are exempt from the prohibition against self-referral in s. 455.654, F.S., the "Patient Self-Referral Act of 1992." The same is the case for a health care provider for diagnostic clinical laboratory services where such services are directly related to renal dialysis. Such services are supposedly exempted because of the highly specialized nature of the services and the limited number of providers of such services.

Requirements for Delivery of Diagnostic Cardiac Catheterization Services

In 1997, the Legislature deregulated adult inpatient diagnostic cardiac catheterization programs from certificate of need (CON) review. The CON program is a health planning process which approves (or denies) the offering of certain health care services by hospitals and other health care facilities. In place of CON review for adult inpatient diagnostic catheterization, s. 408.036(3)(n)2., F.S., requires the Agency for Health Care Administration to adopt licensure requirements by rule to govern cardiac catheterization programs. Specifically, the rules shall ensure that such programs:

a. Perform only adult inpatient diagnostic cardiac catheterization services authorized by the exemption and will not provide therapeutic cardiac catheterization or any other services not authorized by the exemption.

b. Maintain sufficient appropriate equipment and health personnel to ensure quality and safety.

c. Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

d. Maintain appropriate program volumes to ensure quality and safety.

e. Provide a minimum of 2 percent of its services to charity and Medicaid patients each year.

Statutory Requirements Relating to the Sale or Lease of County, District, or Municipal Hospital

Sale or Lease of County, District, or Municipal Hospital

Section 155.40, F.S., which was enacted as part of ch. 82-147, L.O.F., authorizes the sale or lease of a county, district, or municipal hospital "[i]n order that citizens and residents of the state may receive quality health care. . . ." The governing board is required to make a finding that the sale or lease is in the best interest of the public and to state the basis for this finding. The governing board must provide notice of its intentions and to negotiate terms at a public meeting (s. 155.40(1) and (4), F.S.). A sale or lease of a county, district, or municipal hospital must be for fair market value and must be in compliance with state and federal antitrust laws (s. 155.40(4), F.S.).

Section 155.40, F.S., also specifies contractual requirements. Under subsection (2), a contract for the sale or lease of a public hospital must:

(1) Provide for the approval of the articles of incorporation of the corporation by the hospital board;
(2) Require a not-for-profit Florida corporation to become qualified under §501 (c)(3) of the Internal Revenue Code;
(3) Arrange for the orderly transition of the operation and management of the facility;
(4) Provide for the return of the facility to the county, district, or municipality upon termination; and,
(5) Provide for the continued treatment of indigent patients, in accordance with requirements of the Florida Health Care Responsibility Act and as otherwise provided.

Section 155.40(5), F.S., provides that if a hospital operated by a corporation receives $100,000 or more in revenues annually from a governmental entity that owns the hospital, that corporation is accountable to the governmental entity with respect to the manner in which the funds are expended either: (a) by having revenues subject to annual appropriations by the governmental entity; or (b) by permitting contract modification upon twelve months notice where the contract to provide revenues to

the hospital has a term greater than twelve months. A not-for-profit corporation that is a party to a contract with a governmental entity entered into prior to the 1996 revisions of the section that is not in conformity with the subsection is given 12 months from the effective date of the act (ch. 96-304, L.O.F.) to modify the contract to comply with the act.

Public Records Law Requirements

Article I, s. 24, Florida Constitution, expresses Florida's public policy regarding access to government records in providing that:

> (a) Every person has the right to inspect or copy any public records made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except with respect to records exempted pursuant to this section or specifically made confidential by this Constitution. This section specifically includes the legislative, executive, and judicial branches of government and each agency or department created thereunder; counties, municipalities, and districts; and each constitutional officer, board, and commission, or entity created pursuant to law or this Constitution.

Article I, s. 24, Florida Constitution, does, however, permit the Legislature to provide by general law for the exemption of records from the requirements of s. 24. The general law exempting the records must state with specificity the public necessity justifying the exemption and can be no broader than necessary to accomplish the stated purpose of the law.

Public policy regarding access to government records is also addressed in the Florida Statutes. Section 119.07, F.S., provides:

> Every person who has custody of a public record shall permit the record to be inspected and examined by any person desiring to do so, at a reasonable time, under reasonable conditions, and under supervision by the custodian of the public record or the custodian's designee.

Section 119.15, F.S., provides that an exemption may be created or maintained only if it serves an identifiable public purpose and may be no broader than is necessary to meet the public purpose it serves. An identifiable public purpose is served if the exemption meets one of the following purposes and the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption:

1. Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;

2. Protects information of a sensitive personal nature concerning individuals, the release of which information would be defamatory to such individuals or cause unwarranted damage to the good name or reputation of such individuals or would jeopardize the safety of such individuals. However, in exemptions under this subparagraph, only information that would identify the individuals may be exempted; or

3. Protects information of a confidential nature concerning entities, including, but not limited to, a formula, pattern, device, combination of devices, or compilation of information which is used to protect or further a business advantage over those who do not know or use it, the disclosure of which information would injure the affected entity in the marketplace.

Public Meetings Law Requirements

Article I, s. 24(b), Florida Constitution, provides that

> [a]ll meetings of any collegial public body of the executive branch of state government or of any collegial public body of a county, municipality, school district, or special district, at which official acts are to be taken or at which public business of such body is to be transacted or discussed, shall be open and noticed to the public ....

Article I, s. 24(c), Florida Constitution, states that public meetings exemptions may be provided for by general law, if such law states with specificity the public necessity justifying the exemption and is no broader than necessary to accomplish the stated purpose of the law.

Public policy regarding public meetings is also addressed in the Florida Statutes. Section 286.011, F.S., provides that all meetings of any board or commission of any state agency or authority or of any agency or authority or any county, municipal corporation, or political subdivision, except as otherwise provided in the Constitution at which official acts are to be taken are declared to be public meetings open to the public at all times, and no resolution, rule, or formal action shall be considered binding except as taken or made at such meeting. The board or commission must provide reasonable notice of all such meetings.

The provisions of s. 119.15, F.S., the Open Government Sunset Review Act of 1995, as discussed above regarding public records exemptions, are equally applicable to public meetings exemptions.

Confidentiality of Public Hospital Records and Meetings

Section 395.3035(1), F.S., declares that all meetings of a governing board of a *public* hospital and all *public* hospital records are open and available to the public, unless made confidential or exempt. Exemptions are listed in s. 395.3035(2), F.S. Specifically, the following public hospital records and information are confidential and exempt: (a) certain managed care contracts relating to the public hospital's provision of health care services and supporting documentation for such contracts; (b) certain specified strategic plans of public hospitals; (c) trade secrets, including reimbursement methodologies and rates; and (d) documents, offers, and contracts, not including managed care contracts, resulting from negotiations with nongovernmental entities for payment for services that are or may reasonably be expected by a public hospital's governing board to be provided by the hospital's competitors.

Section 395.3035, F.S., provides two Public Meetings Law exemptions relating to public hospitals. The first exemption pertains to that portion of a meeting of a public hospital governing board during which negotiations for contracts with nongovernmental entities occur or that are reported on that relate to competitive market services. All portions of a governing board meeting that is closed to the public must be recorded by a certified court reporter, and no portion of such meeting may be off the record. (The court reporter's notes must be fully transcribed within a reasonable time after the meeting and maintained by the hospital records custodian. The transcript and related tape recordings, minutes, and notes become public documents one year after termination or completion of the contract to which the negotiations relate or, if no contract was executed, one year after termination of negotiations. All governing board meetings at which the board is scheduled to vote to accept, reject, or amend contracts, other than managed care contracts, must be open to the public.)

The other Public Meetings Law exemption relating to public hospitals pertains to the portion of a public hospital governing board's meeting at which written strategic plans, including written plans for marketing its services, are discussed or reported on. As is required for closed portions of meetings at which a public hospital governing board discusses contracts, other than managed-care contracts, a certified court reporter must record activities and no portion of the meeting may be off the record. The transcript and tape recordings, minutes, and notes relating to the discussion of written strategic plans become public documents 3 years after the date of the board meeting.

Section 395.3035(6), F.S., imposes two tracking requirements relating to the closed portions of governing board public meetings and the documents generated during such periods. The first requirement, which is found in paragraph (a) of the subsection, requires the hospital to report in writing to the governing board every three months the number of records for which a public records request has been made where the records were declared to be confidential under s. 395.3035, F.S., along with certain specified descriptive details about the records.

Additionally, the hospital is required to report in writing to the governing board each confidential record to which the public has been granted access since the hospital's last report to the board, including certain specified descriptive details. The governing board is required to retain copies of these reports for 5 years from the date on which the report was submitted. If the governing board of the hospital is comprised of members who are appointed, the board must forward, within 10 working days after the date on which the board received the report from the hospital, the report to the official or authority that appoints board members.

Section 395.3035(6)(b), F.S., provides the second tracking requirement. That paragraph requires the governing board to maintain a written list of the meetings or portions of meetings, which list must include certain specified details about meetings that were closed to the public. The governing board is authorized to purge information about a meeting from the list 5 years after the date on which the meeting was closed. If the governing board of the hospital is comprised of members who are appointed, the board must forward the list to the official or authority that appoints board members every three months.

Section 395.3036, F.S., 1998 Supplement, exempts the records and meetings of the governing board of a private corporation that leases a public hospital or health care facility from public records requirements if the public lessor complies with the public finance accountability provisions of s. 155.40(5), F.S., and if the public lessee meets at least three of five criteria:

1. The lessor that owns the public hospital or other public health care facility was not the incorporator of the private corporation that leases the public hospital or other health care facility;
2. The public lessor and the private lessee do not commingle any of their funds in any account maintained by either of them, other than the payment of the rent and administrative fees or the transfer of funds;
3. Except as otherwise provided by law, the private lessee is not allowed to participate, except as a member of the public, in the decision-making process of the public lessor;
4. The lease agreement does not expressly require the lessee to comply with the public records and public meeting laws; and
5. The public lessor is not entitled to receive any revenues from the lessee, except for rental or administrative fees due under the lease, and the lessor is not responsible for the debts or other obligations of the lessee.

Background Information Relating to a Private Entity Leasing a Public Hospital

In Memorial Hospital-West Volusia, Inc. v. News-Journal Corporation, No. 90, 835, 1999 WL 20562 (Fla. 1999), the Florida Supreme Court held that Memorial Hospital-West Volusia, Inc., a private not-for-profit corporation, was acting on behalf of a governmental entity when it entered into a lease and transfer agreement with the West Volusia Hospital to operate the West Volusia Memorial Hospital. The court rejected West Volusia's argument that requiring it to provide public records access would frustrate the legislative purpose of s. 155.40, F.S. The court noted that s. 155.40 contains no express exemption from public records access and it declined to imply such an exemption. Rather, the court stated that an exemption from public records access is available only after the Legislature has followed the express procedure provided in article I, section 24(c) of the Florida Constitution. Finally, the court acknowledged the difficulty inherent in making a determination as to whether a private actor is acting on behaving of a public agency and reiterated reliance on the totality of factors approach as enumerated in News and Sun-Sentinel Company v. Schwab, Twitty & Hansen Architectural Group, Inc.; 596 So.2d 1029 (Fla. 1992).

Disclosure of Confidential Medical Information

Section 455.651, F.S., 1998 Supplement, prohibits an officer, employee, or person under contract with the Department of Health, or any board of the department, or any subject of an investigation from conveying knowledge or information to any person who is not lawfully entitled to such knowledge or information about any public meeting or public record, which is exempt from disclosure under the requirements of the Public Records and Meetings Laws. This section provides a penalty of a misdemeanor of the first degree for any person who willfully violates any provision of this section, and further provides for such person to be subject to discipline under s. 455.654, F.S., the "Patient Self-Referral Act of 1992," and, if applicable, to be removed from office, employment, or the contractual relationship.

Medicaid Benefits Recovery From Liable Third Parties

According to section 409.910, F.S., it is the intent of the Legislature that Medicaid be the payor of last resort for medically necessary goods and services furnished to Medicaid recipients, and if benefits of a liable third party are available, Medicaid should be repaid in full and prior to any other person. Section 409.910(4), F.S., provides that after the department has provided medical assistance under the Medicaid Program, it shall seek recovery of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits as to claims for which the agency has a waiver pursuant to federal law or situations in which a third party is liable and the liability or benefits available are discovered either before or after medical assistance has been provided by Medicaid. Recovery is limited to the amount of medical assistance by Medicaid. Section 409.910(7), F.S., provides for the parties from whom recovery of Medicaid benefits shall be collected directly.

Economic, Environmental, and Public Health Revitalization of Communities

The environmental justice movement began in the early 1990's when activists contended that minorities and low-income communities suffered a disproportionate exposure to environmental health risks. In 1990, the Environmental Protection Agency ("EPA") formed an environmental work group which studied whether racial minorities and low-income communities bear a higher environmental health risk compared to that of the general population. In June 1992, the EPA issued its Workgroup Report, and reported, among other findings, that racial minority and low income populations experience a higher than average exposure to selected air pollutants, hazardous waste facilities, contaminated fish, and agricultural pesticides in the workplace. Although, *exposure* does not always result in immediate health effects, it is a cause for concern.

As a result of its studies, the EPA recognized the need to increase awareness of environmental equity issues and highlighted concerns to state and local governments. Accordingly, states were encouraged to reform environmental policies and laws which would prevent the alleged environmental inequities in the future. Studies indicate that Texas, Arkansas, and Louisiana were the first states to address this issue.

In response to this movement, in 1994, President Clinton issued Executive Order #12898, which required certain federal agencies to demonstrate that their programs did not inflict a disproportionately high environmental health risk upon minority and low-income populations in the United States. The agencies recommended that the EPA should act to reduce high concentrations of risk to minority and low-income groups. Accordingly, the EPA is conducting several more studies and taking steps to prioritize environmental concerns based on geographic location.

In 1994, the Florida Legislature recognized this movement and addressed a public interest within this state to determine the following: 1) whether penalties assessed against polluters in white communities are disproportionately larger than penalties assessed against polluters in minority communities; 2) whether hazardous waste site evaluations are conducted more slowly and cleanup efforts take longer; and 3) whether waste containment is more frequent in minority communities. The Florida Legislature enacted ch. 94-219, Laws of Florida, which created and defined the responsibilities of the Environmental Equity and Justice Commission (commission). This commission was designed to examine and determine the possible disproportionate concentration of environmental hazards in low-income and minority communities. The commission conducted several studies to determine whether low-income

communities are at a higher risk of environmental hazards than the general population. The commission's final report, issued in October 1996, suggested, among other recommendations, that an effective means of communicating between the government agencies and these communities should be implemented; funds should be appropriated to implement studies and analyses regarding health effects from exposure to environmental pollution; and environmental protection programs should be adjusted to be more responsive to the affected citizens.

In response to the commission's final report, in 1997, the Florida Legislature found that hazardous waste disproportionately impacts minority and low-income communities and enacted the Brownfields Redevelopment Act (ch. 97-277, L.O.F.) which encourages redevelopment and reuse of the Brownfields sites. According to the Brownfields' 1998 annual report, Brownfields sites are "sites that are generally abandoned, idled or under-used industrial and commercial properties where expansion or redevelopment is complicated by actual or perceived environmental contamination." This annual report stated that Florida has several Brownfields pilot programs which are administered and funded by the EPA, such as, Palm Beach, Broward, and Miami-Dade counties. Florida also has several state and locally designated Brownfields areas such as Clearwater, Ocala, and Miami. This act provided a framework for redevelopment of these sites while also providing environmental cleanup and protection of the public health and the environment. Redevelopment of such Brownfields sites may address the overlapping concerns regarding the health risks of minority and low-income communities which are part of or nearby the Brownfields sites.

In 1998, the Florida Legislature, via ch. 98-304, L.O.F., created the Community Environmental Health Program in s. 381.1015, F.S. The purpose of this program is to ensure the availability of health care services to low-income communities which may be adversely affected by nearby contaminated sites, such as, the state and federal Brownfields and Superfund sites. This section also directed the Department of Health to establish a Community Environmental Health Advisory Board to administer this program. The advisory board is currently identifying the needs, types of services, and available resources of the communities. This 1998 enactment also created s. 760.854, F.S., which established the Center for Environmental Equity and Justice within the Environmental Sciences Institute at the Florida Agricultural and Mechanical University. The specified purpose of the new center is "to conduct and facilitate research, develop policies, and engage in education, training, and community outreach with respect to environmental equity and justice issues."

Access to Obstetrical and Gynecological Services

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. Such organizations stress preventive care and make efforts to avoid unnecessary hospitalization and expensive tertiary care. Subscribers must surrender certain freedom-of-choice selections of health care providers and health-care-related services and are restricted as well in their choice of hospitals and other health care delivery facilities. Subscriber choice is typically restricted to a "gatekeeper" physician (primary care physician) who sees the patient first and then makes a referral to a specialist. These provisions enable HMOs to manage utilization, quality of care, and the cost of medical services which contribute to the savings that managed care plans achieve relative to fee-for-service providers (indemnity plans). Florida law provides very few exceptions to the "gatekeeper" regulatory apparatus of HMOs. Examples of existing exceptions include the requirement that HMOs cover emergency services and care at non-contract hospitals under certain circumstances. In 1997, the Legislature provided direct access for subscribers to dermatologists in HMOs and EPOs without the need for the subscriber to go through a primary care physician (ch. 97-171, L.O.F.).

As of June 1998, more than 4.7 million Florida residents were receiving their health care coverage through commercial HMOs. Even more state residents were receiving health care coverage through other managed care programs, such as preferred provider organizations and Medicaid managed care programs. The number of Florida residents receiving health care coverage through managed care plans has steadily increased since the early 1980's when the state's HMO industry began to grow. Since 1988, the number of commercial HMOs has decreased from a high of 47 to the current 35; however, enrollment has increased. Enrollment in most other types of managed care programs continues to increase as well.

Regulation of HMOs is divided between the Department of Insurance and the Agency for Health Care Administration. The Department of Insurance regulates HMO finances, contracting, and marketing activities under part I of chapter 641, F.S., consisting of ss. 641.17-641.3923, F.S. The department is responsible for ensuring that these entities are financially solvent and conduct their marketing activities in accordance with established guidelines. The Agency for Health Care Administration regulates the quality of care provided by HMOs under part III of chapter 641, F.S., consisting of ss. 641.47-641.75, F.S. The quality requirements under this part include demonstrating, to AHCA's satisfaction, that the HMO is capable of providing health care of a quality consistent with prevailing professional standards of health care delivery. Specific HMO quality assurance issues addressed under s. 641.51, F.S., include those relating to internal quality assurance programs, physician professional judgment, second medical opinions, out-of-network specialty referrals, standing referrals, continuity of care, reporting of quality-of-care indicators to AHCA, customer satisfaction surveys, and preventive pediatric services.

Under an EPO or indemnity plan arrangement, health insurers contract with a group of health care providers and then offer subscribers a health benefit plan reflecting the aggregate of services from those providers under contract, often at discounted rates. Policies or certificates issued by the EPO may condition payment of health care benefits on the subscriber’s use of contract providers, if such benefits are accessible and available through the EPO. Under s. 627.6472, F.S., 1998 Supplement, the Agency for Health Care Administration is responsible for regulating the delivery of services by EPOs and has currently approved the plan of operation for 10 EPOs. In addition, as with HMOs, the Department of Insurance regulates the fiscal, contractual, and marketing activities of insurers who provide services to their policy holders and certificate holders through EPOs. Normally an EPO policy does not require the policy holder to designate a primary care physician (“gatekeeper”) nor does the EPO law refer to this practice, but the department has recently approved such provisions for EPO policies.

In 1995, Florida enacted legislation authorizing a female managed care enrollee to select as her primary care provider an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the managed care plan’s network (ch. 95-281, L.O.F.; ss. 409.9122(1)(b) and 641.19(7)(e), F.S.). The following year the Legislature (via ch. 96-195, L.O.F.) addressed maternity length of stay related issues pertaining to various health insurance coverage categories: s. 627.6406, F.S., relating to health insurance; s. 627.6574, F.S., relating to group, blanket, and franchise insurance; and s. 641.31, F.S., relating to health maintenance organizations. One year later, HMOs were mandated to develop policies and procedures allowing standing referrals to subscribers with chronic and disabling conditions which require ongoing speciality care (ch. 97-159, L.O.F.). The term “chronic and disabling conditions” was not defined, but could include an obstetrical/gynecological-related condition.

Under the State of Florida Group Health Insurance Program (s.110.123, F.S.), HMO members are able to visit an obstetrician/gynecologist without a referral, once per year, for a routine gynecological exam. A female HMO member can also have an obstetrician/gynecologist as her primary care physician. Other services provided by an obstetrician/gynecologist are obtained through referrals by the patient’s primary care physician. Direct access of any in-network or out-of-network provider is offered to preferred provider members (PPO Plan) with different reimbursement arrangements according to provider network status.

According to a representative with the Florida Association of Health Maintenance Organizations, the larger HMOs in Florida already allow their female subscribers one annual visit (a so-called “well woman visit”) to their obstetrician/gynecologist. Other officials with HMOs assert that providing direct access to obstetrical/gynecological services for one or more visits, plus follow-up visits, is unnecessary and inappropriate because there is no evidence that HMO subscribers have insufficient access to these specialists. They also assert that the effect of allowing direct access, however limited, would increase utilization of these services, thereby raising the costs to HMOs of providing care as enrollees would seek treatment from higher-paid specialists who would be more likely to make greater use of costly procedures and treatments. This would have the concomitant effect of reducing the HMO’s ability to manage utilization of medical services, an activity which is a major part of the cost savings that managed care plans achieve.

Representatives of obstetricians and gynecologists counter that the revenue impact upon EPOs and HMOs will not be significant because the costs of examination by a primary care physician will be eliminated. Further, the delay in obtaining needed care, that could ultimately result in necessitating more expensive treatment, will be minimized and the costs of misdiagnosis by a nonspecialist provider, that can occur due to inadequate knowledge or lack of the appropriate equipment for making an accurate assessment of the patient's condition, will be reduced. They also state that the health care relationship between a female member and her obstetrician/gynecologist provider is important because a woman's general health is often dependent upon her reproductive health.

A June 1998 assessment by the American College of Obstetricians and Gynecologists indicates that Florida is one of 16 states that has authorized an obstetrician/gynecologist to be a primary care physician. A total of 27 states permit direct access to non-primary care physician obstetrician/gynecologists. (Florida is not one of the 27.) Of these 27 states, 13 permit access to non-physician obstetrician/gynecologist providers; 7 have an option of informing the primary care physician of visits to the obstetrician/gynecologist providers; 7 require that the primary care physician be informed of the obstetrician/gynecologist visit; 11 states require a notice to the enrollee regarding the availability of direct access for obstetrician/gynecologist visits; and 10 states prohibit additional fees for direct obstetrician/gynecologist provider visits.

B. EFFECT OF PROPOSED CHANGES:

HB 2231 will address several health care issues. Specifically, the bill will:

- Amend the "Patient Self-Referral Act of 1992" (s. 455.654, F.S., 1998 Supplement) and address issues raised in the court opinion, Agency for Health Care Administration v. Wingo, 697 So.2d 1231 (1st DCA June 1997). Specifically, the bill will amend the "Patient Self-Referral Act of 1992" to:
  - Add definitions for: "diagnostic imaging services," "direct supervision," "outside referral for diagnostic imaging services," "patient of a group practice," "present in the office suite," and "sole provider."
  - Authorize referrals to sole providers and group practices for diagnostic imaging services, excluding radiation therapy services, under certain circumstances, effective July 1, 1999. In order to accept such referrals, the sole provider or group practice must bill both the technical and the professional fee for or on behalf of the patient, if the referring physician has no investment interest in the practice. The diagnostic imaging service referred must be a diagnostic imaging service normally provided within the scope of practice of the sole provider or group practice. Such sole providers and group practices may accept no more than 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.
  - Authorize sole providers and group practices to accept outside referrals for diagnostic imaging services provided certain conditions are met relating to practice employment, equity ownership, practice management, billing, Medicaid service delivery, and annual report requirements.
  - Impose penalty provisions for those sole providers and group practices that violate the percentage requirements set above, consistent with existing penalty provisions under the Patient Self-Referral Act.
  - Require the submission of an annual attestation by each managing physician member of a group practice and each sole provider to AHCA confirming compliance with referral limitations.
- Require group practices providing diagnostic imaging services to register with AHCA. Specify registration information to be included, and that registration be completed by December 31, 1999.
- Modify the contingent effective date enacted in 1998, for the removal of the Public Medical Assistance Trust Fund (PMATF) assessment on outpatient radiation therapy services and freestanding radiation therapy centers. If the federal Health Care Financing Administration (HCFA) notifies AHCA in writing,

between April 15, 1999, and November 15, 1999, that the removal of the assessment violates federal regulations, then the removal of the assessment is repealed. The repeal will take effect upon the date that the Secretary of State receives notification from AHCA of the federal determination.

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

- Apply Certificate-of-Need statutes and AHCA rules relating to adult inpatient diagnostic cardiac catheterization programs, including specified national professional guidelines, to all providers of such services.

- Modify the law relating to the sale or lease of a public hospital to a private entity such that the transaction does not subject the entity, unless otherwise expressly stated in the lease documents, to the Public Records Law or the Public Meetings Law; and, further, state that under such a transaction the private lessee operating under a lease may not be construed to be "acting on behalf of" the public lessor.

- Allow a person to sue for treble damages, reasonable attorney's fees, and costs for willful disclosure of the person's confidential medical records and information.

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

- Create the Florida Community Health Protection Act to establish community health pilot projects in certain specified low-income rural and urban communities in Pinellas, Escambia, Hillsborough, Pasco, Manatee, Palm Beach, and Broward Counties, and the City of St. Petersburg; under the act, certain duties are delegated to the Department of Health, including preparation of a report to be submitted, by January 1, 2001, to the President of the Senate, the Speaker of the House of Representatives, and the Governor presenting findings, accomplishments, and recommendations of the pilot projects. (This was the substance of HB 1413 and CS/SB 2352.)

- Require exclusive provider organizations (EPOs) and health maintenance organizations (HMOs) to allow direct access for their female subscribers to a contracted obstetrician/gynecologist for one annual visit and medically necessary follow-up care detected during the annual visit, but authorizing EPOs and HMOs to require such an obstetrician/gynecologist treating a covered patient to coordinate the medical care provided through the patient's primary care physician, if applicable. (This was the substance of HB 953 and CS/SB 1554.)

- Provide for a July 1, 1999, effective date, except that sections 10 and 11, relating to establishment of the community health pilot projects, are effective October 1, 1999, and this effective date applies to contracts issued or renewed on or after that date.

C. APPLICATION OF PRINCIPLES:

1. <u>Less Government:</u>

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

N/A

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

The bill requires the establishment of certain community health pilot projects, and requires the Department of Health to assist the pilot projects in certain activities.

Exclusive provider organizations and health maintenance organizations may be forced to offer access to obstetrical and gynecological services that are currently being provided only through a "gatekeeper."

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

The bill does not eliminate or reduce an agency or a program.

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

N/A

b. Does the bill require or authorize an increase in any fees?

N/A

c. Does the bill reduce total taxes, both rates and revenues?

N/A

d. Does the bill reduce total fees, both rates and revenues?

N/A

e. Does the bill authorize any fee or tax increase by any local government?

N/A

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

N/A

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Those insured individuals may see some cost increase as exclusive provider organizations and health maintenance organizations pass on to covered persons any costs associated with compliance with the obstetrical/gynecological access provisions of the bill.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

The bill provides some relief to physician providers in terms of the types of referrals for health care services the physicians can make for their patients under certain circumstances.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

The bill directs physicians to make known to the Agency for Health Care Administration the physician's level of health care referrals in light of a court case that impacted such referrals, and authorizes referrals up to certain specified limits under certain circumstances.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

The bill does not purport to provide services to families or children.

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

The bill does not create or change a program providing services to families or children.

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 155.40, F.S.; 381.100, F.S.; 381.102, F.S.; 381.103, F.S.; 409.910, F.S., 1998 Supplement; 455.651, F.S.; 455.654, F.S., 1998 Supplement; 627.6472, F.S., 1998 Supplement; and 641.51, F.S.; and section 4 of chapter 98-192, Laws of Florida.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 455.654, F.S., 1998 Supplement, the “Patient Self-Referral Act of 1992" to address issues raised in the court opinion, Agency for Health Care Administration v. Wingo, 697 So.2d 1231 (1st DCA June 1997). Specifically, the bill amends the “Patient Self-Referral Act of 1992" to:

- Add definitions for the following terms: “diagnostic imaging services,” “direct supervision,” “outside referral for diagnostic imaging services,” “patient of a group practice,” “present in the office suite,” and “sole provider.”

- Effective July 1, 1999, authorize a physician licensed under ch. 458, ch. 459, ch. 460, or ch. 461 to make referrals to sole providers and group practices for diagnostic imaging services, excluding radiation therapy services, under certain circumstances. In order for such referrals to be made, the sole provider or group practice must bill both the technical and the professional fee for or on behalf of the patient, if the referring physician has no investment interest in the practice. The diagnostic imaging service referred must be a diagnostic imaging service normally provided within the scope of practice to the patients of the sole provider or group practice. Such sole providers and group practices may accept no more than 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.

- Authorize sole providers and group practices to accept outside referrals for diagnostic imaging services provided certain conditions are met relating to: practice employment, equity ownership or tax status, practice management involvement, billing for services, Medicaid service delivery, and annual reporting requirements.

- Impose penalty provisions for a sole provider or group practice that accepts an outside referral for diagnostic imaging services in violation of these requirements or violates the percentage requirements set above, consistent with existing penalty provisions under the Patient Self-Referral Act.

- Require the submission of an annual attestation by each managing physician member of a group practice and each sole provider to AHCA confirming compliance with the percentage limitations for accepting outside referrals and the requirements for accepting outside referrals. The agency is authorized to verify the report submitted by sole providers and group practices.

Section 2. Directs the Agency for Health Care Administration to require registration by all group practices providing diagnostic imaging services, regardless of ownership. Registration information must include: the medical specialty of each physician; address and phone number of the group; UPIN number for the group and each group member; and Medicare, Medicaid, and commercial billing numbers for the group. The agency is directed to complete this registration by December 31, 1999.

Section 3. Modifies the contingent effective date enacted in section 4 of ch. 98-192, L.O.F., for the removal of the Public Medical Assistance Trust Fund (PMATF) assessment on outpatient radiation therapy services and freestanding radiation therapy centers. If the federal Health Care Financing Administration (HCFA) notifies AHCA in writing, between April 15, 1999, and November 15, 1999, that the removal of the assessment violates federal regulations, then the removal of the assessment is repealed. The repeal will take effect upon the date that the Secretary of State receives notification from AHCA of the federal determination. [NOTE: On May 28, 1999, HCFA notified AHCA of federal approval of these revisions. See COMMENTS section for additional details.]

Section 4. Directs the Agency for Health Care Administration, in conjunction with other agencies as appropriate, to conduct a detailed study and analysis of clinical laboratory services for kidney dialysis patients in the state of Florida. The study shall include, but not be limited to: an analysis of the past and present utilization rates of clinical laboratory services for dialysis patients; financial arrangements among kidney dialysis centers, their medical directors, any business relationships and affiliations with clinical laboratories and any self-referral to clinical laboratory services; the quality and responsiveness of clinical laboratory services for dialysis patients in Florida; and the average annual revenue for dialysis patients for clinical laboratory services for the past 10 years. The agency is required to report its findings to the Legislature by February 1, 2000.

Section 5. This section requires providers of diagnostic cardiac catheterization services to comply with s. 408.036(3)(n)2.a.-d., F.S., and the rules of the Agency for Health Care Administration governing the operation of adult inpatient diagnostic cardiac catheterization programs, including the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories. Pursuant to s. 408.036(3)(n)2.a.-d., F.S., agency rules shall ensure that such programs:

a. Perform only adult inpatient diagnostic cardiac catheterization services authorized by the exemption and will not provide therapeutic cardiac catheterization or any other services not authorized by the exemption.

b. Maintain sufficient appropriate equipment and health personnel to ensure quality and safety.

c. Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

d. Maintain appropriate program volumes to ensure quality and safety.

Section 6. Amends s. 155.40, F.S., relating to the sale or lease of a county, district, or municipal hospital, to add a new subsection (6) which specifies that unless otherwise expressly stated in the lease documents, the transaction involving the sale or lease of a hospital shall not be construed as: a transfer of a government function from the county, district, or municipality to the private purchaser or lessee; constituting a financial interest of the public lessor in the private lessee; or making a private lessee an integral part of the public lessor's decision-making process.

This section is further amended to add as a new subsection (7) the requirement that the lessee of a hospital, pursuant to this section or any special act of the Legislature, operating under a lease shall not be construed to be "acting on behalf of" the lessor as that term is used in statute, unless the lease document expressly provides to the contrary.

Section 7. Amends s. 455.651, F.S., 1998 Supplement, relating to disclosure of confidential information, to specify that any person injured as a result of a willful violation of this section shall have a civil cause of action for treble damages, reasonable attorney's fees, and costs.

Section 8. Amends s. 409.910, F.S., 1998 Supplement, relating to Medicaid third-party liability and recovery, to clarify legislative intent underlying the enactment of certain amendments to s. 409.910, F.S., and to provide that the provisions of s. 409.910(7), F.S., do not apply to any proceeds received by the state, or any agency thereof, pursuant to a final order, judgment, or settlement agreement, in any matter in which the state asserts claims brought on its own behalf, and not as a subrogee of a recipient, or under other theories of liability or in any matter in which the state asserted both claims as a subrogee and additional claims, except as to those sums specifically identified in the final order, judgment, or settlement agreement as reimbursements to the recipient as expenditures for the named recipient on the subrogation claim.

Section 9. Provides that the amendments to s. 409.910, F.S., 1998 Supplement, made by section 9 of this act are intended to clarify existing law and are remedial in nature. As such, they are specifically made retroactive to October 1, 1990, and shall apply to all causes of action arising on or after October 1, 1990.

Section 10. Creates s. 381.100, F.S., to specify that sections 381.100, 381.102, and 381.103, F.S., be cited as the "Florida Community Health Protection Act."

Section 11. Creates s. 381.102, F.S., relating to community health pilot projects. This section provides legislative findings establishing Florida's commitment to addressing the community environmental health concerns as a means of sustaining the impacted urban and rural areas. Initial resources towards this goal are to be provided through a series of pilot projects. The section goes on to indicate that community health pilot projects are hereby established to promote disease prevention and health promotion among low-income persons living in urban and rural communities. Pilot projects are authorized to form partnerships with existing health care providers, contribute to health care needs assessment, provide research capacity, and serve as the basis for health care capacity in their communities.

The following pilot projects are created:

- In Pinellas County, for the Greenwood Community Health Center in Clearwater;
- In Escambia County, for the low-income communities within the Palafox Redevelopment Area;
- In Hillsborough, Pasco, Pinellas, and Manatee counties, for the Urban League of Pinellas County, to operate its mobile health screening unit to provide public health care to persons living in low-income urban and rural communities;
- In Palm Beach County, for low-income communities within the City of Riviera Beach;
- In the City of St. Petersburg, for low-income communities within the Challenge 2001 Area; and
- In Broward County, the communities immediately surrounding the Miles Health Center in Ft. Lauderdale.

Section 12. Creates s. 381.103, F.S., relating to community health pilot projects and related responsibilities of the Department of Health. The department is authorized to: act as the granting agency and contract with pilot projects; facilitate pilot project integration with ongoing department programs; develop education and outreach programs for communities and providers; assist projects in obtaining low-cost health care services; prepare a report to be submitted to the Speaker of the House of Representatives, the President of the Senate, and the Governor on the findings, accomplishments, and recommendations of the community pilot projects by or on January 1, 2001; and facilitate cooperation between affected communities, appropriate agencies, and ongoing initiatives, such as Front Porch Florida.

Section 13. Amends s. 627.6472, F.S., 1998 Supplement, relating to exclusive provider organization service coverage requirements, to add as a new subsection (18) the requirement that an exclusive provider organization allow, without prior authorization, a female subscriber to visit a contracted obstetrician/gynecologist for one annual visit and for medically necessary follow-up care detected at that visit. This authorization shall not prevent an organization from requiring that an obstetrician/ gynecologist treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.

Section 14. Amends s. 641.51, F.S., relating to health maintenance organization quality assurance programs and second medical opinion requirements, to add as a new subsection (11) the requirement that a health maintenance organization allow, without prior authorization, a female subscriber to visit a contracted obstetrician/gynecologist for one annual visit and for medically necessary follow-up care detected at that visit. This authorization shall not prevent an organization from requiring that an obstetrician/gynecologist treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.

Section 15. Provides for a July 1, 1999, effective date, except that sections 10 and 11 of the act shall take effect October 1, 1999, and shall apply to contracts issued or renewed on or after that date. [NOTE: See COMMENTS section.]

IV. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

The Agency for Health Care Administration will incur costs associated with the required registration of all group practices providing diagnostic imaging services. The costs of this registration are unknown.

The Division of State Group Insurance will incur costs associated with notifying state employees of the availability of access to services by obstetricians and gynecologists since the implementation date does not coincide with the beginning of the calendar year. The Division of State Group Insurance estimates it will incur non-recurring expenditures related to the notification of benefit changes of $17,500 based on an HMO enrollment of 58,058 subscribers.

2. Recurring Effects:

To the extent that exclusive provider organizations and health maintenance organizations under contract with the state for services for state employees do not currently allow access to obstetricians and gynecologists as specified in these provisions, these plans may incur some costs associated with such access. Conversely, if such plans currently require a woman to see a primary care physician in order to receive a referral to obstetricians and gynecologists, the plans could avoid costs associated with this required step.

3. Long Run Effects Other Than Normal Growth:

N/A

4. Total Revenues and Expenditures:

See above note.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

N/A

2. Recurring Effects:

N/A

3. Long Run Effects Other Than Normal Growth:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

To the extent that exclusive provider organizations and health maintenance organizations do not currently allow access to obstetricians and gynecologists without a referral from a primary care physician, these plans may incur some costs associated with such access. Conversely, if such plans currently require a woman to see a primary care physician in order to receive a referral to obstetricians and gynecologists, the plans could avoid costs associated with this required step.

2. Direct Private Sector Benefits:

To the extent that improved health may contribute to economic viability and growth, low-income urban and rural communities in which a pilot project is established should benefit from the additional health resources made available to them.

Women enrolled in exclusive provider organizations and health maintenance organizations who wish to have access to obstetricians and gynecologists would be allowed to do so.

3. Effects on Competition, Private Enterprise and Employment Markets:

Unknown.

D. FISCAL COMMENTS:

Neither this bill nor the 1999-2000 General Appropriations Act provides any funding for the “Florida Community Health Protection Act.”

V. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

The health insurance benefits required by this bill would apply to local government health insurance plans to the extent that such coverage is provided via exclusive provider organizations or health maintenance organizations. To the extent this bill requires local governments to incur expenses, i.e., to pay additional health insurance costs, the bill falls within the purview of Article VII, Section 18 of the Florida Constitution, which provides that cities and counties are not bound by general laws requiring them to spend funds or to take action which requires the expenditure of funds unless certain specified exemptions or exceptions are met.

This bill may qualify for the exemption for bills having an insignificant fiscal impact.

An exemption would apply if a legislative determination is made that the bill fulfills an important state interest. The bill does not contain a legislative finding to this effect.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenue in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

The bill does not reduce the percentage of a state tax shared with counties or municipalities.

VI. COMMENTS:

Effective Date

The effective date of HB 2231 reads: "This act shall take effect July 1, 1999, except that sections 10 and 11 of this act shall take effect October 1, 1999, and shall apply to contracts issued or renewed on or after that date." The referenced sections 10 and 11 are part of the "Florida Community Health Protection Act" as created by sections 10, 11, and 12 of the act. The effective date reference appears to be a "scrivener's error" that should have been a reference to sections 13 and 14, since these insurance-related coverage provisions are applicable to "contracts" as referenced. This issue has been brought to the attention of the Division of Statutory Revision in the Office of Legislative Services.

Access to Obstetrical and Gynecology Services

As previously mentioned, the bill does not provide a statement of public necessity relative to any local government mandates applicability of the provisions relating to HMO and EPO subscriber access to obstetric/gynecology services, and it is also unclear if the bill's fiscal impact would rise to a level of mandates concern.

Section 624.215, F.S., requires organizations seeking consideration of a legislative proposal that would mandate a health benefit to prepare a report to the Agency for Health Care Administration and the legislative committee with jurisdiction over the proposal to assess the proposal's financial and social impact. No such report has been prepared for the obstetric/gynecology services coverage benefit specified in the bill.

Public Medical Assistance Trust Fund Assessment

As indicated in the PRESENT SITUATION portion of the analysis, at the time of the 1999 Legislative session, Florida was still awaiting word from the federal government as to federal approval or disapproval of Florida's request for an exemption from the assessment on hospital net operating revenues for outpatient radiation therapy services provided by a hospital and for elimination of the assessment on freestanding radiation therapy centers. As directed by ch. 98-192, L.O.F., written federal confirmation of these changes were required prior to the implementation of these assessment revisions. On May 28, 1999, HCFA notified AHCA of federal approval of these revisions. Such changes do, in fact, meet all federal tests relating to a "broad based health care-related tax" and uniformity requirements.

Diagnostic Cardiac Catheterization Services

The effect of section 5 is unclear in several respects. First, it requires "each provider of diagnostic cardiac catheterization services" (emphasis added) to comply with s. 408.036(3)(n)2.a.-d., F.S., without any differentiation as to the type of provider. Consequently, this would appear to include hospitals, diagnostic imaging centers, physicians, or any other provider of the services. Hospitals which have applied for an exemption from CON review for adult inpatient diagnostic cardiac catheterization are already specifically covered by the current statute but other hospitals and providers of diagnostic cardiac catheterization services are not; hence, the new provisions in section 5 would arguably apply to them.

Second, section 5 applies to "each provider of diagnostic cardiac catheterization services" (emphasis added), not just to adults and not just for inpatients. An additional problem arises because providers of diagnostic cardiac catheterization services can, pursuant to s. 408.036(3)(n)2.a., F.S., perform only adult inpatient diagnostic cardiac catheterization services authorized by the exemption and will not provide therapeutic cardiac catheterization or any other services not authorized by the exemption.

Regardless of these ambiguities, it is clear that each provider of diagnostic cardiac catheterization services captured by section 5 does not have to comply with s. 408.036(3)(n)2.e., F.S., which requires the provision of a minimum of 2 percent of its services to charity and Medicaid patients each year.

VII. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

As adopted as PCB HCS 99-08 on April 12, 1999, and filed and numbered as HB 2231, this bill would have:

- Amended the “Patient Self-Referral Act of 1992" to add definitions for specific terms.
- Authorized referrals to sole providers and group practices for diagnostic imaging services, under certain circumstances. Provided separate processes depending on a sole provider’s or group practice’s history of referrals for such services, with a “grandfathering” of certain providers and the establishment of an allowable threshold for other providers.
- Amended the Patient Brokering Act to update the definition of “health care provider or health care facility.”
- Directed AHCA to study and report back to the Governor and the Legislature by January 15, 2000, regarding the need to establish quality of care standards relating to group practices that provide designated health care services.
- Directed AHCA to conduct a study of outpatient designated health care services, and referral patterns for such services, with a report back to the Governor and the Legislature by December 15, 2000.

On April 21, 1999, the Committee on Governmental Operations adopted a strike-everything amendment with three amendments which were incorporated into the strike-everything amendment. The strike-everything amendment as amended made the following substantive changes to the bill:

- Deleted a reference to s. 455.6545, F.S., in the application of the definitions because the bill no longer created such a section;
- Added EEG, EKG, nerve conduction studies, and evoked potentials to the list of terms in the definition of “diagnostic imaging services;”
- Added sole provider to the meaning of “outside referral for diagnostic imaging services” and defined the term “sole provider;”
- Added to the definition of “referral” to provide that certain licensed physicians may refer patients for diagnostic imaging services to sole providers or group practices if the referring physician has no financial interest in the practice, and limits such practices to accepting no more than 35% of their patients through such referrals;
- Added a definition of “present in the office suite;”
- Relocated portions of section 2 of the bill into subparagraph (4) of section 455.654, F.S., regarding requirements for providers for accepting outside referrals for diagnostic imaging services. The amendment added a provision that the agency can seek federal waivers; corrected a cross-reference to the percentage of outside referrals a provider can accept; deleted reference to a manner by which certain physicians who relied on declaratory statements issued by the Board of Medicine may continue to accept referrals; deleted a reference to the employment status of physicians who can perform diagnostic imaging services; provided for annual reporting by such providers to AHCA; deleted a reference to physicians who provide false information to the agency; and deleted a provision that such services are subject to the assessment imposed by s. 395.7015, F.S.;
- Amended the scope of a study AHCA is directed to perform;
- Deleted a provision that AHCA perform a second study;
- Revised the provision that AHCA require registration of certain providers; and
- Restored section 4 of the original bill regarding ch. 98-192, L.O.F., except that the act shall not apply to s. 395.7015, F.S.

When HB 2231 was heard by the full House of Representatives on April 23, 1999, the House concurred with the Governmental Operations Committee, and adopted 3 additional clarifying amendments to the strike-everything amendment.

On April 28, 1999, the Senate substituted HB 2231 for SB 2438, and adopted a strike-everything amendment which completely revised the bill’s original provisions relating to the “Patient Self-Referral Act of 1992,” and also modified the provisions relating to 1998 PMATF assessment revisions, and added provisions relating to: a study of laboratory services for dialysis patients; diagnostic cardiac catheterization service requirements; sale or lease of public hospitals; disclosure of confidential medical

information; and Medicaid third-party liability and recovery. The Senate also adopted two technical amendments to the strike-everything amendment.

On April 29, 1999, the Senate further amended HB 2231 by adding provisions relating to community environmental health and access to obstetrical and gynecological care.

On April 30, 1999, the House unanimously concurred with the Senate amendments.

VIII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams

AS REVISED BY THE COMMITTEE ON GOVERNMENTAL OPERATIONS:

Prepared by:	Staff Director:
Douglas Pile	Jimmy O. Helms

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams