Bill No. CS for CS for CS/SB 2154, CS/SB 1900 & SB 282, 1st Eng.

Amendment No. ___

CHAMBER ACTION

Senate		House
	.	

Senator Latvala moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. This act may be cited as the "Patient Protection Act of 2000."

Section 2. Subsections (2) and (11) of section 400.471, Florida Statutes, are amended to read:

400.471 Application for license; fee; provisional license; temporary permit.--

(2) The applicant must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(a) A listing of services to be provided, either directly by the applicant or through contractual arrangements with existing providers;

(b) The number and discipline of professional staff to be employed; and

(c) Proof of financial ability to operate.

~~If the applicant has applied for a certificate of need under ss. 408.0331-408.045 within the preceding 12 months, the applicant may submit the proof required during the certificate-of-need process along with an attestation that there has been no substantial change in the facts and circumstances underlying the original submission.~~

(11) The agency may not issue a license designated as certified to a home health agency that fails to ~~receive a certificate of need under ss. 408.031-408.045 or that fails to~~ satisfy the requirements of a Medicare certification survey from the agency.

Section 3. Section 408.032, Florida Statutes, is amended to read:

408.032 Definitions.--As used in ss. 408.031-408.045, the term:

(1) "Agency" means the Agency for Health Care Administration.

(2) "Capital expenditure" means an expenditure, including an expenditure for a construction project undertaken by a health care facility as its own contractor, which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance, which is made to change the bed capacity of the facility, or substantially change the services or service area of the health care facility, health service provider, or hospice, and which includes the cost of the studies, surveys, designs, plans, working drawings, specifications, initial financing costs, and other activities essential to acquisition, improvement, expansion, or replacement of the plant and equipment.

1 (3) "Certificate of need" means a written statement
2 issued by the agency evidencing community need for a new,
3 converted, expanded, or otherwise significantly modified
4 health care facility, health service, or hospice.
5 (4) "Commenced construction" means initiation of and
6 continuous activities beyond site preparation associated with
7 erecting or modifying a health care facility, including
8 procurement of a building permit applying the use of
9 agency-approved construction documents, proof of an executed
10 owner/contractor agreement or an irrevocable or binding forced
11 account, and actual undertaking of foundation forming with
12 steel installation and concrete placing.
13 (5) "District" means a health service planning
14 district composed of the following counties:
15 District 1.--Escambia, Santa Rosa, Okaloosa, and Walton
16 Counties.
17 District 2.--Holmes, Washington, Bay, Jackson,
18 Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla,
19 Jefferson, Madison, and Taylor Counties.
20 District 3.--Hamilton, Suwannee, Lafayette, Dixie,
21 Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua,
22 Marion, Citrus, Hernando, Sumter, and Lake Counties.
23 District 4.--Baker, Nassau, Duval, Clay, St. Johns,
24 Flagler, and Volusia Counties.
25 District 5.--Pasco and Pinellas Counties.
26 District 6.--Hillsborough, Manatee, Polk, Hardee, and
27 Highlands Counties.
28 District 7.--Seminole, Orange, Osceola, and Brevard
29 Counties.
30 District 8.--Sarasota, DeSoto, Charlotte, Lee, Glades,
31 Hendry, and Collier Counties.

1 District 9.--Indian River, Okeechobee, St. Lucie,
2 Martin, and Palm Beach Counties.
3 District 10.--Broward County.
4 District 11.--Dade and Monroe Counties.
5 (6) "Exemption" means the process by which a proposal
6 that would otherwise require a certificate of need may proceed
7 without a certificate of need.
8 (7)(6) "Expedited review" means the process by which
9 certain types of applications are not subject to the review
10 cycle requirements contained in s. 408.039(1), and the letter
11 of intent requirements contained in s. 408.039(2).
12 (8)(7) "Health care facility" means a hospital,
13 long-term care hospital, skilled nursing facility, hospice,
14 intermediate care facility, or intermediate care facility for
15 the developmentally disabled. A facility relying solely on
16 spiritual means through prayer for healing is not included as
17 a health care facility.
18 (9)(8) "Health services" means diagnostic, curative,
19 or rehabilitative services and includes alcohol treatment,
20 drug abuse treatment, and mental health services. Obstetric
21 services are not health services for purposes of ss.
22 408.031-408.045.
23 (9) "Home health agency" means an organization, as
24 defined in s. 400.462(4), that is certified or seeks
25 certification as a Medicare home health service provider.
26 (10) "Hospice" or "hospice program" means a hospice as
27 defined in part VI of chapter 400.
28 (11) "Hospital" means a health care facility licensed
29 under chapter 395.
30 (12) "Institutional health service" means a health
31 service which is provided by or through a health care facility

~~and which entails an annual operating cost of $500,000 or more. The agency shall, by rule, adjust the annual operating cost threshold annually using an appropriate inflation index.~~

~~(13) "Intermediate care facility" means an institution which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require health-related care and services above the level of room and board.~~

(12)~~(14)~~ "Intermediate care facility for the developmentally disabled" means a residential facility licensed under chapter 393 and certified by the Federal Government pursuant to the Social Security Act as a provider of Medicaid services to persons who are mentally retarded or who have a related condition.

(13)~~(15)~~ "Long-term care hospital" means a hospital licensed under chapter 395 which meets the requirements of 42 C.F.R. s. 412.23(e) and seeks exclusion from the Medicare prospective payment system for inpatient hospital services.

(14) "Mental health services" means inpatient services provided in a hospital licensed under chapter 395 and listed on the hospital license as psychiatric beds for adults; psychiatric beds for children and adolescents; intensive residential treatment beds for children and adolescents; substance abuse beds for adults; or substance abuse beds for children and adolescents.

~~(16) "Multifacility project" means an integrated residential and health care facility consisting of independent living units, assisted living facility units, and nursing home beds certificated on or after January 1, 1987, where:~~

~~(a) The aggregate total number of independent living units and assisted living facility units exceeds the number of nursing home beds.~~

~~(b) The developer of the project has expended the sum of $500,000 or more on the certificated and noncertificated elements of the project combined, exclusive of land costs, by the conclusion of the 18th month of the life of the certificate of need.~~

~~(c) The total aggregate cost of construction of the certificated element of the project, when combined with other, noncertificated elements, is $10 million or more.~~

~~(d) All elements of the project are contiguous or immediately adjacent to each other and construction of all elements will be continuous.~~

(15)~~(17)~~ "Nursing home geographically underserved area" means:

(a) A county in which there is no existing or approved nursing home;

(b) An area with a radius of at least 20 miles in which there is no existing or approved nursing home; or

(c) An area with a radius of at least 20 miles in which all existing nursing homes have maintained at least a 95 percent occupancy rate for the most recent 6 months or a 90 percent occupancy rate for the most recent 12 months.

~~(18) "Respite care" means short-term care in a licensed health care facility which is personal or custodial and is provided for chronic illness, physical infirmity, or advanced age for the purpose of temporarily relieving family members of the burden of providing care and attendance.~~

(16)~~(19)~~ "Skilled nursing facility" means an institution, or a distinct part of an institution, which is

primarily engaged in providing, to inpatients, skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(17)~~(20)~~ "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The agency shall establish by rule a list of all tertiary health services.

(18)~~(21)~~ "Regional area" means any of those regional health planning areas established by the agency to which local and district health planning funds are directed to local health councils through the General Appropriations Act.

Section 4. Paragraph (b) of subsection (1) and paragraph (a) of subsection (3) of section 408.033, Florida Statutes, are amended to read:

408.033 Local and state health planning.--

(1) LOCAL HEALTH COUNCILS.--

(b) Each local health council may:

1. Develop a district or regional area health plan that permits ~~is consistent with the objectives and strategies in the state health plan, but that shall permit~~ each local

health council to develop strategies and set priorities for implementation based on its unique local health needs. The district or regional area health plan must contain preferences for the development of health services and facilities, which may be considered by the agency in its review of certificate-of-need applications. The district health plan shall be submitted to the agency and updated periodically. The district health plans shall use a uniform format and be submitted to the agency according to a schedule developed by the agency in conjunction with the local health councils. The schedule must provide for ~~coordination between the development of the state health plan and the district health plans and for~~ the development of district health plans by major sections over a multiyear period. The elements of a district plan which are necessary to the review of certificate-of-need applications for proposed projects within the district may be adopted by the agency as a part of its rules.

2. Advise the agency on health care issues and resource allocations.

3. Promote public awareness of community health needs, emphasizing health promotion and cost-effective health service selection.

4. Collect data and conduct analyses and studies related to health care needs of the district, including the needs of medically indigent persons, and assist the agency and other state agencies in carrying out data collection activities that relate to the functions in this subsection.

5. Monitor the onsite construction progress, if any, of certificate-of-need approved projects and report council findings to the agency on forms provided by the agency.

6. Advise and assist any regional planning councils

1 within each district that have elected to address health
2 issues in their strategic regional policy plans with the
3 development of the health element of the plans to address the
4 health goals and policies in the State Comprehensive Plan.
5 7. Advise and assist local governments within each
6 district on the development of an optional health plan element
7 of the comprehensive plan provided in chapter 163, to assure
8 compatibility with the health goals and policies in the State
9 Comprehensive Plan and district health plan. To facilitate
10 the implementation of this section, the local health council
11 shall annually provide the local governments in its service
12 area, upon request, with:
13 a. A copy and appropriate updates of the district
14 health plan;
15 b. A report of hospital and nursing home utilization
16 statistics for facilities within the local government
17 jurisdiction; and
18 c. Applicable agency rules and calculated need
19 methodologies for health facilities and services regulated
20 under s. 408.034 for the district served by the local health
21 council.
22 8. Monitor and evaluate the adequacy, appropriateness,
23 and effectiveness, within the district, of local, state,
24 federal, and private funds distributed to meet the needs of
25 the medically indigent and other underserved population
26 groups.
27 9. In conjunction with the Agency for Health Care
28 Administration, plan for services at the local level for
29 persons infected with the human immunodeficiency virus.
30 10. Provide technical assistance to encourage and
31 support activities by providers, purchasers, consumers, and

local, regional, and state agencies in meeting the health care goals, objectives, and policies adopted by the local health council.

11. Provide the agency with data required by rule for the review of certificate-of-need applications and the projection of need for health services and facilities in the district.

(3) DUTIES AND RESPONSIBILITIES OF THE AGENCY.--

(a) The agency, in conjunction with the local health councils, is responsible for the coordinated planning of ~~all~~ health care services in the state ~~and for the preparation of the state health plan~~.

Section 5. Subsection (2) of section 408.034, Florida Statutes, is amended to read:

408.034 Duties and responsibilities of agency; rules.--

(2) In the exercise of its authority to issue licenses to health care facilities and health service providers, as provided under chapters 393, 395, and parts II~~, IV,~~and VI of chapter 400, the agency may not issue a license to any health care facility, health service provider, hospice, or part of a health care facility which fails to receive a certificate of need or an exemption for the licensed facility or service.

Section 6. Section 408.035, Florida Statutes, is amended to read:

408.035 Review criteria.--

~~(1)~~ The agency shall determine the reviewability of applications and shall review applications for certificate-of-need determinations for health care facilities and health services in context with the following criteria:

(1)~~(a)~~ The need for the health care facilities and

health services being proposed in relation to the applicable district health plan~~, except in emergency circumstances that pose a threat to the public health~~.

(2)~~(b)~~ The availability, quality of care, ~~efficiency, appropriateness,~~accessibility, and extent of utilization of~~, and adequacy of like and~~ existing health care facilities and health services in the service district of the applicant.

(3)~~(c)~~ The ability of the applicant to provide quality of care and the applicant's record of providing quality of care.

~~(d) The availability and adequacy of other health care facilities and health services in the service district of the applicant, such as outpatient care and ambulatory or home care services, which may serve as alternatives for the health care facilities and health services to be provided by the applicant.~~

~~(e) Probable economies and improvements in service which may be derived from operation of joint, cooperative, or shared health care resources.~~

(4)~~(f)~~ The need in the service district of the applicant for special health care ~~equipment and~~ services that are not reasonably and economically accessible in adjoining areas.

(5)~~(g)~~ The needs of ~~need for~~ research and educational facilities, including, but not limited to, facilities with institutional training programs and community training programs for health care practitioners and for doctors of osteopathic medicine and medicine at the student, internship, and residency training levels.

(6)~~(h)~~ The availability of resources, including health personnel, management personnel, and funds for capital and

operating expenditures, for project accomplishment and operation.~~; the effects the project will have on clinical needs of health professional training programs in the service district; the extent to which the services will be accessible to schools for health professions in the service district for training purposes if such services are available in a limited number of facilities; the availability of alternative uses of such resources for the provision of other health services; and~~

(7) The extent to which the proposed services will enhance access to health care for ~~be accessible to all~~ residents of the service district.

(8)~~(i)~~ The immediate and long-term financial feasibility of the proposal.

~~(j) The special needs and circumstances of health maintenance organizations.~~

~~(k) The needs and circumstances of those entities that provide a substantial portion of their services or resources, or both, to individuals not residing in the service district in which the entities are located or in adjacent service districts. Such entities may include medical and other health professions, schools, multidisciplinary clinics, and specialty services such as open-heart surgery, radiation therapy, and renal transplantation.~~

(9)~~(l)~~ The extent to which the proposal will foster competition that promotes quality and cost-effectiveness.~~The probable impact of the proposed project on the costs of providing health services proposed by the applicant, upon consideration of factors including, but not limited to, the effects of competition on the supply of health services being proposed and the improvements or innovations in the financing and delivery of health services which foster competition and~~

~~service to promote quality assurance and cost-effectiveness.~~

(10)~~(m)~~ The costs and methods of the proposed construction, including the costs and methods of energy provision and the availability of alternative, less costly, or more effective methods of construction.

(11)~~(n)~~ The applicant's past and proposed provision of health care services to Medicaid patients and the medically indigent.

~~(o) The applicant's past and proposed provision of services that promote a continuum of care in a multilevel health care system, which may include, but are not limited to, acute care, skilled nursing care, home health care, and assisted living facilities.~~

(12)~~(p)~~ The applicant's designation as a Gold Seal Program nursing facility pursuant to s. 400.235, when the applicant is requesting additional nursing home beds at that facility.

~~(2) In cases of capital expenditure proposals for the provision of new health services to inpatients, the agency shall also reference each of the following in its findings of fact:~~

~~(a) That less costly, more efficient, or more appropriate alternatives to such inpatient services are not available and the development of such alternatives has been studied and found not practicable.~~

~~(b) That existing inpatient facilities providing inpatient services similar to those proposed are being used in an appropriate and efficient manner.~~

~~(c) In the case of new construction or replacement construction, that alternatives to the construction, for example, modernization or sharing arrangements, have been~~

~~considered and have been implemented to the maximum extent practicable.~~

~~(d) That patients will experience serious problems in obtaining inpatient care of the type proposed, in the absence of the proposed new service.~~

~~(e) In the case of a proposal for the addition of beds for the provision of skilled nursing or intermediate care services, that the addition will be consistent with the plans of other agencies of the state responsible for the provision and financing of long-term care, including home health services.~~

Section 7. Section 408.036, Florida Statutes, is amended to read:

408.036 Projects subject to review.--

(1) APPLICABILITY.--Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(h)~~(k)~~, are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.

(a) The addition of beds by new construction or alteration.

(b) The new construction or establishment of additional health care facilities, including a replacement health care facility when the proposed project site is not located on the same site as the existing health care facility.

(c) The conversion from one type of health care facility to another~~, including the conversion from one level of care to another, in a skilled or intermediate nursing facility, if the conversion effects a change in the level of~~

~~care of 10 beds or 10 percent of total bed capacity of the skilled or intermediate nursing facility within a 2-year period. If the nursing facility is certified for both skilled and intermediate nursing care, the provisions of this paragraph do not apply~~.

(d) An ~~Any~~ increase in the total licensed bed capacity of a health care facility.

(e) ~~Subject to the provisions of paragraph (3)(i),~~The establishment of a ~~Medicare-certified home health agency, the establishment of a~~ hospice or hospice inpatient facility~~, or the direct provision of such services by a health care facility or health maintenance organization for those other than the subscribers of the health maintenance organization; except that this paragraph does not apply to the establishment of a Medicare-certified home health agency by a facility described in paragraph (3)(h)~~.

~~(f) An acquisition by or on behalf of a health care facility or health maintenance organization, by any means, which acquisition would have required review if the acquisition had been by purchase.~~

(f)~~(g)~~ The establishment of inpatient institutional health services by a health care facility, or a substantial change in such services.

~~(h) The acquisition by any means of an existing health care facility by any person, unless the person provides the agency with at least 30 days' written notice of the proposed acquisition, which notice is to include the services to be offered and the bed capacity of the facility, and unless the agency does not determine, within 30 days after receipt of such notice, that the services to be provided and the bed capacity of the facility will be changed.~~

~~(i) An increase in the cost of a project for which a certificate of need has been issued when the increase in cost exceeds 20 percent of the originally approved cost of the project, except that a cost overrun review is not necessary when the cost overrun is less than $20,000.~~

(g)~~(j)~~ An increase in the number of beds for acute care, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, mental health services, or hospital-based distinct part skilled nursing units, or at a long-term care hospital ~~psychiatric or rehabilitation beds~~.

(h)~~(k)~~ The establishment of tertiary health services.

(2) PROJECTS SUBJECT TO EXPEDITED REVIEW.--Unless exempt pursuant to subsection (3), projects subject to an expedited review shall include, but not be limited to:

~~(a) Cost overruns, as defined in paragraph (1)(i).~~

(a)~~(b)~~ Research, education, and training programs.

(b)~~(c)~~ Shared services contracts or projects.

(c)~~(d)~~ A transfer of a certificate of need.

(d)~~(e)~~ A 50-percent increase in nursing home beds for a facility incorporated and operating in this state for at least 60 years on or before July 1, 1988, which has a licensed nursing home facility located on a campus providing a variety of residential settings and supportive services. The increased nursing home beds shall be for the exclusive use of the campus residents. Any application on behalf of an applicant meeting this requirement shall be subject to the base fee of $5,000 provided in s. 408.038.

~~(f) Combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict.~~

~~(g) Division into two or more nursing home facilities~~

~~of beds or services authorized by one certificate of need issued in the same planning subdistrict. Such division shall not be approved if it would adversely affect the original certificate's approved cost.~~

(e)~~(h)~~ 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.

(f) The conversion of mental health services beds licensed under chapter 395 or hospital-based distinct part skilled nursing unit beds to general acute care beds; the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services; or the conversion of general acute care beds to beds for mental health services.

1. Conversion under this paragraph shall not establish a new licensed bed category at the hospital but shall apply only to categories of beds licensed at that hospital.

2. Beds converted under this paragraph must be licensed and operational for at least 12 months before the hospital may apply for additional conversion affecting beds of the same type.

The agency shall develop rules to implement the provisions for expedited review, including time schedule, application content which may be reduced from the full requirements of s. 408.037(1), and application processing.

(3) EXEMPTIONS.--Upon request, the following projects are subject to ~~supported by such documentation as the agency requires, the agency shall grant an~~ exemption from the provisions of subsection (1):

~~(a) For the initiation or expansion of obstetric~~

~~services.~~

(a)~~(b)~~ For replacement of ~~any expenditure to replace or renovate any part of~~ a licensed health care facility on the same site, provided that the number of ~~licensed~~ beds in each licensed bed category will not increase ~~and, in the case of a replacement facility, the project site is the same as the facility being replaced~~.

~~(c) For providing respite care services. An individual may be admitted to a respite care program in a hospital without regard to inpatient requirements relating to admitting order and attendance of a member of a medical staff.~~

(b)~~(d)~~ For hospice services ~~or home health services~~ provided by a rural hospital, as defined in s. 395.602, or for swing beds in such rural hospital in a number that does not exceed one-half of its licensed beds.

(c)~~(e)~~ For the conversion of licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital as defined in s. 395.602, so long as the conversion of the beds does not involve the construction of new facilities. The total number of skilled nursing beds, including swing beds, may not exceed one-half of the total number of licensed beds in the rural hospital as of July 1, 1993. Certified skilled nursing beds designated under this paragraph, excluding swing beds, shall be included in the community nursing home bed inventory. A rural hospital which subsequently decertifies any acute care beds exempted under this paragraph shall notify the agency of the decertification, and the agency shall adjust the community nursing home bed inventory accordingly.

(d)~~(f)~~ For the addition of nursing home beds at a skilled nursing facility that is part of a retirement

community that provides a variety of residential settings and supportive services and that has been incorporated and operated in this state for at least 65 years on or before July 1, 1994. All nursing home beds must not be available to the public but must be for the exclusive use of the community residents.

(e)~~(g)~~ For an increase in the bed capacity of a nursing facility licensed for at least 50 beds as of January 1, 1994, under part II of chapter 400 which is not part of a continuing care facility if, after the increase, the total licensed bed capacity of that facility is not more than 60 beds and if the facility has been continuously licensed since 1950 and has received a superior rating on each of its two most recent licensure surveys.

~~(h) For the establishment of a Medicare-certified home health agency by a facility certified under chapter 651; a retirement community, as defined in s. 400.404(2)(g); or a residential facility that serves only retired military personnel, their dependents, and the surviving dependents of deceased military personnel. Medicare-reimbursed home health services provided through such agency shall be offered exclusively to residents of the facility or retirement community or to residents of facilities or retirement communities owned, operated, or managed by the same corporate entity. Each visit made to deliver Medicare-reimbursable home health services to a home health patient who, at the time of service, is not a resident of the facility or retirement community shall be a deceptive and unfair trade practice and constitutes a violation of ss. 501.201-501.213.~~

~~(i) For the establishment of a Medicare-certified home health agency. This paragraph shall take effect 90 days after~~

~~the adjournment sine die of the next regular session of the Legislature occurring after the legislative session in which the Legislature receives a report from the Director of Health Care Administration certifying that the federal Health Care Financing Administration has implemented a per-episode prospective pay system for Medicare-certified home health agencies.~~

(f)~~(j)~~ For an inmate health care facility built by or for the exclusive use of the Department of Corrections as provided in chapter 945. This exemption expires when such facility is converted to other uses.

~~(k) For an expenditure by or on behalf of a health care facility to provide a health service exclusively on an outpatient basis.~~

(g)~~(l)~~ For the termination of an inpatient ~~a~~ health care service, upon 30 days' written notice to the agency.

(h)~~(m)~~ For the delicensure of beds, upon 30 days' written notice to the agency. A request for exemption ~~An application~~ submitted under this paragraph must identify the number, the category of beds ~~classification~~, and the name of the facility in which the beds to be delicensed are located.

(i)~~(n)~~ For the provision of adult inpatient diagnostic cardiac catheterization services in a hospital.

1. In addition to any other documentation otherwise required by the agency, a request for an exemption submitted under this paragraph must comply with the following criteria:

a. The applicant must certify it will not provide therapeutic cardiac catheterization pursuant to the grant of the exemption.

b. The applicant must certify it will meet and continuously maintain the minimum licensure requirements

1 adopted by the agency governing such programs pursuant to
2 subparagraph 2.
3 c. The applicant must certify it will provide a
4 minimum of 2 percent of its services to charity and Medicaid
5 patients.
6 2. The agency shall adopt licensure requirements by
7 rule which govern the operation of adult inpatient diagnostic
8 cardiac catheterization programs established pursuant to the
9 exemption provided in this paragraph. The rules shall ensure
10 that such programs:
11 a. Perform only adult inpatient diagnostic cardiac
12 catheterization services authorized by the exemption and will
13 not provide therapeutic cardiac catheterization or any other
14 services not authorized by the exemption.
15 b. Maintain sufficient appropriate equipment and
16 health personnel to ensure quality and safety.
17 c. Maintain appropriate times of operation and
18 protocols to ensure availability and appropriate referrals in
19 the event of emergencies.
20 d. Maintain appropriate program volumes to ensure
21 quality and safety.
22 e. Provide a minimum of 2 percent of its services to
23 charity and Medicaid patients each year.
24 3.a. The exemption provided by this paragraph shall
25 not apply unless the agency determines that the program is in
26 compliance with the requirements of subparagraph 1. and that
27 the program will, after beginning operation, continuously
28 comply with the rules adopted pursuant to subparagraph 2. The
29 agency shall monitor such programs to ensure compliance with
30 the requirements of subparagraph 2.
31 b.(I) The exemption for a program shall expire

immediately when the program fails to comply with the rules adopted pursuant to sub-subparagraphs 2.a., b., and c.

(II) Beginning 18 months after a program first begins treating patients, the exemption for a program shall expire when the program fails to comply with the rules adopted pursuant to sub-subparagraphs 2.d. and e.

(III) If the exemption for a program expires pursuant to sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the agency shall not grant an exemption pursuant to this paragraph for an adult inpatient diagnostic cardiac catheterization program located at the same hospital until 2 years following the date of the determination by the agency that the program failed to comply with the rules adopted pursuant to subparagraph 2.

~~4. The agency shall not grant any exemption under this paragraph until the adoption of the rules required under this paragraph, or until March 1, 1998, whichever comes first. However, if final rules have not been adopted by March 1, 1998, the proposed rules governing the exemptions shall be used by the agency to grant exemptions under the provisions of this paragraph until final rules become effective.~~

(j)~~(o)~~ For ~~any expenditure to provide~~ mobile surgical facilities and related health care services provided under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957.

(k)~~(p)~~ For state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs in accordance with part II of chapter 296 for which at least 50 percent of the construction cost is federally funded and for which the Federal Government pays a per diem rate not to exceed one-half of the cost of the veterans' care in such

1 state nursing homes. These beds shall not be included in the
2 nursing home bed inventory.
3 (l) For combination within one nursing home facility
4 of the beds or services authorized by two or more certificates
5 of need issued in the same planning subdistrict. An exemption
6 granted under this paragraph shall extend the validity period
7 of the certificates of need to be consolidated by the length
8 of the period beginning upon submission of the exemption
9 request and ending with issuance of the exemption. The
10 longest validity period among the certificates shall be
11 applicable to each of the combined certificates.
12 (m) For division into two or more nursing home
13 facilities of beds or services authorized by one certificate
14 of need issued in the same planning subdistrict. An exemption
15 granted under this paragraph shall extend the validity period
16 of the certificate of need to be divided by the length of the
17 period beginning upon submission of the exemption request and
18 ending with issuance of the exemption.
19 (n) For the addition of hospital beds licensed under
20 chapter 395 for acute care, mental health services, or a
21 hospital-based distinct part skilled nursing unit in a number
22 that may not exceed 10 total beds or 10 percent of the
23 licensed capacity of the bed category being expanded,
24 whichever is greater. Beds for specialty burn units, neonatal
25 intensive care units, or comprehensive rehabilitation, or at a
26 long-term care hospital, may not be increased under this
27 paragraph.
28 1. In addition to any other documentation otherwise
29 required by the agency, a request for exemption submitted
30 under this paragraph must:
31 a. Certify that the prior 12-month average occupancy

1 rate for the category of licensed beds being expanded at the
2 facility meets or exceeds 80 percent or, for a hospital-based
3 distinct part skilled nursing unit, the prior 12-month average
4 occupancy rate meets or exceeds 96 percent.
5 b. Certify that any beds of the same type authorized
6 for the facility under this paragraph before the date of the
7 current request for an exemption have been licensed and
8 operational for at least 12 months.
9 2. The timeframes and monitoring process specified in
10 s. 408.040(2)(a)-(c) apply to any exemption issued under this
11 paragraph.
12 3. The agency shall count beds authorized under this
13 paragraph as approved beds in the published inventory of
14 hospital beds until the beds are licensed.
15 (o) For the addition of acute care beds, as authorized
16 by rule consistent with s. 395.003(4), in a number that may
17 not exceed 10 total beds or 10 percent of licensed bed
18 capacity, whichever is greater, for temporary beds in a
19 hospital which has experienced high seasonal occupancy within
20 the prior 12-month period or in a hospital that must respond
21 to emergency circumstances.
22 (p) For the addition of nursing home beds licensed
23 under chapter 400 in a number not exceeding 10 total beds or
24 10 percent of the number of beds licensed in the facility
25 being expanded, whichever is greater.
26 1. In addition to any other documentation required by
27 the agency, a request for exemption submitted under this
28 paragraph must:
29 a. Certify that the facility has not had any class I
30 or class II deficiencies within the 30 months preceding the
31 request for addition.

1 b. Certify that the prior 12-month average occupancy
2 rate for the nursing home beds at the facility meets or
3 exceeds 96 percent.
4 c. Certify that any beds authorized for the facility
5 under this paragraph before the date of the current request
6 for an exemption have been licensed and operational for at
7 least 12 months.
8 2. The timeframes and monitoring process specified in
9 s. 408.040(2)(a)-(c) apply to any exemption issued under this
10 paragraph.
11 3. The agency shall count beds authorized under this
12 paragraph as approved beds in the published inventory of
13 nursing home beds until the beds are licensed.
14 (q) For establishment of a specialty hospital offering
15 a range of medical service restricted to a defined age or
16 gender group of the population or a restricted range of
17 services appropriate to the diagnosis, care, and treatment of
18 patients with specific categories of medical illnesses or
19 disorders, through the transfer of beds and services from an
20 existing hospital in the same county.
21 (4) A request for exemption under ~~this~~ subsection(3)
22 may be made at any time and is not subject to the batching
23 requirements of this section. The request shall be supported
24 by such documentation as the agency requires by rule. The
25 agency shall assess a fee of $250 for each request for
26 exemption submitted under subsection (3).
27 Section 8. Paragraph (a) of subsection (1) of section
28 408.037, Florida Statutes, is amended to read:
29 408.037 Application content.--
30 (1) An application for a certificate of need must
31 contain:

(a) A detailed description of the proposed project and statement of its purpose and need in relation to the district ~~local~~ health plan ~~and the state health plan~~.

Section 9. Section 408.038, Florida Statutes, is amended to read:

408.038 Fees.--The agency ~~department~~ shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the functions of the local health councils and the activities of the agency ~~department~~ and shall be allocated as provided in s. 408.033. The fee shall be determined as follows:

(1) A minimum base fee of $5,000.

(2) In addition to the base fee of $5,000, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed $22,000.

Section 10. Subsections (3) and (4), paragraph (c) of subsection (5), and paragraphs (a) and (b) of subsection (6) of section 408.039, Florida Statutes, are amended to read:

408.039 Review process.--The review process for certificates of need shall be as follows:

(3) APPLICATION PROCESSING.--

(a) An applicant shall file an application with the agency ~~department~~, and shall furnish a copy of the application to the local health council and the agency ~~department~~. Within 15 days after the applicable application filing deadline established by agency ~~department~~ rule, the staff of the agency ~~department~~ shall determine if the application is complete. If the application is incomplete, the staff shall request specific information from the applicant necessary for the application to be complete; however, the staff may make only one such request. If the requested information is not filed

with the agency ~~department~~ within 21 days of the receipt of the staff's request, the application shall be deemed incomplete and deemed withdrawn from consideration.

(b) Upon the request of any applicant or substantially affected person within 14 days after notice that an application has been filed, a public hearing may be held at the agency's ~~department's~~ discretion if the agency ~~department~~ determines that a proposed project involves issues of great local public interest. The public hearing shall allow applicants and other interested parties reasonable time to present their positions and to present rebuttal information. A recorded verbatim record of the hearing shall be maintained. The public hearing shall be held at the local level within 21 days after the application is deemed complete.

(4) STAFF RECOMMENDATIONS.--

(a) The agency's ~~department's~~ review of and final agency action on applications shall be in accordance with the district health plan, and statutory criteria, and the implementing administrative rules. In the application review process, the agency ~~department~~ shall give a preference, as defined by rule of the agency ~~department~~, to an applicant which proposes to develop a nursing home in a nursing home geographically underserved area.

(b) Within 60 days after all the applications in a review cycle are determined to be complete, the agency ~~department~~ shall issue its State Agency Action Report and Notice of Intent to grant a certificate of need for the project in its entirety, to grant a certificate of need for identifiable portions of the project, or to deny a certificate of need. The State Agency Action Report shall set forth in writing its findings of fact and determinations upon which its

decision is based. If a finding of fact or determination by the agency ~~department~~ is counter to the district health plan of the local health council, the agency ~~department~~ shall provide in writing its reason for its findings, item by item, to the local health council. If the agency ~~department~~ intends to grant a certificate of need, the State Agency Action Report or the Notice of Intent shall also include any conditions which the agency ~~department~~ intends to attach to the certificate of need. The agency ~~department~~ shall designate by rule a senior staff person, other than the person who issues the final order, to issue State Agency Action Reports and Notices of Intent.

(c) The agency ~~department~~ shall publish its proposed decision set forth in the Notice of Intent in the Florida Administrative Weekly within 14 days after the Notice of Intent is issued.

(d) If no administrative hearing is requested pursuant to subsection (5), the State Agency Action Report and the Notice of Intent shall become the final order of the agency ~~department~~. The agency ~~department~~ shall provide a copy of the final order to the appropriate local health council.

(5) ADMINISTRATIVE HEARINGS.--

(c) In administrative proceedings challenging the issuance or denial of a certificate of need, only applicants considered by the agency in the same batching cycle are entitled to a comparative hearing on their applications. Existing health care facilities may initiate or intervene in an administrative hearing upon a showing that an established program will be substantially affected by the issuance of any certificate of need, whether reviewed under s. 408.036(1) or (2),to a competing proposed facility or program within the

1 same district.
2 (6) JUDICIAL REVIEW.--
3 (a) A party to an administrative hearing for an
4 application for a certificate of need has the right, within
5 not more than 30 days after the date of the final order, to
6 seek judicial review in the District Court of Appeal pursuant
7 to s. 120.68. The agency ~~department~~ shall be a party in any
8 such proceeding.
9 (b) In such judicial review, the court shall affirm
10 the final order of the agency ~~department~~, unless the decision
11 is arbitrary, capricious, or not in compliance with ss.
12 408.031-408.045.
13 Section 11. Subsections (1) and (2) of section
14 408.040, Florida Statutes, are amended to read:
15 408.040 Conditions and monitoring.--
16 (1)(a) The agency may issue a certificate of need
17 predicated upon statements of intent expressed by an applicant
18 in the application for a certificate of need. Any conditions
19 imposed on a certificate of need based on such statements of
20 intent shall be stated on the face of the certificate of need.
21 ~~1. Any certificate of need issued for construction of~~
22 ~~a new hospital or for the addition of beds to an existing~~
23 ~~hospital shall include a statement of the number of beds~~
24 ~~approved by category of service, including rehabilitation or~~
25 ~~psychiatric service, for which the agency has adopted by rule~~
26 ~~a specialty-bed-need methodology. All beds that are approved,~~
27 ~~but are not covered by any specialty-bed-need methodology,~~
28 ~~shall be designated as general.~~
29 (b)~~2.~~ The agency may consider, in addition to the
30 other criteria specified in s. 408.035, a statement of intent
31 by the applicant that a specified ~~to designate a~~ percentage of

the annual patient days at ~~beds of~~ the facility will be utilized ~~for use~~ by patients eligible for care under Title XIX of the Social Security Act. Any certificate of need issued to a nursing home in reliance upon an applicant's statements that ~~to provide~~ a specified percentage ~~number~~ of annual patient days will be utilized ~~beds for use~~ by residents eligible for care under Title XIX of the Social Security Act must include a statement that such certification is a condition of issuance of the certificate of need. The certificate-of-need program shall notify the Medicaid program office and the Department of Elderly Affairs when it imposes conditions as authorized in this paragraph ~~subparagraph~~ in an area in which a community diversion pilot project is implemented.

(c)~~(b)~~ A certificateholder may apply to the agency for a modification of conditions imposed under paragraph (a) or paragraph (b). If the holder of a certificate of need demonstrates good cause why the certificate should be modified, the agency shall reissue the certificate of need with such modifications as may be appropriate. The agency shall by rule define the factors constituting good cause for modification.

(d)~~(c)~~ If the holder of a certificate of need fails to comply with a condition upon which the issuance of the certificate was predicated, the agency may assess an administrative fine against the certificateholder in an amount not to exceed $1,000 per failure per day. In assessing the penalty, the agency shall take into account as mitigation the relative lack of severity of a particular failure. Proceeds of such penalties shall be deposited in the Public Medical Assistance Trust Fund.

(2)(a) Unless the applicant has commenced

construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 18 months after the date of issuance~~, except in the case of a multifacility project, as defined in s. 408.032, where the certificate of need shall terminate 2 years after the date of issuance~~. The agency shall monitor the progress of the holder of the certificate of need in meeting the timetable for project development specified in the application with the assistance of the local health council as specified in s. 408.033(1)(b)5., and may revoke the certificate of need, if the holder of the certificate is not meeting such timetable and is not making a good faith effort, as defined by rule, to meet it.

(b) A certificate of need issued to an applicant holding a provisional certificate of authority under chapter 651 shall terminate 1 year after the applicant receives a valid certificate of authority from the Department of Insurance.

(c) The certificate-of-need validity period for a project shall be extended by the agency, to the extent that the applicant demonstrates to the satisfaction of the agency that good faith commencement of the project is being delayed by litigation or by governmental action or inaction with respect to regulations or permitting precluding commencement of the project.

~~(d) If an application is filed to consolidate two or more certificates as authorized by s. 408.036(2)(f) or to divide a certificate of need into two or more facilities as authorized by s. 408.036(2)(g), the validity period of the~~

~~certificate or certificates of need to be consolidated or divided shall be extended for the period beginning upon submission of the application and ending when final agency action and any appeal from such action has been concluded. However, no such suspension shall be effected if the application is withdrawn by the applicant.~~

Section 12. Section 408.044, Florida Statutes, is amended to read:

408.044 Injunction.--Notwithstanding the existence or pursuit of any other remedy, the agency ~~department~~ may maintain an action in the name of the state for injunction or other process against any person to restrain or prevent the pursuit of a project subject to review under ss. 408.031-408.045, in the absence of a valid certificate of need.

Section 13. Section 408.045, Florida Statutes, is amended to read:

408.045 Certificate of need; competitive sealed proposals.--

(1) The application, review, and issuance procedures for a certificate of need for an intermediate care facility for the developmentally disabled may be made by the agency ~~department~~ by competitive sealed proposals.

(2) The agency ~~department~~ shall make a decision regarding the issuance of the certificate of need in accordance with the provisions of s. 287.057(15), rules adopted by the agency ~~department~~ relating to intermediate care facilities for the developmentally disabled, and the criteria in s. 408.035, as further defined by rule.

(3) Notification of the decision shall be issued to all applicants not later than 28 calendar days after the date

1 responses to a request for proposal are due.
2 (4) The procedures provided for under this section are
3 exempt from the batching cycle requirements and the public
4 hearing requirement of s. 408.039.
5 (5) The agency ~~department~~ may use the competitive
6 sealed proposal procedure for determining a certificate of
7 need for other types of health care facilities and services if
8 the agency ~~department~~ identifies an unmet health care need and
9 when funding in whole or in part for such health care
10 facilities or services is authorized by the Legislature.
11 Section 14. (1)(a) There is created a
12 certificate-of-need workgroup staffed by the Agency for Health
13 Care Administration.
14 (b) Workgroup participants shall be responsible for
15 only the expenses that they generate individually through
16 workgroup participation. The agency shall be responsible for
17 expenses incidental to the production of any required data or
18 reports.
19 (2) The workgroup shall consist of 30 members, 10
20 appointed by the Governor, 10 appointed by the President of
21 the Senate, and 10 appointed by the Speaker of the House of
22 Representatives. The workgroup chair shall be selected by
23 majority vote of a quorum present. Sixteen members shall
24 constitute a quorum. The membership shall include, but not be
25 limited to, representatives from health care provider
26 organizations, health care facilities, individual health care
27 practitioners, local health councils, and consumer
28 organizations, and persons with health care market expertise
29 as private-sector consultants.
30 (3) Appointment to the workgroup shall be as follows:
31 (a) The Governor shall appoint one representative each

1 from the hospital industry, the nursing home industry, the
2 hospice industry, the local health councils, and a consumer
3 organization; three health care market consultants, one of
4 whom is a recognized expert on hospital markets, one of whom
5 is a recognized expert on nursing home or long-term care
6 markets, and one of whom is a recognized expert on hospice
7 markets; one representative from the Medicaid program; and one
8 representative from a health care facility that provides a
9 tertiary service.
10 (b) The President of the Senate shall appoint a
11 representative of a for-profit hospital, a representative of a
12 not-for-profit hospital, a representative of a public
13 hospital, two representatives of the nursing home industry,
14 two representatives of the hospice industry, a representative
15 of a consumer organization, a representative from the
16 Department of Elderly Affairs involved with the implementation
17 of a long-term care community diversion program, and a health
18 care market consultant with expertise in health care
19 economics.
20 (c) The Speaker of the House of Representatives shall
21 appoint a representative from the Florida Hospital
22 Association, a representative of the Association of Community
23 Hospitals and Health Systems of Florida, a representative of
24 the Florida League of Health Systems, a representative of the
25 Florida Health Care Association, a representative of the
26 Florida Association of Homes for the Aging, three
27 representatives of Florida Hospices and Palliative Care, one
28 representative of local health councils, and one
29 representative of a consumer organization.
30 (4) The workgroup shall study issues pertaining to the
31 certificate-of-need program, including the impact of trends in

1 health care delivery and financing. The workgroup shall study
2 issues relating to implementation of the certificate-of-need
3 program.
4 (5) The workgroup shall meet at least annually, at the
5 request of the chair. The workgroup shall submit an interim
6 report by December 31, 2001, and a final report by December
7 31, 2002. The workgroup is abolished effective July 1, 2003.
8 Section 15. Subsection (7) of section 651.118, Florida
9 Statutes, is amended to read:
10 651.118 Agency for Health Care Administration;
11 certificates of need; sheltered beds; community beds.--
12 (7) Notwithstanding the provisions of subsection (2),
13 at the discretion of the continuing care provider, sheltered
14 nursing home beds may be used for persons who are not
15 residents of the facility and who are not parties to a
16 continuing care contract for a period of up to 5 years after
17 the date of issuance of the initial nursing home license. A
18 provider whose 5-year period has expired or is expiring may
19 request the Agency for Health Care Administration for an
20 extension, not to exceed 30 percent of the total sheltered
21 nursing home beds, if the utilization by residents of the
22 facility in the sheltered beds will not generate sufficient
23 income to cover facility expenses, as evidenced by one of the
24 following:
25 (a) The facility has a net loss for the most recent
26 fiscal year as determined under generally accepted accounting
27 principles, excluding the effects of extraordinary or unusual
28 items, as demonstrated in the most recently audited financial
29 statement; or
30 (b) The facility would have had a pro forma loss for
31 the most recent fiscal year, excluding the effects of

1 extraordinary or unusual items, if revenues were reduced by
2 the amount of revenues from persons in sheltered beds who were
3 not residents, as reported on by a certified public
4 accountant.
5
6 The agency shall be authorized to grant an extension to the
7 provider based on the evidence required in this subsection.
8 The agency may request a facility to use up to 25 percent of
9 the patient days generated by new admissions of nonresidents
10 during the extension period to serve Medicaid recipients for
11 those beds authorized for extended use if there is a
12 demonstrated need in the respective service area and if funds
13 are available. A provider who obtains an extension is
14 prohibited from applying for additional sheltered beds under
15 the provision of subsection (2), unless additional residential
16 units are built or the provider can demonstrate need by
17 facility residents to the Agency for Health Care
18 Administration. The 5-year limit does not apply to up to five
19 sheltered beds designated for inpatient hospice care as part
20 of a contractual arrangement with a hospice licensed under
21 part VI of chapter 400. A facility that uses such beds after
22 the 5-year period shall report such use to the Agency for
23 Health Care Administration. For purposes of this subsection,
24 "resident" means a person who, upon admission to the facility,
25 initially resides in a part of the facility not licensed under
26 part II of chapter 400.
27 Section 16. Subsection (2) of section 395.701, Florida
28 Statutes, is amended to read:
29 395.701 Annual assessments on net operating revenues
30 for inpatient services to fund public medical assistance;
31 administrative fines for failure to pay assessments when due;

1 exemption.--
2 (2)(a) There is imposed upon each hospital an
3 assessment in an amount equal to 1.5 percent of the annual net
4 operating revenue for inpatient services for each hospital,
5 such revenue to be determined by the agency, based on the
6 actual experience of the hospital as reported to the agency.
7 Within 6 months after the end of each hospital fiscal year,
8 the agency shall certify the amount of the assessment for each
9 hospital. The assessment shall be payable to and collected by
10 the agency in equal quarterly amounts, on or before the first
11 day of each calendar quarter, beginning with the first full
12 calendar quarter that occurs after the agency certifies the
13 amount of the assessment for each hospital. All moneys
14 collected pursuant to this subsection shall be deposited into
15 the Public Medical Assistance Trust Fund.
16 (b) There is imposed upon each hospital an assessment
17 in an amount equal to 1 percent of the annual net operating
18 revenue for outpatient services for each hospital, such
19 revenue to be determined by the agency, based on the actual
20 experience of the hospital as reported to the agency. Within 6
21 months after the end of each hospital fiscal year, the agency
22 shall certify the amount of the assessment for each hospital.
23 The assessment shall be payable to and collected by the agency
24 in equal quarterly amounts, on or before the first day of each
25 calendar quarter, beginning with the first full calendar
26 quarter that occurs after the agency certifies the amount of
27 the assessment for each hospital. All moneys collected
28 pursuant to this subsection shall be deposited into the Public
29 Medical Assistance Trust Fund.
30 Section 17. Paragraph (a) of subsection (2) of section
31 395.7015, Florida Statutes, is amended to read:

395.7015 Annual assessment on health care entities.--

(2) There is imposed an annual assessment against certain health care entities as described in this section:

(a) The assessment shall be equal to 1 ~~1.5~~ percent of the annual net operating revenues of health care entities. The assessment shall be payable to and collected by the agency. Assessments shall be based on annual net operating revenues for the entity's most recently completed fiscal year as provided in subsection (3).

Section 18. Paragraph (c) of subsection (2) of section 408.904, Florida Statutes, is amended to read:

408.904 Benefits.--

(2) Covered health services include:

(c) Hospital outpatient services. Those services provided to a member in the outpatient portion of a hospital licensed under part I of chapter 395, up to a limit of $1,500 ~~$1,000~~ per calendar year per member, that are preventive, diagnostic, therapeutic, or palliative.

Section 19. Paragraph (e) is added to subsection (3) of section 409.912, Florida Statutes, and subsection (9) of said section is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to

1 minimize the exposure of recipients to the need for acute
2 inpatient, custodial, and other institutional care and the
3 inappropriate or unnecessary use of high-cost services.
4 (3) The agency may contract with:
5 (e) An entity in Pasco County or Pinellas County that
6 provides in-home physician services to Medicaid recipients
7 with degenerative neurological diseases in order to test the
8 cost-effectiveness of enhanced home-based medical care. The
9 entity providing the services shall be reimbursed on a
10 fee-for-service basis at a rate not less than comparable
11 Medicare reimbursement rates. The agency may apply for waivers
12 of federal regulations necessary to implement such program.
13 This paragraph shall be repealed on July 1, 2002.
14 (9) The agency, after notifying the Legislature, may
15 apply for waivers of applicable federal laws and regulations
16 as necessary to implement more appropriate systems of health
17 care for Medicaid recipients and reduce the cost of the
18 Medicaid program to the state and federal governments and
19 shall implement such programs, after legislative approval,
20 within a reasonable period of time after federal approval.
21 These programs must be designed primarily to reduce the need
22 for inpatient care, custodial care and other long-term or
23 institutional care, and other high-cost services.
24 (a) Prior to seeking legislative approval of such a
25 waiver as authorized by this subsection, the agency shall
26 provide notice and an opportunity for public comment. Notice
27 shall be provided to all persons who have made requests of the
28 agency for advance notice and shall be published in the
29 Florida Administrative Weekly not less than 28 days prior to
30 the intended action.
31 (b) Notwithstanding s. 216.292, funds that are

1 appropriated to the Department of Elderly Affairs for the
2 Assisted Living for the Elderly Medicaid waiver and are not
3 expended shall be transferred to the agency to fund
4 Medicaid-reimbursed nursing home care.
5 Section 20. The Legislature shall appropriate each
6 fiscal year from either the General Revenue Fund or the Agency
7 for Health Care Administration Tobacco Settlement Trust Fund
8 an amount sufficient to replace the funds lost due to
9 reduction by this act of the assessment on other health care
10 entities under s. 395.7015, Florida Statutes, and the
11 reduction by this act in the assessment on hospitals under s.
12 395.701, Florida Statutes, and to maintain federal approval of
13 the reduced amount of funds deposited into the Public Medical
14 Assistance Trust Fund under s. 395.701, Florida Statutes, as
15 state match for the state's Medicaid program.
16 Section 21. There is hereby appropriated the sum of
17 $28.3 million from the General Revenue Fund to the Agency for
18 Health Care Administration to implement the provisions of this
19 act relating to the Public Medical Assistance Trust Fund,
20 provided, however, that no portion of this appropriation shall
21 be effective that duplicates a similar appropriation for the
22 same purpose contained in other legislation from the 2000
23 Legislative Session that becomes law.
24 Section 22. The amendments to ss. 395.701 and
25 395.7015, Florida Statutes, by this act shall take effect only
26 upon the Agency for Health Care Administration receiving
27 written confirmation from the federal Health Care Financing
28 Administration that the changes contained in such amendments
29 will not adversely affect the use of the remaining assessments
30 as state match for the state's Medicaid program.
31 Section 23. Effective July 1, 2000, and applicable to

1 provider contracts entered into or renewed on or after that
2 date, subsection (39) is added to section 641.31, Florida
3 Statutes, to read:
4 641.31 Health maintenance contracts.--
5 (39) A health maintenance organization contract may
6 not prohibit or restrict a subscriber from receiving inpatient
7 services in a contracted hospital from a contracted primary
8 care or admitting physician if such services are determined by
9 the organization to be medically necessary and covered
10 services under the organization's contract with the contract
11 holder.
12 Section 24. Effective July 1, 2000, and applicable to
13 provider contracts entered into or renewed on or after that
14 date, subsection (11) is added to section 641.315, Florida
15 Statutes, to read:
16 641.315 Provider contracts.--
17 (11) A contract between a health maintenance
18 organization and a contracted primary care or admitting
19 physician may not contain any provision that prohibits such
20 physician from providing inpatient services in a contracted
21 hospital to a subscriber if such services are determined by
22 the organization to be medically necessary and covered
23 services under the organization's contract with the contract
24 holder.
25 Section 25. Effective July 1, 2000, and applicable to
26 provider contracts entered into or renewed on or after that
27 date, subsection (5) is added to section 641.3155, Florida
28 Statutes, to read:
29 641.3155 Provider contracts; payment of claims.--
30 (5) A health maintenance organization shall pay a
31 contracted primary care or admitting physician, pursuant to

1 such physician's contract, for providing inpatient services in
2 a contracted hospital to a subscriber, if such services are
3 determined by the organization to be medically necessary and
4 covered services under the organization's contract with the
5 contract holder.
6 Section 26. Subsections (4) through (10) of section
7 641.51, Florida Statutes, are renumbered as subsections (5)
8 through (11), respectively, and a new subsection (4) is added
9 to said section to read:
10 641.51 Quality assurance program; second medical
11 opinion requirement.--
12 (4) The organization shall ensure that only a
13 physician licensed under chapter 458 or chapter 459, or an
14 allopathic or osteopathic physician with an active,
15 unencumbered license in another state with similar licensing
16 requirements may render an adverse determination regarding a
17 service provided by a physician licensed in this state. The
18 organization shall submit to the treating provider and the
19 subscriber written notification regarding the organization's
20 adverse determination within 2 working days after the
21 subscriber or provider is notified of the adverse
22 determination. The written notification must include the
23 utilization review criteria or benefits provisions used in the
24 adverse determination, identify the physician who rendered the
25 adverse determination, and be signed by an authorized
26 representative of the organization or the physician who
27 rendered the adverse determination. The organization must
28 include with the notification of an adverse determination
29 information concerning the appeal process for adverse
30 determinations.
31 Section 27. Section 381.7351, Florida Statutes, is

1 created to read:
2 381.7351 Short title.--Sections 381.7351-381.7356 may
3 be cited as the "Reducing Racial and Ethnic Health
4 Disparities: Closing the Gap Act."
5 Section 28. Section 381.7352, Florida Statutes, is
6 created to read:
7 381.7352 Legislative findings and intent.--
8 (1) The Legislature finds that despite state
9 investments in health care programs, certain racial and ethnic
10 populations in Florida continue to have significantly poorer
11 health outcomes when compared to non-Hispanic whites. The
12 Legislature finds that local solutions to health care problems
13 can have a dramatic and positive effect on the health status
14 of these populations. Local governments and communities are
15 best equipped to identify the health education, health
16 promotion, and disease prevention needs of the racial and
17 ethnic populations in their communities, mobilize the
18 community to address health outcome disparities, enlist and
19 organize local public and private resources, and faith-based
20 organizations to address these disparities, and evaluate the
21 effectiveness of interventions.
22 (2) It is therefore the intent of the Legislature to
23 provide funds within Florida counties and Front Porch Florida
24 Communities, in the form of Reducing Racial and Ethnic Health
25 Disparities: Closing the Gap grants, to stimulate the
26 development of community-based and neighborhood-based projects
27 which will improve the health outcomes of racial and ethnic
28 populations. Further, it is the intent of the Legislature
29 that these programs foster the development of coordinated,
30 collaborative, and broad-based participation by public and
31 private entities, and faith-based organizations. Finally, it

1 is the intent of the Legislature that the grant program
2 function as a partnership between state and local governments,
3 faith-based organizations, and private-sector health care
4 providers, including managed care, voluntary health care
5 resources, social service providers, and nontraditional
6 partners.
7 Section 29. Section 381.7353, Florida Statutes, is
8 created to read:
9 381.7353 Reducing Racial and Ethnic Health
10 Disparities: Closing the Gap grant program; administration;
11 department duties.--
12 (1) The Reducing Racial and Ethnic Health Disparities:
13 Closing the Gap grant program shall be administered by the
14 Department of Health.
15 (2) The department shall:
16 (a) Publicize the availability of funds and establish
17 an application process for submitting a grant proposal.
18 (b) Provide technical assistance and training,
19 including a statewide meeting promoting best practice
20 programs, as requested, to grant recipients.
21 (c) Develop uniform data reporting requirements for
22 the purpose of evaluating the performance of the grant
23 recipients and demonstrating improved health outcomes.
24 (d) Develop a monitoring process to evaluate progress
25 toward meeting grant objectives.
26 (e) Coordinate with existing community-based programs,
27 such as chronic disease community intervention programs,
28 cancer prevention and control programs, diabetes control
29 programs, the Healthy Start program, the Florida KidCare
30 Program, the HIV/AIDS program, immunization programs, and
31 other related programs at the state and local levels, to avoid

1 duplication of effort and promote consistency.
2 (3) Pursuant to s. 20.43(6), the secretary may appoint
3 an ad hoc advisory committee to: examine areas where public
4 awareness, public education, research, and coordination
5 regarding racial and ethnic health outcome disparities are
6 lacking; consider access and transportation issues which
7 contribute to health status disparities; and make
8 recommendations for closing gaps in health outcomes and
9 increasing the public's awareness and understanding of health
10 disparities that exist between racial and ethnic populations.
11 Section 30. Section 381.7354, Florida Statutes, is
12 created to read:
13 381.7354 Eligibility.--
14 (1) Any person, entity, or organization within a
15 county may apply for a Closing the Gap grant and may serve as
16 the lead agency to administer and coordinate project
17 activities within the county and develop community
18 partnerships necessary to implement the grant.
19 (2) Persons, entities, or organizations within
20 adjoining counties with populations of less than 100,000,
21 based on the annual estimates produced by the Population
22 Program of the University of Florida Bureau of Economic and
23 Business Research, may jointly submit a multicounty Closing
24 the Gap grant proposal. However, the proposal must clearly
25 identify a single lead agency with respect to program
26 accountability and administration.
27 (3) In addition to the grants awarded under
28 subsections (1) and (2), up to 20 percent of the funding for
29 the Reducing Racial and Ethnic Health Disparities: Closing the
30 Gap grant program shall be dedicated to projects that address
31 improving racial and ethnic health status within specific

1 Front Porch Florida Communities, as designated pursuant to s.
2 14.2015(9)(b).
3 (4) Nothing in ss. 381.7351-381.7356 shall prevent a
4 person, entity, or organization within a county or group of
5 counties from separately contracting for the provision of
6 racial and ethnic health promotion, health awareness, and
7 disease prevention services.
8 Section 31. Section 381.7355, Florida Statutes, is
9 created to read:
10 381.7355 Project requirements; review criteria.--
11 (1) Closing the Gap grant proposals shall be submitted
12 to the Department of Health for review.
13 (2) A proposal must include each of the following
14 elements:
15 (a) The purpose and objectives of the proposal,
16 including identification of the particular racial or ethnic
17 disparity the project will address. The proposal must address
18 one or more of the following priority areas:
19 1. Decreasing racial and ethnic disparities in
20 maternal and infant mortality rates.
21 2. Decreasing racial and ethnic disparities in
22 morbidity and mortality rates relating to cancer.
23 3. Decreasing racial and ethnic disparities in
24 morbidity and mortality rates relating to HIV/AIDS.
25 4. Decreasing racial and ethnic disparities in
26 morbidity and mortality rates relating to cardiovascular
27 disease.
28 5. Decreasing racial and ethnic disparities in
29 morbidity and mortality rates relating to diabetes.
30 6. Increasing adult and child immunization rates in
31 certain racial and ethnic populations.

1 (b) Identification and relevance of the target
2 population.
3 (c) Methods for obtaining baseline health status data
4 and assessment of community health needs.
5 (d) Mechanisms for mobilizing community resources and
6 gaining local commitment.
7 (e) Development and implementation of health promotion
8 and disease prevention interventions.
9 (f) Mechanisms and strategies for evaluating the
10 project's objectives, procedures, and outcomes.
11 (g) A proposed work plan, including a timeline for
12 implementing the project.
13 (h) Likelihood that project activities will occur and
14 continue in the absence of funding.
15 (3) Priority shall be given to proposals that:
16 (a) Represent areas with the greatest documented
17 racial and ethnic health status disparities.
18 (b) Exceed the minimum local contribution requirements
19 specified in s. 381.7356.
20 (c) Demonstrate broad-based local support and
21 commitment from entities representing racial and ethnic
22 populations, including non-Hispanic whites. Indicators of
23 support and commitment may include agreements to participate
24 in the program, letters of endorsement, letters of commitment,
25 interagency agreements, or other forms of support.
26 (d) Demonstrate a high degree of participation by the
27 health care community in clinical preventive service
28 activities and community-based health promotion and disease
29 prevention interventions.
30 (e) Have been submitted from counties with a high
31 proportion of residents living in poverty and with poor health

1 status indicators.
2 (f) Demonstrate a coordinated community approach to
3 addressing racial and ethnic health issues within existing
4 publicly financed health care programs.
5 (g) Incorporate intervention mechanisms which have a
6 high probability of improving the targeted population's health
7 status.
8 (h) Demonstrate a commitment to quality management in
9 all aspects of project administration and implementation.
10 Section 32. Section 381.7356, Florida Statutes, is
11 created to read:
12 381.7356 Local matching funds; grant awards.--
13 (1) One or more Closing the Gap grants may be awarded
14 in a county, or in a group of adjoining counties from which a
15 multicounty application is submitted. Front Porch Florida
16 Communities grants may also be awarded in a county or group of
17 adjoining counties that are also receiving a grant award.
18 (2) Closing the Gap grants shall be awarded on a
19 matching basis. One dollar in local matching funds must be
20 provided for each $3 grant payment made by the state, except
21 that:
22 (a) In counties with populations greater than 50,000,
23 up to 50 percent of the local match may be in kind in the form
24 of free services or human resources. Fifty percent of the
25 local match must be in the form of cash.
26 (b) In counties with populations of 50,000 or less,
27 the required local matching funds may be provided entirely
28 through in-kind contributions.
29 (c) Grant awards to Front Porch Florida Communities
30 shall not be required to have a matching requirement.
31 (3) The amount of the grant award shall be based on

1 the county or neighborhood's population, or on the combined
2 population in a group of adjoining counties from which a
3 multicounty application is submitted, and on other factors, as
4 determined by the department.
5 (4) Dissemination of grant awards shall begin no later
6 than January 1, 2001.
7 (5) A Closing the Gap grant shall be funded for 1 year
8 and may be renewed annually upon application to and approval
9 by the department, subject to the achievement of quality
10 standards, objectives, and outcomes and to the availability of
11 funds.
12 (6) Implementation of the Reducing Racial and Ethnic
13 Health Disparities: Closing the Gap grant program shall be
14 subject to a specific appropriation provided in the General
15 Appropriations Act.
16 Section 33. Florida Commission on Excellence in Health
17 Care.--
18 (1) LEGISLATIVE FINDINGS AND INTENT.--The Legislature
19 finds that the health care delivery industry is one of the
20 largest and most complex industries in Florida. The
21 Legislature finds that the current system of regulating health
22 care practitioners and health care providers is one of blame
23 and punishment and does not encourage voluntary admission of
24 errors and immediate corrective action on a large scale. The
25 Legislature finds that previous attempts to identify and
26 address areas which impact the quality of care provided by the
27 health care industry have suffered from a lack of coordination
28 among the industry's stakeholders and regulators. The
29 Legislature finds that additional focus on strengthening
30 health care delivery systems by eliminating avoidable mistakes
31 in the diagnosis and treatment of Floridians holds tremendous

1 promise to increase the quality of health care services
2 available to Floridians, thereby reducing the costs associated
3 with medical mistakes and malpractice and in turn increasing
4 access to health care in the state. To achieve this enhanced
5 focus, it is the intent of the Legislature to create the
6 Florida Commission on Excellence in Health Care to facilitate
7 the development of a comprehensive statewide strategy for
8 improving health care delivery systems through meaningful
9 reporting standards, data collection and review, and quality
10 measurement.
11 (2) DEFINITIONS.--As used in this act, the term:
12 (a) "Agency" means the Agency for Health Care
13 Administration.
14 (b) "Commission" means the Florida Commission on
15 Excellence in Health Care.
16 (c) "Department" means the Department of Health.
17 (d) "Error," with respect to health care, means an
18 unintended act, by omission or commission.
19 (e) "Health care practitioner" means any person
20 licensed under chapter 457; chapter 458; chapter 459; chapter
21 460; chapter 461; chapter 462; chapter 463; chapter 464;
22 chapter 465; chapter 466; chapter 467; part I, part II, part
23 III, part V, part X, part XIII, or part XIV of chapter 468;
24 chapter 478; chapter 480; part III or part IV of chapter 483;
25 chapter 484; chapter 486; chapter 490; or chapter 491, Florida
26 Statutes.
27 (f) "Health care provider" means any health care
28 facility or other health care organization licensed or
29 certified to provide approved medical and allied health
30 services in this state.
31 (3) COMMISSION; DUTIES AND RESPONSIBILITIES.--There is

1 hereby created the Florida Commission on Excellence in Health
2 Care. The commission shall:
3 (a) Identify existing data sources that evaluate
4 quality of care in Florida and collect, analyze, and evaluate
5 this data.
6 (b) Establish guidelines for data sharing and
7 coordination.
8 (c) Identify core sets of quality measures for
9 standardized reporting by appropriate components of the health
10 care continuum.
11 (d) Recommend a framework for quality measurement and
12 outcome reporting.
13 (e) Develop quality measures that enhance and improve
14 the ability to evaluate and improve care.
15 (f) Make recommendations regarding research and
16 development needed to advance quality measurement and
17 reporting.
18 (g) Evaluate regulatory issues relating to the
19 pharmacy profession and recommend changes necessary to
20 optimize patient safety.
21 (h) Facilitate open discussion of a process to ensure
22 that comparative information on health care quality is valid,
23 reliable, comprehensive, understandable, and widely available
24 in the public domain.
25 (i) Sponsor public hearings to share information and
26 expertise, identify "best practices," and recommend methods to
27 promote their acceptance.
28 (j) Evaluate current regulatory programs to determine
29 what changes, if any, need to be made to facilitate patient
30 safety.
31 (k) Review public and private health care purchasing

1 systems to determine if there are sufficient mandates and
2 incentives to facilitate continuous improvement in patient
3 safety.
4 (l) Analyze how effective existing regulatory systems
5 are in ensuring continuous competence and knowledge of
6 effective safety practices.
7 (m) Develop a framework for organizations that
8 license, accredit, or credential health care practitioners and
9 health care providers to more quickly and effectively identify
10 unsafe providers and practitioners and to take action
11 necessary to remove the unsafe provider or practitioner from
12 practice or operation until such time as the practitioner or
13 provider has proven safe to practice or operate.
14 (n) Recommend procedures for development of a
15 curriculum on patient safety and methods of incorporating such
16 curriculum into training, licensure, and certification
17 requirements.
18 (o) Develop a framework for regulatory bodies to
19 disseminate information on patient safety to health care
20 practitioners, health care providers, and consumers through
21 conferences, journal articles and editorials, newsletters,
22 publications, and Internet websites.
23 (p) Recommend procedures to incorporate recognized
24 patient safety considerations into practice guidelines and
25 into standards related to the introduction and diffusion of
26 new technologies, therapies, and drugs.
27 (q) Recommend a framework for development of
28 community-based collaborative initiatives for error reporting
29 and analysis and implementation of patient safety
30 improvements.
31 (r) Evaluate the role of advertising in promoting or

1 adversely affecting patient safety.
2 (s) Evaluate and make recommendations regarding the
3 need for licensure of additional persons who participate in
4 the delivery of health care to Floridians, including, but not
5 limited to, surgical technologists and pharmacy technicians.
6 (t) Evaluate the benefits and problems of the current
7 disciplinary systems and make recommendations regarding
8 alternatives and improvements.
9 (4) MEMBERSHIP, ORGANIZATION, MEETINGS, PROCEDURES,
10 STAFF.--
11 (a) The commission shall consist of:
12 1. The Secretary of Health and the Executive Director
13 of the Agency for Health Care Administration.
14 2. One representative each from the following agencies
15 or organizations: the Board of Medicine, the Board of
16 Osteopathic Medicine, the Board of Pharmacy, the Board of
17 Nursing, the Board of Dentistry, the Florida Dental
18 Association, the Florida Medical Association, the Florida
19 Osteopathic Medical Association, the Florida Academy of
20 Physician Assistants, the Florida Chiropractic Society, the
21 Florida Chiropractic Association, the Florida Podiatric
22 Medical Association, the Florida Society of Ambulatory
23 Surgical Centers, the Florida Statutory Teaching Hospital
24 Council, Inc., the Florida Statutory Rural Hospital Council,
25 the Florida Nurses Association, the Florida Organization of
26 Nursing Executives, the Florida Pharmacy Association, the
27 Florida Society of Health System Pharmacists, Inc., the
28 Florida Hospital Association, the Association of Community
29 Hospitals and Health Systems of Florida, Inc., the Florida
30 League of Health Care Systems, the Florida Health Care Risk
31 Management Advisory Council, the Florida Health Care

1 Association, and the Florida Association of Homes for the
2 Aging;
3 3. One licensed clinical laboratory director,
4 appointed by the Secretary of Health;
5 4. Two health lawyers, appointed by the Secretary of
6 Health, one of whom shall be a member of The Florida Bar
7 Health Law Section who defends physicians and one of whom
8 shall be a member of the Florida Academy of Trial Lawyers;
9 5. One representative of the medical malpractice
10 professional liability insurance industry, appointed by the
11 Secretary of Health;
12 6. One representative of a Florida medical school
13 appointed by the Secretary of Health;
14 7. Two representatives of the health insurance
15 industry, appointed by the Executive Director of the Agency
16 for Health Care Administration, one of whom shall represent
17 indemnity plans and one of whom shall represent managed care;
18 8. Five consumer advocates, consisting of one from the
19 Association for Responsible Medicine, two appointed by the
20 Governor, one appointed by the President of the Senate, and
21 one appointed by the Speaker of the House of Representatives;
22 and
23 9. Two legislators, one appointed by the President of
24 the Senate and one appointed by the Speaker of the House of
25 Representatives.
26
27 Commission membership shall reflect the geographic and
28 demographic diversity of the state.
29 (b) The Secretary of Health and the Executive Director
30 of the Agency for Health Care Administration shall jointly
31 chair the commission. Subcommittees shall be formed by the

1 joint chairs, as needed, to make recommendations to the full
2 commission on the subjects assigned. However, all votes on
3 work products of the commission shall be at the full
4 commission level, and all recommendations to the Governor, the
5 President of the Senate, and the Speaker of the House of
6 Representatives must pass by a two-thirds vote of the full
7 commission. Sponsoring agencies and organizations may
8 designate an alternative member who may attend and vote on
9 behalf of the sponsoring agency or organization in the event
10 the appointed member is unable to attend a meeting of the
11 commission or any subcommittee. The commission shall be
12 staffed by employees of the Department of Health and the
13 Agency for Health Care Administration. Sponsoring agencies or
14 organizations must fund the travel and related expenses of
15 their appointed members on the commission. Travel and related
16 expenses for the consumer members of the commission shall be
17 reimbursed by the state pursuant to s. 112.061, Florida
18 Statutes. The commission shall hold its first meeting no later
19 than July 15, 2000.
20 (5) EVIDENTIARY PROHIBITIONS.--
21 (a) The findings, recommendations, evaluations,
22 opinions, investigations, proceedings, records, reports,
23 minutes, testimony, correspondence, work product, and actions
24 of the commission shall be available to the public, but may
25 not be introduced into evidence at any civil, criminal,
26 special, or administrative proceeding against a health care
27 practitioner or health care provider arising out of the
28 matters which are the subject of the findings of the
29 commission. Moreover, no member of the commission shall be
30 examined in any civil, criminal, special, or administrative
31 proceeding against a health care practitioner or health care

1 provider as to any evidence or other matters produced or
2 presented during the proceedings of this commission or as to
3 any findings, recommendations, evaluations, opinions,
4 investigations, proceedings, records, reports, minutes,
5 testimony, correspondence, work product, or other actions of
6 the commission or any members thereof. However, nothing in
7 this section shall be construed to mean that information,
8 documents, or records otherwise available and obtained from
9 original sources are immune from discovery or use in any
10 civil, criminal, special, or administrative proceeding merely
11 because they were presented during proceedings of the
12 commission. Nor shall any person who testifies before the
13 commission or who is a member of the commission be prevented
14 from testifying as to matters within his or her knowledge in a
15 subsequent civil, criminal, special, or administrative
16 proceeding merely because such person testified in front of
17 the commission.
18 (b) The findings, recommendations, evaluations,
19 opinions, investigations, proceedings, records, reports,
20 minutes, testimony, correspondence, work product, and actions
21 of the commission shall be used as a guide and resource and
22 shall not be construed as establishing or advocating the
23 standard of care for health care practitioners or health care
24 providers unless subsequently enacted into law or adopted in
25 rule. Nor shall any findings, recommendations, evaluations,
26 opinions, investigations, proceedings, records, reports,
27 minutes, testimony, correspondence, work product, or actions
28 of the commission be admissible as evidence in any way,
29 directly or indirectly, by introduction of documents or as a
30 basis of an expert opinion as to the standard of care
31 applicable to health care practitioners or health care

1 providers in any civil, criminal, special, or administrative
2 proceeding unless subsequently enacted into law or adopted in
3 rule.
4 (c) No person who testifies before the commission or
5 who is a member of the commission may specifically identify
6 any patient, health care practitioner, or health care provider
7 by name. Moreover, the findings, recommendations, evaluations,
8 opinions, investigations, proceedings, records, reports,
9 minutes, testimony, correspondence, work product, and actions
10 of the commission may not specifically identify any patient,
11 health care practitioner, or health care provider by name.
12 (6) REPORT; TERMINATION.--The commission shall provide
13 a report of its findings and recommendations to the Governor,
14 the President of the Senate, and the Speaker of the House of
15 Representatives no later than February 1, 2001. After
16 submission of the report, the commission shall continue to
17 exist for the purpose of assisting the Department of Health,
18 the Agency for Health Care Administration, and the regulatory
19 boards in their drafting of proposed legislation and rules to
20 implement its recommendations and for the purpose of providing
21 information to the health care industry on its
22 recommendations. The commission shall be terminated June 1,
23 2001.
24 Section 34. Effective October 1, 2000, subsection (1)
25 of section 408.7056, Florida Statutes, is amended to read:
26 408.7056 Statewide Provider and Subscriber Assistance
27 Program.--
28 (1) As used in this section, the term:
29 (a) "Agency" means the Agency for Health Care
30 Administration.
31 (b) "Department" means the Department of Insurance.

1 (c) "Grievance procedure" means an established set of
2 rules that specify a process for appeal of an organizational
3 decision.
4 (d) "Health care provider" or "provider" means a
5 state-licensed or state-authorized facility, a facility
6 principally supported by a local government or by funds from a
7 charitable organization that holds a current exemption from
8 federal income tax under s. 501(c)(3) of the Internal Revenue
9 Code, a licensed practitioner, a county health department
10 established under part I of chapter 154, a prescribed
11 pediatric extended care center defined in s. 400.902, a
12 federally supported primary care program such as a migrant
13 health center or a community health center authorized under s.
14 329 or s. 330 of the United States Public Health Services Act
15 that delivers health care services to individuals, or a
16 community facility that receives funds from the state under
17 the Community Alcohol, Drug Abuse, and Mental Health Services
18 Act and provides mental health services to individuals.
19 (e)~~(a)~~ "Managed care entity" means a health
20 maintenance organization or a prepaid health clinic certified
21 under chapter 641, a prepaid health plan authorized under s.
22 409.912, or an exclusive provider organization certified under
23 s. 627.6472.
24 (f)~~(b)~~ "Panel" means a statewide provider and
25 subscriber assistance panel selected as provided in subsection
26 (11).
27 Section 35. Effective October 1, 2000, section
28 627.654, Florida Statutes, is amended to read:
29 627.654 Labor union,~~and~~ association, and small
30 employer health alliance groups.--
31 (1)(a) A group of individuals may be insured under a

1 policy issued to an association, including a labor union,
2 which association has a constitution and bylaws and not less
3 than 25 individual members and which has been organized and
4 has been maintained in good faith for a period of 1 year for
5 purposes other than that of obtaining insurance, or to the
6 trustees of a fund established by such an association, which
7 association or trustees shall be deemed the policyholder,
8 insuring at least 15 individual members of the association for
9 the benefit of persons other than the officers of the
10 association, the association or trustees.
11 (b) A small employer, as defined in s. 627.6699 and
12 including the employer's eligible employees and the spouses
13 and dependents of such employees, may be insured under a
14 policy issued to a small employer health alliance by a carrier
15 as defined in s. 627.6699. A small employer health alliance
16 must be organized as a not-for-profit corporation under
17 chapter 617. Notwithstanding any other law, if a small
18 employer member of an alliance loses eligibility to purchase
19 health care through the alliance solely because the business
20 of the small employer member expands to more than 50 and fewer
21 than 75 eligible employees, the small employer member may, at
22 its next renewal date, purchase coverage through the alliance
23 for not more than 1 additional year. A small employer health
24 alliance shall establish conditions of participation in the
25 alliance by a small employer, including, but not limited to:
26 1. Assurance that the small employer is not formed for
27 the purpose of securing health benefit coverage.
28 2. Assurance that the employees of a small employer
29 have not been added for the purpose of securing health benefit
30 coverage.
31 (2) No such policy of insurance as defined in

1 subsection (1) may be issued to any such association or
2 alliance, unless all individual members of such association,
3 or all small employer members of an alliance,or all of any
4 class or classes thereof, are declared eligible and acceptable
5 to the insurer at the time of issuance of the policy.
6 (3) Any such policy issued under paragraph (1)(a)may
7 insure the spouse or dependent children with or without the
8 member being insured.
9 (4) A single master policy issued to an association,
10 labor union, or small employer health alliance may include
11 more than one health plan from the same insurer or affiliated
12 insurer group as alternatives for an employer, employee, or
13 member to select.
14 Section 36. Effective October 1, 2000, paragraph (f)
15 of subsection (2), paragraph (b) of subsection (4), and
16 subsection (6) of section 627.6571, Florida Statutes, are
17 amended to read:
18 627.6571 Guaranteed renewability of coverage.--
19 (2) An insurer may nonrenew or discontinue a group
20 health insurance policy based only on one or more of the
21 following conditions:
22 (f) In the case of health insurance coverage that is
23 made available only through one or more bona fide associations
24 as defined in subsection (5) or through one or more small
25 employer health alliances as described in s. 627.654(1)(b),
26 the membership of an employer in the association or in the
27 small employer health alliance, on the basis of which the
28 coverage is provided, ceases, but only if such coverage is
29 terminated under this paragraph uniformly without regard to
30 any health-status-related factor that relates to any covered
31 individuals.

1 (4) At the time of coverage renewal, an insurer may
2 modify the health insurance coverage for a product offered:
3 (b) In the small-group market if, for coverage that is
4 available in such market other than only through one or more
5 bona fide associations as defined in subsection (5) or through
6 one or more small employer health alliances as described in s.
7 627.654(1)(b), such modification is consistent with s.
8 627.6699 and effective on a uniform basis among group health
9 plans with that product.
10 (6) In applying this section in the case of health
11 insurance coverage that is made available by an insurer in the
12 small-group market or large-group market to employers only
13 through one or more associations or through one or more small
14 employer health alliances as described in s. 627.654(1)(b), a
15 reference to "policyholder" is deemed, with respect to
16 coverage provided to an employer member of the association, to
17 include a reference to such employer.
18 Section 37. Effective October 1, 2000, paragraph (h)
19 of subsection (5), paragraph (b) of subsection (6), and
20 paragraph (a) of subsection (12) of section 627.6699, Florida
21 Statutes, are amended to read:
22 627.6699 Employee Health Care Access Act.--
23 (5) AVAILABILITY OF COVERAGE.--
24 (h) All health benefit plans issued under this section
25 must comply with the following conditions:
26 1. For employers who have fewer than two employees, a
27 late enrollee may be excluded from coverage for no longer than
28 24 months if he or she was not covered by creditable coverage
29 continually to a date not more than 63 days before the
30 effective date of his or her new coverage.
31 2. Any requirement used by a small employer carrier in

determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

3. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider as an eligible employee employees or dependents who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met. However, a small employer carrier may count eligible employees and dependents who have coverage under another health plan that is sponsored by that employer ~~except if such plan is offered pursuant to s. 408.706~~.

4. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the

1 requirements that are applicable to the new group size.
2 5. If a small employer carrier offers coverage to a
3 small employer, it must offer coverage to all the small
4 employer's eligible employees and their dependents. A small
5 employer carrier may not offer coverage limited to certain
6 persons in a group or to part of a group, except with respect
7 to late enrollees.
8 6. A small employer carrier may not modify any health
9 benefit plan issued to a small employer with respect to a
10 small employer or any eligible employee or dependent through
11 riders, endorsements, or otherwise to restrict or exclude
12 coverage for certain diseases or medical conditions otherwise
13 covered by the health benefit plan.
14 7. An initial enrollment period of at least 30 days
15 must be provided. An annual 30-day open enrollment period
16 must be offered to each small employer's eligible employees
17 and their dependents. A small employer carrier must provide
18 special enrollment periods as required by s. 627.65615.
19 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
20 (b) For all small employer health benefit plans that
21 are subject to this section and are issued by small employer
22 carriers on or after January 1, 1994, premium rates for health
23 benefit plans subject to this section are subject to the
24 following:
25 1. Small employer carriers must use a modified
26 community rating methodology in which the premium for each
27 small employer must be determined solely on the basis of the
28 eligible employee's and eligible dependent's gender, age,
29 family composition, tobacco use, or geographic area as
30 determined under paragraph (5)(j).
31 2. Rating factors related to age, gender, family

1 composition, tobacco use, or geographic location may be
2 developed by each carrier to reflect the carrier's experience.
3 The factors used by carriers are subject to department review
4 and approval.
5 3. Small employer carriers may not modify the rate for
6 a small employer for 12 months from the initial issue date or
7 renewal date, unless the composition of the group changes or
8 benefits are changed. However, a small employer carrier may
9 modify the rate one time prior to 12 months after the initial
10 issue date for a small employer who enrolls under a previously
11 issued group policy that has a common anniversary date for all
12 employers covered under the policy if:
13 a. The carrier discloses to the employer in a clear
14 and conspicuous manner the date of the first renewal and the
15 fact that the premium may increase on or after that date.
16 b. The insurer demonstrates to the department that
17 efficiencies in administration are achieved and reflected in
18 the rates charged to small employers covered under the policy.
19 4. A carrier may issue a group health insurance policy
20 to a small employer health alliance or other group association
21 with rates that reflect a premium credit for expense savings
22 attributable to administrative activities being performed by
23 the alliance or group association if such expense savings are
24 specifically documented in the insurer's rate filing and are
25 approved by the department. Any such credit may not be based
26 on different morbidity assumptions or on any other factor
27 related to the health status or claims experience of any
28 person covered under the policy. Nothing in this subparagraph
29 exempts an alliance or group association from licensure for
30 any activities that require licensure under the Insurance
31 Code. A carrier issuing a group health insurance policy to a

1 small employer health alliance or other group association
2 shall allow any properly licensed and appointed agent of that
3 carrier to market and sell the small employer health alliance
4 or other group association policy. Such agent shall be paid
5 the usual and customary commission paid to any agent selling
6 the policy.~~Carriers participating in the alliance program, in~~
7 ~~accordance with ss. 408.70-408.706, may apply a different~~
8 ~~community rate to business written in that program.~~
9 (12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT
10 PLANS.--
11 (a)1. By May 15, 1993, the commissioner shall appoint
12 a health benefit plan committee composed of four
13 representatives of carriers which shall include at least two
14 representatives of HMOs, at least one of which is a staff
15 model HMO, two representatives of agents, four representatives
16 of small employers, and one employee of a small employer. The
17 carrier members shall be selected from a list of individuals
18 recommended by the board. The commissioner may require the
19 board to submit additional recommendations of individuals for
20 appointment. ~~As alliances are established under s. 408.702,~~
21 ~~each alliance shall also appoint an additional member to the~~
22 ~~committee.~~
23 2. The committee shall develop changes to the form and
24 level of coverages for the standard health benefit plan and
25 the basic health benefit plan, and shall submit the forms, and
26 levels of coverages to the department by September 30, 1993.
27 The department must approve such forms and levels of coverages
28 by November 30, 1993, and may return the submissions to the
29 committee for modification on a schedule that allows the
30 department to grant final approval by November 30, 1993.
31 3. The plans shall comply with all of the requirements

1 of this subsection.
2 4. The plans must be filed with and approved by the
3 department prior to issuance or delivery by any small employer
4 carrier.
5 5. After approval of the revised health benefit plans,
6 if the department determines that modifications to a plan
7 might be appropriate, the commissioner shall appoint a new
8 health benefit plan committee in the manner provided in
9 subparagraph 1. to submit recommended modifications to the
10 department for approval.
11 Section 38. Effective October 1, 2000, subsection (1)
12 of section 240.2995, Florida Statutes, is amended to read:
13 240.2995 University health services support
14 organizations.--
15 (1) Each state university is authorized to establish
16 university health services support organizations which shall
17 have the ability to enter into, for the benefit of the
18 university academic health sciences center, arrangements with
19 other entities as providers ~~for accountable health~~
20 ~~partnerships, as defined in s. 408.701, and providers~~ in other
21 integrated health care systems or similar entities. To the
22 extent required by law or rule, university health services
23 support organizations shall become licensed as insurance
24 companies, pursuant to chapter 624, or be certified as health
25 maintenance organizations, pursuant to chapter 641.
26 University health services support organizations shall have
27 sole responsibility for the acts, debts, liabilities, and
28 obligations of the organization. In no case shall the state
29 or university have any responsibility for such acts, debts,
30 liabilities, and obligations incurred or assumed by university
31 health services support organizations.

Section 39. Effective October 1, 2000, paragraph (a) of subsection (2) of section 240.2996, Florida Statutes, is amended to read:

240.2996 University health services support organization; confidentiality of information.--

(2) The following university health services support organization's records and information are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Contracts for managed care arrangements~~, as managed care is defined in s. 408.701,~~ under which the university health services support organization provides health care services, including preferred provider organization contracts, health maintenance organization contracts, alliance network arrangements, and exclusive provider organization contracts, and any documents directly relating to the negotiation, performance, and implementation of any such contracts for managed care arrangements or alliance network arrangements. As used in this paragraph, the term "managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

The exemptions in this subsection are subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15 and shall stand repealed on October 2, 2001, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 40. Effective October 1, 2000, paragraph (b) of subsection (8) of section 240.512, Florida Statutes, is amended to read:

240.512 H. Lee Moffitt Cancer Center and Research Institute.--There is established the H. Lee Moffitt Cancer Center and Research Institute at the University of South Florida.

(8)

(b) Proprietary confidential business information is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, the Auditor General and Board of Regents, pursuant to their oversight and auditing functions, must be given access to all proprietary confidential business information upon request and without subpoena and must maintain the confidentiality of information so received. As used in this paragraph, the term "proprietary confidential business information" means information, regardless of its form or characteristics, which is owned or controlled by the not-for-profit corporation or its subsidiaries; is intended to be and is treated by the not-for-profit corporation or its subsidiaries as private and the disclosure of which would harm the business operations of the not-for-profit corporation or its subsidiaries; has not been intentionally disclosed by the corporation or its subsidiaries unless pursuant to law, an order of a court or

1 administrative body, a legislative proceeding pursuant to s.
2 5, Art. III of the State Constitution, or a private agreement
3 that provides that the information may be released to the
4 public; and which is information concerning:
5 1. Internal auditing controls and reports of internal
6 auditors;
7 2. Matters reasonably encompassed in privileged
8 attorney-client communications;
9 3. Contracts for managed-care arrangements, ~~as managed~~
10 ~~care is defined in s. 408.701,~~including preferred provider
11 organization contracts, health maintenance organization
12 contracts, and exclusive provider organization contracts, and
13 any documents directly relating to the negotiation,
14 performance, and implementation of any such contracts for
15 managed-care arrangements;
16 4. Bids or other contractual data, banking records,
17 and credit agreements the disclosure of which would impair the
18 efforts of the not-for-profit corporation or its subsidiaries
19 to contract for goods or services on favorable terms;
20 5. Information relating to private contractual data,
21 the disclosure of which would impair the competitive interest
22 of the provider of the information;
23 6. Corporate officer and employee personnel
24 information;
25 7. Information relating to the proceedings and records
26 of credentialing panels and committees and of the governing
27 board of the not-for-profit corporation or its subsidiaries
28 relating to credentialing;
29 8. Minutes of meetings of the governing board of the
30 not-for-profit corporation and its subsidiaries, except
31 minutes of meetings open to the public pursuant to subsection

1 (9);
2 9. Information that reveals plans for marketing
3 services that the corporation or its subsidiaries reasonably
4 expect to be provided by competitors;
5 10. Trade secrets as defined in s. 688.002, including
6 reimbursement methodologies or rates; or
7 11. The identity of donors or prospective donors of
8 property who wish to remain anonymous or any information
9 identifying such donors or prospective donors. The anonymity
10 of these donors or prospective donors must be maintained in
11 the auditor's report.
12
13 As used in this paragraph, the term "managed care" means
14 systems or techniques generally used by third-party payors or
15 their agents to affect access to and control payment for
16 health care services. Managed-care techniques most often
17 include one or more of the following: prior, concurrent, and
18 retrospective review of the medical necessity and
19 appropriateness of services or site of services; contracts
20 with selected health care providers; financial incentives or
21 disincentives related to the use of specific providers,
22 services, or service sites; controlled access to and
23 coordination of services by a case manager; and payor efforts
24 to identify treatment alternatives and modify benefit
25 restrictions for high-cost patient care.
26 Section 41. Effective October 1, 2000, subsection (14)
27 of section 381.0406, Florida Statutes, is amended to read:
28 381.0406 Rural health networks.--
29 (14) NETWORK FINANCING.--Networks may use all sources
30 of public and private funds to support network activities.
31 Nothing in this section prohibits networks from becoming

1 managed care providers, or accountable health partnerships,
2 provided they meet the requirements for an accountable health
3 partnership as specified in s. 408.706.
4 Section 42. Effective October 1, 2000, paragraph (a)
5 of subsection (2) of section 395.3035, Florida Statutes, is
6 amended to read:
7 395.3035 Confidentiality of hospital records and
8 meetings.--
9 (2) The following records and information of any
10 hospital that is subject to chapter 119 and s. 24(a), Art. I
11 of the State Constitution are confidential and exempt from the
12 provisions of s. 119.07(1) and s. 24(a), Art. I of the State
13 Constitution:
14 (a) Contracts for managed care arrangements, as
15 managed care is defined in s. 408.701, under which the public
16 hospital provides health care services, including preferred
17 provider organization contracts, health maintenance
18 organization contracts, exclusive provider organization
19 contracts, and alliance network arrangements, and any
20 documents directly relating to the negotiation, performance,
21 and implementation of any such contracts for managed care or
22 alliance network arrangements. As used in this paragraph, the
23 term "managed care" means systems or techniques generally used
24 by third-party payors or their agents to affect access to and
25 control payment for health care services. Managed-care
26 techniques most often include one or more of the following:
27 prior, concurrent, and retrospective review of the medical
28 necessity and appropriateness of services or site of services;
29 contracts with selected health care providers; financial
30 incentives or disincentives related to the use of specific
31 providers, services, or service sites; controlled access to

1 and coordination of services by a case manager; and payor
2 efforts to identify treatment alternatives and modify benefit
3 restrictions for high-cost patient care.
4 Section 43. Effective October 1, 2000, paragraph (b)
5 of subsection (1) of section 627.4301, Florida Statutes, is
6 amended to read:
7 627.4301 Genetic information for insurance purposes.--
8 (1) DEFINITIONS.--As used in this section, the term:
9 (b) "Health insurer" means an authorized insurer
10 offering health insurance as defined in s. 624.603, a
11 self-insured plan as defined in s. 624.031, a
12 multiple-employer welfare arrangement as defined in s.
13 624.437, a prepaid limited health service organization as
14 defined in s. 636.003, a health maintenance organization as
15 defined in s. 641.19, a prepaid health clinic as defined in s.
16 641.402, a fraternal benefit society as defined in s. 632.601,
17 ~~an accountable health partnership as defined in s. 408.701,~~ or
18 any health care arrangement whereby risk is assumed.
19 Section 44. Section 641.185, Florida Statutes, is
20 created to read:
21 641.185 Health maintenance organization subscriber
22 protections.--
23 (1) With respect to the provisions of this part and
24 part III, the principles expressed in the following statements
25 shall serve as standards to be followed by the Department of
26 Insurance and the Agency for Health Care Administration in
27 exercising their powers and duties, in exercising
28 administrative discretion, in administrative interpretations
29 of the law, in enforcing its provisions, and in adopting
30 rules:
31 (a) A health maintenance organization shall ensure

1 that the health care services provided to its subscribers
2 shall be rendered under reasonable standards of quality of
3 care which are at a minimum consistent with the prevailing
4 standards of medical practice in the community pursuant to ss.
5 641.495(1) and 641.51.
6 (b) A health maintenance organization subscriber
7 should receive quality health care from a broad panel of
8 providers, including referrals, preventive care pursuant to s.
9 641.402(1), emergency screening and services pursuant to ss.
10 641.31(12) and 641.513, and second opinions pursuant to s.
11 641.51.
12 (c) A health maintenance organization subscriber
13 should receive assurance that the health maintenance
14 organization has been independently accredited by a national
15 review organization pursuant to s. 641.512, and is financially
16 secure as determined by the state pursuant to ss. 641.221,
17 641.225, and 641.228.
18 (d) A health maintenance organization subscriber
19 should receive continuity of health care, even after the
20 provider is no longer with the health maintenance organization
21 pursuant to s. 641.51(7).
22 (e) A health maintenance organization subscriber
23 should receive timely, concise information regarding the
24 health maintenance organization's reimbursement to providers
25 and services pursuant to ss. 641.31 and 641.31015.
26 (f) A health maintenance organization subscriber
27 should receive the flexibility to transfer to another Florida
28 health maintenance organization, regardless of health status,
29 pursuant to ss. 641.3104, 641.3107, 641.3111, 641.3921,
30 641.3922, and 641.228.
31 (g) A health maintenance organization subscriber

1 should be eligible for coverage without discrimination against
2 individual participants and beneficiaries of group plans based
3 on health status pursuant to s. 641.31073.
4 (h) A health maintenance organization that issues a
5 group health contract must: provide coverage for preexisting
6 conditions pursuant to s. 641.31071; guarantee renewability of
7 coverage pursuant to s. 641.31074; provide notice of
8 cancellation pursuant to s. 641.3108; provide extension of
9 benefits pursuant to s. 641.3111; provide for conversion on
10 termination of eligibility pursuant to s. 641.3921; and
11 provide for conversion contracts and conditions pursuant to s.
12 641.3922.
13 (i) A health maintenance organization subscriber
14 should receive timely, and, if necessary, urgent grievances
15 and appeals within the health maintenance organization
16 pursuant to ss. 641.228, 641.31(5), 641.47, and 641.511.
17 (j) A health maintenance organization should receive
18 timely and, if necessary, urgent review by an independent
19 state external review organization for unresolved grievances
20 and appeals pursuant to s. 408.7056.
21 (k) A health maintenance organization subscriber shall
22 be given written notice at least 30 days in advance of a rate
23 change pursuant to s. 641.31(3)(b). In the case of a group
24 member, there may be a contractual agreement with the health
25 maintenance organization to have the employer provide the
26 required notice to the individual members of the group
27 pursuant to s. 641.31(3)(b).
28 (l) A health maintenance organization subscriber shall
29 be given a copy of the applicable health maintenance contract,
30 certificate, or member handbook specifying: all the
31 provisions, disclosure, and limitations required pursuant to

1 s. 641.31(1) and (4); the covered services, including those
2 services, medical conditions, and provider types specified in
3 ss. 641.31, 641.31094, 641.31095, 641.31096, 641.51(10), and
4 641.513; and where and in what manner services may be obtained
5 pursuant to s. 641.31(4).
6 (2) This section shall not be construed as creating a
7 civil cause of action by any subscriber or provider against
8 any health maintenance organization.
9 Section 45. Subsection (11) of section 641.511,
10 Florida Statutes, is renumbered as subsection (12) and a new
11 subsection (11) is added to said section to read:
12 641.511 Subscriber grievance reporting and resolution
13 requirements.--
14 (11) Each organization, as part of its contract with
15 any provider, must require the provider to post a consumer
16 assistance notice prominently displayed in the reception area
17 of the provider and clearly noticeable by all patients. The
18 consumer assistance notice must state the addresses and
19 toll-free telephone numbers of the Agency for Health Care
20 Administration, the Statewide Provider and Subscriber
21 Assistance Program, and the Department of Insurance. The
22 consumer assistance notice must also clearly state that the
23 address and toll-free telephone number of the organization's
24 grievance department shall be provided upon request. The
25 agency is authorized to promulgate rules to implement this
26 section.
27 Section 46. Paragraph (n) of subsection (3), paragraph
28 (c) of subsection (5), and paragraphs (b) and (d) of
29 subsection (6) of section 627.6699, Florida Statutes, are
30 amended to read:
31 627.6699 Employee Health Care Access Act.--

(3) DEFINITIONS.--As used in this section, the term:

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population, ~~and~~ allows the use of separate rating factors ~~adjustments~~ for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j); and allows adjustments for claims experience, health status, or duration of coverage as provided in subparagraph (6)(b)5.; and administrative and acquisition expenses as provided in subparagraph (6)(b)6.

(5) AVAILABILITY OF COVERAGE.--

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Beginning July 1, 2000 ~~January 1, 1994~~, offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with two ~~3~~ to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

2. Beginning August 1, 2000 ~~April 15, 1994~~, offer and issue basic and standard small employer health benefit plans on a guaranteed-issue basis, during an open enrollment period of August 1 through August 31 of each year, to every eligible small employer, with less than ~~one or~~ two eligible employees, which is not formed primarily for purposes of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies

the other provisions of the plan. Coverage provided pursuant to this subparagraph shall begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children shall constitute a single eligible employee if such person and spouse are employed by the same small employer and either one has a normal work week of less than 25 hours.

~~3. Offer to eligible small employers the standard and basic health benefit plans.~~ This paragraph ~~subparagraph~~ does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans subject to this section are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j) and may be adjusted as

1 permitted by subparagraphs 5. and 6.
2 2. Rating factors related to age, gender, family
3 composition, tobacco use, or geographic location may be
4 developed by each carrier to reflect the carrier's experience.
5 The factors used by carriers are subject to department review
6 and approval.
7 3. Small employer carriers may not modify the rate for
8 a small employer for 12 months from the initial issue date or
9 renewal date, unless the composition of the group changes or
10 benefits are changed.
11 4. Carriers participating in the alliance program, in
12 accordance with ss. 408.70-408.706, may apply a different
13 community rate to business written in that program.
14 5. Any adjustments in rates for claims experience,
15 health status, or duration of coverage may not be charged to
16 individual employees or dependents. For a small employer's
17 policy, such adjustments may not result in a rate for the
18 small employer which deviates more than 15 percent from the
19 carrier's approved rate. Any such adjustment must be applied
20 uniformly to the rates charged for all employees and
21 dependents of the small employer. A small employer carrier may
22 make an adjustment to a small employer's renewal premium, not
23 to exceed 10 percent annually, due to the claims experience,
24 health status, or duration of coverage of the employees or
25 dependents of the small employer. Semiannually, small group
26 carriers shall report information on forms adopted by rule by
27 the department, to enable the department to monitor the
28 relationship of aggregate adjusted premiums actually charged
29 policyholders by each carrier to the premiums that would have
30 been charged by application of the carrier's approved modified
31 community rates. If the aggregate resulting from the

1 application of such adjustment exceeds the premium that would
2 have been charged by application of the approved modified
3 community rate by 5 percent for the current reporting period,
4 the carrier shall limit the application of such adjustments to
5 only minus adjustments beginning not more than 60 days after
6 the report is sent to the department. For any subsequent
7 reporting period, if the total aggregate adjusted premium
8 actually charged does not exceed the premium that would have
9 been charged by application of the approved modified community
10 rate by 5 percent, the carrier may apply both plus and minus
11 adjustments.
12 6. A small employer carrier may provide a credit to a
13 small employer's premium based on administrative and
14 acquisition expense differences resulting from the size of the
15 group. Group size administrative and acquisition expense
16 factors may be developed by each carrier to reflect the
17 carrier's experience and are subject to department review and
18 approval.
19 7. A small employer carrier rating methodology may
20 include separate rating categories for one dependent child,
21 for two dependent children, and for three or more dependent
22 children for family coverage of employees having a spouse and
23 dependent children or employees having dependent children
24 only. A small employer carrier may have fewer, but not
25 greater, numbers of categories for dependent children than
26 those specified in this subparagraph.
27 8. Small employer carriers may not use a composite
28 rating methodology to rate a small employer with fewer than 10
29 employees. For the purposes of this subparagraph a "composite
30 rating methodology" means a rating methodology that averages
31 the impact of the rating factors for age and gender in the

premiums charged to all of the employees of a small employer.

(d) Notwithstanding s. 627.401(2), this section and ss. 627.410 and 627.411 apply to any health benefit plan provided by a small employer carrier that is an insurer, and this section and s. 641.31 apply to any health benefit provided by a small employer carrier that is a health maintenance organization, that provides coverage to one or more employees of a small employer regardless of where the policy, certificate, or contract is issued or delivered, if the health benefit plan covers employees or their covered dependents who are residents of this state.

Section 47. Subsection (6) of section 409.212, Florida Statutes, is renumbered as subsection (7), and new subsection (6) is added to said section to read:

409.212 Optional supplementation.--

(6) The optional state supplementation rate shall be increased by the cost-of-living adjustment to the federal benefits rate provided the average state optional supplementation contribution does not increase as a result.

Section 48. Subsections (3), (15), and (18) of section 409.901, Florida Statutes, are amended to read:

409.901 Definitions.--As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(3) "Applicant" means an individual whose written application for medical assistance provided by Medicaid under ss. 409.903-409.906 has been submitted to the Department of Children and Family Services ~~agency~~, or to the Social Security Administration if the application is for Supplemental Security Income, but has not received final action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a

1 representative or a person acting for the individual.
2 (15) "Medicaid program" means the program authorized
3 under Title XIX of the federal Social Security Act which
4 provides for payments for medical items or services, or both,
5 on behalf of any person who is determined by the Department of
6 Children and Family Services, or, for Supplemental Security
7 Income, by the Social Security Administration, to be eligible
8 on the date of service for Medicaid assistance.
9 (18) "Medicaid recipient" or "recipient" means an
10 individual whom the Department of Children and Family
11 Services, or, for Supplemental Security Income, by the Social
12 Security Administration, determines is eligible, pursuant to
13 federal and state law, to receive medical assistance and
14 related services for which the agency may make payments under
15 the Medicaid program. For the purposes of determining
16 third-party liability, the term includes an individual
17 formerly determined to be eligible for Medicaid, an individual
18 who has received medical assistance under the Medicaid
19 program, or an individual on whose behalf Medicaid has become
20 obligated.
21 Section 49. Section 409.902, Florida Statutes, is
22 amended to read:
23 409.902 Designated single state agency; payment
24 requirements; program title.--The Agency for Health Care
25 Administration is designated as the single state agency
26 authorized to make payments for medical assistance and related
27 services under Title XIX of the Social Security Act. These
28 payments shall be made, subject to any limitations or
29 directions provided for in the General Appropriations Act,
30 only for services included in the program, shall be made only
31 on behalf of eligible individuals, and shall be made only to

qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated the "Medicaid program." The Department of Children and Family Services is responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility.

Section 50. Section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.--The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, ~~agency~~ determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) Low-income families with children are eligible for Medicaid provided they meet the following requirements:

(a) The family includes a dependent child who is living with a caretaker relative.

(b) The family's income does not exceed the gross income test limit.

(c) The family's countable income and resources do not exceed the applicable Aid to Families with Dependent Children (AFDC) income and resource standards under the AFDC state plan

1 in effect in July 1996, except as amended in the Medicaid
2 state plan to conform as closely as possible to the
3 requirements of the WAGES Program as created in s. 414.015, to
4 the extent permitted by federal law.
5 (2) A person who receives payments from, who is
6 determined eligible for, or who was eligible for but lost cash
7 benefits from the federal program known as the Supplemental
8 Security Income program (SSI). This category includes a
9 low-income person age 65 or over and a low-income person under
10 age 65 considered to be permanently and totally disabled.
11 (3) A child under age 21 living in a low-income,
12 two-parent family, and a child under age 7 living with a
13 nonrelative, if the income and assets of the family or child,
14 as applicable, do not exceed the resource limits under the
15 WAGES Program.
16 (4) A child who is eligible under Title IV-E of the
17 Social Security Act for subsidized board payments, foster
18 care, or adoption subsidies, and a child for whom the state
19 has assumed temporary or permanent responsibility and who does
20 not qualify for Title IV-E assistance but is in foster care,
21 shelter or emergency shelter care, or subsidized adoption.
22 (5) A pregnant woman for the duration of her pregnancy
23 and for the post partum period as defined in federal law and
24 rule, or a child under age 1, if either is living in a family
25 that has an income which is at or below 150 percent of the
26 most current federal poverty level, or, effective January 1,
27 1992, that has an income which is at or below 185 percent of
28 the most current federal poverty level. Such a person is not
29 subject to an assets test. Further, a pregnant woman who
30 applies for eligibility for the Medicaid program through a
31 qualified Medicaid provider must be offered the opportunity,

1 subject to federal rules, to be made presumptively eligible
2 for the Medicaid program.
3 (6) A child born after September 30, 1983, living in a
4 family that has an income which is at or below 100 percent of
5 the current federal poverty level, who has attained the age of
6 6, but has not attained the age of 19. In determining the
7 eligibility of such a child, an assets test is not required.
8 (7) A child living in a family that has an income
9 which is at or below 133 percent of the current federal
10 poverty level, who has attained the age of 1, but has not
11 attained the age of 6. In determining the eligibility of such
12 a child, an assets test is not required.
13 (8) A person who is age 65 or over or is determined by
14 the agency to be disabled, whose income is at or below 100
15 percent of the most current federal poverty level and whose
16 assets do not exceed limitations established by the agency.
17 However, the agency may only pay for premiums, coinsurance,
18 and deductibles, as required by federal law, unless additional
19 coverage is provided for any or all members of this group by
20 s. 409.904(1).
21 Section 51. Subsection (6) of section 409.905, Florida
22 Statutes, is amended to read:
23 409.905 Mandatory Medicaid services.--The agency may
24 make payments for the following services, which are required
25 of the state by Title XIX of the Social Security Act,
26 furnished by Medicaid providers to recipients who are
27 determined to be eligible on the dates on which the services
28 were provided. Any service under this section shall be
29 provided only when medically necessary and in accordance with
30 state and federal law. Nothing in this section shall be
31 construed to prevent or limit the agency from adjusting fees,

1 reimbursement rates, lengths of stay, number of visits, number
2 of services, or any other adjustments necessary to comply with
3 the availability of moneys and any limitations or directions
4 provided for in the General Appropriations Act or chapter 216.
5 (6) HOSPITAL OUTPATIENT SERVICES.--The agency shall
6 pay for preventive, diagnostic, therapeutic, or palliative
7 care and other services provided to a recipient in the
8 outpatient portion of a hospital licensed under part I of
9 chapter 395, and provided under the direction of a licensed
10 physician or licensed dentist, except that payment for such
11 care and services is limited to $1,500 ~~$1,000~~ per state fiscal
12 year per recipient, unless an exception has been made by the
13 agency, and with the exception of a Medicaid recipient under
14 age 21, in which case the only limitation is medical
15 necessity.
16 Section 52. Subsection (5) of section 409.906, Florida
17 Statutes, is amended to read:
18 409.906 Optional Medicaid services.--Subject to
19 specific appropriations, the agency may make payments for
20 services which are optional to the state under Title XIX of
21 the Social Security Act and are furnished by Medicaid
22 providers to recipients who are determined to be eligible on
23 the dates on which the services were provided. Any optional
24 service that is provided shall be provided only when medically
25 necessary and in accordance with state and federal law.
26 Nothing in this section shall be construed to prevent or limit
27 the agency from adjusting fees, reimbursement rates, lengths
28 of stay, number of visits, or number of services, or making
29 any other adjustments necessary to comply with the
30 availability of moneys and any limitations or directions
31 provided for in the General Appropriations Act or chapter 216.

1 If necessary to safeguard the state's systems of providing
2 services to elderly and disabled persons and subject to the
3 notice and review provisions of s. 216.177, the Governor may
4 direct the Agency for Health Care Administration to amend the
5 Medicaid state plan to delete the optional Medicaid service
6 known as "Intermediate Care Facilities for the Developmentally
7 Disabled." Optional services may include:
8 (5) CASE MANAGEMENT SERVICES.--The agency may pay for
9 primary care case management services rendered to a recipient
10 pursuant to a federally approved waiver, and targeted case
11 management services for specific groups of targeted
12 recipients, for which funding has been provided and which are
13 rendered pursuant to federal guidelines. The agency is
14 authorized to limit reimbursement for targeted case management
15 services in order to comply with any limitations or directions
16 provided for in the General Appropriations Act.
17 Notwithstanding s. 216.292, the Department of Children and
18 Family Services may transfer general funds to the Agency for
19 Health Care Administration to fund state match requirements
20 exceeding the amount specified in the General Appropriations
21 Act for targeted case management services.
22 Section 53. Subsection (7), (9), and (10) of section
23 409.907, Florida Statutes, are amended to read:
24 409.907 Medicaid provider agreements.--The agency may
25 make payments for medical assistance and related services
26 rendered to Medicaid recipients only to an individual or
27 entity who has a provider agreement in effect with the agency,
28 who is performing services or supplying goods in accordance
29 with federal, state, and local law, and who agrees that no
30 person shall, on the grounds of handicap, race, color, or
31 national origin, or for any other reason, be subjected to

1 discrimination under any program or activity for which the
2 provider receives payment from the agency.
3 (7) The agency may require, as a condition of
4 participating in the Medicaid program and before entering into
5 the provider agreement, that the provider submit information
6 concerning the professional, business, and personal background
7 of the provider and permit an onsite inspection of the
8 provider's service location by agency staff or other personnel
9 designated by the agency to perform ~~assist in~~ this function.
10 Before entering into the provider agreement, or as a condition
11 of continuing in the Medicaid program, the agency ~~and~~ may also
12 require that Medicaid providers reimbursed on a
13 fee-for-services basis or fee schedule basis which is not
14 cost-based, post a surety bond ~~from the provider~~ not to exceed
15 $50,000 or the total amount billed by the provider to the
16 program during the currant or most recent calendar year,
17 whichever is greater. For new providers, the amount of the
18 surety bond shall be determined by the agency based on the
19 provider's estimate of its first year's billing. If the
20 provider's billing during the first year exceeds the bond
21 amount, the agency may require the provider to acquire an
22 additional bond equal to the actual billing level of the
23 provider. A provider's bond shall not exceed $50,000 if a
24 physician or group of physicians licensed under chapter 458,
25 chapter 459, or chapter 460 has a 50 percent or greater
26 ownership interest in the provider or if the provider is an
27 assisted living facility licensed under part III of chapter
28 400. The bonds permitted by this section are in addition to
29 the bonds referenced in s. 400.179(4)(d).If the provider is a
30 corporation, partnership, association, or other entity, the
31 agency may require the provider to submit information

1 concerning the background of that entity and of any principal
2 of the entity, including any partner or shareholder having an
3 ownership interest in the entity equal to 5 percent or
4 greater, and any treating provider who participates in or
5 intends to participate in Medicaid through the entity. The
6 information must include:
7 (a) Proof of holding a valid license or operating
8 certificate, as applicable, if required by the state or local
9 jurisdiction in which the provider is located or if required
10 by the Federal Government.
11 (b) Information concerning any prior violation, fine,
12 suspension, termination, or other administrative action taken
13 under the Medicaid laws, rules, or regulations of this state
14 or of any other state or the Federal Government; any prior
15 violation of the laws, rules, or regulations relating to the
16 Medicare program; any prior violation of the rules or
17 regulations of any other public or private insurer; and any
18 prior violation of the laws, rules, or regulations of any
19 regulatory body of this or any other state.
20 (c) Full and accurate disclosure of any financial or
21 ownership interest that the provider, or any principal,
22 partner, or major shareholder thereof, may hold in any other
23 Medicaid provider or health care related entity or any other
24 entity that is licensed by the state to provide health or
25 residential care and treatment to persons.
26 (d) If a group provider, identification of all members
27 of the group and attestation that all members of the group are
28 enrolled in or have applied to enroll in the Medicaid program.
29 (9) Upon receipt of a completed, signed, and dated
30 application, and completion of any necessary background
31 investigation and criminal history record check, the agency

1 must either:
2 (a) Enroll the applicant as a Medicaid provider; or
3 (b) Deny the application if the agency finds that,
4 based on the grounds listed in subsection (10), it is in the
5 best interest of the Medicaid program to do so, specifying the
6 reasons for denial. The agency may consider the factors listed
7 in subsection (10), as well as any other factor that could
8 affect the effective and efficient administration of the
9 program, including, but not limited to, the current
10 availability of medical care, services, or supplies to
11 recipients, taking into account geographic location and
12 reasonable travel time.
13 (10) The agency may consider whether deny enrollment
14 in the Medicaid program to a provider if the provider, or any
15 officer, director, agent, managing employee, or affiliated
16 person, or any partner or shareholder having an ownership
17 interest equal to 5 percent or greater in the provider if the
18 provider is a corporation, partnership, or other business
19 entity, has:
20 (a) Made a false representation or omission of any
21 material fact in making the application, including the
22 submission of an application that conceals the controlling or
23 ownership interest of any officer, director, agent, managing
24 employee, affiliated person, or partner or shareholder who may
25 not be eligible to participate;
26 (b) Been or is currently excluded, suspended,
27 terminated from, or has involuntarily withdrawn from
28 participation in, Florida's Medicaid program or any other
29 state's Medicaid program, or from participation in any other
30 governmental or private health care or health insurance
31 program;

1 (c) Been convicted of a criminal offense relating to
2 the delivery of any goods or services under Medicaid or
3 Medicare or any other public or private health care or health
4 insurance program including the performance of management or
5 administrative services relating to the delivery of goods or
6 services under any such program;
7 (d) Been convicted under federal or state law of a
8 criminal offense related to the neglect or abuse of a patient
9 in connection with the delivery of any health care goods or
10 services;
11 (e) Been convicted under federal or state law of a
12 criminal offense relating to the unlawful manufacture,
13 distribution, prescription, or dispensing of a controlled
14 substance;
15 (f) Been convicted of any criminal offense relating to
16 fraud, theft, embezzlement, breach of fiduciary
17 responsibility, or other financial misconduct;
18 (g) Been convicted under federal or state law of a
19 crime punishable by imprisonment of a year or more which
20 involves moral turpitude;
21 (h) Been convicted in connection with the interference
22 or obstruction of any investigation into any criminal offense
23 listed in this subsection;
24 (i) Been found to have violated federal or state laws,
25 rules, or regulations governing Florida's Medicaid program or
26 any other state's Medicaid program, the Medicare program, or
27 any other publicly funded federal or state health care or
28 health insurance program, and been sanctioned accordingly;
29 (j) Been previously found by a licensing, certifying,
30 or professional standards board or agency to have violated the
31 standards or conditions relating to licensure or certification

1 or the quality of services provided; or
2 (k) Failed to pay any fine or overpayment properly
3 assessed under the Medicaid program in which no appeal is
4 pending or after resolution of the proceeding by stipulation
5 or agreement, unless the agency has issued a specific letter
6 of forgiveness or has approved a repayment schedule to which
7 the provider agrees to adhere.
8 Section 54. Paragraph (a) of subsection (1) of section
9 409.908, Florida Statutes, is amended to read:
10 409.908 Reimbursement of Medicaid providers.--Subject
11 to specific appropriations, the agency shall reimburse
12 Medicaid providers, in accordance with state and federal law,
13 according to methodologies set forth in the rules of the
14 agency and in policy manuals and handbooks incorporated by
15 reference therein. These methodologies may include fee
16 schedules, reimbursement methods based on cost reporting,
17 negotiated fees, competitive bidding pursuant to s. 287.057,
18 and other mechanisms the agency considers efficient and
19 effective for purchasing services or goods on behalf of
20 recipients. Payment for Medicaid compensable services made on
21 behalf of Medicaid eligible persons is subject to the
22 availability of moneys and any limitations or directions
23 provided for in the General Appropriations Act or chapter 216.
24 Further, nothing in this section shall be construed to prevent
25 or limit the agency from adjusting fees, reimbursement rates,
26 lengths of stay, number of visits, or number of services, or
27 making any other adjustments necessary to comply with the
28 availability of moneys and any limitations or directions
29 provided for in the General Appropriations Act, provided the
30 adjustment is consistent with legislative intent.
31 (1) Reimbursement to hospitals licensed under part I

1 of chapter 395 must be made prospectively or on the basis of
2 negotiation.
3 (a) Reimbursement for inpatient care is limited as
4 provided for in s. 409.905(5). Reimbursement for hospital
5 outpatient care is limited to $1,500 ~~$1,000~~ per state fiscal
6 year per recipient, except for:
7 1. Such care provided to a Medicaid recipient under
8 age 21, in which case the only limitation is medical
9 necessity;
10 2. Renal dialysis services; and
11 3. Other exceptions made by the agency.
12 Section 55. Section 409.9119, Florida Statutes, is
13 created to read:
14 409.9119 Disproportionate share program for children's
15 hospitals.--In addition to the payments made under s. 409.911,
16 the Agency for Health Care Administration shall develop and
17 implement a system under which disproportionate share payments
18 are made to those hospitals that are licensed by the state as
19 a children's hospital. This system of payments must conform to
20 federal requirements and must distribute funds in each fiscal
21 year for which an appropriation is made by making quarterly
22 Medicaid payments. Notwithstanding s. 409.915, counties are
23 exempt from contributing toward the cost of this special
24 reimbursement for hospitals that serve a disproportionate
25 share of low-income patients.
26 (1) The agency shall use the following formula to
27 calculate the total amount earned for hospitals that
28 participate in the children's hospital disproportionate share
29 program:
30 TAE = DSR x BMPD x MD
31 Where:

1 TAE = total amount earned by a children's hospital.
2 DSR = disproportionate share rate.
3 BMPD = base Medicaid per diem.
4 MD = Medicaid days.
5 (2) The agency shall calculate the total additional
6 payment for hospitals that participate in the children's
7 hospital disproportionate share program as follows:
8
9-11

$$TAP = \frac{(TAE \times TA)}{STAE}$$

12 Where:
13 TAP = total additional payment for a children's
14 hospital.
15 TAE = total amount earned by a children's hospital.
16 STAE = sum of total amount earned by each hospital that
17 participates in the children's hospital disproportionate share
18 program.
19 TA = total appropriation for the children's hospital
20 disproportionate share program.
21
22 (3) A hospital may not receive any payments under this
23 section until it achieves full compliance with the applicable
24 rules of the agency. A hospital that is not in compliance for
25 two or more consecutive quarters may not receive its share of
26 the funds. Any forfeited funds must be distributed to the
27 remaining participating children's hospitals that are in
28 compliance.
29 Section 56. Section 409.919, Florida Statutes, is
30 amended to read:
31 409.919 Rules.--The agency shall adopt any rules

1 necessary to comply with or administer ss. 409.901-409.920 and
2 all rules necessary to comply with federal requirements. In
3 addition, the Department of Children and Family Services shall
4 adopt and accept transfer of any rules necessary to carry out
5 its responsibilities for receiving and processing Medicaid
6 applications and determining Medicaid eligibility, and for
7 assuring compliance with and administering ss. 409.901-409.906
8 and any other provisions related to responsibility for the
9 determination of Medicaid eligibility.
10 Section 57. Notwithstanding the provisions of ss.
11 236.0812, 409.9071, and 409.908(21), Florida Statutes,
12 developmental research schools, as authorized under s.
13 228.053, Florida Statutes, shall be authorized to participate
14 in the Medicaid certified school match program subject to the
15 provisions of ss. 236.0812, 409.9071, and 409.908(21), Florida
16 Statutes.
17 Section 58. (1) The Agency for Health Care
18 Administration is directed to submit to the Health Care
19 Financing Administration a request for a waiver that will
20 allow the agency to undertake a pilot project that would
21 implement a coordinated system of care for adult ventilator
22 dependent patients. Under this pilot program, the agency shall
23 identify a network of skilled nursing facilities that have
24 respiratory departments geared towards intensive treatment and
25 rehabilitation of adult ventilator patients and will contract
26 with such a network for respiratory services under a
27 capitation arrangement. The pilot project must allow the
28 agency to evaluate a coordinated and focused system of care
29 for adult ventilator dependent patients to determine the
30 overall cost-effectiveness and improved outcomes for
31 participants.

1 (2) The agency shall submit the waiver by September 1,
2 2000. The agency shall forward a preliminary report of the
3 pilot project's findings to the Governor, the Speaker of the
4 House of Representatives, and the President of the Senate 6
5 months after project implementation. The agency shall submit
6 a final report of the pilot project's findings to the
7 Governor, the Speaker of the House of Representatives, and the
8 President of the Senate no later than February 15, 2002.
9 Section 59. Subsection (3) of section 400.464 and
10 paragraph (b) of subsection (4) of section 409.912, Florida
11 Statutes, are repealed.
12 Section 60. Effective October 1, 2000, subsection (3)
13 of section 408.70 and sections 408.701, 408.702, 408.703,
14 408.704, 408.7041, 408.7042, 408.7045, 408.7055, and 408.706,
15 Florida Statutes, are repealed.
16 Section 61. The sum of $91,000 in nonrecurring general
17 revenue is hereby appropriated from the General Revenue Fund
18 to the Department of Health to cover costs of the Florida
19 Commission on Excellence in Health Care relating to the travel
20 and related expenses of staff, consumer members, and members
21 appointed by the department or agency; the hiring of
22 consultants, if necessary; and the reproduction and
23 dissemination of documents; however, no portion of this
24 appropriation shall be effective that duplicates a similar
25 appropriation for the same purpose contained in other
26 legislation from the 2000 legislative session that becomes
27 law.
28 Section 62. The sum of $200,000 is appropriated from
29 the Insurance Commissioner's Regulatory Trust Fund to the
30 Office of Legislative Services for the purpose of implementing
31 the legislative intent expressed in s. 624.215(1), Florida

1 Statutes, for a systematic review of current mandated health
2 coverages. The review must be conducted by certified actuaries
3 and other appropriate professionals and shall consist of an
4 assessment of the impact, including, but not limited to, the
5 costs and benefits, of current mandated health coverages using
6 the guidelines provided in s. 624.215(2), Florida Statutes.
7 This assessment shall establish the aggregate cost of mandated
8 health coverages.
9 Section 63. The General Appropriations Act for Fiscal
10 Year 2000-2001 shall be reduced by four full-time-equivalent
11 positions and $260,719 from the Health Care Trust Fund in the
12 Agency for Health Care Administration for purposes of
13 implementing the provisions of this act; however, the
14 reductions shall not be effective if duplicative of similar
15 reductions for the same purpose contained in other legislation
16 from the 2000 legislative session that becomes law.
17 Section 64. Except as otherwise provided herein, this
18 act shall take effect July 1, 2000.
19
20
21 =============== T I T L E A M E N D M E N T ===============
22 And the title is amended as follows:
23 Delete everything before the enacting clause
24
25 and insert:
26 A bill to be entitled
27 An act relating to comprehensive health care;
28 providing a short title; amending s. 400.471,
29 F.S.; deleting the certificate-of-need
30 requirement for licensure of Medicare-certified
31 home health agencies; amending s. 408.032,

1 F.S.; adding definitions of "exemption" and
2 "mental health services"; deleting the
3 definitions of "home health agency,"
4 "institutional health service," "intermediate
5 care facility," "multifacility project," and
6 "respite care"; revising the definition of
7 "health services"; amending s. 408.033, F.S.;
8 deleting references to the state health plan;
9 amending s. 408.034, F.S.; deleting a reference
10 to licensing of home health agencies by the
11 Agency for Health Care Administration; amending
12 s. 408.035, F.S.; deleting obsolete
13 certificate-of-need review criteria and
14 revising other criteria; amending s. 408.036,
15 F.S.; revising provisions relating to projects
16 subject to review; deleting references to
17 Medicare-certified home health agencies;
18 deleting the review of certain acquisitions;
19 specifying the types of bed increases subject
20 to review; deleting cost overruns from review;
21 deleting review of combinations or division of
22 nursing home certificates of need; providing
23 for expedited review of certain conversions of
24 licensed hospital beds; deleting the
25 requirement for an exemption for initiation or
26 expansion of obstetric services, provision of
27 respite care services, establishment of a
28 Medicare-certified home health agency, or
29 provision of a health service exclusively on an
30 outpatient basis; providing exemptions for
31 combinations or divisions of nursing home

1 certificates of need and additions of certain
2 hospital beds and nursing home beds within
3 specified limitations; providing exemptions for
4 the addition of temporary acute care beds in
5 certain hospitals and for the establishment of
6 certain types of specialty hospitals through
7 transfer of beds and services from certain
8 existing hospitals; requiring a fee for each
9 request for exemption; amending s. 408.037,
10 F.S.; deleting reference to the state health
11 plan; amending ss. 408.038, 408.039, 408.044,
12 and 408.045, F.S.; replacing "department" with
13 "agency"; clarifying the opportunity to
14 challenge an intended award of a certificate of
15 need; amending s. 408.040, F.S.; deleting an
16 obsolete reference; revising the format of
17 conditions related to Medicaid; creating a
18 certificate-of-need workgroup within the Agency
19 for Health Care Administration; providing for
20 expenses; providing membership, duties, and
21 meetings; requiring reports; providing for
22 termination; amending s. 651.118, F.S.;
23 excluding a specified number of beds from a
24 time limit imposed on extension of
25 authorization for continuing care residential
26 community providers to use sheltered beds for
27 nonresidents; requiring a facility to report
28 such use after the expiration of the extension;
29 amending s. 395.701, F.S.; reducing the annual
30 assessment on hospitals to fund public medical
31 assistance; providing for contingent effect;

1 amending s. 395.7015, F.S.; reducing the annual
2 assessment on certain health care entities;
3 amending s. 408.904, F.S.; increasing certain
4 benefits for hospital outpatient services;
5 amending s. 409.912, F.S.; providing for a
6 contract with reimbursement of an entity in
7 Pasco or Pinellas County that provides in-home
8 physician services to Medicaid recipients with
9 degenerative neurological diseases; providing
10 for future repeal; providing appropriations;
11 providing for effect of amendments to ss.
12 395.701 and 395.7015, F.S., contingent on a
13 federal waiver; providing for the transfer of
14 certain unexpended Medicaid funds from the
15 Department of Elderly Affairs to the Agency for
16 Health Care Administration; amending ss.
17 641.31, 641.315, and 641.3155, F.S.;
18 prohibiting a health maintenance organization
19 from restricting a provider's ability to
20 provide inpatient hospital services to a
21 subscriber; requiring payment for medically
22 necessary inpatient hospital services;
23 providing applicability; amending s. 641.51,
24 F.S.; relating to quality assurance program
25 requirements for certain managed care
26 organizations; allowing the rendering of
27 adverse determinations by physicians licensed
28 in any state; requiring the submission of facts
29 and documentation pertaining to rendered
30 adverse determinations; providing timeframe for
31 organizations to submit facts and documentation

1 to providers and subscribers in writing;
2 requiring an authorized representative to sign
3 the notification; creating s. 381.7351, F.S.;
4 creating the "Reducing Racial and Ethnic Health
5 Disparities: Closing the Gap Act"; creating s.
6 381.7352, F.S.; providing legislative findings
7 and intent; creating s. 381.7353, F.S.;
8 providing for the creation of the Reducing
9 Racial and Ethnic Health Disparities: Closing
10 the Gap grant program, to be administered by
11 the Department of Health; providing department
12 duties and responsibilities; authorizing
13 appointment of an advisory committee; creating
14 s. 381.7354, F.S.; providing eligibility for
15 grant awards; creating s. 381.7355, F.S.;
16 providing project requirements, an application
17 process, and review criteria; creating s.
18 381.7356, F.S.; providing for Closing the Gap
19 grant awards; providing for local matching
20 funds; providing factors for determination of
21 the amount of grant awards; providing for award
22 of grants to begin by a specified date, subject
23 to specific appropriation; providing for annual
24 renewal of grants; creating the Florida
25 Commission on Excellence in Health Care;
26 providing legislative findings and intent;
27 providing definitions; providing duties and
28 responsibilities; providing for membership,
29 organization, meetings, procedures, and staff;
30 providing for reimbursement of travel and
31 related expenses of certain members; providing

1 certain evidentiary prohibitions; requiring a
2 report to the Governor, the President of the
3 Senate, and the Speaker of the House of
4 Representatives; providing for termination of
5 the commission; amending s. 408.7056, F.S.;
6 providing additional definitions for the
7 Statewide Provider and Subscriber Assistance
8 Program; amending s. 627.654, F.S.; providing
9 for insuring small employers under policies
10 issued to small employer health alliances;
11 providing requirements for participation;
12 providing limitations; providing for insuring
13 spouses and dependent children; allowing a
14 single master policy to include alternative
15 health plans; amending s. 627.6571, F.S.;
16 including small employer health alliances
17 within policy nonrenewal or discontinuance,
18 coverage modification, and application
19 provisions; amending s. 627.6699, F.S.;
20 revising restrictions relating to premium rates
21 to authorize small employer carriers to modify
22 rates under certain circumstances and to
23 authorize carriers to issue group health
24 insurance policies to small employer health
25 alliances under certain circumstances;
26 requiring carriers issuing a policy to an
27 alliance to allow appointed agents to sell such
28 a policy; amending ss. 240.2995, 240.2996,
29 240.512, 381.0406, 395.3035, and 627.4301,
30 F.S.; conforming cross references; defining the
31 term "managed care"; creating s. 641.185, F.S.;

1 providing health maintenance organization
2 subscriber protections; specifying the
3 principles to serve as standards for the
4 Department of Insurance and the Agency for
5 Health Care Administration exercising their
6 duties and responsibilities; requiring that a
7 health maintenance organization observe certain
8 standards in providing health care for
9 subscribers; providing for subscribers to
10 receive quality care from a broad panel of
11 providers, referrals, preventive care,
12 emergency screening services, and second
13 opinions; providing for assurance of
14 independent accreditation by a national review
15 organization and financial security of the
16 organization; providing for continuity of
17 health care; providing for timely, concise
18 information regarding reimbursement to
19 providers and services; providing for
20 flexibility to transfer to another health
21 maintenance organization within the state;
22 providing for eligibility without
23 discrimination based on health status;
24 providing requirements for health maintenance
25 organizations that issue group health contracts
26 relating to preexisting conditions, contract
27 renewability, cancellation, extension,
28 termination, and conversion; providing for
29 timely, urgent grievances and appeals within
30 the organization; providing for timely and
31 urgent review of grievances and appeals by an

1 independent state external review agency;
2 providing for notice of rate changes; providing
3 for information regarding contract provisions,
4 services, medical conditions, providers, and
5 service delivery; providing that no civil cause
6 of action is created; amending s. 641.511,
7 F.S.; requiring posting of certain consumer
8 assistance notices; providing requirements;
9 amending s. 627.6699, F.S.; revising a
10 definition; requiring small employer carriers
11 to begin to offer and issue all small employer
12 benefit plans on a specified date; deleting a
13 requirement that basic and standard small
14 employer health benefit plans be issued;
15 providing additional requirements for
16 determining premium rates for benefit plans;
17 providing for application to plans provided by
18 certain small employer carriers under certain
19 circumstances; amending s. 409.212, F.S.;
20 providing for periodic increase in the optional
21 state supplementation rate; amending s.
22 409.901, F.S.; amending definitions of terms
23 used in ss. 409.910-409.920, F.S.; amending s.
24 409.902, F.S.; providing that the Department of
25 Children and Family Services is responsible for
26 Medicaid eligibility determinations; amending
27 s. 409.903, F.S.; providing responsibility for
28 determinations of eligibility for payments for
29 medical assistance and related services;
30 amending s. 409.905, F.S.; increasing the
31 maximum amount that may be paid under Medicaid

1 for hospital outpatient services; amending s.
2 409.906, F.S.; allowing the Department of
3 Children and Family Services to transfer funds
4 to the Agency for Health Care Administration to
5 cover state match requirements as specified;
6 amending s. 409.907, F.S.; specifying bonding
7 requirements for providers; specifying grounds
8 on which provider applications may be denied;
9 amending s. 409.908, F.S.; increasing the
10 maximum amount of reimbursement allowable to
11 Medicaid providers for hospital inpatient care;
12 creating s. 409.9119, F.S.; creating a
13 disproportionate share program for children's
14 hospitals; providing formulas governing
15 payments made to hospitals under the program;
16 providing for withholding payments from a
17 hospital that is not complying with agency
18 rules; amending s. 409.919, F.S.; providing for
19 the adoption and the transfer of certain rules
20 relating to the determination of Medicaid
21 eligibility; authorizing developmental research
22 schools to participate in Medicaid certified
23 school match program; providing for the Agency
24 for Health Care Administration to seek a
25 federal waiver allowing the agency to undertake
26 a pilot project that involves contracting with
27 skilled nursing facilities for the provision of
28 rehabilitation services to adult ventilator
29 dependent patients; providing for evaluation of
30 the pilot program; repealing s. 400.464(3),
31 F.S., relating to home health agency licenses

1 provided to certificate-of-need exempt
2 entities; repealing ss. 408.70(3), 408.701,
3 408.702, 408.703, 408.704, 408.7041, 408.7042,
4 408.7045, 408.7055, and 408.706, F.S., relating
5 to community health purchasing alliances;
6 repealing s. 409.912(4)(b), F.S., relating to
7 the authorization of the agency to contract
8 with certain prepaid health care services
9 providers; providing appropriations; reducing
10 certain allocation of positions and funds;
11 providing effective dates.
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