HOUSE AMENDMENT

Bill No. CS for SB 992, 1st Eng.

Amendment No. ___ (for drafter's use only)

CHAMBER ACTION

Senate | House

ORIGINAL STAMP BELOW

Representative(s) Rubio offered the following:

Amendment (with title amendment)

On page 3, lines 1-2,

remove from the bill: all of said lines

and insert in lieu thereof:

Section 4. Section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency.Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number

of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.--The agency shall pay for services provided to a recipient by a licensed advanced registered nurse practitioner who has a valid collaboration agreement with a licensed physician on file with the Department of Health or who provides anesthesia services in accordance with established protocol required by state law and approved by the medical staff of the facility in which the anesthetic service is performed. Reimbursement for such services must be provided in an amount that equals not less than 80 percent of the reimbursement to a physician who provides the same services, unless otherwise provided for in the General Appropriations Act.

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

(3) FAMILY PLANNING SERVICES.--The agency shall pay for services necessary to enable a recipient voluntarily to plan family size or to space children. These services include information; education; counseling regarding the availability,

benefits, and risks of each method of pregnancy prevention; drugs and supplies; and necessary medical care and followup. Each recipient participating in the family planning portion of the Medicaid program must be provided freedom to choose any alternative method of family planning, as required by federal law.

(4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to this subsection shall be licensed under part IV of chapter 400 or part II of chapter 499, if appropriate. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility. In providing home health care services, the agency may require prior authorization of care based on diagnosis.

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a) The agency is authorized to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; enhanced

utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase.

(b) A licensed hospital maintained primarily for the care and treatment of patients having mental disorders or mental diseases is not eligible to participate in the hospital inpatient portion of the Medicaid program except as provided in federal law. However, the department shall apply for a waiver, within 9 months after June 5, 1991, designed to provide hospitalization services for mental health reasons to children and adults in the most cost-effective and lowest cost setting possible. Such waiver shall include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMD's." The waiver proposal shall propose no additional aggregate cost to the state or Federal Government, and shall be conducted in Hillsborough County, Highlands County, Hardee County, Manatee County, and Polk County. The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. When developing the waiver proposal, the department shall take into account price, quality, accessibility, linkages of the hospital to community services and family support programs, plans of the hospital to ensure the earliest discharge possible, and the comprehensiveness of the mental health and other health care services offered by participating providers.

(c) Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995; or

2. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year.

No later than November 1, 2000, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Budget Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the 2001-2002 General Appropriations Act to support the increase in cost as estimated by the agency. This paragraph is repealed on July 1, 2001.

(6) HOSPITAL OUTPATIENT SERVICES.--The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,500 per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under

age 21, in which case the only limitation is medical necessity.

(7) INDEPENDENT LABORATORY SERVICES.--The agency shall pay for medically necessary diagnostic laboratory procedures ordered by a licensed physician or other licensed practitioner of the healing arts which are provided for a recipient in a laboratory that meets the requirements for Medicare participation and is licensed under chapter 483, if required.

(8) NURSING FACILITY SERVICES.--The agency shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital, as defined by s. 395.002(11), that is licensed under part I of chapter 395, and in accordance with provisions set forth in s. 409.908(2)(a), which services are ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another nursing facility is not available, the agency must pay for similar services temporarily in a hospital licensed under part I of chapter 395 provided federal funding is approved and available.

(9) PHYSICIAN SERVICES.--The agency shall pay for covered services and procedures rendered to a recipient by, or under the personal supervision of, a person licensed under state law to practice medicine or osteopathic medicine. These services may be furnished in the physician's office, the Medicaid recipient's home, a hospital, a nursing facility, or elsewhere, but shall be medically necessary for the treatment of an injury, illness, or disease within the scope of the

practice of medicine or osteopathic medicine as defined by state law. The agency shall not pay for services that are clinically unproven, experimental, or for purely cosmetic purposes.

(10) PORTABLE X-RAY SERVICES.--The agency shall pay for professional and technical portable radiological services ordered by a licensed physician or other licensed practitioner of the healing arts which are provided by a licensed professional in a setting other than a hospital, clinic, or office of a physician or practitioner of the healing arts, on behalf of a recipient.

(11) RURAL HEALTH CLINIC SERVICES.--The agency shall pay for outpatient primary health care services for a recipient provided by a clinic certified by and participating in the Medicare program which is located in a federally designated, rural, medically underserved area and has on its staff one or more licensed primary care nurse practitioners or physician assistants, and a licensed staff supervising physician or a consulting supervising physician.

(12) TRANSPORTATION SERVICES.--The agency shall ensure that appropriate transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for medically necessary and Medicaid-compensable services, provided a client's ability to choose a specific transportation provider shall be limited to those options resulting from policies established by the agency to meet the fiscal limitations of the General Appropriations Act. The agency may pay for transportation and other related travel expenses as necessary only if these services are not otherwise available.

Section 5. Section 409.906, Florida Statutes, is

amended to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency.Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(1) ADULT DENTURE SERVICES.--The agency may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is age 21 or older. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.

(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.

(2) ADULT HEALTH SCREENING SERVICES.--The agency may pay for an annual routine physical examination, conducted by or under the direction of a licensed physician, for a recipient age 21 or older, without regard to medical necessity, in order to detect and prevent disease, disability, or other health condition or its progression.

(3) AMBULATORY SURGICAL CENTER SERVICES.--The agency may pay for services provided to a recipient in an ambulatory surgical center licensed under part I of chapter 395, by or under the direction of a licensed physician or dentist.

(4) BIRTH CENTER SERVICES.--The agency may pay for examinations and delivery, recovery, and newborn assessment, and related services, provided in a licensed birth center staffed with licensed physicians, certified nurse midwives, and midwives licensed in accordance with chapter 467, to a recipient expected to experience a low-risk pregnancy and

delivery.

(5) CASE MANAGEMENT SERVICES.--The agency may pay for primary care case management services rendered to a recipient pursuant to a federally approved waiver, and targeted case management services for specific groups of targeted recipients, for which funding has been provided and which are rendered pursuant to federal guidelines. The agency is authorized to limit reimbursement for targeted case management services in order to comply with any limitations or directions provided for in the General Appropriations Act. Notwithstanding s. 216.292, the Department of Children and Family Services may transfer general funds to the Agency for Health Care Administration to fund state match requirements exceeding the amount specified in the General Appropriations Act for targeted case management services.

(6) CHILDREN'S DENTAL SERVICES.--The agency may pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist. Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.

(b) Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

(d) Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.

(7) CHIROPRACTIC SERVICES.--The agency may pay for manual manipulation of the spine and initial services, screening, and X rays provided to a recipient by a licensed chiropractic physician.

(8) COMMUNITY MENTAL HEALTH SERVICES.--The agency may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider licensed by the agency and under contract with the agency or the Department of Children and Family Services to provide such services. Those services which are psychiatric in nature shall be rendered or recommended by a psychiatrist, and those services which are medical in nature shall be rendered or recommended by a physician or psychiatrist. The agency must develop a provider enrollment process for community mental health providers which bases provider enrollment on an assessment of service need. The provider enrollment process shall be designed to control costs, prevent fraud and abuse, consider provider expertise and capacity, and assess provider success in managing utilization of care and measuring treatment outcomes. Providers will be selected through a competitive procurement or selective contracting process. In addition to other

community mental health providers, the agency shall consider for enrollment mental health programs licensed under chapter 395 and group practices licensed under chapter 458, chapter 459, chapter 490, or chapter 491. The agency is also authorized to continue operation of its behavioral health utilization management program and may develop new services if these actions are necessary to ensure savings from the implementation of the utilization management system. The agency shall coordinate the implementation of this enrollment process with the Department of Children and Family Services and the Department of Juvenile Justice. The agency is authorized to utilize diagnostic criteria in setting reimbursement rates, to preauthorize certain high-cost or highly utilized services, to limit or eliminate coverage for certain services, or to make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.

(9) DIALYSIS FACILITY SERVICES.--Subject to specific appropriations being provided for this purpose, the agency may pay a dialysis facility that is approved as a dialysis facility in accordance with Title XVIII of the Social Security Act, for dialysis services that are provided to a Medicaid recipient under the direction of a physician licensed to practice medicine or osteopathic medicine in this state, including dialysis services provided in the recipient's home by a hospital-based or freestanding dialysis facility.

(10) DURABLE MEDICAL EQUIPMENT.--The agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary.

(11) HEALTHY START SERVICES.--The agency may pay for a

continuum of risk-appropriate medical and psychosocial services for the Healthy Start program in accordance with a federal waiver. The agency may not implement the federal waiver unless the waiver permits the state to limit enrollment or the amount, duration, and scope of services to ensure that expenditures will not exceed funds appropriated by the Legislature or available from local sources. If the Health Care Financing Administration does not approve a federal waiver for Healthy Start services, the agency, in consultation with the Department of Health and the Florida Association of Healthy Start Coalitions, is authorized to establish a Medicaid certified-match program for Healthy Start services. Participation in the Healthy Start certified-match program shall be voluntary, and reimbursement shall be limited to the federal Medicaid share to Medicaid-enrolled Healthy Start coalitions for services provided to Medicaid recipients. The agency shall take no action to implement a certified-match program without ensuring that the amendment and review requirements of ss. 216.177 and 216.181 have been met.

(12) HEARING SERVICES.--The agency may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(13) HOME AND COMMUNITY-BASED SERVICES.--The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program.

(14) HOSPICE CARE SERVICES.--The agency may pay for all reasonable and necessary services for the palliation or

management of a recipient's terminal illness, if the services are provided by a hospice that is licensed under part VI of chapter 400 and meets Medicare certification requirements.

(15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED SERVICES.--The agency may pay for health-related care and services provided on a 24-hour-a-day basis by a facility licensed and certified as a Medicaid Intermediate Care Facility for the Developmentally Disabled, for a recipient who needs such care because of a developmental disability.

(16) INTERMEDIATE CARE SERVICES.--The agency may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part II of chapter 400, if the services are ordered by and provided under the direction of a physician.

(17) OPTOMETRIC SERVICES.--The agency may pay for services provided to a recipient, including examination, diagnosis, treatment, and management, related to ocular pathology, if the services are provided by a licensed optometrist or physician.

(18) PHYSICIAN ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by a physician assistant licensed under s. 458.347 or s. 459.022. Reimbursement for such services must be not less than 80 percent of the reimbursement that would be paid to a physician who provided the same services.

(19) PODIATRIC SERVICES.--The agency may pay for services, including diagnosis and medical, surgical, palliative, and mechanical treatment, related to ailments of the human foot and lower leg, if provided to a recipient by a podiatric physician licensed under state law.

(20) PRESCRIBED DRUG SERVICES.--The agency may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law.

(21) REGISTERED NURSE FIRST ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by a registered nurse first assistant as described in s. 464.027. Reimbursement for such services may not be less than 80 percent of the reimbursement that would be paid to a physician providing the same services.

(22) STATE HOSPITAL SERVICES.--The agency may pay for all-inclusive psychiatric inpatient hospital care provided to a recipient age 65 or older in a state mental hospital.

(23) VISUAL SERVICES.--The agency may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient, if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

(24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.--The Agency for Health Care Administration, in consultation with the Department of Children and Family Services, may establish a targeted case-management pilot project in those counties identified by the Department of Children and Family Services and for the community-based child welfare project in Sarasota and Manatee counties, as authorized under s. 409.1671. These projects shall be established for the purpose of determining the impact of targeted case management on the child welfare program and the earnings from the child welfare program. Results of the pilot projects shall be reported to the Child

Welfare Estimating Conference and the Social Services Estimating Conference established under s. 216.136. The number of projects may not be increased until requested by the Department of Children and Family Services, recommended by the Child Welfare Estimating Conference and the Social Services Estimating Conference, and approved by the Legislature. The covered group of individuals who are eligible to receive targeted case management include children who are eligible for Medicaid; who are between the ages of birth through 21; and who are under protective supervision or postplacement supervision, under foster-care supervision, or in shelter care or foster care. The number of individuals who are eligible to receive targeted case management shall be limited to the number for whom the Department of Children and Family Services has available matching funds to cover the costs. The general revenue funds required to match the funds for services provided by the community-based child welfare projects are limited to funds available for services described under s. 409.1671. The Department of Children and Family Services may transfer the general revenue matching funds as billed by the Agency for Health Care Administration.

Section 6. Effective January 1, 2002, subsection (1) of section 490.012, Florida Statutes, is amended to read:

490.012 Violations; penalties; injunction.--

(1)(a) No person shall hold herself or himself out by any professional title, name, or description incorporating the word "psychologist" unless such person holds a valid, active license as a psychologist under this chapter.

(b) No person shall hold herself or himself out by any professional title, name, or description incorporating the words "school psychologist" unless such person holds a valid,

active license as a school psychologist under this chapter or is certified as a school psychologist by the Department of Education.

(c)~~(1)(a)~~ No person shall hold herself or himself out by any title or description incorporating the words, or permutations of them,~~"psychologist,"~~"psychology," "psychological," or "psychodiagnostic," ~~or "school psychologist,"~~or describe any test or report as psychological, unless such person holds a valid, active license under this chapter or is exempt from the provisions of this chapter.

(d)~~(b)~~ No person shall hold herself or himself out by any title or description incorporating the word, or a permutation of the word, "psychotherapy" unless such person holds a valid, active license under chapter 458, chapter 459, chapter 490, or chapter 491, or such person is certified as an advanced registered nurse practitioner, pursuant to s. 464.012, who has been determined by the Board of Nursing as a specialist in psychiatric mental health.

(e)~~(c)~~ No person licensed or provisionally licensed pursuant to this chapter shall hold herself or himself out by any title or description which indicates licensure other than that which has been granted to her or him.

Section 7. Effective January 1, 2002, section 490.014, Florida Statutes, is amended to read:

490.014 Exemptions.--

(1)(a) No provision of this chapter shall be construed to limit the practice of physicians licensed pursuant to chapter 458 or chapter 459 so long as they do not hold themselves out to the public as psychologists or use a professional title protected by this chapter.

(b) No provision of this chapter shall be construed to limit the practice of nursing, clinical social work, marriage and family therapy, mental health counseling, or other recognized businesses or professions, or to prevent qualified members of other professions from doing work of a nature consistent with their training, so long as they do not hold themselves out to the public as psychologists or use a title or description protected by this chapter. Nothing in this subsection shall be construed to exempt any person from the provisions of s. 490.012.

(2) No person shall be required to be licensed or provisionally licensed under this chapter who:

(a) Is a salaried employee of a government agency; developmental services program, mental health, alcohol, or drug abuse facility operating pursuant to chapter 393, chapter 394, or chapter 397; subsidized child care program, subsidized child care case management program, or child care resource and referral program operating pursuant to chapter 402; child-placing or child-caring agency licensed pursuant to chapter 409; domestic violence center certified pursuant to chapter 39; accredited academic institution; or research institution, if such employee is performing duties for which he or she was trained and hired solely within the confines of such agency, facility, or institution, so long as the employee is not held out to the public as a psychologist pursuant to s. 490.012(1)(a).

(b) Is a salaried employee of a private, nonprofit organization providing counseling services to children, youth, and families, if such services are provided for no charge, if such employee is performing duties for which he or she was trained and hired, so long as the employee is not held out to

the public as a psychologist pursuant to s. 490.012(1)(a).

(c) Is a student who is pursuing a course of study which leads to a degree in medicine or a profession regulated by this chapter who is providing services in a training setting, provided such activities or services constitute part of a supervised course of study, or is a graduate accumulating the experience required for any licensure under this chapter, provided such graduate or student is designated by a title such as "intern" or "trainee" which clearly indicates the in-training status of the student.

(d) Is certified in school psychology by the Department of Education and is performing psychological services as an employee of a public or private educational institution. Such exemption shall not be construed to authorize any unlicensed practice which is not performed as a direct employee of an educational institution.

(e) Is not a resident of the state but offers services in this state, provided:

1. Such services are performed for no more than 5 days in any month and no more than 15 days in any calendar year; and

2. Such nonresident is licensed or certified by a state or territory of the United States, or by a foreign country or province, the standards of which were, at the date of his or her licensure or certification, equivalent to or higher than the requirements of this chapter in the opinion of the department or, in the case of psychologists, in the opinion of the board.

(f) Is a rabbi, priest, minister, or member of the clergy of any religious denomination or sect when engaging in activities which are within the scope of the performance of

his or her regular or specialized ministerial duties and for which no separate charge is made, or when such activities are performed, with or without charge, for or under the auspices or sponsorship, individually or in conjunction with others, of an established and legally cognizable church, denomination, or sect, and when the person rendering service remains accountable to the established authority thereof.

(3) No provision of this chapter shall be construed to limit the practice of any individual who solely engages in behavior analysis so long as he or she does not hold himself or herself out to the public as possessing a license issued pursuant to this chapter or use a title or description protected by this chapter.

(4) Nothing in this section shall exempt any person from the provisions ~~provision~~ of s. 490.012(1)(a)-(b).

(5) Except as stipulated by the board, the exemptions contained in this section do not apply to any person licensed under this chapter whose license has been suspended or revoked by the board or another jurisdiction.

Section 8. Except as otherwise provided herein, this act shall take effect July 1, 2001, and sections 1-3 of this act shall apply to policies issued or renewed after July 1, 2001.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

On page 1, lines 2-12,

remove from the title of the bill: all of said lines

and insert in lieu thereof:

An act relating to health care; amending s. 627.419, F.S.; providing for appeals from certain adverse determinations; amending s. 456.031, F.S.; providing an alternative by which licensees may comply with a general requirement that they take domestic-violence education courses; amending s. 456.033, F.S.; providing an alternative by which licensees may comply with a general requirement that they take AIDS/HIV education courses; amending s. 409.905, F.S.; providing that the Agency for Health Care Administration may restrict the provision of mandatory Medicaid services by mobile providers; amending s. 409.906, F.S.; providing that the agency may restrict or prohibit the provision of optional Medicaid services by mobile providers; providing that Medicaid will not provide reimbursement for dental services provided in mobile dental units, except for certain units; amending s. 490.012, F.S.; prohibiting the use of certain titles or descriptions relating to the practice of psychology or school psychology unless properly licensed; providing penalties; amending s. 490.014, F.S.; revising exemptions from regulation under ch. 490, F.S., relating to psychology; providing effective dates.