1 A bill to be entitled
2 An act relating to health care; providing a
3 short title; amending s. 395.701, F.S.;
4 reducing an assessment against hospitals for
5 outpatient services; amending s. 395.7015,
6 F.S.; reducing an assessment against certain
7 health care entities; amending s. 408.904,
8 F.S.; increasing benefits for certain persons
9 who receive hospital outpatient services;
10 amending s. 408.905, F.S.; increasing benefits
11 furnished by Medicaid providers to recipients
12 of hospital outpatient services; amending s.
13 905.908, F.S.; increasing reimbursement to
14 hospitals for outpatient care; amending s.
15 409.912, F.S.; providing for a contract with
16 and reimbursement of an entity in Pasco or
17 Pinellas County that provides in-home physician
18 services to Medicaid recipients with
19 degenerative neurological diseases; providing
20 for future repeal; providing appropriations;
21 amending s. 400.471, F.S.; deleting the
22 certificate-of-need requirement for licensure
23 of Medicare-certified home health agencies;
24 amending s. 408.032, F.S.; adding definitions
25 of "exemption" and "mental health services";
26 revising the term "health service"; deleting
27 the definitions of "home health agency,"
28 "institutional health service," "intermediate
29 care facility," "multifacility project," and
30 "respite care"; amending s. 408.033, F.S.;
31 deleting references to the state health plan;

1 amending s. 408.034, F.S.; deleting a reference
2 to licensing of home health agencies by the
3 Agency for Health Care Administration; amending
4 s. 408.035, F.S.; deleting obsolete
5 certificate-of-need review criteria and
6 revising other criteria; amending s. 408.036,
7 F.S.; revising provisions relating to projects
8 subject to review; deleting references to
9 Medicare-certified home health agencies;
10 deleting the review of certain acquisitions;
11 specifying the types of bed increases subject
12 to review; deleting cost overruns from review;
13 deleting review of combinations or division of
14 nursing home certificates of need; providing
15 for expedited review of certain conversions of
16 licensed hospital beds; deleting the
17 requirement for an exemption for initiation or
18 expansion of obstetric services, provision of
19 respite care services, establishment of a
20 Medicare-certified home health agency, or
21 provision of a health service exclusively on an
22 outpatient basis; providing exemptions for
23 combinations or divisions of nursing home
24 certificates of need and additions of certain
25 hospital beds and nursing home beds within
26 specified limitations; requiring a fee for each
27 request for exemption; amending s. 408.037,
28 F.S.; deleting reference to the state health
29 plan; amending ss. 408.038, 408.039, 408.044,
30 and 408.045, F.S.; replacing "department" with
31 "agency"; clarifying the opportunity to

1 challenge an intended award of a certificate of
2 need; amending s. 408.040, F.S.; deleting an
3 obsolete reference; revising the format of
4 conditions related to Medicaid; amending s.
5 430.703, F.S.; defining "other qualified
6 provider"; amending s. 430.707, F.S.;
7 authorizing the Department of Elderly Affairs
8 to contract with other qualified providers to
9 provide long-term care within the pilot project
10 areas; exempting other qualified providers from
11 specified licensing requirements; creating a
12 certificate-of-need workgroup within the Agency
13 for Health Care Administration; providing for
14 expenses; providing membership, duties, and
15 meetings; providing for termination; amending
16 s. 651.118, F.S.; excluding a specified number
17 of beds from a time limit imposed on extension
18 of authorization for continuing care
19 residential community providers to use
20 sheltered beds for nonresidents; requiring a
21 facility to report such use after the
22 expiration of the extension; repealing s.
23 400.464(3), F.S., relating to home health
24 agency licenses provided to certificate-of-need
25 exempt entities; providing applicability;
26 reducing the allocation of funds and positions
27 from the Health Care Trust Fund in the Agency
28 for Health Care Administration; amending s.
29 216.136, F.S.; creating the Mandated Health
30 Insurance Benefits and Providers Estimating
31 Conference; providing for membership and duties

1 of the conference; providing duties of
2 legislative committees that have jurisdiction
3 over health insurance matters; amending s.
4 624.215, F.S.; providing that certain
5 legislative proposals must be submitted to and
6 assessed by the conference, rather than the
7 Agency for Health Care Administration; amending
8 guidelines for assessing the impact of a
9 proposal to legislatively mandate certain
10 health coverage; providing prerequisites to
11 legislative consideration of such proposals;
12 requiring physicians and hospitals to post a
13 sign and provide a statement informing patients
14 about the toll-free health care hotline;
15 amending s. 408.7056, F.S.; providing
16 additional definitions for the Statewide
17 Provider and Subscriber Assistance Program;
18 amending s. 627.654, F.S.; providing for
19 insuring small employers under policies issued
20 to small employer health alliances; providing
21 requirements for participation; providing
22 limitations; providing for insuring spouses and
23 dependent children; allowing a single master
24 policy to include alternative health plans;
25 amending s. 627.6571, F.S.; including small
26 employer health alliances within policy
27 nonrenewal or discontinuance, coverage
28 modification, and application provisions;
29 amending s. 627.6699, F.S.; revising
30 restrictions relating to premium rates to
31 authorize small employer carriers to modify

1 rates under certain circumstances and to
2 authorize carriers to issue group health
3 insurance policies to small employer health
4 alliances under certain circumstances;
5 requiring carriers issuing a policy to an
6 alliance to allow appointed agents to sell such
7 a policy; amending ss. 240.2995, 240.2996,
8 240.512, 381.0406, 395.3035, and 627.4301,
9 F.S.; conforming cross-references; defining the
10 term "managed care"; repealing ss. 408.70(3),
11 408.701, 408.702, 408.703, 408.704, 408.7041,
12 408.7042, 408.7045, 408.7055, and 408.706,
13 F.S., relating to community health purchasing
14 alliances; amending s. 627.6699, F.S.;
15 modifying definitions; requiring small employer
16 carriers to begin to offer and issue all small
17 employer benefit plans on a specified date;
18 deleting the requirement that basic and
19 standard small employer health benefit plans be
20 issued; providing additional requirements for
21 determining premium rates for benefit plans;
22 providing for applicability of the act to plans
23 provided by small employer carriers that are
24 insurers or health maintenance organizations
25 notwithstanding the provisions of certain other
26 specified statutes under specified conditions;
27 amending s. 641.201, F.S.; clarifying
28 applicability of the Florida Insurance Code to
29 health maintenance organizations; amending s.
30 641.234, F.S.; providing conditions under which
31 the Department of Insurance may order a health

1 maintenance organization to cancel a contract;
2 amending s. 641.27, F.S.; providing for payment
3 by a health maintenance organization of fees to
4 outside examiners appointed by the Department
5 of Insurance; creating s. 641.226, F.S.;
6 providing for application of federal solvency
7 requirements to provider-sponsored
8 organizations; creating s. 641.39, F.S.;
9 prohibiting the solicitation or acceptance of
10 contracts by insolvent or impaired health
11 maintenance organizations; providing a criminal
12 penalty; creating s. 641.2011, F.S.; providing
13 that part IV of chapter 628, F.S., applies to
14 health maintenance organizations; creating s.
15 641.275, F.S.; providing legislative intent
16 that the rights of subscribers who are covered
17 under health maintenance organization contracts
18 be recognized and summarized; requiring health
19 maintenance organizations to operate in
20 conformity with such rights; requiring
21 organizations to provide subscribers with a
22 copy of their rights; listing specified
23 requirements for organizations that are
24 currently required by other statutes;
25 authorizing administrative penalties for
26 enforcing the rights specified in s. 641.275,
27 F.S.; amending s. 641.28, F.S.; revising award
28 of attorney's fees in civil actions under
29 certain circumstances; amending s. 641.3917,
30 F.S.; authorizing civil actions against health
31 maintenance organizations by certain persons

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1 under certain circumstances; providing
2 requirements and procedures; providing for
3 liability for damages and attorney's fees;
4 prohibiting punitive damages under certain
5 circumstances; requiring the advance posting of
6 discovery costs; amending s. 440.11, F.S.;
7 establishing exclusive liability of health
8 maintenance organizations; providing
9 application; providing a legislative
10 declaration; providing an appropriation;
11 amending ss. 641.31, 641.315, 641.3155, F.S.;
12 prohibiting a health maintenance organization
13 from restricting a provider's ability to
14 provide in-patient hospital services to a
15 subscriber; requiring payment for medically
16 necessary in-patient hospital services;
17 amending s. 641.51, F.S., relating to quality
18 assurance program requirements for certain
19 managed-care organizations; allowing the
20 rendering of adverse determinations by
21 physicians licensed in Florida or states with
22 similar requirements; requiring the submission
23 of facts and documentation pertaining to
24 rendered adverse determinations; providing
25 timeframe for organizations to submit facts and
26 documentation to providers and subscribers in
27 writing; requiring an authorized representative
28 to sign the notification; amending s. 212.055,
29 F.S.; expanding the authorized use of the
30 indigent care surtax to include trauma centers;
31 renaming the surtax; requiring the plan set out

1 in the ordinance to include additional
2 provisions concerning Level I trauma centers;
3 providing requirements for annual disbursements
4 to hospitals on October 1 to be in recognition
5 of the Level I trauma center status and to be
6 in addition to a base contract amount, plus any
7 negotiated additions to indigent care funding;
8 authorizing funds received to be used to
9 generate federal matching funds under certain
10 conditions and authorizing payment by the clerk
11 of the court; creating the Florida Commission
12 on Excellence in Health Care; providing
13 legislative findings and intent; providing
14 definitions; providing duties and
15 responsibilities; providing for membership,
16 organization, meetings, procedures, and staff;
17 providing for reimbursement of travel and
18 related expenses of certain members; providing
19 certain evidentiary prohibitions; requiring a
20 report to the Governor, the President of the
21 Senate, and the Speaker of the House of
22 Representatives; providing for termination of
23 the commission; providing an appropriation;
24 amending s. 400.408, F.S.; requiring field
25 offices of the Agency for Health Care
26 Administration to establish local coordinating
27 workgroups to identify the operation of
28 unlicensed assisted living facilities and to
29 develop a plan to enforce state laws relating
30 to unlicensed assisted living facilities;
31 requiring a report to the agency of the

1 workgroup's findings and recommendations;
2 requiring health care practitioners to report
3 known operations of unlicensed facilities;
4 prohibiting hospitals and community mental
5 health centers from discharging a patient or
6 client to an unlicensed facility; amending s.
7 415.1034, F.S.; requiring paramedics and
8 emergency medical technicians to report acts of
9 abuse committed against a disabled adult or
10 elderly person; providing effective dates.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. <u>This act may be cited as the "Health Care</u>
15 <u>Protection Act of 2000."</u>
16 Section 2. Subsection (2) of section 395.701, Florida
17 Statutes, is amended to read:
18 395.701 Annual assessments on net operating revenues
19 to fund public medical assistance; administrative fines for
20 failure to pay assessments when due; exemption.--
21 (2) There is imposed upon each hospital an assessment
22 in an amount equal to 1.5 percent of the annual net operating
23 revenue for <u>inpatient services and an assessment in an amount</u>
24 <u>equal to 1 percent of the annual net operating revenue for</u>
25 <u>outpatient services for</u> each hospital, such revenue to be
26 determined by the agency, based on the actual experience of
27 the hospital as reported to the agency. Within 6 months after
28 the end of each hospital fiscal year, the agency shall certify
29 the amount of the assessment for each hospital. The
30 assessment shall be payable to and collected by the agency in
31 equal quarterly amounts, on or before the first day of each

calendar quarter, beginning with the first full calendar quarter that occurs after the agency certifies the amount of the assessment for each hospital. All moneys collected pursuant to this subsection shall be deposited into the Public Medical Assistance Trust Fund.

Section 3. Subsection (2) of section 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).

(b) For the purpose of this section, "health care entities" include the following:

1. Ambulatory surgical centers and mobile surgical facilities licensed under s. 395.003. This subsection shall only apply to mobile surgical facilities operating under contracts entered into on or after July 1, 1998.

2. Clinical laboratories licensed under s. 483.091, excluding any hospital laboratory defined under s. 483.041(5), any clinical laboratory operated by the state or a political subdivision of the state, any clinical laboratory which qualifies as an exempt organization under s. 501(c)(3) of the Internal Revenue Code of 1986, as amended, and which receives 70 percent or more of its gross revenues from services to charity patients or Medicaid patients, and any blood, plasma, or tissue bank procuring, storing, or distributing blood,

1 plasma, or tissue either for future manufacture or research or
2 distributed on a nonprofit basis, and further excluding any
3 clinical laboratory which is wholly owned and operated by 6 or
4 fewer physicians who are licensed pursuant to chapter 458 or
5 chapter 459 and who practice in the same group practice, and
6 at which no clinical laboratory work is performed for patients
7 referred by any health care provider who is not a member of
8 the same group.
9 3. Diagnostic-imaging centers that are freestanding
10 outpatient facilities that provide specialized services for
11 the identification or determination of a disease through
12 examination and also provide sophisticated radiological
13 services, and in which services are rendered by a physician
14 licensed by the Board of Medicine under s. 458.311, s.
15 458.313, or s. 458.317, or by an osteopathic physician
16 licensed by the Board of Osteopathic Medicine under s.
17 459.006, s. 459.007, or s. 459.0075. For purposes of this
18 paragraph, "sophisticated radiological services" means the
19 following: magnetic resonance imaging; nuclear medicine;
20 angiography; arteriography; computed tomography; positron
21 emission tomography; digital vascular imaging; bronchography;
22 lymphangiography; splenography; ultrasound, excluding
23 ultrasound providers that are part of a private physician's
24 office practice or when ultrasound is provided by two or more
25 physicians licensed under chapter 458 or chapter 459 who are
26 members of the same professional association and who practice
27 in the same medical specialties; and such other sophisticated
28 radiological services, excluding mammography, as adopted in
29 rule by the board.
30 Section 4. Paragraph (c) of subsection (2) of section
31 408.904, Florida Statutes, is amended to read:

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1 408.904 Benefits.--
2 (2) Covered health services include:
3 (c) Hospital outpatient services. Those services
4 provided to a member in the outpatient portion of a hospital
5 licensed under part I of chapter 395, up to a limit of $1,500
6 ~~$1,000~~ per calendar year per member, that are preventive,
7 diagnostic, therapeutic, or palliative.
8 Section 5. Subsection (6) of section 409.905, Florida
9 Statutes, is amended to read:
10 409.905 Mandatory Medicaid services.--The agency may
11 make payments for the following services, which are required
12 of the state by Title XIX of the Social Security Act,
13 furnished by Medicaid providers to recipients who are
14 determined to be eligible on the dates on which the services
15 were provided. Any service under this section shall be
16 provided only when medically necessary and in accordance with
17 state and federal law. Nothing in this section shall be
18 construed to prevent or limit the agency from adjusting fees,
19 reimbursement rates, lengths of stay, number of visits, number
20 of services, or any other adjustments necessary to comply with
21 the availability of moneys and any limitations or directions
22 provided for in the General Appropriations Act or chapter 216.
23 (6) HOSPITAL OUTPATIENT SERVICES.--The agency shall
24 pay for preventive, diagnostic, therapeutic, or palliative
25 care and other services provided to a recipient in the
26 outpatient portion of a hospital licensed under part I of
27 chapter 395, and provided under the direction of a licensed
28 physician or licensed dentist, except that payment for such
29 care and services is limited to $1,500 ~~$1,000~~ per state fiscal
30 year per recipient, unless an exception has been made by the
31 agency, and with the exception of a Medicaid recipient under

1 age 21, in which case the only limitation is medical
2 necessity.
3 Section 6. Paragraph (a) of subsection (1) of section
4 409.908, Florida Statutes, is amended to read:
5 409.908 Reimbursement of Medicaid providers.--Subject
6 to specific appropriations, the agency shall reimburse
7 Medicaid providers, in accordance with state and federal law,
8 according to methodologies set forth in the rules of the
9 agency and in policy manuals and handbooks incorporated by
10 reference therein. These methodologies may include fee
11 schedules, reimbursement methods based on cost reporting,
12 negotiated fees, competitive bidding pursuant to s. 287.057,
13 and other mechanisms the agency considers efficient and
14 effective for purchasing services or goods on behalf of
15 recipients. Payment for Medicaid compensable services made on
16 behalf of Medicaid eligible persons is subject to the
17 availability of moneys and any limitations or directions
18 provided for in the General Appropriations Act or chapter 216.
19 Further, nothing in this section shall be construed to prevent
20 or limit the agency from adjusting fees, reimbursement rates,
21 lengths of stay, number of visits, or number of services, or
22 making any other adjustments necessary to comply with the
23 availability of moneys and any limitations or directions
24 provided for in the General Appropriations Act, provided the
25 adjustment is consistent with legislative intent.
26 (1) Reimbursement to hospitals licensed under part I
27 of chapter 395 must be made prospectively or on the basis of
28 negotiation.
29 (a) Reimbursement for inpatient care is limited as
30 provided for in s. 409.905(5). Reimbursement for hospital
31

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1 outpatient care is limited to$1,500~~$1,000~~ per state fiscal
2 year per recipient, except for:
3 1. Such care provided to a Medicaid recipient under
4 age 21, in which case the only limitation is medical
5 necessity;
6 2. Renal dialysis services; and
7 3. Other exceptions made by the agency.
8 Section 7. Paragraph (e) is added to subsection (3) of
9 section 409.912, Florida Statutes, to read:
10 409.912 Cost-effective purchasing of health care.--The
11 agency shall purchase goods and services for Medicaid
12 recipients in the most cost-effective manner consistent with
13 the delivery of quality medical care. The agency shall
14 maximize the use of prepaid per capita and prepaid aggregate
15 fixed-sum basis services when appropriate and other
16 alternative service delivery and reimbursement methodologies,
17 including competitive bidding pursuant to s. 287.057, designed
18 to facilitate the cost-effective purchase of a case-managed
19 continuum of care. The agency shall also require providers to
20 minimize the exposure of recipients to the need for acute
21 inpatient, custodial, and other institutional care and the
22 inappropriate or unnecessary use of high-cost services.
23 (3) The agency may contract with:
24 (e) An entity in Pasco County or Pinellas County that
25 provides in-home physician services to Medicaid recipients
26 having degenerative neurological diseases in order to test the
27 cost-effectiveness of enhanced home-based medical care. The
28 entity providing the services shall be reimbursed on a
29 fee-for-service basis at a rate not less than comparable
30 Medicare reimbursement rates. The agency may apply for waivers
31

1 of federal regulations necessary to implement such program.
2 This paragraph expires July 1, 2002.
3 Section 8. The Legislature shall appropriate each
4 fiscal year from the General Revenue Fund to the Public
5 Medical Assistance Trust Fund an amount sufficient to replace
6 the funds lost due to the reduction by this act of the
7 assessment on other health care entities under section
8 395.7015, Florida Statutes, and the reduction by this act in
9 the assessment on hospitals under section 395.701, Florida
10 Statutes, and to maintain federal approval of the reduced
11 amount of funds deposited into the Public Medical Assistance
12 Trust Fund under section 395.701, Florida Statutes, as state
13 matching funds for the state's Medicaid program.
14 Section 9. The sum of $28.3 million is appropriated
15 from the General Revenue Fund to the Agency for Health Care
16 Administration for the purpose of implementing this act.
17 However, such appropriation shall be reduced by an amount
18 equal to any similar appropriation for the same purpose which
19 is contained in other legislation adopted during the 2000
20 legislative session and which becomes a law.
21 Section 10. Subsections (2) and (11) of section
22 400.471, Florida Statutes, are amended to read:
23 400.471 Application for license; fee; provisional
24 license; temporary permit.--
25 (2) The applicant must file with the application
26 satisfactory proof that the home health agency is in
27 compliance with this part and applicable rules, including:
28 (a) A listing of services to be provided, either
29 directly by the applicant or through contractual arrangements
30 with existing providers;
31

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1 (b) The number and discipline of professional staff to
2 be employed; and
3 (c) Proof of financial ability to operate.
4
5 ~~If the applicant has applied for a certificate of need under~~
6 ~~ss. 408.0331-408.045 within the preceding 12 months, the~~
7 ~~applicant may submit the proof required during the~~
8 ~~certificate-of-need process along with an attestation that~~
9 ~~there has been no substantial change in the facts and~~
10 ~~circumstances underlying the original submission.~~
11 (11) The agency may not issue a license designated as
12 certified to a home health agency that fails to ~~receive a~~
13 ~~certificate of need under ss. 408.031-408.045 or that fails to~~
14 satisfy the requirements of a Medicare certification survey
15 from the agency.
16 Section 11. Section 408.032, Florida Statutes, is
17 amended to read:
18 408.032 Definitions.--As used in ss. 408.031-408.045,
19 the term:
20 (1) "Agency" means the Agency for Health Care
21 Administration.
22 (2) "Capital expenditure" means an expenditure,
23 including an expenditure for a construction project undertaken
24 by a health care facility as its own contractor, which, under
25 generally accepted accounting principles, is not properly
26 chargeable as an expense of operation and maintenance, which
27 is made to change the bed capacity of the facility, or
28 substantially change the services or service area of the
29 health care facility, health service provider, or hospice, and
30 which includes the cost of the studies, surveys, designs,
31 plans, working drawings, specifications, initial financing

costs, and other activities essential to acquisition, improvement, expansion, or replacement of the plant and equipment.

(3) "Certificate of need" means a written statement issued by the agency evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.

(4) "Commenced construction" means initiation of and continuous activities beyond site preparation associated with erecting or modifying a health care facility, including procurement of a building permit applying the use of agency-approved construction documents, proof of an executed owner/contractor agreement or an irrevocable or binding forced account, and actual undertaking of foundation forming with steel installation and concrete placing.

(5) "District" means a health service planning district composed of the following counties:

District 1.--Escambia, Santa Rosa, Okaloosa, and Walton Counties.

District 2.--Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties.

District 3.--Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties.

District 4.--Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties.

District 5.--Pasco and Pinellas Counties.

District 6.--Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.

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District 7.--Seminole, Orange, Osceola, and Brevard Counties.

District 8.--Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.

District 9.--Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.

District 10.--Broward County.

District 11.--Dade and Monroe Counties.

(6) "Exemption" means the process by which a proposal that would otherwise require a certificate of need may proceed without a certificate of need.

(7)~~(6)~~ "Expedited review" means the process by which certain types of applications are not subject to the review cycle requirements contained in s. 408.039(1), and the letter of intent requirements contained in s. 408.039(2).

(8)~~(7)~~ "Health care facility" means a hospital, long-term care hospital, skilled nursing facility, hospice, ~~intermediate care facility,~~or intermediate care facility for the developmentally disabled. A facility relying solely on spiritual means through prayer for healing is not included as a health care facility.

(9)~~(8)~~ "Health services" means diagnostic, curative, or rehabilitative services and includes ~~alcohol treatment, drug abuse treatment, and~~ mental health services. Obstetric services are not health services for purposes of ss. 408.031-408.045.

~~(9) "Home health agency" means an organization, as defined in s. 400.462(4), that is certified or seeks certification as a Medicare home health service provider.~~

(10) "Hospice" or "hospice program" means a hospice as defined in part VI of chapter 400.

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(11) "Hospital" means a health care facility licensed under chapter 395.

~~(12) "Institutional health service" means a health 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 12. 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.

1 5. Monitor the onsite construction progress, if any,
2 of certificate-of-need approved projects and report council
3 findings to the agency on forms provided by the agency.
4 6. Advise and assist any regional planning councils
5 within each district that have elected to address health
6 issues in their strategic regional policy plans with the
7 development of the health element of the plans to address the
8 health goals and policies in the State Comprehensive Plan.
9 7. Advise and assist local governments within each
10 district on the development of an optional health plan element
11 of the comprehensive plan provided in chapter 163, to assure
12 compatibility with the health goals and policies in the State
13 Comprehensive Plan and district health plan. To facilitate
14 the implementation of this section, the local health council
15 shall annually provide the local governments in its service
16 area, upon request, with:
17 a. A copy and appropriate updates of the district
18 health plan;
19 b. A report of hospital and nursing home utilization
20 statistics for facilities within the local government
21 jurisdiction; and
22 c. Applicable agency rules and calculated need
23 methodologies for health facilities and services regulated
24 under s. 408.034 for the district served by the local health
25 council.
26 8. Monitor and evaluate the adequacy, appropriateness,
27 and effectiveness, within the district, of local, state,
28 federal, and private funds distributed to meet the needs of
29 the medically indigent and other underserved population
30 groups.
31

9. In conjunction with the Agency for Health Care Administration, plan for services at the local level for persons infected with the human immunodeficiency virus.

10. Provide technical assistance to encourage and 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 13. 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 14. 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

1 programs for health care practitioners and for doctors of
2 osteopathic medicine and medicine at the student, internship,
3 and residency training levels.
4 (6)(h) The availability of resources, including health
5 personnel, management personnel, and funds for capital and
6 operating expenditures, for project accomplishment and
7 operation.; the effects the project will have on clinical
8 needs of health professional training programs in the service
9 district; the extent to which the services will be accessible
10 to schools for health professions in the service district for
11 training purposes if such services are available in a limited
12 number of facilities; the availability of alternative uses of
13 such resources for the provision of other health services; and
14 (7) The extent to which the proposed services will
15 enhance access to health care for be accessible to all
16 residents of the service district.
17 (8)(i) The immediate and long-term financial
18 feasibility of the proposal.
19 (j) The special needs and circumstances of health
20 maintenance organizations.
21 (k) The needs and circumstances of those entities that
22 provide a substantial portion of their services or resources,
23 or both, to individuals not residing in the service district
24 in which the entities are located or in adjacent service
25 districts. Such entities may include medical and other health
26 professions, schools, multidisciplinary clinics, and specialty
27 services such as open-heart surgery, radiation therapy, and
28 renal transplantation.
29 (9)(l) The extent to which the proposal will foster
30 competition that promotes quality and cost-effectiveness.The
31 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 15. 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, except as provided in s. 408.043 ~~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, nursing home care beds, 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.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 The agency shall develop rules to implement the provisions for
2 expedited review, including time schedule, application content
3 which may be reduced from the full requirements of s.
4 408.037(1), and application processing.
5 (3) EXEMPTIONS.--Upon request, the following projects
6 are subject to ~~supported by such documentation as the agency~~
7 ~~requires, the agency shall grant an~~ exemption from the
8 provisions of subsection (1):
9 ~~(a) For the initiation or expansion of obstetric~~
10 ~~services.~~
11 (a)~~(b)~~ For replacement of ~~any expenditure to replace~~
12 ~~or renovate any part of~~ a licensed health care facility on the
13 same site, provided that the number of ~~licensed~~ beds in each
14 licensed bed category will not increase ~~and, in the case of a~~
15 ~~replacement facility, the project site is the same as the~~
16 ~~facility being replaced~~.
17 ~~(c) For providing respite care services. An individual~~
18 ~~may be admitted to a respite care program in a hospital~~
19 ~~without regard to inpatient requirements relating to admitting~~
20 ~~order and attendance of a member of a medical staff.~~
21 (b)~~(d)~~ For hospice services or ~~home health services~~
22 ~~provided by a rural hospital, as defined in s. 395.602, or~~ for
23 swing beds in a ~~such~~ rural hospital, as defined in s. 395.602,
24 in a number that does not exceed one-half of its licensed
25 beds.
26 (c)~~(e)~~ For the conversion of licensed acute care
27 hospital beds to Medicare and Medicaid certified skilled
28 nursing beds in a rural hospital, as defined in s. 395.602, so
29 long as the conversion of the beds does not involve the
30 construction of new facilities. The total number of skilled
31 nursing beds, including swing beds, may not exceed one-half of

1 the total number of licensed beds in the rural hospital as of
2 July 1, 1993. Certified skilled nursing beds designated under
3 this paragraph, excluding swing beds, shall be included in the
4 community nursing home bed inventory. A rural hospital which
5 subsequently decertifies any acute care beds exempted under
6 this paragraph shall notify the agency of the decertification,
7 and the agency shall adjust the community nursing home bed
8 inventory accordingly.
9 (d)~~(f)~~ For the addition of nursing home beds at a
10 skilled nursing facility that is part of a retirement
11 community that provides a variety of residential settings and
12 supportive services and that has been incorporated and
13 operated in this state for at least 65 years on or before July
14 1, 1994. All nursing home beds must not be available to the
15 public but must be for the exclusive use of the community
16 residents.
17 (e)~~(g)~~ For an increase in the bed capacity of a
18 nursing facility licensed for at least 50 beds as of January
19 1, 1994, under part II of chapter 400 which is not part of a
20 continuing care facility if, after the increase, the total
21 licensed bed capacity of that facility is not more than 60
22 beds and if the facility has been continuously licensed since
23 1950 and has received a superior rating on each of its two
24 most recent licensure surveys.
25 ~~(h) For the establishment of a Medicare-certified home~~
26 ~~health agency by a facility certified under chapter 651; a~~
27 ~~retirement community, as defined in s. 400.404(2)(g); or a~~
28 ~~residential facility that serves only retired military~~
29 ~~personnel, their dependents, and the surviving dependents of~~
30 ~~deceased military personnel. Medicare-reimbursed home health~~
31 ~~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.

(h)~~(m)~~ For the delicensure of beds. 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.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 (i)~~(n)~~ For the provision of adult inpatient diagnostic
2 cardiac catheterization services in a hospital.
3 1. In addition to any other documentation otherwise
4 required by the agency, a request for an exemption submitted
5 under this paragraph must comply with the following criteria:
6 a. The applicant must certify it will not provide
7 therapeutic cardiac catheterization pursuant to the grant of
8 the exemption.
9 b. The applicant must certify it will meet and
10 continuously maintain the minimum licensure requirements
11 adopted by the agency governing such programs pursuant to
12 subparagraph 2.
13 c. The applicant must certify it will provide a
14 minimum of 2 percent of its services to charity and Medicaid
15 patients.
16 2. The agency shall adopt licensure requirements by
17 rule which govern the operation of adult inpatient diagnostic
18 cardiac catheterization programs established pursuant to the
19 exemption provided in this paragraph. The rules shall ensure
20 that such programs:
21 a. Perform only adult inpatient diagnostic cardiac
22 catheterization services authorized by the exemption and will
23 not provide therapeutic cardiac catheterization or any other
24 services not authorized by the exemption.
25 b. Maintain sufficient appropriate equipment and
26 health personnel to ensure quality and safety.
27 c. Maintain appropriate times of operation and
28 protocols to ensure availability and appropriate referrals in
29 the event of emergencies.
30 d. Maintain appropriate program volumes to ensure
31 quality and safety.

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1 e. Provide a minimum of 2 percent of its services to
2 charity and Medicaid patients each year.
3 3.a. The exemption provided by this paragraph shall
4 not apply unless the agency determines that the program is in
5 compliance with the requirements of subparagraph 1. and that
6 the program will, after beginning operation, continuously
7 comply with the rules adopted pursuant to subparagraph 2. The
8 agency shall monitor such programs to ensure compliance with
9 the requirements of subparagraph 2.
10 b.(I) The exemption for a program shall expire
11 immediately when the program fails to comply with the rules
12 adopted pursuant to sub-subparagraphs 2.a., b., and c.
13 (II) Beginning 18 months after a program first begins
14 treating patients, the exemption for a program shall expire
15 when the program fails to comply with the rules adopted
16 pursuant to sub-subparagraphs 2.d. and e.
17 (III) If the exemption for a program expires pursuant
18 to sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the
19 agency shall not grant an exemption pursuant to this paragraph
20 for an adult inpatient diagnostic cardiac catheterization
21 program located at the same hospital until 2 years following
22 the date of the determination by the agency that the program
23 failed to comply with the rules adopted pursuant to
24 subparagraph 2.
25 ~~4. The agency shall not grant any exemption under this~~
26 ~~paragraph until the adoption of the rules required under this~~
27 ~~paragraph, or until March 1, 1998, whichever comes first.~~
28 ~~However, if final rules have not been adopted by March 1,~~
29 ~~1998, the proposed rules governing the exemptions shall be~~
30 ~~used by the agency to grant exemptions under the provisions of~~
31 ~~this paragraph until final rules become effective.~~

1 (j)~~(o)~~ For ~~any expenditure to provide~~ mobile surgical
2 facilities and related health care services provided under
3 contract with the Department of Corrections or a private
4 correctional facility operating pursuant to chapter 957.
5 (k)~~(p)~~ For state veterans' nursing homes operated by
6 or on behalf of the Florida Department of Veterans' Affairs in
7 accordance with part II of chapter 296 for which at least 50
8 percent of the construction cost is federally funded and for
9 which the Federal Government pays a per diem rate not to
10 exceed one-half of the cost of the veterans' care in such
11 state nursing homes. These beds shall not be included in the
12 nursing home bed inventory.
13 (l) For combination within one nursing home facility
14 of the beds or services authorized by two or more certificates
15 of need issued in the same planning subdistrict. An exemption
16 granted under this paragraph shall extend the validity period
17 of the certificates of need to be consolidated by the length
18 of the period beginning upon submission of the exemption
19 request and ending with issuance of the exemption. The
20 longest validity period among the certificates shall be
21 applicable to each of the combined certificates.
22 (m) For division into two or more nursing home
23 facilities of beds or services authorized by one certificate
24 of need issued in the same planning subdistrict. An exemption
25 granted under this paragraph shall extend the validity period
26 of the certificate of need to be divided by the length of the
27 period beginning upon submission of the exemption request and
28 ending with issuance of the exemption.
29 (n) For the addition of hospital beds licensed under
30 chapter 395 for acute care, mental health services, or a
31 hospital-based distinct part skilled nursing unit in a number

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

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1 (p) For the addition of nursing home beds licensed
2 under chapter 400 in a number not exceeding 10 total beds or
3 10 percent of the number of beds licensed in the facility
4 being expanded, whichever is greater.
5 1. In addition to any other documentation required by
6 the agency, a request for exemption submitted under this
7 paragraph must:
8 a. Effective until June 30, 2001, certify that the
9 facility has not had any class I or class II deficiencies
10 within the 30 months preceding the request for addition.
11 b. Effective on July 1, 2001, certify that the
12 facility has been designated as a Gold Seal nursing home under
13 s. 400.235.
14 c. Certify that the prior 12-month average occupancy
15 rate for the nursing home beds at the facility meets or
16 exceeds 96 percent.
17 d. Certify that any beds authorized for the facility
18 under this paragraph before the date of the current request
19 for an exemption have been licensed and operational for at
20 least 12 months.
21 2. The timeframes and monitoring process specified in
22 s. 408.040(2)(a)-(c) apply to any exemption issued under this
23 paragraph.
24 3. The agency shall count beds authorized under this
25 paragraph as approved beds in the published inventory of
26 nursing home beds until the beds are licensed.
27 (4) A request for exemption under ~~this~~ subsection(3)
28 may be made at any time and is not subject to the batching
29 requirements of this section. The request shall be supported
30 by such documentation as the agency requires by rule. The
31

agency shall assess a fee of $250 for each request for exemption submitted under subsection (3).

Section 16. Paragraph (a) of subsection (1) of section 408.037, Florida Statutes, is amended to read:

408.037 Application content.--

(1) An application for a certificate of need must contain:

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

Section 17. 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 18. Subsections (3) and (4) 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

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1 15 days after the applicable application filing deadline
2 established by agency ~~department~~ rule, the staff of the agency
3 ~~department~~ shall determine if the application is complete. If
4 the application is incomplete, the staff shall request
5 specific information from the applicant necessary for the
6 application to be complete; however, the staff may make only
7 one such request. If the requested information is not filed
8 with the agency ~~department~~ within 21 days of the receipt of
9 the staff's request, the application shall be deemed
10 incomplete and deemed withdrawn from consideration.
11 (b) Upon the request of any applicant or substantially
12 affected person within 14 days after notice that an
13 application has been filed, a public hearing may be held at
14 the agency's ~~department's~~ discretion if the agency ~~department~~
15 determines that a proposed project involves issues of great
16 local public interest. The public hearing shall allow
17 applicants and other interested parties reasonable time to
18 present their positions and to present rebuttal information. A
19 recorded verbatim record of the hearing shall be maintained.
20 The public hearing shall be held at the local level within 21
21 days after the application is deemed complete.
22 (4) STAFF RECOMMENDATIONS.--
23 (a) The agency's ~~department's~~ review of and final
24 agency action on applications shall be in accordance with the
25 district health plan, and statutory criteria, and the
26 implementing administrative rules. In the application review
27 process, the agency ~~department~~ shall give a preference, as
28 defined by rule of the agency ~~department~~, to an applicant
29 which proposes to develop a nursing home in a nursing home
30 geographically underserved area.
31

(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.

(6) JUDICIAL REVIEW.--

(a) A party to an administrative hearing for an application for a certificate of need has the right, within not more than 30 days after the date of the final order, to seek judicial review in the District Court of Appeal pursuant to s. 120.68. The agency ~~department~~ shall be a party in any such proceeding.

(b) In such judicial review, the court shall affirm the final order of the agency ~~department~~, unless the decision is arbitrary, capricious, or not in compliance with ss. 408.031-408.045.

Section 19. Subsections (1) and (2) of section 408.040, Florida Statutes, are amended to read:

408.040 Conditions and monitoring.--

(1)(a) The agency may issue a certificate of need predicated upon statements of intent expressed by an applicant in the application for a certificate of need. Any conditions imposed on a certificate of need based on such statements of intent shall be stated on the face of the certificate of need.

~~1. Any certificate of need issued for construction of a new hospital or for the addition of beds to an existing hospital shall include a statement of the number of beds approved by category of service, including rehabilitation or psychiatric service, for which the agency has adopted by rule a specialty-bed-need methodology. All beds that are approved, but are not covered by any specialty-bed-need methodology, shall be designated as general.~~

(b)~~2.~~ The agency may consider, in addition to the other criteria specified in s. 408.035, a statement of intent 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

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1 of the Social Security Act. Any certificate of need issued to
2 a nursing home in reliance upon an applicant's statements that
3 ~~to provide~~ a specified percentage ~~number~~ of annual patient
4 days will be utilized ~~beds for use~~ by residents eligible for
5 care under Title XIX of the Social Security Act must include a
6 statement that such certification is a condition of issuance
7 of the certificate of need. The certificate-of-need program
8 shall notify the Medicaid program office and the Department of
9 Elderly Affairs when it imposes conditions as authorized in
10 this paragraph ~~subparagraph~~ in an area in which a community
11 diversion pilot project is implemented.
12 (c)~~(b)~~ A certificateholder may apply to the agency for
13 a modification of conditions imposed under paragraph (a) or
14 paragraph (b). If the holder of a certificate of need
15 demonstrates good cause why the certificate should be
16 modified, the agency shall reissue the certificate of need
17 with such modifications as may be appropriate. The agency
18 shall by rule define the factors constituting good cause for
19 modification.
20 (d)~~(c)~~ If the holder of a certificate of need fails to
21 comply with a condition upon which the issuance of the
22 certificate was predicated, the agency may assess an
23 administrative fine against the certificateholder in an amount
24 not to exceed $1,000 per failure per day. In assessing the
25 penalty, the agency shall take into account as mitigation the
26 relative lack of severity of a particular failure. Proceeds
27 of such penalties shall be deposited in the Public Medical
28 Assistance Trust Fund.
29 (2)(a) Unless the applicant has commenced
30 construction, if the project provides for construction, unless
31 the applicant has incurred an enforceable capital expenditure

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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 ~~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 ~~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 20. 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 21. 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 responses to a request for proposal are due.

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1 (4) The procedures provided for under this section are
2 exempt from the batching cycle requirements and the public
3 hearing requirement of s. 408.039.
4 (5) The agency ~~department~~ may use the competitive
5 sealed proposal procedure for determining a certificate of
6 need for other types of health care facilities and services if
7 the agency ~~department~~ identifies an unmet health care need and
8 when funding in whole or in part for such health care
9 facilities or services is authorized by the Legislature.
10 Section 22. Subsection (7) of section 430.703, Florida
11 Statutes, is renumbered as subsection (8), and a new
12 subsection (7) is added to that section to read:
13 430.703 Definitions.--As used in this act, the term:
14 (7) "Other qualified provider" means an entity
15 licensed under chapter 400 that meets all the financial and
16 quality assurance requirements for a provider service network
17 as specified in s. 409.912 and can demonstrate a long-term
18 care continuum.
19 Section 23. Subsection (1) of section 430.707, Florida
20 Statutes, is amended to read:
21 430.707 Contracts.--
22 (1) The department, in consultation with the agency,
23 shall select and contract with managed care organizations and
24 with other qualified providers to provide long-term care
25 within community diversion pilot project areas. Other
26 qualified providers are exempt from all licensure and
27 authorization requirements under the Florida Insurance Code
28 with respect to the provision of long term care under a
29 contract with the department.
30
31

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Section 24. (1)(a) There is created a certificate-of-need workgroup staffed by the Agency for Health Care Administration.

(b) Workgroup participants shall be responsible for only the expenses that they generate individually through workgroup participation. The agency shall be responsible for expenses incidental to the production of any required data or reports.

(2) The workgroup shall consist of 30 members, 10 appointed by the Governor, 10 appointed by the President of the Senate, and 10 appointed by the Speaker of the House of Representatives. The workgroup chairperson shall be selected by majority vote of a quorum present. Sixteen members shall constitute a quorum. The membership shall include, but not be limited to, representatives from health care provider organizations, health care facilities, individual health care practitioners, local health councils, and consumer organizations, and persons with health care market expertise as a private-sector consultant.

(3) Appointment to the workgroup shall be as follows:

(a) The Governor shall appoint one representative each from the hospital industry; nursing home industry; hospice industry; local health councils; a consumer organization; and three health care market consultants, one of whom is a recognized expert on hospital markets, one of whom is a recognized expert on nursing home or long-term-care markets, and one of whom is a recognized expert on hospice markets; one representative from the Medicaid program; and one representative from a health care facility that provides a tertiary service.

1 (b) The President of the Senate shall appoint a
2 representative of a for-profit hospital, a representative of a
3 not-for-profit hospital, a representative of a public
4 hospital, two representatives of the nursing home industry,
5 two representatives of the hospice industry, a representative
6 of a consumer organization, a representative from the
7 Department of Elderly Affairs involved with the implementation
8 of a long-term-care community diversion program, and a health
9 care market consultant with expertise in health care
10 economics.
11 (c) The Speaker of the House of Representatives shall
12 appoint a representative from the Florida Hospital
13 Association, a representative of the Association of Community
14 Hospitals and Health Systems of Florida, a representative of
15 the Florida League of Health Systems, a representative of the
16 Florida Health Care Association, a representative of the
17 Florida Association of Homes for the Aging, three
18 representatives of Florida Hospices and Palliative Care, one
19 representative of local health councils, and one
20 representative of a consumer organization.
21 (4) The workgroup shall study issues pertaining to the
22 certificate-of-need program, including the impact of trends in
23 health care delivery and financing. The workgroup shall study
24 issues relating to implementation of the certificate-of-need
25 program.
26 (5) The workgroup shall meet at least annually, at the
27 request of the chairperson. The workgroup shall submit an
28 interim report by December 31, 2001, and a final report by
29 December 31, 2002. The workgroup is abolished effective July
30 1, 2003.
31

1 Section 25. Subsection (7) of section 651.118, Florida
2 Statutes, is amended to read:
3 651.118 Agency for Health Care Administration;
4 certificates of need; sheltered beds; community beds.--
5 (7) Notwithstanding the provisions of subsection (2),
6 at the discretion of the continuing care provider, sheltered
7 nursing home beds may be used for persons who are not
8 residents of the facility and who are not parties to a
9 continuing care contract for a period of up to 5 years after
10 the date of issuance of the initial nursing home license. A
11 provider whose 5-year period has expired or is expiring may
12 request the Agency for Health Care Administration for an
13 extension, not to exceed 30 percent of the total sheltered
14 nursing home beds, if the utilization by residents of the
15 facility in the sheltered beds will not generate sufficient
16 income to cover facility expenses, as evidenced by one of the
17 following:
18 (a) The facility has a net loss for the most recent
19 fiscal year as determined under generally accepted accounting
20 principles, excluding the effects of extraordinary or unusual
21 items, as demonstrated in the most recently audited financial
22 statement; or
23 (b) The facility would have had a pro forma loss for
24 the most recent fiscal year, excluding the effects of
25 extraordinary or unusual items, if revenues were reduced by
26 the amount of revenues from persons in sheltered beds who were
27 not residents, as reported on by a certified public
28 accountant.
29
30 The agency shall be authorized to grant an extension to the
31 provider based on the evidence required in this subsection.

1 The agency may request a facility to use up to 25 percent of
2 the patient days generated by new admissions of nonresidents
3 during the extension period to serve Medicaid recipients for
4 those beds authorized for extended use if there is a
5 demonstrated need in the respective service area and if funds
6 are available. A provider who obtains an extension is
7 prohibited from applying for additional sheltered beds under
8 the provision of subsection (2), unless additional residential
9 units are built or the provider can demonstrate need by
10 facility residents to the Agency for Health Care
11 Administration. The 5-year limit does not apply to up to five
12 sheltered beds designated for inpatient hospice care as part
13 of a contractual arrangement with a hospice licensed under
14 part VI of chapter 400. A facility that uses such beds after
15 the 5-year period shall report such use to the Agency for
16 Health Care Administration.For purposes of this subsection,
17 "resident" means a person who, upon admission to the facility,
18 initially resides in a part of the facility not licensed under
19 part II of chapter 400.
20 Section 26. Subsection (3) of section 400.464, Florida
21 Statutes, is repealed.
22 Section 27. Applications for certificates of need
23 submitted under section 408.031-408.045, Florida Statutes,
24 before the effective date of this act shall be governed by the
25 law in effect at the time the application was submitted.
26 Section 28. The General Appropriations Act for Fiscal
27 Year 2000-2001 shall be reduced by 4 FTE and $260,719 from the
28 Health Care Trust Fund in the Agency for Health Care
29 Administration for purposes of implementing the provisions of
30 sections 10 through 25 of this act.
31

1 Section 29. Subsection (12) is added to section
2 216.136, Florida Statutes, to read:
3 216.136 Consensus estimating conferences; duties and
4 principals.--
5 (12) MANDATED HEALTH INSURANCE BENEFITS AND PROVIDERS
6 ESTIMATING CONFERENCE.--
7 (a) Duties.--The Mandated Health Insurance Benefits
8 and Providers Estimating Conference shall:
9 1. Develop and maintain, with the Department of
10 Insurance, a system and program of data collection to assess
11 the impact of mandated benefits and providers, including costs
12 to employers and insurers, impact of treatment, cost savings
13 in the health care system, number of providers, and other
14 appropriate data.
15 2. Prescribe the format, content, and timing of
16 information that is to be submitted to the conference and used
17 by the conference in its assessment of proposed and existing
18 mandated benefits and providers. Such format, content, and
19 timing requirements are binding upon all parties submitting
20 information for the conference to use in its assessment of
21 proposed and existing mandated benefits and providers.
22 3. Provide assessments of proposed and existing
23 mandated benefits and providers and other studies of mandated
24 benefits and provider issues as requested by the Legislature
25 or the Governor. When a legislative measure containing a
26 mandated health insurance benefit or provider is proposed, the
27 standing committee of the Legislature which has jurisdiction
28 over the proposal shall request that the conference prepare
29 and forward to the Governor and the Legislature a study that
30 provides, for each measure, a cost-benefit analysis that
31 assesses the social and financial impact and the medical

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1 efficacy according to prevailing medical standards of the
2 proposed mandate. The conference has 12 months after the
3 committee makes its request in which to complete and submit
4 the conference's report. The standing committee may not
5 consider such a proposed legislative measure until 12 months
6 after it has requested the report and has received the
7 conference's report on the measure.
8 4. The standing committees of the Legislature which
9 have jurisdiction over health insurance matters shall request
10 that the conference assess the social and financial impact and
11 the medical efficacy of existing mandated benefits and
12 providers. The committees shall submit to the conference by
13 January 1, 2001, a schedule of evaluations that sets forth the
14 respective dates by which the conference must have completed
15 its evaluations of particular existing mandates.
16 (b) Principals.--The Executive Office of the Governor,
17 the Insurance Commissioner, the Agency for Health Care
18 Administration, the Director of the Division of Economic and
19 Demographic Research of the Joint Legislative Management
20 Committee, and professional staff of the Senate and the House
21 of Representatives who have health insurance expertise, or
22 their designees, are the principals of the Mandated Health
23 Insurance Benefits and Providers Estimating Conference. The
24 responsibility of presiding over sessions of the conference
25 shall be rotated among the principals.
26 Section 30. Section 624.215, Florida Statutes, is
27 amended to read:
28 624.215 Proposals for legislation which mandates
29 health benefit coverage; review by Legislature.--
30 (1) LEGISLATIVE INTENT.--The Legislature finds that
31 there is an increasing number of proposals which mandate that

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1 certain health benefits be provided by insurers and health
2 maintenance organizations as components of individual and
3 group policies. The Legislature further finds that many of
4 these benefits provide beneficial social and health
5 consequences which may be in the public interest. However,
6 the Legislature also recognizes that most mandated benefits
7 contribute to the increasing cost of health insurance
8 premiums. Therefore, it is the intent of the Legislature to
9 conduct a systematic review of current and proposed mandated
10 or mandatorily offered health coverages and to establish
11 guidelines for such a review. This review will assist the
12 Legislature in determining whether mandating a particular
13 coverage is in the public interest.
14 (2) MANDATED HEALTH COVERAGE; REPORT TO THE MANDATED
15 HEALTH INSURANCE BENEFITS AND PROVIDERS ESTIMATING CONFERENCE
16 ~~AGENCY FOR HEALTH CARE ADMINISTRATION AND LEGISLATIVE~~
17 ~~COMMITTEES~~; GUIDELINES FOR ASSESSING IMPACT.--Every person or
18 organization seeking consideration of a legislative proposal
19 which would mandate a health coverage or the offering of a
20 health coverage by an insurance carrier, health care service
21 contractor, or health maintenance organization as a component
22 of individual or group policies, shall submit to the Mandated
23 Health Insurance Benefits and Providers Estimating Conference
24 ~~Agency for Health Care Administration and the legislative~~
25 ~~committees having jurisdiction~~ a report which assesses the
26 social and financial impacts of the proposed coverage.
27 Guidelines for assessing the impact of a proposed mandated or
28 mandatorily offered health coverage must, to the extent that
29 information is available, ~~shall~~ include:
30 (a) To what extent is the treatment or service
31 generally used by a significant portion of the population.

(b) To what extent is the insurance coverage generally available.

(c) If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.

(d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.

(e) The level of public demand for the treatment or service.

(f) The level of public demand for insurance coverage of the treatment or service.

(g) The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.

(h) A report of the extent to which ~~To what extent will~~ the coverage will increase or decrease the cost of the treatment or service.

(i) A report of the extent to which ~~To what extent will~~ the coverage will increase the appropriate uses of the treatment or service.

(j) A report of the extent to which ~~To what extent will~~ the mandated treatment or service will be a substitute for a more expensive treatment or service.

(k) A report of the extent to which ~~To what extent will~~ the coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

(l) A report as to the impact of this coverage on the total cost of health care.

1 The reports required in paragraphs (h) through (l) shall be
2 reviewed by the Mandated Health Insurance Benefits and
3 Providers Estimating Conference using a certified actuary. The
4 standing committee of the Legislature which has jurisdiction
5 over the legislative proposal must request and receive a
6 report from the Mandated Health Insurance Benefits and
7 Providers Estimating Conference before the committee considers
8 the proposal. The committee may not consider a legislative
9 proposal that would mandate a health coverage or the offering
10 of a health coverage by an insurance carrier, health care
11 service contractor, or health maintenance organization until
12 after the committee's request to the Mandated Health Insurance
13 Benefits and Providers Estimating Conference has been
14 answered. As used in this section, the term "health coverage
15 mandate" includes mandating the use of a type of provider.
16 Section 31. Effective January 1, 2001, a physician
17 licensed under chapter 458, Florida Statutes, or chapter 459,
18 Florida Statutes, or a hospital licensed under chapter 395,
19 Florida Statutes, shall provide a consumer-assistance notice
20 in the form of a sign that is prominently displayed in the
21 reception area and clearly noticeable by all patients and in
22 the form of a written statement that is given to each person
23 to whom medical services are being provided. Such a sign or
24 statement must state that consumer information regarding a
25 doctor, hospital, or health plan is available through a
26 toll-free number and website maintained by the Agency for
27 Health Care Administration. In addition, the sign and
28 statement must state that any complaint regarding medical
29 services received or the patient's health plan may be
30 submitted through the toll-free number. The agency, in
31 cooperation with other appropriate agencies, shall establish

1 the consumer-assistance program and provide physicians and
2 hospitals with information regarding the toll-free number and
3 website and with signs for posting in facilities at no cost to
4 the provider.
5 Section 32. Subsection (1) of section 408.7056,
6 Florida Statutes, is amended to read:
7 408.7056 Statewide Provider and Subscriber Assistance
8 Program.--
9 (1) As used in this section, the term:
10 (a) "Agency" means the Agency for Health Care
11 Administration.
12 (b) "Department" means the Department of Insurance.
13 (c) "Grievance procedure" means an established set of
14 rules that specify a process for appeal of an organizational
15 decision.
16 (d) "Health care provider" or "provider" means a
17 state-licensed or state-authorized facility, a facility
18 principally supported by a local government or by funds from a
19 charitable organization that holds a current exemption from
20 federal income tax under s. 501(c)(3) of the Internal Revenue
21 Code, a licensed practitioner, a county health department
22 established under part I of chapter 154, a prescribed
23 pediatric extended care center defined in s. 400.902, a
24 federally supported primary care program such as a migrant
25 health center or a community health center authorized under s.
26 329 or s. 330 of the United States Public Health Services Act
27 that delivers health care services to individuals, or a
28 community facility that receives funds from the state under
29 the Community Alcohol, Drug Abuse, and Mental Health Services
30 Act and provides mental health services to individuals.
31

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1 (e)~~(a)~~ "Managed care entity" means a health
2 maintenance organization or a prepaid health clinic certified
3 under chapter 641, a prepaid health plan authorized under s.
4 409.912, or an exclusive provider organization certified under
5 s. 627.6472.
6 (f)~~(b)~~ "Panel" means a statewide provider and
7 subscriber assistance panel selected as provided in subsection
8 (11).
9 Section 33. Section 627.654, Florida Statutes, is
10 amended to read:
11 627.654 Labor union, ~~and~~ association, and small
12 employer health alliance groups.--
13 (1)(a) A group of individuals may be insured under a
14 policy issued to an association, including a labor union,
15 which association has a constitution and bylaws and not less
16 than 25 individual members and which has been organized and
17 has been maintained in good faith for a period of 1 year for
18 purposes other than that of obtaining insurance, or to the
19 trustees of a fund established by such an association, which
20 association or trustees shall be deemed the policyholder,
21 insuring at least 15 individual members of the association for
22 the benefit of persons other than the officers of the
23 association, the association or trustees.
24 (b) A small employer, as defined in s. 627.6699 and
25 including the employer's eligible employees and the spouses
26 and dependents of such employees, may be insured under a
27 policy issued to a small employer health alliance by a carrier
28 as defined in s. 627.6699. A small employer health alliance
29 must be organized as a not-for-profit corporation under
30 chapter 617. Notwithstanding any other law, if a
31 small-employer member of an alliance loses eligibility to

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1 purchase health care through the alliance solely because the
2 business of the small-employer member expands to more than 50
3 and fewer than 75 eligible employees, the small-employer
4 member may, at its next renewal date, purchase coverage
5 through the alliance for not more than 1 additional year. A
6 small employer health alliance shall establish conditions of
7 participation in the alliance by a small employer, including,
8 but not limited to:
9 1. Assurance that the small employer is not formed for
10 the purpose of securing health benefit coverage.
11 2. Assurance that the employees of a small employer
12 have not been added for the purpose of securing health benefit
13 coverage.
14 (2) No such policy of insurance as defined in
15 subsection (1) may be issued to any such association or
16 alliance, unless all individual members of such association,
17 or all small-employer members of an alliance, or all of any
18 class or classes thereof, are declared eligible and acceptable
19 to the insurer at the time of issuance of the policy.
20 (3) Any such policy issued under paragraph (1)(a)may
21 insure the spouse or dependent children with or without the
22 member being insured.
23 (4) A single master policy issued to an association,
24 labor union, or small-employer health alliance may include
25 more than one health plan from the same insurer or affiliated
26 insurer group as alternatives for an employer, employee, or
27 member to select.
28 Section 34. Paragraph (f) of subsection (2), paragraph
29 (b) of subsection (4), and subsection (6) of section 627.6571,
30 Florida Statutes, are amended to read:
31 627.6571 Guaranteed renewability of coverage.--

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1 (2) An insurer may nonrenew or discontinue a group
2 health insurance policy based only on one or more of the
3 following conditions:
4 (f) In the case of health insurance coverage that is
5 made available only through one or more bona fide associations
6 as defined in subsection (5) or through one or more small
7 employer health alliances as described in s. 627.654(1)(b),
8 the membership of an employer in the association or in the
9 small employer health alliance, on the basis of which the
10 coverage is provided, ceases, but only if such coverage is
11 terminated under this paragraph uniformly without regard to
12 any health-status-related factor that relates to any covered
13 individuals.
14 (4) At the time of coverage renewal, an insurer may
15 modify the health insurance coverage for a product offered:
16 (b) In the small-group market if, for coverage that is
17 available in such market other than only through one or more
18 bona fide associations as defined in subsection (5) or through
19 one or more small employer health alliances as described in s.
20 627.654(1)(b), such modification is consistent with s.
21 627.6699 and effective on a uniform basis among group health
22 plans with that product.
23 (6) In applying this section in the case of health
24 insurance coverage that is made available by an insurer in the
25 small-group market or large-group market to employers only
26 through one or more associations or through one or more small
27 employer health alliances as described in s. 627.654(1)(b), a
28 reference to "policyholder" is deemed, with respect to
29 coverage provided to an employer member of the association, to
30 include a reference to such employer.
31

1 Section 35. Paragraph (h) of subsection (5), and
2 paragraph (a) of subsection (12) of section 627.6699, Florida
3 Statutes, are amended to read:
4 627.6699 Employee Health Care Access Act.--
5 (5) AVAILABILITY OF COVERAGE.--
6 (h) All health benefit plans issued under this section
7 must comply with the following conditions:
8 1. For employers who have fewer than two employees, a
9 late enrollee may be excluded from coverage for no longer than
10 24 months if he or she was not covered by creditable coverage
11 continually to a date not more than 63 days before the
12 effective date of his or her new coverage.
13 2. Any requirement used by a small employer carrier in
14 determining whether to provide coverage to a small employer
15 group, including requirements for minimum participation of
16 eligible employees and minimum employer contributions, must be
17 applied uniformly among all small employer groups having the
18 same number of eligible employees applying for coverage or
19 receiving coverage from the small employer carrier, except
20 that a small employer carrier that participates in,
21 administers, or issues health benefits pursuant to s. 381.0406
22 which do not include a preexisting condition exclusion may
23 require as a condition of offering such benefits that the
24 employer has had no health insurance coverage for its
25 employees for a period of at least 6 months. A small employer
26 carrier may vary application of minimum participation
27 requirements and minimum employer contribution requirements
28 only by the size of the small employer group.
29 3. In applying minimum participation requirements with
30 respect to a small employer, a small employer carrier shall
31 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 requirements that are applicable to the new group size.

5. If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

6. A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

7. An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

1 (12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT
2 PLANS.--
3 (a)1. By May 15, 1993, the commissioner shall appoint
4 a health benefit plan committee composed of four
5 representatives of carriers which shall include at least two
6 representatives of HMOs, at least one of which is a staff
7 model HMO, two representatives of agents, four representatives
8 of small employers, and one employee of a small employer. The
9 carrier members shall be selected from a list of individuals
10 recommended by the board. The commissioner may require the
11 board to submit additional recommendations of individuals for
12 appointment. ~~As alliances are established under s. 408.702,~~
13 ~~each alliance shall also appoint an additional member to the~~
14 ~~committee.~~
15 2. The committee shall develop changes to the form and
16 level of coverages for the standard health benefit plan and
17 the basic health benefit plan, and shall submit the forms, and
18 levels of coverages to the department by September 30, 1993.
19 The department must approve such forms and levels of coverages
20 by November 30, 1993, and may return the submissions to the
21 committee for modification on a schedule that allows the
22 department to grant final approval by November 30, 1993.
23 3. The plans shall comply with all of the requirements
24 of this subsection.
25 4. The plans must be filed with and approved by the
26 department prior to issuance or delivery by any small employer
27 carrier.
28 5. After approval of the revised health benefit plans,
29 if the department determines that modifications to a plan
30 might be appropriate, the commissioner shall appoint a new
31 health benefit plan committee in the manner provided in

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subparagraph 1. to submit recommended modifications to the department for approval.

Section 36. Subsection (1) of section 240.2995, Florida Statutes, is amended to read:

240.2995 University health services support organizations.--

(1) Each state university is authorized to establish university health services support organizations which shall have the ability to enter into, for the benefit of the university academic health sciences center, and arrangements with other entities as providers ~~for accountable health partnerships, as defined in s. 408.701, and providers~~ in other integrated health care systems or similar entities. To the extent required by law or rule, university health services support organizations shall become licensed as insurance companies, pursuant to chapter 624, or be certified as health maintenance organizations, pursuant to chapter 641. University health services support organizations shall have sole responsibility for the acts, debts, liabilities, and obligations of the organization. In no case shall the state or university have any responsibility for such acts, debts, liabilities, and obligations incurred or assumed by university health services support organizations.

Section 37. 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:

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(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 38. Paragraph (b) of subsection (8) of section 240.512, Florida Statutes, is amended to read:

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1 240.512 H. Lee Moffitt Cancer Center and Research
2 Institute.--There is established the H. Lee Moffitt Cancer
3 Center and Research Institute at the University of South
4 Florida.
5 (8)
6 (b) Proprietary confidential business information is
7 confidential and exempt from the provisions of s. 119.07(1)
8 and s. 24(a), Art. I of the State Constitution. However, the
9 Auditor General and Board of Regents, pursuant to their
10 oversight and auditing functions, must be given access to all
11 proprietary confidential business information upon request and
12 without subpoena and must maintain the confidentiality of
13 information so received. As used in this paragraph, the term
14 "proprietary confidential business information" means
15 information, regardless of its form or characteristics, which
16 is owned or controlled by the not-for-profit corporation or
17 its subsidiaries; is intended to be and is treated by the
18 not-for-profit corporation or its subsidiaries as private and
19 the disclosure of which would harm the business operations of
20 the not-for-profit corporation or its subsidiaries; has not
21 been intentionally disclosed by the corporation or its
22 subsidiaries unless pursuant to law, an order of a court or
23 administrative body, a legislative proceeding pursuant to s.
24 5, Art. III of the State Constitution, or a private agreement
25 that provides that the information may be released to the
26 public; and which is information concerning:
27 1. Internal auditing controls and reports of internal
28 auditors;
29 2. Matters reasonably encompassed in privileged
30 attorney-client communications;
31

1 3. Contracts for managed-care arrangements~~, as managed~~
2 ~~care is defined in s. 408.701,~~including preferred provider
3 organization contracts, health maintenance organization
4 contracts, and exclusive provider organization contracts, and
5 any documents directly relating to the negotiation,
6 performance, and implementation of any such contracts for
7 managed-care arrangements;
8 4. Bids or other contractual data, banking records,
9 and credit agreements the disclosure of which would impair the
10 efforts of the not-for-profit corporation or its subsidiaries
11 to contract for goods or services on favorable terms;
12 5. Information relating to private contractual data,
13 the disclosure of which would impair the competitive interest
14 of the provider of the information;
15 6. Corporate officer and employee personnel
16 information;
17 7. Information relating to the proceedings and records
18 of credentialing panels and committees and of the governing
19 board of the not-for-profit corporation or its subsidiaries
20 relating to credentialing;
21 8. Minutes of meetings of the governing board of the
22 not-for-profit corporation and its subsidiaries, except
23 minutes of meetings open to the public pursuant to subsection
24 (9);
25 9. Information that reveals plans for marketing
26 services that the corporation or its subsidiaries reasonably
27 expect to be provided by competitors;
28 10. Trade secrets as defined in s. 688.002, including
29 reimbursement methodologies or rates; or
30 11. The identity of donors or prospective donors of
31 property who wish to remain anonymous or any information

identifying such donors or prospective donors. The anonymity of these donors or prospective donors must be maintained in the auditor's report.

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.

Section 39. Subsection (14) of section 381.0406, Florida Statutes, is amended to read:

381.0406 Rural health networks.--

(14) NETWORK FINANCING.--Networks may use all sources of public and private funds to support network activities. Nothing in this section prohibits networks from becoming managed care providers~~, or accountable health partnerships, provided they meet the requirements for an accountable health partnership as specified in s. 408.706~~.

Section 40. Paragraph (a) of subsection (2) of section 395.3035, Florida Statutes, is amended to read:

395.3035 Confidentiality of hospital records and meetings.--

(2) The following records and information of any hospital that is subject to chapter 119 and s. 24(a), Art. I of the State Constitution 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 public hospital provides health care services, including preferred provider organization contracts, health maintenance organization contracts, exclusive provider organization contracts, and alliance network arrangements, and any documents directly relating to the negotiation, performance, and implementation of any such contracts for managed care 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.

Section 41. Paragraph (b) of subsection (1) of section 627.4301, Florida Statutes, is amended to read:

627.4301 Genetic information for insurance purposes.--

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

1 (b) "Health insurer" means an authorized insurer
2 offering health insurance as defined in s. 624.603, a
3 self-insured plan as defined in s. 624.031, a
4 multiple-employer welfare arrangement as defined in s.
5 624.437, a prepaid limited health service organization as
6 defined in s. 636.003, a health maintenance organization as
7 defined in s. 641.19, a prepaid health clinic as defined in s.
8 641.402, a fraternal benefit society as defined in s. 632.601,
9 ~~an accountable health partnership as defined in s. 408.701,~~ or
10 any health care arrangement whereby risk is assumed.
11 Section 42. Subsection (3) of section 408.70, and
12 sections 408.701, 408.702, 408.703, 408.704, 408.7041,
13 408.7042, 408.7045, 408.7055, and 408.706, Florida Statutes,
14 are repealed.
15 Section 43. Paragraph (n) of subsection (3), paragraph
16 (c) of subsection (5), and paragraphs (b) and (d) of
17 subsection (6) of section 627.6699, Florida Statutes, are
18 amended to read:
19 627.6699 Employee Health Care Access Act.--
20 (3) DEFINITIONS.--As used in this section, the term:
21 (n) "Modified community rating" means a method used to
22 develop carrier premiums which spreads financial risk across a
23 large population and allows adjustments for age, gender,
24 family composition, tobacco usage, and geographic area as
25 determined under paragraph (5)(j); claims experience, health
26 status, or duration of coverage as permitted under
27 subparagraph (6)(b)5.; and administrative and acquisition
28 expenses as permitted under subparagraph (6)(b)6.
29 (5) AVAILABILITY OF COVERAGE.--
30 (c) Every small employer carrier must, as a condition
31 of transacting business in this state:

1 1. Beginning July 1, 2000,~~January 1, 1994,~~offer and
2 issue all small employer health benefit plans on a
3 guaranteed-issue basis to every eligible small employer, with
4 2 ~~3~~ to 50 eligible employees, that elects to be covered under
5 such plan, agrees to make the required premium payments, and
6 satisfies the other provisions of the plan. A rider for
7 additional or increased benefits may be medically underwritten
8 and may only be added to the standard health benefit plan.
9 The increased rate charged for the additional or increased
10 benefit must be rated in accordance with this section.
11 2. Beginning July 1, 2000, and until July 31, 2001,
12 offer and issue basic and standard small employer health
13 benefit plans on a guaranteed-issue basis to every eligible
14 small employer which is eligible for guaranteed renewal, has
15 less than two eligible employees, is not formed primarily for
16 the purpose of buying health insurance, elects to be covered
17 under such plan, agrees to make the required premium payments,
18 and satisfies the other provisions of the plan. A rider for
19 additional or increased benefits may be medically underwritten
20 and may be added only to the standard benefit plan. The
21 increased rate charged for the additional or increased benefit
22 must be rated in accordance with this section. For purposes of
23 this subparagraph, a person, his or her spouse, and his or her
24 dependent children shall constitute a single eligible employee
25 if that person and spouse are employed by the same small
26 employer and either one has a normal work week of less than 25
27 hours.
28 3.~~2.~~ Beginning August 1, 2001 ~~April 15, 1994~~, offer
29 and issue basic and standard small employer health benefit
30 plans on a guaranteed-issue basis, during a 31-day open
31 enrollment period of August 1 through August 31 of each year,

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1 to every eligible small employer, with less than ~~one or~~ two
2 eligible employees, which small employer is not formed
3 primarily for the purpose of buying health insurance and which
4 elects to be covered under such plan, agrees to make the
5 required premium payments, and satisfies the other provisions
6 of the plan. Coverage provided under this subparagraph shall
7 begin on October 1 of the same year as the date of enrollment,
8 unless the small employer carrier and the small employer agree
9 to a different date.A rider for additional or increased
10 benefits may be medically underwritten and may only be added
11 to the standard health benefit plan. The increased rate
12 charged for the additional or increased benefit must be rated
13 in accordance with this section. For purposes of this
14 subparagraph, a person, his or her spouse, and his or her
15 dependent children constitute a single eligible employee if
16 that person and spouse are employed by the same small employer
17 and either that person or his or her spouse has a normal work
18 week of less than 25 hours.
19 4. ~~3. Offer to eligible small employers the standard~~
20 ~~and basic health benefit plans.~~ This paragraph ~~subparagraph~~
21 does not limit a carrier's ability to offer other health
22 benefit plans to small employers if the standard and basic
23 health benefit plans are offered and rejected.
24 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
25 (b) For all small employer health benefit plans that
26 are subject to this section and are issued by small employer
27 carriers on or after January 1, 1994, premium rates for health
28 benefit plans subject to this section are subject to the
29 following:
30 1. Small employer carriers must use a modified
31 community rating methodology in which the premium for each

1 small employer must be determined solely on the basis of the
2 eligible employee's and eligible dependent's gender, age,
3 family composition, tobacco use, or geographic area as
4 determined under paragraph (5)(j) and in which the premium may
5 be adjusted as permitted by subparagraphs 5. and 6.
6 2. Rating factors related to age, gender, family
7 composition, tobacco use, or geographic location may be
8 developed by each carrier to reflect the carrier's experience.
9 The factors used by carriers are subject to department review
10 and approval.
11 3. Small employer carriers may not modify the rate for
12 a small employer for 12 months from the initial issue date or
13 renewal date, unless the composition of the group changes or
14 benefits are changed. However, a small employer carrier may
15 modify the rate one time prior to 12 months after the initial
16 issue date for a small employer who enrolls under a previously
17 issued group policy that has a common anniversary date for all
18 employers covered under the policy if:
19 a. The carrier discloses to the employer in a clear
20 and conspicuous manner the date of the first renewal and the
21 fact that the premium may increase on or after that date.
22 b. The insurer demonstrates to the department that
23 efficiencies in administration are achieved and reflected in
24 the rates charged to small employers covered under the policy.
25 4. A carrier may issue a group health insurance policy
26 to a small employer health alliance or other group association
27 with rates that reflect a premium credit for expense savings
28 attributable to administrative activities being performed by
29 the alliance or group association if such expense savings are
30 specifically documented in the insurer's rate filing and are
31 approved by the department. Any such credit may not be based

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1 on different morbidity assumptions or on any other factor
2 related to the health status or claims experience of any
3 person covered under the policy. Nothing in this subparagraph
4 exempts an alliance or group association from licensure for
5 any activities that require licensure under the Insurance
6 Code. A carrier issuing a group health insurance policy to a
7 small-employer health alliance or other group association
8 shall allow any properly licensed and appointed agent of that
9 carrier to market and sell the small-employer health alliance
10 or other group association policy. Such agent shall be paid
11 the usual and customary commission paid to any agent selling
12 the policy.~~Carriers participating in the alliance program, in~~
13 ~~accordance with ss. 408.70-408.706, may apply a different~~
14 ~~community rate to business written in that program.~~
15 5. Any adjustments in rates for claims experience,
16 health status, or duration of coverage may not be charged to
17 individual employees or dependents. For a small employer's
18 policy, such adjustments may not result in a rate for the
19 small employer which deviates more than 15 percent from the
20 carrier's approved rate. Any such adjustment must be applied
21 uniformly to the rates charged for all employees and
22 dependents of the small employer. A small employer carrier may
23 make an adjustment to a small employer's renewal premium, not
24 to exceed 10 percent annually, due to the claims experience,
25 health status, or duration of coverage of the employees or
26 dependents of the small employer. Semiannually small group
27 carriers shall report information on forms adopted by rule by
28 the department to enable the department to monitor the
29 relationship of aggregate adjusted premiums actually charged
30 policyholders by each carrier to the premiums that would have
31 been charged by application of the carrier's approved modified

1 community rates. If the aggregate resulting from the
2 application of such adjustment exceeds the premium that would
3 have been charged by application of the approved modified
4 community rate by 5 percent for the current reporting period,
5 the carrier shall limit the application of such adjustments
6 only to minus adjustments beginning not more than 60 days
7 after the report is sent to the department. For any subsequent
8 reporting period, if the total aggregate adjusted premium
9 actually charged does not exceed the premium that would have
10 been charged by application of the approved modified community
11 rate by 5 percent, the carrier may apply both plus and minus
12 adjustments. A small employer carrier may provide a credit to
13 a 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 6. 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 7. 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

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1 the impact of the rating factors for age and gender in the
2 premiums charged to all of the employees of a small employer.
3 (d) Notwithstanding s. 627.401(2), this section and
4 ss. 627.410 and 627.411 apply to any health benefit plan
5 provided by a small employer carrier that is an insurer, and
6 this section and s. 641.31 apply to any health benefit
7 provided by a small employer carrier that is a health
8 maintenance organization that provides coverage to one or more
9 employees of a small employer regardless of where the policy,
10 certificate, or contract is issued or delivered, if the health
11 benefit plan covers employees or their covered dependents who
12 are residents of this state.
13 Section 44. Section 641.201, Florida Statutes, is
14 amended to read:
15 641.201 Applicability of other laws.--Except as
16 provided in this part, health maintenance organizations shall
17 be governed by the provisions of this part and part III of
18 this chapter and shall be exempt from all other provisions of
19 the Florida Insurance Code except those provisions of the
20 Florida Insurance Code that are explicitly made applicable to
21 health maintenance organizations.
22 Section 45. Section 641.234, Florida Statutes, is
23 amended to read:
24 641.234 Administrative, provider, and management
25 contracts.--
26 (1) The department may require a health maintenance
27 organization to submit any contract for administrative
28 services, contract with a provider other than an individual
29 physician, contract for management services, and contract with
30 an affiliated entity to the department.
31

(2) After review of a contract the department may order the health maintenance organization to cancel the contract in accordance with the terms of the contract and applicable law if it determines:

(a) That the fees to be paid by the health maintenance organization under the contract are so unreasonably high as compared with similar contracts entered into by the health maintenance organization or as compared with similar contracts entered into by other health maintenance organizations in similar circumstances that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the health maintenance organization; or~~.~~

(b) That the contract is with an entity that is not licensed under state statutes, if such license is required, or is not in good standing with the applicable regulatory agency.

(3) All contracts for administrative services, management services, provider services other than individual physician contracts, and with affiliated entities entered into or renewed by a health maintenance organization on or after October 1, 1988, shall contain a provision that the contract shall be canceled upon issuance of an order by the department pursuant to this section.

Section 46. Subsection (2) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department.--

(2) The department may contract, at reasonable fees for work performed, with qualified, impartial outside sources to perform audits or examinations or portions thereof pertaining to the qualification of an entity for issuance of a certificate of authority or to determine continued compliance with the requirements of this part, in which case the payment

1 must be made, directly to the contracted examiner by the
2 health maintenance organization examined, in accordance with
3 the rates and terms agreed to by the department and the
4 examiner. Any contracted assistance shall be under the direct
5 supervision of the department. The results of any contracted
6 assistance shall be subject to the review of, and approval,
7 disapproval, or modification by, the department.
8 Section 47. Section 641.226, Florida Statutes, is
9 created to read:
10 641.226 Application of federal solvency requirements
11 to provider-sponsored organizations.--The solvency
12 requirements of sections 1855 and 1856 of the Balanced Budget
13 Act of 1997 and rules adopted by the Secretary of the United
14 States Department of Health and Human Services apply to a
15 health maintenance organization that is a provider-sponsored
16 organization rather than the solvency requirements of this
17 part. However, if the provider-sponsored organization does not
18 meet the solvency requirements of this part, the organization
19 is limited to the issuance of Medicare+Choice plans to
20 eligible individuals. For the purposes of this section, the
21 terms "Medicare+Choice plans," "provider-sponsored
22 organizations," and "solvency requirements" have the same
23 meaning as defined in the federal act and federal rules and
24 regulations.
25 Section 48. Section 641.39, Florida Statutes, is
26 created to read:
27 641.39 Soliciting or accepting new or renewal health
28 maintenance contracts by insolvent or impaired health
29 maintenance organization prohibited; penalty.--
30 (1) Whether or not delinquency proceedings as to a
31 health maintenance organization have been or are to be

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1 initiated, a director or officer of a health maintenance
2 organization, except with the written permission of the
3 Department of Insurance, may not authorize or permit the
4 health maintenance organization to solicit or accept new or
5 renewal health maintenance contracts or provider contracts in
6 this state after the director or officer knew, or reasonably
7 should have known, that the health maintenance organization
8 was insolvent or impaired. As used in this section, the term
9 "impaired" means that the health maintenance organization does
10 not meet the requirements of s. 641.225.
11 (2) Any director or officer who violates this section
12 is guilty of a felony of the third degree, punishable as
13 provided in s. 775.082, s. 775.083, or s. 775.084.
14 Section 49. Section 641.2011, Florida Statutes, is
15 created to read:
16 641.2011 Insurance holding companies.--Part IV of
17 chapter 628 applies to health maintenance organizations
18 licensed under part I of chapter 641.
19 Section 50. Section 641.275, Florida Statutes, is
20 created to read:
21 641.275 Subscriber's rights under health maintenance
22 contracts; required notice.--
23 (1) It is the intent of the Legislature that the
24 rights of subscribers who are covered under health maintenance
25 organization contracts be recognized and summarized in a
26 statement of subscriber rights. An organization may not
27 require a subscriber to waive his or her rights as a condition
28 of coverage or treatment and must operate in conformity with
29 such rights.
30
31

1 (2) Each organization must provide subscribers with a
2 copy of their rights as set forth in this section, in such
3 form as approved by the department.
4 (3) An organization shall:
5 (a) Ensure that health care services provided to
6 subscribers are rendered under reasonable standards of quality
7 of care consistent with the prevailing standards of medical
8 practice in the community, as required by s. 641.51;
9 (b) Have a quality assurance program for health care
10 services, as required by s. 641.51;
11 (c) Not modify the professional judgment of a
12 physician unless the course of treatment is inconsistent with
13 the prevailing standards of medical practice in the community,
14 as required by s. 641.51;
15 (d) Not restrict a provider's ability to communicate
16 information to the subscriber/patient regarding medical care
17 options that are in the best interest of the
18 subscriber/patient, as required by s. 641.315(8);
19 (e) Provide for standing referrals to specialists for
20 subscribers with chronic and disabling conditions, as required
21 by s. 641.51;
22 (f) Allow a female subscriber to select an
23 obstetrician/gynecologist as her primary care physician, as
24 required by s. 641.19(13)(e);
25 (g) Provide direct access, without prior
26 authorization, for a female subscriber to visit a
27 obstetrician/gynecologist, as required by s. 641.51(10);
28 (h) Provide direct access, without prior
29 authorization, to a dermatologist, as required by s.
30 641.31(33);
31

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1 (i) Not limit coverage for the length of stay in a
2 hospital for a mastectomy for any time period that is less
3 than that determined to be medically necessary by the treating
4 physician, as required by s. 641.31(33);
5 (j) Not limit coverage for the length of a maternity
6 or newborn stay in a hospital or for follow-up care outside
7 the hospital to any time period less than that determined to
8 be medically necessary by the treating provider, as required
9 by s. 641.31(18);
10 (k) Not exclude coverage for bone marrow transplant
11 procedures determined by the Agency for Health Care
12 Administration to not be experimental, as required by s.
13 627.4236;
14 (l) Not exclude coverage for drugs on the ground that
15 the drug is not approved by the U.S. Food and Drug
16 Administration, as required by s. 627.4239;
17 (m) Give the subscriber the right to a second medical
18 opinion as required by s. 641.51(4);
19 (n) Allow subscribers to continue treatment from a
20 provider after the provider's contract with the organization
21 has been terminated, as required by s. 641.51(7);
22 (o) Establish a procedure for resolving subscriber
23 grievances, including review of adverse determinations by the
24 organization and expedited review of urgent subscriber
25 grievances, as required by s. 641.511;
26 (p) Notify subscribers of the right to an independent
27 external review of grievances not resolved by the
28 organization, as required by s. 408.7056;
29 (q) Provide, without prior authorization, coverage for
30 emergency services and care, as required by s. 641.513;
31

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1 (r) Not require or solicit genetic information or use
2 genetic test results for any insurance purposes, as required
3 by s. 627.4310;
4 (s) Promptly pay or deny claims as required by s.
5 641.3155;
6 (t) Provide information to subscribers regarding
7 benefits, limitations, resolving grievances, emergency
8 services and care, treatment by non-contract providers, list
9 of contract providers, authorization and referral process, the
10 process used to determine whether services are medically
11 necessary, quality assurance program, prescription drug
12 benefits and use of a drug formulary, confidentiality and
13 disclosure of medical records, process of determining
14 experimental or investigational medical treatments, and
15 process used to examine qualifications of contract providers,
16 as required by ss. 641.31, 641.495, and 641.54.
17 (4) The statement of rights in subsection (3) is a
18 summary of selected requirements for organizations contained
19 in other sections of the Florida Statutes. This section does
20 not alter the requirements of such other sections.
21 (5)(a) The department may impose a fine against a
22 health maintenance organization for a violation of this
23 section which refers to a section in this part or in chapter
24 627. Such fines shall be in the amounts specified in s.
25 641.25.
26 (b) The agency may impose a fine against a health
27 maintenance organization for a violation of this section which
28 refers to a section in part III of this chapter or in chapter
29 408. Such fines shall be in the amounts specified in s.
30 641.52.
31

1 Section 51. Section 641.28, Florida Statutes, is
2 amended to read:
3 641.28 Civil remedy.--
4 (1) In any civil action brought to enforce the terms
5 and conditions of a health maintenance organization contract:
6 (a) If the civil action is filed before or within 60
7 days after the subscriber or enrollee filed a notice of intent
8 to sue with the statewide provider and subscriber assistance
9 program established pursuant to s. 408.7056 or a notice
10 pursuant to s. 641.3917, the prevailing party is entitled to
11 recover reasonable attorney's fees and court costs.
12 (b) If the civil action is filed more than 60 days
13 after the subscriber or enrollee filed a notice of intent to
14 sue with the statewide provider and subscriber assistance
15 program established pursuant to s. 408.7056 or a notice
16 pursuant to s. 641.3917, and the subscriber or enrollee
17 receives a final judgment or decree against the health
18 maintenance organization in favor of the subscriber or
19 enrollee, the court shall enter a judgment or decree against
20 the health maintenance organization in favor of the subscriber
21 or enrollee for reasonable attorney's fees and court costs.
22 (2) This section shall not be construed to authorize a
23 civil action against the department, its employees, or the
24 Insurance Commissioner or against the Agency for Health Care
25 Administration, its employees, or the director of the agency.
26 Section 52. Paragraphs (c), (d), and (e) are added to
27 subsection (10) of section 641.3903, Florida Statutes, and
28 subsection (15) is added to that section, to read:
29 641.3903 Unfair methods of competition and unfair or
30 deceptive acts or practices defined.--The following are
31

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1 defined as unfair methods of competition and unfair or
2 deceptive acts or practices:
3 (10) ILLEGAL DEALINGS IN PREMIUMS; EXCESS OR REDUCED
4 CHARGES FOR HEALTH MAINTENANCE COVERAGE.--
5 (c) Cancelling or otherwise terminating any health
6 maintenance contract or coverage, or requiring execution of a
7 consent to rate endorsement, during the stated contract term
8 for the purpose of offering to issue, or issuing, a similar or
9 identical contract to the same subscriber or enrollee with the
10 same exposure at a higher premium rate or continuing an
11 existing contract with the same exposure at an increased
12 premium.
13 (d) Issuing a nonrenewal notice on any health
14 maintenance organization contract, or requiring execution of a
15 consent to rate endorsement, for the purpose of offering to
16 issue, or issuing, a similar or identical contract to the same
17 subscriber or enrollee at a higher premium rate or continuing
18 an existing contract at an increased premium without meeting
19 any applicable notice requirements.
20 (e) Cancelling or issuing a nonrenewal notice on any
21 health maintenance organization contract without complying
22 with any applicable cancellation or nonrenewal provision
23 required under the Florida Insurance Code.
24 (15) REFUSAL TO COVER.--In addition to other
25 provisions of this code, the refusal to cover, or continue to
26 cover, any individual solely because of:
27 (a) Race, color, creed, marital status, sex, or
28 national origin;
29 (b) The residence, age, or lawful occupation of the
30 individual, unless there is a reasonable relationship between
31

1 the residence, age, or lawful occupation of the individual and
2 the coverage issued or to be issued; or
3 (c) The fact that the enrollee or applicant had been
4 previously refused insurance coverage or health maintenance
5 organization coverage by any insurer or health maintenance
6 organization when such refusal to cover or continue to cover
7 for this reason occurs with such frequency as to indicate a
8 general business practice.
9 Section 53. Section 641.3917, Florida Statutes, is
10 amended to read:
11 641.3917 Civil liability.--The provisions of this part
12 are cumulative to rights under the general civil and common
13 law, and no action of the department shall abrogate such
14 rights to damage or other relief in any court.
15 (1) Any person to whom a duty is owed may bring a
16 civil action against a health maintenance organization when
17 such person suffers damages as a result of:
18 (a) A violation of s. 641.3903(5)(a), (b), (c)1.-7.,
19 (10), or (15) by the health maintenance organization; or
20 (b) The health maintenance organization's failure to
21 provide a covered service when in good faith the health
22 maintenance organization should have provided the service if
23 it had acted fairly and honestly toward its subscriber or
24 enrollee and with due regard for his or her interests and, in
25 the independent medical judgment of a contract treating
26 physician or other physician authorized by the health
27 maintenance organization, the service is medically necessary.
28
29 However, a person pursuing a remedy under this section need
30 not prove that such acts were committed or performed with such
31 frequency as to indicate a general business practice.

1 (2)(a) As a condition precedent to bringing an action
2 under this section, the department and the health maintenance
3 organization must have been given 60 days' written notice of
4 the violation. If the department returns a notice for lack of
5 specificity, the 60-day time period does not begin until a
6 proper notice is filed.
7 (b) The notice must be on a form provided by the
8 department and must state with specificity the following
9 information and such other information as the department
10 requires:
11 1. The provision of law, including the specific
12 language of the law, which the health maintenance organization
13 has allegedly violated.
14 2. The facts and circumstances giving rise to the
15 violation.
16 3. The name of any individual involved in the
17 violation.
18 4. Any reference to specific contract language that is
19 relevant to the violation.
20 5. A statement that the notice is given in order to
21 perfect the right to pursue the civil remedy authorized by
22 this section.
23 (c) Within 20 days after receipt of the notice, the
24 department may return any notice that does not provide the
25 specific information required by this section, and the
26 department shall indicate the specific deficiencies contained
27 in the notice. A determination by the department to return a
28 notice for lack of specificity is exempt from the requirements
29 of chapter 120.
30
31

1 (d) No action shall lie under this section if, within
2 60 days after filing notice, the damages are paid or the
3 circumstances giving rise to the violation are corrected.
4 (e) The health maintenance organization that is the
5 recipient of a notice filed under this section shall report to
6 the department on the disposition of the alleged violation.
7 (f) The applicable statute of limitations for an
8 action under this section shall be tolled for a period of 65
9 days by the mailing of the notice required by this subsection
10 or the mailing of a subsequent notice required by this
11 subsection.
12 (3) Upon adverse adjudication at trial or upon appeal,
13 the health maintenance organization is liable for damages,
14 together with court costs and reasonable attorney's fees,
15 incurred by the plaintiff.
16 (4) Punitive damages shall not be awarded under this
17 section unless the acts giving rise to the violation occur
18 with such frequency as to indicate a general business practice
19 and are either willful, wanton, and malicious or are in
20 reckless disregard for the rights of any subscriber or
21 enrollee. Any person who pursues a claim under this
22 subsection shall post, in advance, the costs of discovery.
23 Such costs shall be awarded to the health maintenance
24 organization if no punitive damages are awarded to the
25 plaintiff.
26 (5) This section shall not be construed to authorize a
27 class action suit against a health maintenance organization or
28 a civil action against the department, its employees, or the
29 Insurance Commissioner, or against the Agency for Health Care
30 Administration, its employees, or the director of the agency
31 or to create a cause of action when a health maintenance

1 organization refuses to pay a claim for reimbursement on the
2 grounds that the charge for a service was unreasonably high or
3 that the service provided was not medically necessary.
4 (6)(a) The civil remedy specified in this section does
5 not preempt any other remedy or cause of action provided for
6 pursuant to any other law or pursuant to the common law of
7 this state. Any person may obtain a judgment under either the
8 common law remedy of bad faith or the remedy provided in this
9 section, but is not entitled to a judgment under both
10 remedies. This section does not create a common law cause of
11 action. The damages recoverable under this section include
12 damages that are a reasonably foreseeable result of a
13 specified violation of this section by the health maintenance
14 organization and may include an award or judgment in an amount
15 that exceeds contract limits.
16 (b) This section does not create a cause of action for
17 medical malpractice. Such an action is subject to the
18 provisions of chapter 766.
19 (c) This section does not apply to the provision of
20 medical care, treatment, or attendance pursuant to chapter
21 440.
22 Section 54. Subsection (4) of section 440.11, Florida
23 Statutes, is amended to read:
24 440.11 Exclusiveness of liability.--
25 (4) Notwithstanding the provisions of s. 624.155 or s.
26 641.3917, the liability of a carrier or a health maintenance
27 organization to an employee or to anyone entitled to bring
28 suit in the name of the employee shall be as provided in this
29 chapter, which shall be exclusive and in place of all other
30 liability.
31

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1 Section 55. The Legislature finds that the provisions
2 of this act will fulfill an important state interest.
3 Section 56. The sum of $112,000 is appropriated from
4 the Insurance Commissioner's Regulatory Trust Fund to the
5 Department of Insurance and three positions are authorized for
6 the purposes of carrying out the provisions of sections 51
7 through 54 of this act.
8 Section 57. Subsection (39) is added to section
9 641.31, Florida Statutes, to read:
10 641.31 Health maintenance contracts.--
11 (39) A health maintenance organization contract may
12 not prohibit or restrict a subscriber from receiving
13 in-patient services in a contracted hospital from a contracted
14 primary care or admitting physician if such services are
15 determined by the organization to be medically necessary and
16 covered services under the organization's contract with the
17 contract holder.
18 Section 58. Subsection (11) is added to section
19 641.315, Florida Statutes, to read:
20 641.315 Provider contracts.--
21 (11) A contract between a health maintenance
22 organization and a contracted primary-care or admitting
23 physician may not contain any provision that prohibits such
24 physician from providing in-patient services in a contracted
25 hospital to a subscriber if such services are determined by
26 the organization to be medically necessary and covered
27 services under the organization's contract with the contract
28 holder.
29 Section 59. Subsection (5) is added to section
30 641.3155, Florida Statutes, to read:
31 641.3155 Provider contracts; payment of claims.--

1 (5) A health maintenance organization shall pay a
2 contracted primary-care or admitting physician, pursuant to
3 such physician's contract, for providing in-patient services
4 in a contracted hospital to a subscriber, if such services are
5 determined by the organization to be medically necessary and
6 covered services under the organization's contract with the
7 contract holder.
8 Section 60. Present subsections (4), (5), (6), (7),
9 (8), (9), and (10) of section 641.51, Florida Statutes, are
10 redesignated as subsections (5), (6), (7), (8), (9), (10), and
11 (11), respectively, and a new subsection (4) is added to that
12 section to read:
13 641.51 Quality assurance program; second medical
14 opinion requirement.--
15 (4) The organization shall ensure that only a
16 physician licensed under chapter 458 or chapter 459; or an
17 M.D. or D.O. physician with an active, unencumbered license in
18 another state with similar licensing requirements may render
19 an adverse determination regarding a service provided by a
20 physician licensed in this state. The organization shall
21 submit to the treating provider and the subscriber written
22 notification regarding the organization's adverse
23 determination within 2 working days after the subscriber or
24 provider is notified of the adverse determination. The written
25 notification must include the utilization review criteria or
26 benefits provisions used in the adverse determination,
27 identify the physician who rendered the adverse determination,
28 and be signed by an authorized representative of the
29 organization or the physician who renders the adverse
30 determination. The organization must include with the
31

notification of an adverse determination information concerning the appeal process for adverse determinations.

Section 61. Subsection (4) of section 212.055, Florida Statutes, is amended to read:

212.055 Discretionary sales surtaxes; legislative intent; authorization and use of proceeds.--It is the legislative intent that any authorization for imposition of a discretionary sales surtax shall be published in the Florida Statutes as a subsection of this section, irrespective of the duration of the levy. Each enactment shall specify the types of counties authorized to levy; the rate or rates which may be imposed; the maximum length of time the surtax may be imposed, if any; the procedure which must be followed to secure voter approval, if required; the purpose for which the proceeds may be expended; and such other requirements as the Legislature may provide. Taxable transactions and administrative procedures shall be as provided in s. 212.054.

(4) INDIGENT CARE AND TRAUMA CENTER SURTAX.--

(a) The governing body in each county the government of which is not consolidated with that of one or more municipalities, which has a population of at least 800,000 residents and is not authorized to levy a surtax under subsection (5) or subsection (6), may levy, pursuant to an ordinance either approved by an extraordinary vote of the governing body or conditioned to take effect only upon approval by a majority vote of the electors of the county voting in a referendum, a discretionary sales surtax at a rate that may not exceed 0.5 percent.

(b) If the ordinance is conditioned on a referendum, a statement that includes a brief and general description of the purposes to be funded by the surtax and that conforms to the

1 requirements of s. 101.161 shall be placed on the ballot by
2 the governing body of the county. The following questions
3 shall be placed on the ballot:
4
5 FOR THE. . . .CENTS TAX
6 AGAINST THE. . . .CENTS TAX
7
8 (c) The ordinance adopted by the governing body
9 providing for the imposition of the surtax shall set forth a
10 plan for providing health care services to qualified
11 residents, as defined in paragraph (d). Such plan and
12 subsequent amendments to it shall fund a broad range of health
13 care services for both indigent persons and the medically
14 poor, including, but not limited to, primary care and
15 preventive care as well as hospital care. <u>The plan must also</u>
16 <u>address the services to be provided by the Level I trauma</u>
17 <u>center.</u>It shall emphasize a continuity of care in the most
18 cost-effective setting, taking into consideration both a high
19 quality of care and geographic access. Where consistent with
20 these objectives, it shall include, without limitation,
21 services rendered by physicians, clinics, community hospitals,
22 mental health centers, and alternative delivery sites, as well
23 as at least one regional referral hospital where appropriate.
24 It shall provide that agreements negotiated between the county
25 and providers<u>, including hospitals with a Level I trauma</u>
26 <u>center,</u>will include reimbursement methodologies that take
27 into account the cost of services rendered to eligible
28 patients, recognize hospitals that render a disproportionate
29 share of indigent care, provide other incentives to promote
30 the delivery of charity care, <u>promote the advancement of</u>
31 <u>technology in medical services, recognize the level of</u>

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1 responsiveness to medical needs in trauma cases,and require
2 cost containment including, but not limited to, case
3 management. It must also provide that any hospitals that are
4 owned and operated by government entities on May 21, 1991,
5 must, as a condition of receiving funds under this subsection,
6 afford public access equal to that provided under s. 286.011
7 as to meetings of the governing board, the subject of which is
8 budgeting resources for the rendition of charity care as that
9 term is defined in the Florida Hospital Uniform Reporting
10 System (FHURS) manual referenced in s. 408.07. The plan shall
11 also include innovative health care programs that provide
12 cost-effective alternatives to traditional methods of service
13 delivery and funding.
14 (d) For the purpose of this subsection, the term
15 "qualified resident" means residents of the authorizing county
16 who are:
17 1. Qualified as indigent persons as certified by the
18 authorizing county;
19 2. Certified by the authorizing county as meeting the
20 definition of the medically poor, defined as persons having
21 insufficient income, resources, and assets to provide the
22 needed medical care without using resources required to meet
23 basic needs for shelter, food, clothing, and personal
24 expenses; or not being eligible for any other state or federal
25 program, or having medical needs that are not covered by any
26 such program; or having insufficient third-party insurance
27 coverage. In all cases, the authorizing county is intended to
28 serve as the payor of last resort; or
29 3. Participating in innovative, cost-effective
30 programs approved by the authorizing county.
31

1 (e) Moneys collected pursuant to this subsection
2 remain the property of the state and shall be distributed by
3 the Department of Revenue on a regular and periodic basis to
4 the clerk of the circuit court as ex officio custodian of the
5 funds of the authorizing county. The clerk of the circuit
6 court shall:
7 1. Maintain the moneys in an indigent health care
8 trust fund;
9 2. Invest any funds held on deposit in the trust fund
10 pursuant to general law; and
11 3. Disburse the funds, including any interest earned,
12 to any provider of health care services, as provided in
13 paragraphs (c) and (d), upon directive from the authorizing
14 county. However, if a county has a population of at least
15 800,000 residents and has levied the surtax authorized in this
16 subsection, notwithstanding any directive from the authorizing
17 county, on October 1 of each calendar year, the clerk of the
18 court shall issue a check in the amount of $6.5 million to a
19 hospital in its jurisdiction that has a Level I trauma center
20 or shall issue a check in the amount of $3.5 million to a
21 hospital in its jurisdiction that has a Level I trauma center
22 if that county enacts and implements a hospital lien law in
23 accordance with chapter 98-499, Laws of Florida. The issuance
24 of the checks on October 1 of each year is provided in
25 recognition of the Level I trauma center status and shall be
26 in addition to the base contract amount received during fiscal
27 year 1999-2000 and any additional amount negotiated to the
28 base contract. If the hospital receiving funds for its Level I
29 trauma center status requests such funds to be used to
30 generate federal matching funds under Medicaid, the clerk of
31 the court shall instead issue a check to the Agency for Health

1 Care Administration to accomplish that purpose to the extent
2 that it is allowed through the General Appropriations Act.
3 (f) Notwithstanding any other provision of this
4 section, a county shall not levy local option sales surtaxes
5 authorized in this subsection and subsections (2) and (3) in
6 excess of a combined rate of 1 percent.
7 (g) This subsection expires October 1, 2005.
8 Section 62. Florida Commission on Excellence in Health
9 Care.--
10 (1) LEGISLATIVE FINDINGS AND INTENT.--The Legislature
11 finds that the health care delivery industry is one of the
12 largest and most complex industries in Florida. The
13 Legislature finds that additional focus on strengthening
14 health care delivery systems by eliminating avoidable mistakes
15 in the diagnosis and treatment of Floridians holds tremendous
16 promise to increase the quality of health care services
17 available to Floridians. To achieve this enhanced focus, it is
18 the intent of the Legislature to create the Florida Commission
19 on Excellence in Health Care to facilitate the development of
20 a comprehensive statewide strategy for improving health care
21 delivery systems through meaningful reporting standards, data
22 collection and review, and quality measurement.
23 (2) DEFINITIONS.--As used in this act, the term:
24 (a) "Agency" means the Agency for Health Care
25 Administration.
26 (b) "Commission" means the Florida Commission on
27 Excellence in Health Care.
28 (c) "Department" means the Department of Health.
29 (d) "Error," with respect to health care, means an
30 unintended act, by omission or commission.
31

(e) "Health care practitioner" means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part III or part IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491, Florida Statutes.

(f) "Health care provider" means any health care facility or other health care organization licensed or certified to provide approved medical and allied health services in this state.

(3) COMMISSION; DUTIES AND RESPONSIBILITIES.--There is created the Florida Commission on Excellence in Health Care. The commission shall:

(a) Identify existing data sources that evaluate quality of care in Florida and collect, analyze, and evaluate this data.

(b) Establish guidelines for data sharing and coordination.

(c) Identify core sets of quality measures for standardized reporting by appropriate components of the health care continuum.

(d) Recommend a framework for quality measurement and outcome reporting.

(e) Develop quality measures that enhance and improve the ability to evaluate and improve care.

(f) Make recommendations regarding research and development needed to advance quality measurement and reporting.

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1 (g) Evaluate regulatory issues relating to the
2 pharmacy profession and recommend changes necessary to
3 optimize patient safety.
4 (h) Facilitate open discussion of a process to ensure
5 that comparative information on health care quality is valid,
6 reliable, comprehensive, understandable, and widely available
7 in the public domain.
8 (i) Sponsor public hearings to share information and
9 expertise, identify "best practices," and recommend methods to
10 promote their acceptance.
11 (j) Evaluate current regulatory programs to determine
12 what changes, if any, need to be made to facilitate patient
13 safety.
14 (k) Review public and private health care purchasing
15 systems to determine if there are sufficient mandates and
16 incentives to facilitate continuous improvement in patient
17 safety.
18 (l) Analyze how effective existing regulatory systems
19 are in ensuring continuous competence and knowledge of
20 effective safety practices.
21 (m) Develop a framework for organizations that
22 license, accredit, or credential health care practitioners and
23 health care providers to more quickly and effectively identify
24 unsafe providers and practitioners and to take action
25 necessary to remove the unsafe provider or practitioner from
26 practice or operation until such time as the practitioner or
27 provider has proven safe to practice or operate.
28 (n) Recommend procedures for development of a
29 curriculum on patient safety and methods of incorporating such
30 curriculum into training, licensure, and certification
31 requirements.

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1 (o) Develop a framework for regulatory bodies to
2 disseminate information on patient safety to health care
3 practitioners, health care providers, and consumers through
4 conferences, journal articles and editorials, newsletters,
5 publications, and Internet websites.
6 (p) Recommend procedures to incorporate recognized
7 patient safety considerations into practice guidelines and
8 into standards related to the introduction and diffusion of
9 new technologies, therapies, and drugs.
10 (q) Recommend a framework for development of
11 community-based collaborative initiatives for error reporting
12 and analysis and implementation of patient safety
13 improvements.
14 (r) Evaluate the role of advertising in promoting or
15 adversely affecting patient safety.
16 (4) MEMBERSHIP, ORGANIZATION, MEETINGS, PROCEDURES,
17 STAFF.--
18 (a) The commission shall consist of:
19 1. The Secretary of Health and the Director of Health
20 Care Administration;
21 2. One representative each from the following agencies
22 or organizations: the Board of Medicine, the Board of
23 Osteopathic Medicine, the Board of Pharmacy, the Board of
24 Dentistry, the Board of Nursing, the Florida Dental
25 Association, the Florida Medical Association, the Florida
26 Osteopathic Medical Association, the Florida Chiropractic
27 Association, the Florida Podiatric Medical Association, the
28 Florida Nurses Association, the Florida Organization of
29 Nursing Executives, the Florida Pharmacy Association, the
30 Florida Society of Health System Pharmacists, Inc., the
31 Florida Hospital Association, the Association of Community

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1 Hospitals and Health Systems of Florida, Inc., the Florida
2 League of Health Systems, the Florida Health Care Risk
3 Management Advisory Council, the Florida Health Care
4 Association, the Florida Statutory Teaching Hospital Council,
5 Inc., the Florida Statutory Rural Hospital Council, the
6 Florida Association of Homes for the Aging, and the Florida
7 Society for Respiratory Care;
8 3. Two health lawyers, appointed by the Secretary of
9 Health, one of whom must be a member of the Health Law Section
10 of The Florida Bar who defends physicians and one of whom must
11 be a member of the Academy of Florida Trial Lawyers;
12 4. Two representatives of the health insurance
13 industry, appointed by the Director of Health Care
14 Administration, one of whom shall represent indemnity plans
15 and one of whom shall represent managed care;
16 5. Five consumer advocates, consisting of one from the
17 Association for Responsible Medicine, two appointed by the
18 Governor, one appointed by the President of the Senate, and
19 one appointed by the Speaker of the House of Representatives;
20 6. Two legislators, one appointed by the President of
21 the Senate and one appointed by the Speaker of the House of
22 Representatives; and
23 7. One representative of a Florida medical school
24 appointed by the Secretary of Health.
25
26 Commission membership shall reflect the geographic and
27 demographic diversity of the state.
28 (b) The Secretary of Health and the Director of Health
29 Care Administration shall jointly chair the commission.
30 Subcommittees shall be formed by the joint chairs, as needed,
31 to make recommendations to the full commission on the subjects

assigned. However, all votes on work products of the commission shall be at the full commission level, and all recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives must pass by a two-thirds vote of the full commission. Sponsoring agencies and organizations may designate an alternative member who may attend and vote on behalf of the sponsoring agency or organization in the event the appointed member is unable to attend a meeting of the commission or any subcommittee. The commission shall be staffed by employees of the Department of Health and the Agency for Health Care Administration. Sponsoring agencies or organizations must fund the travel and related expenses of their appointed members on the commission. Travel and related expenses for the consumer members of the commission shall be reimbursed by the state pursuant to section 112.061, Florida Statutes. The commission shall hold its first meeting no later than July 15, 2000.

(5) EVIDENTIARY PROHIBITIONS.--

(a) The findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, and actions of the commission shall be available to the public, but may not be introduced into evidence at any civil, criminal, special, or administrative proceeding against a health care practitioner or health care provider arising out of the matters which are the subject of the findings of the commission. Moreover, no member of the commission shall be examined in any civil, criminal, special, or administrative proceeding against a health care practitioner or health care provider as to any evidence or other matters produced or presented during the proceedings of this commission or as to

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

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1 proceeding unless subsequently enacted into law or adopted in
2 rule.
3 (c) No person who testifies before the commission or
4 who is a member of the commission may specifically identify
5 any patient, health care practitioner, or health care provider
6 by name. Moreover, the findings, recommendations, evaluations,
7 opinions, investigations, proceedings, records, reports,
8 minutes, testimony, correspondence, work product, and actions
9 of the commission may not specifically identify any patient,
10 health care practitioner, or health care provider by name.
11 (6) REPORT; TERMINATION.--The commission shall provide
12 a report of its findings and recommendations to the Governor,
13 the President of the Senate, and the Speaker of the House of
14 Representatives no later than February 1, 2001. After
15 submission of the report, the commission shall continue to
16 exist for the purpose of assisting the Department of Health,
17 the Agency for Health Care Administration, and the regulatory
18 boards in their drafting of proposed legislation and rules to
19 implement its recommendations and for the purpose of providing
20 information to the health care industry on its
21 recommendations. The commission shall be terminated June 1,
22 2001.
23 Section 63. The sum of $91,000 in nonrecurring general
24 revenue is hereby appropriated from the General Revenue Fund
25 to the Department of Health to cover costs of the Florida
26 Commission on Excellence in Health Care relating to the travel
27 and related expenses of staff and consumer members and the
28 reproduction and dissemination of documents.
29 Section 64. Subsections (1) and (2) of section
30 400.408, Florida Statutes, are amended to read:
31

1 400.408 Unlicensed facilities; referral of person for
2 residency to unlicensed facility; penalties; verification of
3 licensure status.--
4 (1)(a) It is unlawful to own, operate, or maintain an
5 assisted living facility without obtaining a license under
6 this part.
7 (b) Except as provided under paragraph (d), any person
8 who owns, operates, or maintains an unlicensed assisted living
9 facility commits a felony of the third degree, punishable as
10 provided in s. 775.082, s. 775.083, or s. 775.084. Each day of
11 continued operation is a separate offense.
12 (c) Any person found guilty of violating paragraph (a)
13 a second or subsequent time commits a felony of the second
14 degree, punishable as provided under s. 775.082, s. 775.083,
15 or s. 775.084. Each day of continued operation is a separate
16 offense.
17 (d) Any person who owns, operates, or maintains an
18 unlicensed assisted living facility due to a change in this
19 part or a modification in department rule within 6 months
20 after the effective date of such change and who, within 10
21 working days after receiving notification from the agency,
22 fails to cease operation or apply for a license under this
23 part commits a felony of the third degree, punishable as
24 provided in s. 775.082, s. 775.083, or s. 775.084. Each day of
25 continued operation is a separate offense.
26 (e) Any facility that fails to cease operation after
27 agency notification may be fined for each day of noncompliance
28 pursuant to s. 400.419.
29 (f) When a licensee has an interest in more than one
30 assisted living facility, and fails to license any one of
31 these facilities, the agency may revoke the license, impose a

1 moratorium, or impose a fine pursuant to s. 400.419, on any or
2 all of the licensed facilities until such time as the
3 unlicensed facility is licensed or ceases operation.
4 (g) If the agency determines that an owner is
5 operating or maintaining an assisted living facility without
6 obtaining a license and determines that a condition exists in
7 the facility that poses a threat to the health, safety, or
8 welfare of a resident of the facility, the owner is subject to
9 the same actions and fines imposed against a licensed facility
10 as specified in ss. 400.414 and 400.419.
11 (h) Any person aware of the operation of an unlicensed
12 assisted living facility must report that facility to the
13 agency. The agency shall provide to the department's elder
14 information and referral providers a list, by county, of
15 licensed assisted living facilities, to assist persons who are
16 considering an assisted living facility placement in locating
17 a licensed facility.
18 (i) Each field office of the Agency for Health Care
19 Administration shall establish a local coordinating workgroup
20 which includes representatives of local law enforcement
21 agencies, state attorneys, local fire authorities, the
22 Department of Children and Family Services, the district
23 long-term care ombudsman council, and the district human
24 rights advocacy committee to assist in identifying the
25 operation of unlicensed facilities and to develop and
26 implement a plan to ensure effective enforcement of state laws
27 relating to such facilities. The workgroup shall report its
28 findings, actions, and recommendations semi-annually to the
29 Director of Health Facility Regulation of the agency.
30 (2) It is unlawful to knowingly refer a person for
31 residency to an unlicensed assisted living facility; to an

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1 assisted living facility the license of which is under denial
2 or has been suspended or revoked; or to an assisted living
3 facility that has a moratorium on admissions. Any person who
4 violates this subsection commits a noncriminal violation,
5 punishable by a fine not exceeding $500 as provided in s.
6 775.083.
7 (a) Any health care practitioner, as defined in s.
8 455.501, which is aware of the operation of an unlicensed
9 facility shall report that facility to the agency. Failure to
10 report a facility that the practitioner knows or has
11 reasonable cause to suspect is unlicensed shall be reported to
12 the practitioner's licensing board.
13 (b) Any hospital or community mental health center
14 licensed under chapter 395 or chapter 394 which knowingly
15 discharges a patient or client to an unlicensed facility is
16 subject to sanction by the agency.
17 (c)~~(a)~~ Any employee of the agency or department, or
18 the Department of Children and Family Services, who knowingly
19 refers a person for residency to an unlicensed facility; to a
20 facility the license of which is under denial or has been
21 suspended or revoked; or to a facility that has a moratorium
22 on admissions is subject to disciplinary action by the agency
23 or department, or the Department of Children and Family
24 Services.
25 (d)~~(b)~~ The employer of any person who is under
26 contract with the agency or department, or the Department of
27 Children and Family Services, and who knowingly refers a
28 person for residency to an unlicensed facility; to a facility
29 the license of which is under denial or has been suspended or
30 revoked; or to a facility that has a moratorium on admissions
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1 shall be fined and required to prepare a corrective action
2 plan designed to prevent such referrals.
3 (e)~~(c)~~ The agency shall provide the department and the
4 Department of Children and Family Services with a list of
5 licensed facilities within each county and shall update the
6 list at least quarterly.
7 (f)~~(d)~~ At least annually, the agency shall notify, in
8 appropriate trade publications, physicians licensed under
9 chapter 458 or chapter 459, hospitals licensed under chapter
10 395, nursing home facilities licensed under part II of this
11 chapter, and employees of the agency or the department, or the
12 Department of Children and Family Services, who are
13 responsible for referring persons for residency, that it is
14 unlawful to knowingly refer a person for residency to an
15 unlicensed assisted living facility and shall notify them of
16 the penalty for violating such prohibition. The department and
17 the Department of Children and Family Services shall, in turn,
18 notify service providers under contract to the respective
19 departments who have responsibility for resident referrals to
20 facilities. Further, the notice must direct each noticed
21 facility and individual to contact the appropriate agency
22 office in order to verify the licensure status of any facility
23 prior to referring any person for residency. Each notice must
24 include the name, telephone number, and mailing address of the
25 appropriate office to contact.
26 Section 65. Subsection (1) of section 415.1034,
27 Florida Statutes, is amended to read:
28 415.1034 Mandatory reporting of abuse, neglect, or
29 exploitation of disabled adults or elderly persons; mandatory
30 reports of death.--
31 (1) MANDATORY REPORTING.--

1 (a) Any person, including, but not limited to, any:
2 1. Physician, osteopathic physician, medical examiner,
3 chiropractic physician, nurse, paramedic, emergency medical
4 technician, or hospital personnel engaged in the admission,
5 examination, care, or treatment of disabled adults or elderly
6 persons;
7 2. Health professional or mental health professional
8 other than one listed in subparagraph 1.;
9 3. Practitioner who relies solely on spiritual means
10 for healing;
11 4. Nursing home staff; assisted living facility staff;
12 adult day care center staff; adult family-care home staff;
13 social worker; or other professional adult care, residential,
14 or institutional staff;
15 5. State, county, or municipal criminal justice
16 employee or law enforcement officer;
17 6. An employee of the Department of Business and
18 Professional Regulation conducting inspections of public
19 lodging establishments under s. 509.032;
20 7. ~~6.~~ Human rights advocacy committee or long-term care
21 ombudsman council member; or
22 8. ~~7.~~ Bank, savings and loan, or credit union officer,
23 trustee, or employee,
24
25 who knows, or has reasonable cause to suspect, that a disabled
26 adult or an elderly person has been or is being abused,
27 neglected, or exploited shall immediately report such
28 knowledge or suspicion to the central abuse registry and
29 tracking system on the single statewide toll-free telephone
30 number.
31

1 (b) To the extent possible, a report made pursuant to
2 paragraph (a) must contain, but need not be limited to, the
3 following information:
4 1. Name, age, race, sex, physical description, and
5 location of each disabled adult or an elderly person alleged
6 to have been abused, neglected, or exploited.
7 2. Names, addresses, and telephone numbers of the
8 disabled adult's or elderly person's family members.
9 3. Name, address, and telephone number of each alleged
10 perpetrator.
11 4. Name, address, and telephone number of the
12 caregiver of the disabled adult or elderly person, if
13 different from the alleged perpetrator.
14 5. Name, address, and telephone number of the person
15 reporting the alleged abuse, neglect, or exploitation.
16 6. Description of the physical or psychological
17 injuries sustained.
18 7. Actions taken by the reporter, if any, such as
19 notification of the criminal justice agency.
20 8. Any other information available to the reporting
21 person which may establish the cause of abuse, neglect, or
22 exploitation that occurred or is occurring.
23 Section 66. This act shall take effect July 1, 2000,
24 and apply to contracts issued or renewed on or after that
25 date, except as otherwise provided in this act and except that
26 the amendment to section 395.701, Florida Statutes, by this
27 act shall take effect only upon the receipt by the Agency for
28 Health Care Administration of written confirmation from the
29 federal Health Care Financing Administration that the changes
30 contained in such amendment will not adversely affect the use
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1 of the remaining assessments as state match for the state's
2 Medicaid program.
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