AGING AND LONG-TERM CARE

CS/CS/CS/SB 1202 — Long-Term Care

by Appropriations Committee; Judiciary Committee; Health, Aging Long-Term Care Committee; and Senators Brown-Waite and Holzendorf

The bill modifies regulatory provisions and standards for long-term care facilities (nursing homes and assisted living facilities) regulated under parts II and III of ch. 400, F.S.; makes changes to provisions regarding civil actions to enforce nursing home and assisted living facility residents' rights and to seek damages in negligence actions; revises qualifications for certified nursing assistants; modifies provisions related to reimbursement of nursing homes; and provides appropriations.

Licensure Provisions

The bill defines "controlling interest" and "voluntary board member" as applied to nursing home licensure applicants or nursing home licensees; to require an applicant for licensure to provide identifying information for any controlling interest. A subsection is added requiring a signed affidavit disclosing any financial or ownership interest held by specified individuals in the last 5 years in an entity in this or any other state which has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason any such entity was closed, whether voluntarily or involuntarily. The agency is required to establish standards for reporting this information.

The agency is authorized to issue an inactive license to a nursing home temporarily unable to provide services, which is reasonably expected to resume services. A nursing home seeking an inactive license must obtain agency approval prior to suspending services or notifying residents of the need to be transferred or discharged. Facilities must establish and submit plans for quality assurance and risk management with applications for licensure.

Licensure fees for nursing homes are raised from a maximum of $35 per bed to $50 per bed, which can be adjusted annually based on the Consumer Price Index. The bill revises the minimum deposit amount from $500,000 to $1 million in the Resident Protection Trust Fund and provides for rate adjustments when funds are below that level to bring up the balance in the trust fund. It also revises the balance in the trust fund from $500,000 to $1 million for which the increased rates must revert back to the minimum rate per bed. Additionally, the bill revises the threshold amount from $800,000 to $2 million for reversions to the Health Care Trust Fund. The bill revises the licensure fee structure for assisted living facilities, including fees for a standard license, a license for extended congregate care services, and a license for limited nursing

services. Optional state supplementation beds are exempted from licensure fees. Each per bed licensure fee and the minimum and maximum limits must be adjusted annually for inflation.

Electronic Monitoring of Residents

The bill requires the Agency for Health Care Administration and the Attorney General to jointly study the potential use of electronic monitoring devices in nursing home facilities. The bill delineates areas to be studied, including the impact of such devices on the privacy and dignity of the resident on whose behalf the device is installed and on other residents who may be affected, the effects of such devices on staff, the impact on the care environment, and the use of the tapes in litigation. A report to the Governor and the Legislature is required by January 1, 2002.

Staffing Ratios in Nursing Homes

The bill requires 2.3 hours of direct care per resident per day by certified nursing assistants beginning January 1, 2002, increasing to 2.6 hours beginning January 1, 2003, and up to 2.9 hours beginning January 1, 2004, with a minimum, at all times, of one CNA per 20 residents. The bill requires 1 hour of direct care per resident per day by licensed nurses, with a minimum, at all times, of one licensed nurse per 40 residents. The bill requires nursing homes to report, at least twice a year, information regarding staff-to-resident ratios, staff turnover, staff stability and vacant beds. The bill requires a nursing home to cease admissions when staffing is below minimums. Failure to self-impose a moratorium constitutes a class II deficiency.

Training

Training of certified nursing assistants in nursing homes must include training on resident feeding, nutrition and hydration, cognitively impaired residents, end-of-life care techniques and pressure ulcers and falls. Costs associated with this training may not be reimbursed from additional Medicaid funding through interim rate adjustments. Certification as a nursing assistant continues in effect unless the nursing assistant has not performed any nursing-related services for compensation for a period of 24 months. If certification lapses, the nursing assistant must complete a new training and/or competency evaluation. The bill adds a requirement for 18 hours of continuing education per year for certified nursing assistants.

Increased Authority of the Agency for Health Care Administration to Enforce Quality Requirements

Facility monitoring is increased to require a quarterly visit to each nursing home by a quality-of-care monitor with priority for additional visits being given to problem facilities. Biennial unannounced onsite reviews are required in facilities that have been cited for serious violations or multiple violations and such facilities must pay additional fines to cover the cost of these reviews. A registered nurse or other appropriate designee of the agency is to visit assisted living facilities that have an extended congregate care license at least quarterly (instead of twice

a year) and each assisted living facility with a limited nursing license at least twice a year (instead of once a year) to monitor resident care.

The bill requires nursing home licensure applicants to submit information about controlling interests and management companies and authorizes the agency to deny licensure if the information about controlling interests indicates certain problems. The bill requires nursing home licensure renewal applicants to submit information about facility closures, bankruptcy, receivership, negative licensure action, or injunctions initiated by a regulatory agency; and prohibits the agency from renewing a license if the applicant has failed to pay fines assessed by final order. The bill authorizes the agency to deny, revoke, or suspend a nursing home license for a demonstrated pattern of deficient practice, for failure to pay outstanding fines, for exclusion from the Medicare or Medicaid program, or for an adverse action by a regulatory agency against any controlling interest or other facility with a common controlling interest. The bill provides that administrative proceedings challenging agency licensure enforcement actions must be reviewed on the basis of facts and conditions that resulted in the agency action. The agency is to revoke or deny a nursing home license if the licensee operates a facility that has had two moratoria imposed for quality-of-care problems within a 30 month period; is conditionally licensed for 180 or more continuous days; is cited for two unrelated class I deficiencies in a survey, or has two class I deficiencies on separate surveys in a 30 month period.

The minimum dollar amount of fines for deficiencies in nursing homes and assisted living facilities is increased and fines are required to be imposed against facilities for deficiencies. The agency is to deny nursing home license renewals where the applicant has failed to pay prior agency or HCFA fines. Falsification of records is added as a basis for agency action against a nursing home license; falsification of records is made a second degree misdemeanor. Falsification of records in an assisted living facility is made a second degree misdemeanor and conviction is grounds for agency action against the license.

The bill increases the penalty for operation of an unlicensed assisted living facility from $500 to $1,000 per day for each day beyond five days after agency notification. If the unlicensed facility is operated by a person who concurrently operates a licensed facility, the fine is increased from $500 per day to $5,000 per day. The bill provides for a mandatory $5,000 fine for owners who fail to apply for a change-of-ownership license. Minimum notice for relocation of a resident is increased from 30 to 45 days.

The bill provides a statutory basis for the agency's existing watch list of facilities that meet the criteria for a conditional licensure status or are operating under bankruptcy protection and requires nursing homes to post the watch list.

When a facility has been cited for a class I deficiency, cited for 2 or more class II deficiencies in a 60 day period, or has had 3 or more substantiated complaints in a 6 month period which resulted in a class I or II deficiency, the agency must increase survey frequency to every 6 months for a 2 year period. The agency is to assess an additional $6,000 fine, which may be adjusted by the Consumer Price Index, for each facility subject to the 6-month survey cycle.

Newly hired facility surveyors must complete training and educational requirements as specified. A surveyor may not survey a home where he or she had been employed within the preceding five years. Joint training with surveyors and facility staff is required on a semiannual basis. A physician or nurse with geriatric experience must participate in any necessary informal dispute resolution with a nursing home.

Nursing Home Administration

Every nursing home must have a grievance procedure available to its residents and their families. Nursing homes and assisted living facilities are required to notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition. The physician must be notified within 30 days of acknowledgement of signs by facility staff. The facility is required to arrange for necessary care and services to treat any underlying condition. If a nursing home implements a dining and hospitality attendant program, it must be developed and implemented under the supervision of the facility director of nursing; a licensed nurse, licensed speech or occupational therapist, or dietitian must conduct the training of the attendants; and a person employed in this program must perform tasks under the direct supervision of a licensed nurse.

Each nursing facility is required to report to the agency, within 30 days, any filing for bankruptcy protection by the facility or a parent corporation, spin-off or divestiture of assets, and corporate reorganization. Each facility is required to maintain liability insurance coverage that is in force at all times. The agency is prohibited from taking any administrative action to enforce liability insurance requirements until after January 1, 2002.

Nursing homes are to maintain a daily chart of certified nursing assistant services provided, including assistance with activities of daily living and offers of nutrition and hydration. Charting must be completed by the end of each shift. Nursing assistants must receive annual performance reviews. Nursing homes may employ on a short-term basis, nursing assistants who have not completed minimum requirements as specified.

Nursing homes are allowed to require volunteers to sign in and out, wear identification badges, and participate in an orientation and training program.

Nursing homes are required to post a copy of the most recent "Nursing Home Guide Watch List."

The bill requires training of staff in nursing home facilities that provide care for residents with Alzheimer's disease. The training is to be approved by the Department of Elderly Affairs.

Internal Risk Management and Quality Assurance

The bill requires nursing homes to have an internal risk management and quality assurance program and report adverse incidents to the agency. Each nursing facility must have an internal risk-management and quality-assurance committee and must provide training to staff on how to reduce the risk of adverse incidents to residents. Assisted living facilities may establish a voluntary risk management program, but must report adverse incidents. Nursing homes and assisted living facilities must submit, as a condition of licensure, a plan for quality assurance and risk management. Each nursing home and assisted living facility must report monthly to the agency any liability claim filed against it. The agency is required to annually report specified information about adverse incidents in nursing homes and assisted living facilities.

Medicaid "Up-or-Out" Pilot Project

The bill requires the agency to develop a pilot project to manage the medical and supportive care needs of residents in nursing homes in selected counties. The project is to ensure the quality of care of residents by placing skilled and trained medical personnel in highest scoring nursing homes in the Florida Nursing Home Guide, subject to an appropriation. The project is to be modeled after Medicare-approved demonstration projects. The agency is required to report to the Legislature and Governor and assess the program and submit a proposal for expansion to additional facilities. The bill specifies several criteria for the project. The agency is authorized to provide this service through contract.

Reimbursement

The bill authorizes re-basing of both the direct and indirect patient care components of the Medicaid reimbursement rate for nursing homes and prohibits change of ownership rate increases. The bill provides that nursing homes filing for a change of ownership on or after September 1, 2001, will not be eligible for step-up increases in Medicaid rates associated with the change of ownership. The amendment allows nursing homes to include the costs of contracted nursing services as a part of the direct care subcomponent of patient care.

The agency is authorized to request and implement Medicaid waivers from the federal Health Care Financing Administration to treat a portion of the Medicaid nursing home per diem as capital for creating and operating a risk-retention group for self-insurance purposes, consistent with federal and state laws and rules.

The agency is required to develop a standardized chart of accounts for nursing home cost reports. The Auditor General is to approve this chart of accounts. The chart of accounts may not be revised without consent of the Auditor General. Nursing home cost reports must contain detailed information on salaries, benefits, overtime costs, and hours for direct care staff.

Nursing home cost reports filed with AHCA for periods ending on or after December 31, 2003, must be filed electronically in a format and manner prescribed by AHCA.

Alternatives to Nursing Homes

The bill places a moratorium on the issuance of additional Certificates of Need for nursing home construction, stating that it is the intent of the Legislature to limit the increase in Medicaid nursing home expenditures to invest these funds in community-based care, which is more effective and in keeping with the wishes of the elderly residents or this state. Sheltered beds in continuing care retirement communities are excluded from the moratorium.

When a receiver is appointed for a nursing home, each resident must be assessed by the Comprehensive Assessment and Review for Long-Term-Care program to evaluate each resident's need for nursing home care. Residents who could be served in less restricted settings are to be referred for such care and shall be given priority for Community Care For the Elderly Services.

Department of Elderly Affairs

The Department of Elderly Affairs, in consultation with the Agency for Health Care Administration and the Department of Community Affairs is required to adopt rules regarding the components of a comprehensive emergency management plan for adult day care centers. The office of the State Long-Term Care Ombudsman is to be responsible for the cost of leasing its own office space, but shall not be co-located with the headquarters office of the Department of Elderly Affairs.

Civil Litigation

The bill substantially revises the statutes providing for civil enforcement of violations of long-term care residents' rights and negligent acts for causes of action arising after May 15, 2001. For actions alleging a violation of resident rights or negligence causing the death of a resident, the claimant must elect either survival damages pursuant to s. 46.021, F.S., or wrongful death damages pursuant to s. 768.21, F.S. For actions alleging a violation of resident rights or negligence not resulting in a resident's death, damages for negligence may be recovered. A resident who prevails in seeking injunctive or administrative relief is entitled to recover costs, and attorney's fees up to $25,000. Attorney's fees are not recoverable for claims, or portions of claims, involving personal injury or death.

Chapter 400, F.S., provides the exclusive remedy for recovery of damages for personal injury or death of a long-term care resident due to negligence or a violation of resident rights. In accordance with this exclusivity, a conforming change is made to s. 415.1111, F.S., which provides a civil action for the abuse of a vulnerable adult. Actions not based upon negligence or a violation of resident rights are not precluded, except that no medical malpractice actions may be brought under ch. 400, F.S.

A claimant is required to prove that a defendant owed a duty to the resident, the duty was breached by the defendant, the breach of that duty was a legal cause of injury, and damages resulted therefrom. The defendant has a duty to exercise reasonable care, and a nurse has a duty to exercise care consistent with the prevailing professional standard. A violation of any resident rights or standards is evidence of negligence, but not negligence per se or strict liability. Copies of complaints filed with court clerks under ch. 400, F.S., must be submitted to the Agency for Health Care Administration.

The bill provides for presuit: notice of an asserted violation of a resident's rights or deviation from the standard of care; evaluation of the claim during a 75-day waiting period before a suit may be filed; informal discovery; and mediation requirements. Unsworn statements and other informal discovery material generated by this presuit process are not discoverable or admissible in any civil action. Failure to furnish complete copies of resident records in the custody of the long-term care facility is evidence of a failure to comply with good faith discovery requirements.

Actions for damages must be commenced within two years from the time the incident occurred, is discovered or should have been discovered, up to four years from the date of the incident. In the event of fraudulent concealment or intentional misrepresentation, an additional two years to file suit is available, up to six years from the date of the incident.

To recover punitive damages there must be clear and convincing evidence that a defendant was personally guilty of intentional misconduct or gross negligence. An employer will be responsible for punitive damages resulting from an employee's conduct only if the employer: knowingly participated in such conduct; condoned, ratified, or consented to the employee's conduct; or the employer's gross negligence contributed to the resident's injury. Punitive damages are generally limited to the greater of three times compensatory damages or $1,000,000. If the defendant's conduct was motivated primarily by unreasonable financial gain and the unreasonably dangerous conduct and high likelihood of injury was actually known by the person responsible for facility policy decisions, punitive damages are limited to the greater of four times compensatory damages or $4,000,000. If the defendant had a specific intent to harm the claimant there is no cap on punitive damages. Attorney's fees are to be calculated based on the final judgment including any punitive damages. Any jury involved may not be informed of the limitations on punitive damages. Punitive damages awarded must be equally divided between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund. In any case where punitive damages are awarded under ch. 400, F.S., the clerk of the court must refer the case to the appropriate law enforcement authorities for the initiation of a criminal investigation.

Appropriations

The Agency for Health Care Administration is appropriated $5,035,636 from the General Revenue Fund, $3,428,975 from the Health Care Trust Fund, and $6,710,164 from the Medical Care Trust Fund and 79 positions.

The Department of Elderly Affairs is appropriated $100,000.

The Long-Term Care Ombudsman is appropriated $948,782.

If approved by the Governor, these provisions take effect upon becoming law except as otherwise provided.
Vote: Senate 38-0; House 109-8

HB 1003 – Nursing Home Vaccinations

by Rep. Paul and others (CS/SB 634 by Appropriations Committee; Senators Clary and Cowin)

This bill provides that all residents of nursing homes who consent shall be given an influenza vaccination each year by November 30 or within 5 working days of admission if the resident is admitted after November 30 but before March 31, subject to exemptions for medical contraindications, religious or personal beliefs, documentation of previous vaccination, and availability of an adequate supply of vaccine. Each nursing home must assess all its residents for eligibility for pnuemococcal polysaccharide vaccination (PPV) within 60 days after the effective date of this act and vaccinate residents when indicated, subject to exemptions for medical contraindications, religious or personal beliefs, and documentation of previous vaccination. Residents admitted after the effective date of this act shall be assessed within 5 working days of admission, and vaccinated where indicated within 60 days of assessment. A resident may receive the flu or PPV immunization from his or her personal physician. Nursing homes are also required to encourage and promote influenza vaccination to their employees annually. The Agency for Health Care Administration may adopt and enforce rules necessary to comply with or implement the provisions of the bill.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 39-0; House 117-0

HEALTH CARE REGULATION

HB 69 — Pharmacy/Generic and Brand-Name Drugs

by Reps. Argenziano, Fasano, and others (SB 342 by Senators Clary, Latvala, Klein, Silver, Lee, Dyer, Brown-Waite, Geller, Campbell, Rossin, Smith, Diaz de la Portilla, and Crist)

The bill requires the Board of Pharmacy and the Board of Medicine to remove from the negative drug formulary any generic drug for which all commercially marketed equivalents of that drug product are "A" rated as therapeutically equivalent to a reference listed drug or is a reference listed drug in the *Orange Book* published by the United States Food and Drug Administration. The practical effect of this bill is to allow pharmacists to dispense a generic form of the particular drug instead of the brand-name version. According to the staff with the Board of

Pharmacy, the bill would require 4 drugs (digoxin, warfarin, quinidine gluconate, and phenytoin) to be taken off the negative drug formulary. The bill specifies that it does not alter or amend existing law authorizing a physician to prohibit generic drug substitution by writing "medically necessary" on the prescription.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 30-9; House 106-12

HB 401 — Pubic Records Exemption/Health Care Provider Information for Antitrust Review

by State Administration Committee and Rep. Brummer (SB 414 by Health, Aging & Long-Term Care Committee)

This bill reenacts s. 408.185, F. S., without substantive changes, in accordance with a review pursuant to the Open Government Sunset Review Act of 1995. Section 408.185, F.S., makes trade secrets and other confidential proprietary business information held by the Office of the Attorney General, which is submitted by a member of the health care community pursuant to a request for an antitrust no-action letter, confidential and exempt from the Public Records Law for one year after the date of submission. This section of law is subject to the Open Government Sunset Review Act of 1995, and expires on October 2, 2001, unless reviewed and saved from repeal by reenactment of the Legislature.

If approved by the Governor, these provisions take effect October 1, 2001.
Vote: Senate 39-0; House 116-1

SB 654 — Pharmacy/Licensure by Endorsement

by Senators Saunders, Latvala, Miller, Pruitt, Dyer, Peaden, Brown-Waite, and Klein

The bill creates s. 465.0075, F.S., providing licensure by endorsement requirements for a pharmacist who is licensed in another jurisdiction who has met certain other requirements to practice pharmacy in Florida. The bill requires the Florida Board of Pharmacy to certify that licensure by endorsement applicants have met the specified requirements. Under s. 465.0075, F.S., the Department of Health must issue a license to practice pharmacy by endorsement, to any applicant who has submitted a non-refundable application fee no greater than $100, and who the Board of Pharmacy certifies has met the following licensure by examination requirements specified in s. 465.007(1)(b) and (c), F.S.: has attained 18 years of age; has received a degree from a school or college of pharmacy accredited by an accrediting agency recognized and approved by the United States Office of Education or has graduated from a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States and has demonstrated proficiency in English by passing both the Test of English as a Foreign Language

and the Test of Spoken English; and has completed an internship program approved by the board. In addition, a graduate of a foreign school or college of pharmacy must have completed a minimum of 500 hours of supervised work in Florida under a licensed pharmacist and have passed the board-approved Foreign Pharmacy Graduate Equivalency Examination.

The opportunity to obtain licensure by endorsement is limited to a pharmacist who has actively practiced as a pharmacist in another jurisdiction for at least 2 of the preceding 5 years before application to practice in Florida, has successfully completed a board-approved postgraduate training or board-approved clinical competency examination within the year before application, or has completed an internship meeting existing statutory internship requirements within the 2 years immediately preceding application. The applicant must obtain a passing score on the pharmacy jurisprudence portions of the licensure examination and must document completion of 30 hours of board-approved continuing education in the 2 years preceding application. The bill requires the Board of Pharmacy to certify that the licensure by endorsement applicant has obtained a passing score on the licensure examination of the National Association of Boards of Pharmacy (NABPLEX) or a similar national organization not more than 12 years prior to applying for a license by endorsement in Florida. The bill prohibits the Department of Health from issuing a license to any applicant who is being investigated for acts that would violate regulations applicable to Florida-licensed pharmacists until the investigation is complete, or to any pharmacist whose license has been suspended or revoked in another state, or to any applicant whose license to practice pharmacy is currently the subject of any disciplinary proceeding.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 38-1; House 118-0

SB 666 — Physician Assistants

by Senator Sullivan

The bill authorizes physician assistants to dispense drug samples to patients within the regular course of the physician assistant's practice. The bill revises requirements for physician assistants to prescribe only medications listed on a formulary developed by a statutorily created committee. In lieu of the requirements for physician assistants to prescribe from that formulary, the bill authorizes the Council on Physician Assistants to establish a "negative" formulary, i.e., a formulary of medicinal drugs that a fully licensed physician assistant may not prescribe.

The "negative" formulary created by the bill must include controlled substances as defined in ch. 893, F.S., antipsychotics, general anesthetics and radiographic contrast materials, and all parenteral preparations except insulin and epinephrine. The bill requires the Council on Physician Assistants to consult with a Florida-licensed pharmacist who is not also licensed as a medical physician or osteopathic physician and who must be selected by the Secretary of the Department of Health. The Council on Physician Assistants is the only entity authorized to add to, delete from, or modify the "negative" formulary.

The Board of Medicine and the Board of Osteopathic Medicine must adopt, by administrative rule, the "negative" formulary of medicinal drugs that a fully licensed physician assistant may not prescribe. The "negative" formulary must be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the "negative" formulary, the Department of Health must mail a copy of the formulary to each fully licensed physician assistant and to each pharmacy licensed by the state.

If approved by the Governor, these provisions take effect October 1, 2001.
Vote: Senate 38-0; House 118-0

CS/SB 962 — Orthotics, Prosthetics, and Pedorthics

by Health, Aging & Long-Term Care Committee and Senator Diaz de la Portilla

This bill revises grandfathering provisions in s. 468.805(3), F.S., to extend the deadline from July 1, 2002, to July 1, 2003, to allow certain applicants for licensure as an orthotist, a prosthetist, a prosthetist-orthotist, or a pedorthist who have not received certification from a certifying body which requires successful completion of an examination before March 1, 1998, to waive the education requirements for licensure and to sit for the state licensure examination until July 1, 2003. The bill provides the Board of Orthotists and Prosthetists may not limit the number of times that an applicant may sit for the examination. An applicant has until July 1, 2003, to complete the examination process. To conform, the repeal date of s. 468.805, F.S., is extended from July 1, 2002, to July 1, 2003.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 31-0; House 116-0

CS/SB 1128 — Access to Medical Treatment Act

by Health, Aging & Long-Term Care Committee and Senator Latvala

The bill creates the "Access to Medical Treatment Act" to allow an allopathic or osteopathic physician to treat an individual for a life-threatening illness, disease, or condition by means of an investigational medical treatment subject to the individual's or the individual's legal representative's authorization, provided the following steps are followed:

- The physician examines the individual;
- There is no reasonable basis on which to conclude that the treatment itself when used as directed, poses an unreasonable and significant risk of danger to the individual;

- The physician provides an oral explanation and a written statement disclosing the facts regarding the nature of the treatment, that the treatment is experimental and not approved by the FDA for such indication, any available alternative treatments, and the risks of side effects which are generally recognized by reasonably prudent physicians.

- The individual acknowledges, in writing, receipt of such oral explanation and written statement.

If these steps are followed, the physician's investigational treatment cannot constitute *unprofessional conduct* by the physician on that basis alone. The bill provides that this provision is not intended to modify or change the scope of practice of any licensees of the Department of Health or alter in any way the provisions of individual practice acts, including the standard of care within the respective physician's practice act and the prohibition against fraud and exploitation.

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 36-0; House 118-0

SB 1324 — Health Care/Alternative Treatment

by Senators Peaden, Brown-Waite, Clary, and Klein

This bill authorizes licensed health care practitioners to provide complementary or alternative health care treatment as an option to conventional treatment. Legislative intent is provided that citizens should be able to make informed choices for any type of health care they deem to be an effective option, to include prevailing or conventional treatment methods as well as complementary or substitute methods. The Legislature intends that health care practitioners be able to offer complementary or alternative treatments with the same professional practice requirements as those of prevailing or conventional methods. The bill defines complementary or alternative health care treatment as any treatment in addition to or in place of prevailing or conventional treatment methods. Explicit documentation of informed consent communication with the patient is required, including communicating the benefits and risks associated with the complementary or alternative treatment sufficient for the patient to make an informed and prudent decision. The health care practitioner may recommend any mode of treatment that in the practitioner's judgment is in the best interests of the patient, including complementary or alternative methods. The bill specifies that it does not modify or change the scope of practice of any Florida health care practitioner or the provisions of the individual practice acts, which require licensees to practice within their respective standards of care and ethics. Finally, the bill revises the Florida Patient's Bill of Rights and Responsibilities to include the right to access complementary or alternative health care.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 32-1; House 118-0

CS/SB 1558 — Health Care

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

Reducing Medical Errors

The bill: exempts licensed health care practitioners in hospitals and ambulatory surgical centers from the required annual 1 hour of risk management and risk prevention education, but requires all health care practitioners to complete a 2-hour Department of Health or board-approved course relating to the prevention of medical errors as part of licensure; requires risk management programs in hospitals and ambulatory surgical centers to implement measures to minimize surgical mistakes; requires the Agency for Health Care Administration to publish certain information relating to adverse incidents on its website; requires the Department of Health to maintain a website that contains copies of the boards' newsletters, information relating to adverse incident reports without identifying the patient, practitioner, or facility in which the adverse incident occurred until 10 days after probable cause is found, and information about error prevention and safety strategies; requires risk managers to report every allegation of sexual misconduct by a licensed health care practitioner to the Department of Health; creates a privilege against civil liability for any licensed risk manager or facility with regard to information furnished under ch. 395, F.S., unless it involved bad faith or malice; makes it unlawful to interfere with a risk manager in the performance of his or her reporting obligations; revises the composition of the Health Care Risk Manager Advisory Council; specifies additional grounds for discipline related to medical errors and penalties for licensed health care practitioners; requires the Department of Health to notify the patient named in a complaint regarding the status of disciplinary investigations and authorizes the complainant to receive the department's expert report; specifies additional disciplinary violations which boards may subject to resolution by the issuance of a citation; provides for emergency suspension of a health care licensee for fraud; and makes nursing home administrators subject to discipline for failing to implement an ongoing quality-assurance program.

Medical Quality Assurance Trust Fund

The bill contains numerous provisions designed to improve the efficiency of health care practitioner regulation and to enable the Department of Health to adequately fund its Medical Quality Assurance function. The bill specifies legislative intent that the Medical Quality Assurance Trust Fund (MQATF) should be administered in a fiscally responsible manner. The Auditor General is required to complete a follow-up audit of the MQATF and to issue a report to the Legislature by January 31, 2002. The Office of Program Policy Analysis and Government Accountability must complete a study on the feasibility of maintaining the Medical Quality Assurance function within a single department and to issue a report to the Legislature by November 30, 2001. The Department of Health and the Agency for Health Care Administration must review all statutorily imposed reporting requirements and recommend changes to streamline reporting requirements.

The Department of Health must reimburse the Agency for Health Care Administration for the agency's actual direct costs and the agency's indirect costs incurred as a result of the contract between both agencies, subject to appropriated funds. The Agency for Health Care Administration must provide the Department of Health with documentation, explanation, and justification of all direct and indirect costs incurred, by budget entity.

The Department of Health's rulemaking authority for professions it regulates is expanded to specify the expiration dates of licenses and the process for tracking compliance with continuing education requirements, financial responsibility requirements, and any other conditions of renewal established in statute or in rule. Examination fees must include all costs to develop, validate, administer, and defend the examination and the examination fee is defined as an amount certain to cover all administrative costs plus the actual per-applicant cost of the examination. The department must electronically provide the scores of state-developed examinations to licensure candidates and post aggregate scores on the department's website without identifying the names of the candidates. The department or the appropriate board must approve and begin administering a national examination no later than December 31, 2001. Section 458.31151, F.S., which provided limits on fees for a special examination for foreign licensed physicians, is repealed.

Only candidates who fail an examination by less than ten percent are entitled to challenge the validity of the examination at an administrative hearing. Examination applicants using an examination in a language other than English must pay the full cost of the examination prior to the examination being administered. The department may implement electronic administration of examinations if adequate security measures are used.

The manner in which the Department of Health and boards set licensure renewal fees is revised to require the consideration of specified criteria. The department must charge an initial license fee as determined by the applicable board and must provide each board an annual report of revenue and direct and allocated expenses related to the operation of that profession on or before October 1 of each year. The board chairpersons must meet annually to review the department's long-range plan and proposed fee schedules and make recommendations for statutory changes. If the cash balance of the trust fund at the end of any fiscal year exceeds the total appropriation for regulation of the health care professions in the prior fiscal year, the boards, in consultation with the department may lower the fees. Unless otherwise approved in advance by the director of the Division of Medical Quality Assurance, board meetings must be conducted through teleconferencing or other technological means with specified exceptions. Each board's option to earmark $5 of the current licensure fee for unlicensed activity, if the board or profession is not in a deficit and has a reasonable cash balance, is deleted.

The department, if there is no board, must set a fee not to exceed $250, for approval of continuing education providers and a biennial renewal fee. The use of continuing education fees is specified and the department must implement an electronic continuing education tracking system, for which electronic renewals are implemented. Continuing education providers must provide information on course attendance to the department.

The disciplinary penalties and procedures for health care practitioners are revised and streamlined and made more uniform. A six year statute of limitation is imposed on the filing of a disciplinary complaint against a licensed health care practitioner with specified exceptions. The statute of limitation does not apply to bar the initiation of an investigation or filing of an administrative complaint beyond the six year timeframe if the incident or occurrence involved criminal actions, diversion of controlled substances, sexual misconduct, or impairment by the licensee. In cases in which it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented discovery of the violation of law, the period of limitations is extended forward, but may not exceed 12 years after the time of the incident or occurrence. The department, in consultation with the applicable board, must establish a plan to expedite rather than reduce any investigation or disciplinary proceeding that is not before the Division of Administrative Hearings or otherwise completed by the department within 1 year after filing of the complaint. A specific finding of aggravating or mitigating circumstances must be in final order to allow the department or applicable board to impose a disciplinary penalty other than that provided for in disciplinary guidelines. In addition to any other discipline imposed for a violation of any practice act, the board or department when there is no board must assess costs related to the investigation and prosecution of the disciplinary case.

Authority of Department of Health and Boards

The boards or the Department of Health are authorized to temporarily or permanently appoint a person or entity as a custodian of medical records in the event of the death of a practitioner, the mental or physical incapacitation of the practitioner, or the abandonment of medical records by a practitioner. The appointed custodian must comply with all requirements for the maintenance and release of the medical records. Unless expressly and specifically granted in statute, the duties conferred on the boards do not include the enlargement, modification, or contravention of the lawful scope of the profession regulated by the boards.

Credentialing System for Health Care Practitioners

The bill revises the Department of Health's credentialing program for health care practitioners to provide intent that the department and all entities and practitioners work cooperatively to ensure the integrity and accuracy of the program and to revise definitions. The bill provides that healthcare entities and credentials verification organizations may rely upon any data that has been primary-source verified by the department or its designee to meet primary-source verification requirements of national accrediting organizations.

Medical and Osteopathic Physicians

The bill revises procedures for persons obtaining a temporary certificate to practice medicine in an underserved area to require the Board of Medicine or the Board of Osteopathic Medicine to review the application and issue a temporary certificate or notify the applicant of denial within 60 days after the receipt of the application.

Medical School Eligibility

The bill creates s. 458.3147, F.S., to allow certain Florida residents who are students at or graduates of the United States military academies and who have command approval to apply to medical school prior to assignment to the medical corps of the United States military to be admitted to any medical school in the State University System. Each medical school in the State University System must admit two such applicants each academic year.

Physician Assistants

Effective October 1, 2001, physician assistants may dispense drug samples to patients within the regular course of the physician assistant's practice. The bill revises requirements for physician assistants to prescribe only medications listed on a formulary developed by a statutorily created committee. In lieu of the requirements for physician assistants to prescribe from that formulary, the bill authorizes the Council on Physician Assistants to establish a "negative" formulary, i.e., a formulary of medicinal drugs that a fully licensed physician assistant may not prescribe.

The "negative" formulary created by the bill must include controlled substances as defined in ch. 893, F.S., antipsychotics, general anesthetics and radiographic contrast materials, and all parenteral preparations except insulin and epinephrine. The bill requires the Council on Physician Assistants to consult with a Florida-licensed pharmacist who is not also licensed as a medical physician or osteopathic physician and who must be selected by the Secretary of the Department of Health. The Council on Physician Assistants is the only entity authorized to add to, delete from, or modify the "negative" formulary.

The Board of Medicine and the Board of Osteopathic Medicine must adopt, by administrative rule, the "negative" formulary of medicinal drugs that a fully licensed physician assistant may not prescribe. The "negative" formulary must be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the "negative" formulary, the Department of Health must mail a copy of the formulary to each fully licensed physician assistant and to each pharmacy licensed by the state.

Pharmacy

Institutional pharmacies or pharmacies with special permits that employ or utilize pharmacy technicians are required to have a written policy and procedures manual specifying those duties, tasks, and functions that a pharmacy technician is allowed to perform. The bill amends s. 499.012, F.S., relating to wholesale drug distribution, to revise one of the conditions under which a retail pharmacy may engage in wholesale distribution, to include certain transfers between a modified class II institutional pharmacy and another retail pharmacy or a health care practitioner licensed in Florida and authorized to dispense or prescribe drugs.

Nursing

The bill amends requirements for the Nursing Student Loan Forgiveness Program to include public schools as employing institutions whose nurse employees are eligible to receive loan repayment under the program. The bill extends an exemption to public schools, family practice teaching hospitals, and specialty children's hospitals from the requirement to match loan forgiveness funding for those nurses employed by those entities. The bill creates a priority listing, by employer, for the disbursement of funds from the Nursing Student Loan Forgiveness Trust Fund, if insufficient funding prevents the grant of all eligible applicant's request for awards.

The bill transfers, by a type two transfer, the Nursing Student Loan Forgiveness Program and the Nursing Scholarship Program from the Department of Education to the Department of Health.

The Nursing Scholarship Program requirements are also amended to include nursing homes, hospitals, public schools, university colleges of nursing, and community college nursing programs in the list of places where scholarship recipients can complete their service obligation. The bill expands the eligibility for the Nursing Scholarship Program to include scholarship applicants who are enrolled as full-time or part-time students in the upper division of an approved nursing program leading to the award of a graduate degree that qualifies the recipient for a nursing faculty position.

The bill revises nursing licensing procedures to allow the Board of Nursing to determine the equivalency of other nursing programs to an approved nursing program for applicants to meet the licensure by examination requirements. The bill requires nursing licensure by endorsement applicants to submit to a national criminal history check in addition to the state criminal history check currently required. The department must develop an electronic applicant notification process for endorsement applicants and must issue a license within 30 days after the completion of all required data collection and verification. The application and processing fee is eliminated for persons applying for retired volunteer nurse certificates.

The Board of Nursing is transferred from Jacksonville to Tallahassee, effective July 1, 2003. The bill creates the Florida Center for Nursing to address issues of supply and demand for nursing, including recruitment, retention, and utilization of nurse workforce resources. The center is to be governed by a policy-setting board of directors consisting of 16 members as specified. The Board of Nursing is directed to hold in abeyance until July 1, 2002, the development of any rule, which relates to the establishment of faculty/student clinical ratios. The Board of Nursing and the Department of Education must submit an implementation plan for proposed rule changes to the Legislature by December 31, 2001.

Dentistry

The bill amends s. 456.031, F.S., relating to continuing education requirements for health care practitioners, to permit dentists and dental hygienists to take a course designated by the Board of

Dentistry, in lieu of completing a course in domestic violence, if the licensee has completed an approved domestic violence course in the immediately preceding biennium. The bill amends s. 456.033, F.S., relating to a requirement for instruction on human immunodeficiency virus and acquired immune deficiency syndrome, to permit dentists and dental hygienists to take a course designated by the Board of Dentistry, in lieu of completing a course in AIDS/HIV, if the licensee has completed an approved AIDS/HIV course in the immediately preceding biennium.

Radiation Therapy

The bill revises exceptions to radiologic technology certification to allow a general radiographer certified under part IV, ch. 468, F.S., who receives additional training and skills in radiation therapy technology procedures to assist with managing patients undergoing radiation therapy treatments, if that assistance is provided to a person who is certified as a radiation therapy technologist under part IV, ch. 468, F.S., and who is also registered with the American Registry of Radiologic Technologists in radiation therapy. Both the general radiographer and the radiation therapy technologist must perform these radiation therapy services under the general supervision of a Florida-licensed medical or osteopathic physician. The radiation therapy technologist may not delegate any function to the general radiographer which could create an unnecessary danger to the patient's life, health, or safety. The bill specifies training requirements for the general radiographer and other limitations on the tasks delegated to the general radiographer.

Opticianry

The bill enhances the criminal penalty applicable to the preparing or dispensing of optical devices without a prescription under the opticianry practice act from a second-degree misdemeanor to a third degree felony. The bill provides a definition of the terms, "optical dispensing" and "contact lenses." "Contact lenses" mean a prescribed medical device intended to be worn directly against the cornea of the eye to correct vision conditions, act as a therapeutic device, or provide a cosmetic effect. In effect, persons who are not licensed to practice opticianry in Florida and who are not otherwise exempt from opticianry licensure may not prepare or dispense contact lenses as defined in the bill without a prescription from a duly licensed physician or optometrist. The new offense is a second degree misdemeanor punishable by up to 60 days in jail and maximum fine of $500.

The bill replaces references to the term "medical doctor" with the term "allopathic or osteopathic physician" and revises requirements for prescribing optical devices to clarify that such prescriptions must be written by licensed allopathic or osteopathic physicians. The bill revises the Criminal Punishment Code to specify that practicing opticianry without a license (a third degree felony) is a level 7 offense, for purposes of a minimum sentence calculation. Additionally, the bill expands the inspection authority of the Department of Health from establishments where optical devices are prepared and dispensed to include establishments of any kind in the state in which lenses, spectacles, eyeglasses, contact lenses, and any other optical device is prepared or dispensed.

Miscellaneous Regulatory Provisions

The bill revises provisions governing prohibited referrals to clinical laboratories to prohibit certain fee arrangements between dialysis facilities and clinical laboratories.

The bill provides that the Agency for Health Care Administration must create an Organ Transplant Task Force of up to 15 members from the agency, organ transplant providers and transplant recipients. The purpose of the task force is to study and make recommendations regarding the supply of organs, the number of existing transplant programs and the necessity of the current certificate-of-need requirement as to proposed programs. The task force must submit a report to the Legislature by January 15, 2002, consisting of at a minimum: a summary of the method of allocation and distribution of organs; a list of the facilities performing multiple organ transplants and the number being performed; the number of Medicaid and charity care patients who have received organs from existing transplant programs; suggested mechanisms for funding transplants including a potential organ transplant fund for Medicaid and charity patients; the impact of trends in transplant delivery and financing; and the number of transplant certificate-of-need applications reviewed, approved, denied and litigated in the previous five years. The task force will be dissolved December 31, 2002.

The bill directs the Department of Health to conduct a study of the area of specialty certification relating to the Board of Medicine, the Board of Osteopathic Medicine, and the Board of Dentistry. The study should review current statutes and administrative rules to determine if any barriers exist in board recognition of certifying organizations and if restrictions placed on a licensee's speech target an identifiable harm and mitigate against such harm in a direct and effective manner. The department must submit a final report no later than January 1, 2002, to the President of the Senate and the Speaker of the House of Representatives.

Respiratory Care

The bill restricts the use of specified titles to only Florida-licensed respiratory care practitioners to reflect credentials from national certification entities such as the National Board for Respiratory Care in addition to State licensure.

Psychology and Psychotherapy

The bill revises requirements for the use of specified protected titles relating to the practice of psychology and psychotherapy. Effective January 1, 2002, the bill amends s. 490.012, F.S., relating to psychology, to prohibit any person from holding herself or himself out by any title or description incorporating the word "psychologist" unless such person holds a valid active license as a psychologist under ch. 490, F.S. A person is prohibited from holding 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 ch. 490, F.S., or is certified as a school psychologist by the Department of Education.

Effective January 1, 2002, the bill amends s. 490.014, F.S., relating to psychology and s. 491.014, F.S., relating to psychotherapy, to limit an exemption to licensure by employees of: governmental agencies, developmental services programs, mental health, alcohol, or drug abuse facilities operating under chs. 393, 394, or 397, F.S., subsidized child care programs, subsidized child care case management programs, or child care resources and referral programs operating under ch. 402, F.S.; child-placing or child-caring agencies licensed under ch. 409, F.S.; domestic violence centers certified under ch. 39, F.S.; accredited academic institutions; research institutions, if such employees are performing duties for which he or she was trained and hired solely within the confines of such agency, facility, or institution and the employee is not held out to the public as a psychologist pursuant to s. 490.012(1)(a), F.S., or as a psychologist, clinical social worker, mental health counselor, or marriage and family therapist. Effective January 1, 2002, the bill similarly limits the exemption to the psychology and psychotherapy licensing requirements for employees of a private, nonprofit organization providing counseling services to children, youth, and families when such services are provided for no charge, if the employee is performing duties for which he or she was trained and hired and if the employee is not held out to the public as a psychologist pursuant to s. 490.012(1)(a), F.S., or as a clinical social worker, mental health counselor, or marriage and family therapist.

Effective January 1, 2002, the bill amends s. 491.012, F.S., relating to clinical social work, marriage and family therapy, and mental health counseling, to revise criminal violations for unlicensed practice of these professions, to allow interns registered with the Department of Health to provide comparable services without being subject to the specified criminal penalties.

Hearing Aid Specialists

The bill amends s. 484.0445, F.S., relating to the hearing aid specialists' training program and examinations, to delete requirements and procedures for the Department of Health to administer the written and practical examinations for persons to qualify for licensure to practice as a hearing aid specialist. The Board of Hearing Aid Specialist's rulemaking authority over training programs is revised to provide for a training program that has a minimum duration of 6 months. The board currently may only adopt by rule a training program that does not exceed a duration of 6 months. The bill revises license examination requirements to eliminate a clinical component, and to conform to changes to reflect that the Department of Health will no longer administer the examination. In lieu thereof, licensure candidates must pass an examination adopted by board rule and must demonstrate a knowledge of state laws relating to the fitting and dispensing of hearing aids. Restrictions on the number of times an applicant may sit for the licensure examination is eliminated. Any person who fails the examination may apply for reexamination to the appropriate examining entity as prescribed by board rule.

Massage

The bill amends s. 480.033, F.S., relating to definitions for the practice of massage therapy, to revise the definition of "massage" to mean the manipulation of the "soft" rather than "superficial" tissues of the human body with the hand, foot, arm, or elbow, whether or not such

manipulation is aided by hydrotherapy, including colonic irrigation, or thermal therapy; any electrical device; or the application to the human body of a chemical or herbal preparation.

Speech-language Pathology and Audiology

The bill amends s. 468.1155, F.S., relating to speech-language pathology and audiology, to revise provisional license requirements, to allow candidates to obtain provisional licensure who have not yet received a master's degree and who are currently enrolled in a doctoral degree program from an accredited institution in speech-language pathology or audiology and who have completed the number of clock hours required by an accredited institution meeting national certification standards in lieu of the current requirements for such applicants that include obtaining a master's degree and the 300 supervised clinical clock hours. The bill revises certification requirements for speech-language pathology assistants and audiology assistants to require applicants to complete at least 24 semester hours of coursework that are currently required for certification at an institution accredited by an accrediting agency recognized by the Council for Higher Education Accreditation. The Council for Higher Education Accreditation is the successor to the Commission on Recognition of Postsecondary Accreditation.

Orthotics, Prosthetics, and Pedorthics

The bill revises grandfathering requirements for licensure to practice orthotics, prosthetics, or pedorthics without meeting statutory educational requirements. The bill repeals s. 1. of Chapter 99-158, L.O.F., which extended the licensure application deadline established in s. 468.805(1), F.S., from March 1, 1998, to July 1, 1999, to allow a person who had met the experience requirements to practice orthotics, prosthetics, and pedorthics before March 1, 1998, to apply for licensure, based on the person's experience and educational preparation, without meeting the statutory educational requirements for licensure.

Registration of Medical Clinics

Effective October 1, 2001, the bill creates s. 456.0375, F.S., to require clinics to register with the Department of Health within 60 days after October 1, 2001. "Clinic" is defined to mean a business operating in a single structure or facility or group of adjacent structures or facilities operating under the same business name or management at which health care services are provided to individuals and which tenders charges for reimbursement for such services. Clinics that are not exempt must comply with the bill's requirements to employ or contract with a medical director who is a Florida-licensed physician or with a clinic director who is a Florida-licensed health care practitioner.

A clinic licensed or registered under chapters 390 (abortion), 394 (mental health), 395 (hospitals), 397 (substance abuse services), 400 (nursing homes), 463 (optometry), 465 (pharmacy), 466 (dental), 478 (electrolysis), 480 (massage), or 484 (optical/ hearing aid specialist), F.S., or that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) of the Tax Code is exempt from the bill's requirements. The bill exempts a sole proprietorship, group

practice, partnership, or corporation that provides health care services pursuant to ch. 457(acupuncture), 458 (medicine), 459 (osteopathic medicine), 460 (chiropractic medicine), 461 (podiatric medicine), 462 (naturopathy), 463 (optometry), 466 (dentistry), 467 (midwifery), 484 (hearing aid specialist/opticianry), 486 (physical therapy), 490 (psychology and school psychology), 491 (marriage and family therapy, mental health counseling, and clinical social work), and parts I, III, X, XIII, or XIV of ch. 468, F.S., (speech-language pathology and audiology, occupational therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics) or s. 464.012, F.S., (advanced registered nurse practitioners) which are wholly owned by licensed health care practitioners or wholly owned by licensed health care practitioners and the spouse, parent, or child of a licensed health care practitioner, if one of the owners who is a licensed health care practitioner is supervising the services performed therein and is legally responsible for the entity's compliance with all federal and state laws. No health care practitioner may supervise services beyond the scope of the practitioner's license.

Each clinic must employ or contract with a Florida-licensed allopathic or osteopathic physician, chiropractic physician, podiatric physician to serve as the medical director. However, if the clinic is limited to providing health care service services pursuant to ch. 457(acupuncture), 484 (hearing aid specialist/opticianry), 486 (physical therapy), 490 (psychology and school psychology), 491 (marriage and family therapy, mental health counseling, and clinical social work), and parts I, III, X, XIII, or XIV of ch. 468, F.S., (speech-language pathology and audiology, occupational therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics), the clinic may appoint a health care practitioner licensed under that chapter to serve as the clinic director who is responsible for the clinic's activities. A health care practitioner may not serve as the clinic director who is responsible for the clinic's activities if the services provided at the clinic are beyond the scope of that practitioner's license.

All clinics that are not otherwise exempt must register with the Department of Health. Registration may be performed electronically. The Department of Health must adopt rules to implement a registration program, including rules prescribing registration fees. The fees must not exceed an amount that will provide sufficient revenue to administer the registration program.

The medical director or clinic director is required to be legally responsible for activities on behalf of the clinic and the bill specifies the duties of the medical director or clinic director of such clinic.

Any person operating or managing an unregistered clinic commits a third degree felony. A third degree felony carries a maximum prison sentence of 5 years and a maximum fine of $5,000. The Department of Health must revoke the registration of clinics found to be in violation of the provisions of the bill. The Department of Health must investigate allegations of noncompliance with this section and the rules adopted pursuant to s. 456.0375, F.S. Also, a violation by a licensed health care practitioner would be grounds for discipline under ch. 456, F.S., and the practice act of that practitioner. All charges or any reimbursement claims made by or on behalf of unregistered clinics are considered to be unlawful charges and therefore be noncompensable and unenforceable. The bill makes any contract to serve as a medical director or clinic director

entered into or renewed by a physician or licensed health care practitioner after October 1, 2001, that violates the provisions of the bill void.

The sum of $100,000 is appropriated from the registration fees collected from the clinic pursuant to s. 456.0375, F.S., and one-half of one full-time equivalent position is authorized to the Department of Health for the purposes of regulating medical clinics pursuant to s. 456.0375, F.S. The appropriated funds must deposited into the Medical Quality Assurance Trust Fund.

Public Medical Assistance Trust Fund

Effective upon becoming a law and operating retroactively to July 1, 2000, the bill revises requirements for the Public Medical Assistance Trust Fund to delete an effective date contingent on the Agency for Health Care Administration receiving written confirmation from the federal Health Care Financing Administration that the changes contained in such amendments will not adversely affect the use of the remaining assessments as state match for the state's Medicaid program. The bill amends s. 395.701, F.S., relating to the annual hospital assessment to fund public medical assistance, to specify that worksheets from a hospital's prior year financial report to the Agency for Health Care Administration may be reconciled to the hospital's audited financial statements, but no additional audited financial components may be required, other than those in effect on July 1, 2000, for purposes of determining the amount of the assessment.

Managed Care Organizations/Adverse Determinations

The bill amends s. 641.51, F.S., to provide that only those allopathic or osteopathic physicians with an active and unencumbered Florida license may render an adverse determination regarding a service provided by a Florida-licensed physician to a subscriber of an HMO or prepaid health clinic. Out of state physicians and physicians with inactive or encumbered Florida licenses could no longer make adverse determinations for an HMO. Further, the bill clarifies that this provision does not create authority for either the Board of Medicine or the Board of Osteopathic Medicine to regulate an HMO or prepaid health clinic, however, such boards may continue to have jurisdiction over licensees of their respective boards.

Dental Claims

The bill amends s. 627.419, F.S., relating to the construction of insurance policies, to establish a process to appeal adverse decisions as to dental coverage. It provides that for any group or individual insurer covering dental services, that a claimant, or provider acting on the behalf of a claimant, who has had an adverse decision rendered on a claim, must be given an opportunity to appeal to the insurer's licensed dentist who is responsible for the dentally necessary reviews under the plan or is a member of the plan's peer review group. The appeal may be made by telephone and the insurance company's licensed dentist must respond within 15 business days.

Interscholastic Athletics

The bill amends s. 232.435, F.S., relating to extracurricular athletic activities and athletic trainers, to revise requirements for the employment classification and advancement scheme for school district programs to delete the positions and requirements for teacher apprentice trainer I and teacher apprentice trainer II. The requirements for teacher athletic trainer are revised to require a person to possess a professional, temporary, part-time, adjunct, or substitute certificate pursuant to s. 232.17, F.S., and to hold a Florida license to practice as an athletic trainer. The requirements for a first responder position is created. To qualify for first responder, a person must possess a professional, temporary, part-time, adjunct, or substitute certificate pursuant to s. 232.17, F.S., and be certified in cardiopulmonary resuscitation, first aid, and have 15 semester hours in specified coursework. The first responder may only administer first aid and similar care.

The bill amends s. 232.61, F.S., to require the Florida High School Activities Association (FHSAA) to adopt bylaws requiring all students participating in interscholastic athletic competition or who are candidates for an athletic team to satisfactorily pass an annual medical evaluation before participating in athletic competition or engaging in practices, tryouts, workouts, or any other physical activity associated with the student's candidacy for a position on an athletic team. The evaluation must be administered by a medical physician licensed under provisions of ch. 458, F.S., an osteopathic physician licensed under ch. 459, F.S., a chiropractic physician licensed under ch. 460, F.S., or a licensed nurse who is certified as an advanced registered nurse practitioner under s. 464.012, F.S. If the medical practitioner administering the evaluation determines there may be an abnormality in the student's cardiovascular system, the student may not participate in any school related athletic activities unless an electrocardiogram (EKG) or other cardiovascular assessment indicates the abnormality will not place the student at risk during athletic activity. If a student's parent or guardian objects to the requirement for a medical evaluation, the student still may participate in interscholastic athletic competition or be a candidate for a team as long as the parent or guardian objects in writing and attests that the medical evaluation is contrary to his or her religious beliefs, and as long as no person is held liable in the event the student is injured while participating in an athletic competition, or at a practice or workout as a candidate for a team.

Palliative Care

The bill redefines "end-stage condition" in ch. 765, F.S., to be a condition that has resulted in progressively severe and permanent deterioration and for which, treatment of the condition would be ineffective to a reasonable degree of medical probability. "Palliative care" is defined in s. 765.102, F.S., to be the comprehensive management of the physical, psychological, social, spiritual and existential needs of the patient, particularly those patients with an incurable, progressive illness. The bill amends s. 765.1103, F.S., relating to pain management and palliative care, to require providers and practitioners regulated under chapters 458 (medicine), 459 (osteopathic medicine), or 464 (nursing), F.S., to comply with a request for pain management or palliative care from a patient under their care or, for an incapacitated patient under their care, from a surrogate, proxy, guardian, or other representative permitted to make health care

decisions for the incapacitated patient. Facilities regulated under ch. 400, F.S., or ch. 395, F.S., must comply with the pain management or palliative care measures ordered by the patient's physician. Requirements for the court-appointed guardian or attorney in fact to have been delegated authority to make health care decisions on behalf of the patient are eliminated. The statutory responsibilities of health care surrogates and proxies under ch. 765, F.S., are revised to provide that absent patient intent, the surrogate or proxy may consider the patient's best interest in deciding whether to withhold or withdraw treatment.

Medicaid

The bill prohibits Medicaid reimbursement of dental services provided in a mobile dental unit except for a mobile dental unit owned or operated by the Department of Health or a Federally Qualified Health Center in compliance with Medicaid program specifications, a mobile dental unit that provides services at a nursing facility, or a mobile unit having a contractual agreement with a state-approved dental educational institution. The bill allows the Agency for Health Care Administration to restrict mandatory services rendered by providers in mobile units and to restrict or prohibit optional services rendered by providers in mobile units. The bill amends s. 409.91188, F.S., to require the Agency for Health Care Administration to seek all necessary federal waivers to allow Medicare beneficiaries who test positive for HIV infection and who also qualify for Medicaid benefits to participate in the Medipass HIV disease management program.

The bill amends s. 409.9205, F.S., relating to the Medicaid Fraud Control Unit, to transfer all positions in the Medicaid Fraud Control Unit of the Department of Legal Affairs to the Career Service System, except as provided in s. 110.205, F.S. Investigators employed by the Medicaid Fraud Control Unit are no longer ineligible for membership in the Special Risk Class of the Florida Retirement System.

Nursing Homes/Influenza and Pneumococcal Vaccinations

The bill provides that all residents of nursing homes who consent shall be given an influenza vaccination each year by November 30 or within 5 working days of admission if the resident is admitted after November 30 but before March 31, subject to exemptions for medical contraindications, or religious or personal beliefs. Each nursing home must assess all its residents for eligibility for pnuemococcal polysaccharide vaccination within 60 days after the effective date of this act and vaccinate residents when indicated, subject to exemptions for medical contraindications and religious or personal beliefs. Nursing homes are also encouraged to promote vaccination of their employees against influenza virus. The Agency for Health Care Administration may adopt and enforce rules necessary to comply with or implement these provisions of the bill.

Medical Records/Solicitation

The bill prohibits the use of patient information for solicitation or marketing the sale of goods or services absent a specific written release or authorization permitting utilization of patient

information for that purpose. The Department of Insurance must adopt rules to govern the use of a consumer's nonpublic financial and health information by health insurers and health maintenance organizations (HMOs) consistent with the National Association of Insurance Commissioners' Privacy of Consumer and Health Information Regulation adopted September 26, 2000. Such rules must be consistent with, and not more restrictive than, the standards contained in Title V of the Gramm-Leach-Bliley Act of 1999 (Pub. L. No. 106-102).

Health Care Background Screening

Effective June 1, 2001, the bill saves from repeal provisions establishing the background screening requirements for owners and operators of health care facilities and programs enacted in Chapter 98-171, L.O.F.

Florida Birth-Related Neurological Injury Compensation Plan

The bill revises the definition of "birth-related neurological injury" to mean injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital that renders the infant permanently and substantially mentally and physical impaired. The bill establishes that an administrative law judge must make an award for payment of funeral expenses not to exceed $1,500. Section 766.308, F.S., is repealed that requires each claim filed under Florida Birth-Related Neurological Injury Compensation Plan to be reviewed by a medical advisory panel.

Office of Community Partners

The bill creates the Office of Community Partners within the Department of Health for purposes of receiving, coordinating, and dispensing federal funds set aside to expand the delivery of social services through eligible private community organizations and programs. The office must provide policy direction and promote civic initiatives which seek to preserve and strengthen families.

If approved by the Governor, except as otherwise provided, these provisions take effect July 1, 2001.
Vote: Senate 38-0; House 114-0

CS/SB 1568 — Health Care Service Programs

by Banking & Insurance Committee and Senators Sebesta, Crist, and Cowin

This bill provides that only those allopathic or osteopathic physicians with an active and unencumbered Florida license may render an adverse determination regarding a service provided by a Florida-licensed physician to a subscriber of a health maintenance organization or prepaid

health clinic. Out-of-state physicians and physicians with inactive or encumbered Florida licenses will be precluded from making adverse determinations. The bill clarifies that this provision does not create authority for either the Board of Medicine or the Board of Osteopathic Medicine to regulate a health maintenance organization or prepaid health clinic, however, such boards continue to have jurisdiction over their respective licensees.

If approved by the Governor, these provisions take effect January 1, 2002.
Vote: Senate 38-0; House 116-3

CS/SB 1788 — Dentistry

by Health, Aging & Long-Term Care Committee and Senators Wasserman Schultz , Peaden, Sanderson, Clary and Cowin

Dental Continuing Education

The bill amends the domestic violence continuing education requirements for certain health care professionals in s. 456.031, F.S., to provide a licensed dentist or dental hygienist the option of completing a course approved by the Board of Dentistry in lieu of a domestic violence course for licensure renewal, if the licensed dentist or dental hygienist has completed a domestic violence course in the immediately preceding 2 years.

The bill amends the AIDS/HIV continuing education requirements for certain health care professionals in s. 456.033, F.S., to provide a licensed dentist or dental hygienist the option of completing a course approved by the Board of Dentistry in lieu of an AIDS/HIV course for licensure renewal, if the licensed dentist or dental hygienist has completed an AIDS/HIV course in the immediately preceding 2 years.

Dental Claims

The bill amends s. 627.419, F.S., relating to the construction of insurance policies, to establish a process to appeal adverse decisions as to dental coverage. It provides that for any group or individual insurer covering dental services, a claimant, or provider acting on the behalf of a claimant, who has had an adverse decision rendered on a claim, must be given an opportunity to appeal to the insurer's licensed dentist who is responsible for the dentally necessary reviews under the plan or is a member of the plan's peer review group. The appeal may be made by telephone and the insurance company's licensed dentist must respond within 15 business days. Section 627.419, F.S., as amended by this bill shall apply to policies issued or renewed after July 1, 2001.

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 37-0; House 115-0

CS/CS/SB 2156 — End-of-Life Care

by Judiciary Committee; Health, Aging & Long-Term Care Committee; and Senator Klein

This bill amends continuing education requirements for licensed dentists and dental hygienists, to provide an option of completing a course approved by the Board of Dentistry in lieu of a domestic violence course or an AIDS/HIV course for licensure renewal, if the licensee has completed a course in domestic violence or AIDS/HIV in the immediately preceding two years.

The term "end-stage condition" is defined to be an irreversible condition resulting in progressively severe and permanent deterioration, for which, to a reasonable degree of medical probability, treatment would be ineffective. "Palliative care" is defined as the comprehensive management of all the needs of the patient, particularly those patients with an incurable, progressive illness. Palliative care must include: end-of-life care planning; attendance to suffering; honoring life-sustaining preferences; prioritization of personal goals and dignity; assurance of care and family support; respect for advance directives; and assurance of adequate organizational mechanisms, reimbursement and cultural propriety.

The bill provides that allopathic and osteopathic physicians and nurses must comply with a request for pain management or palliative care from a patient. A surrogate, proxy, guardian, or other representative is permitted to make health care decisions for an incapacitated patient. Long-term care facilities and hospitals must comply with the pain management or palliative care measures ordered by the patient's physician. Where there is no indication of an incapacitated patient's health care preferences, a surrogate or proxy may consider the patient's best interest.

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 39-0; House 119-0

CS/SB 684 — Organ Transplantation

by Health, Aging & Long-Term Care Committee and Senators Cowin, Smith, Sullivan, Mitchell, and Latvala

This bill provides that the Agency for Health Care Administration must create an Organ Transplant Task Force of up to 15 members from the agency, organ transplant providers and transplant recipients. The purpose of the task force is to study and make recommendations regarding the supply of organs, the number of existing transplant programs and the necessity of the current certificate-of-need requirement as to proposed programs. The task force must submit a report to the Legislature by January 15, 2002, consisting of at a minimum: a summary of the method of allocation and distribution of organs; a list of the facilities performing multiple organ transplants and the number being performed; the number of Medicaid and charity care patients who have received organs from existing transplant programs; suggested mechanisms for funding transplants including a potential organ transplant fund for Medicaid and charity patients; the impact of trends in transplant delivery and financing; and the number of transplant

certificate-of-need applications reviewed, approved, denied and litigated in the previous five years. The task force will be dissolved December 31, 2002.

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 39-0; House 118-0

CS/SB 688 — Health Care Background Screening

by Health, Aging & Long-Term Care Committee

The bill requires the Agency for Health Care Administration to convene an interagency workgroup to study the establishment of uniform background screening requirements for health care licensees. The interagency workgroup is required to review ch. 435, F.S., providing for criminal background screening, and propose updates to the list of criminal offenses used in the screening process, specify appropriate statutes of limitation for disqualifying offenses, and identify any civil actions that might be added to the list of current criminal screens. The workgroup will consist of at least five members from various state agencies and two members from the Legislature, and is required to report to the Governor and the Legislature by December 1, 2001, after which it is abolished. The bill repeals the June 30, 2001, repeal date for the background screening requirements enacted in Chapter 98-171, L.O.F.

If approved by the Governor, these provisions take effect June 1, 2001.
Vote: Senate 39-0; House 120-0

CS/CS/SB 2092 — Health Care

by Appropriations Committee; Health, Aging & Long-Term Care Committee; and Senator Sanderson

Indigent Health Care

The bill specifies procedures for computing the maximum amount that counties having a population of 100,000 or less must pay for the treatment of indigent residents of the county at a hospital located outside the county. It provides for the exclusion of active-duty military personnel and certain institutionalized county residents from the state population estimates when calculating a county's financial responsibility for the hospital care. The bill requires the county of residence to accept the hospital's documentation of financial eligibility and county residence and requires that the documentation meet specified criteria.

Community Hospital Education Program

The bill transfers by a type two transfer, defined in s. 20.06, F.S., the Community Hospital Education Program (CHEP) from the Board of Regents to the Department of Health. The bill provides that the Department of Health may spend up to $75,000 of the state appropriations allocated to the CHEP for administrative costs. The bill implements the recommendation of the

Graduate Medical Education Committee to allow Florida medical schools to apply for Graduate Medical Education Innovations Program funding for the direct costs of providing graduate medical education in community-based clinical settings on a competitive grant or formula basis with specified exceptions. The bill modifies the membership of the Graduate Medical Education Committee.

Medicaid Program

The agency is authorized to certify all local governmental funds used as state match for Medicaid, to the extent that the identified local provider is the benefactor under the Medicaid program as determined in the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. The bill requires the local governmental entity to use a certification form prescribed by the agency which must, at a minimum, include the amount being certified and describe the relationship between the local governmental entity and the health care provider. The agency is to prepare an annual statement to be submitted no later than January 1 annually, documenting activities undertaken pursuant to these provisions.

The bill revises the definition of "charity care" or "uncompensated charity care" for purposes of the Medicaid disproportionate share program to mean that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent rather than 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income.

The bill revises the eligibility criteria for the Primary Care Disproportionate Share Program to allow payment to hospitals when they agree to coordinate and provide primary care services free of charge, except for copayments, to all persons with incomes up to 100 percent of the federal poverty level and to persons on a sliding fee scale with incomes up to 200 percent of the federal poverty level, to specify that such persons must not otherwise be covered by Medicaid or another program administered by a governmental entity.

The bill amends s. 409.912, F.S., to revise the duration of Medicaid program demonstration projects for direct contracting for provider services from 2 to 4 years from the date of implementation.

Medical Records/Solicitation

The bill prohibits the use of patient information for solicitation or marketing the sale of goods or services absent a specific written release or authorization permitting utilization of patient information for that purpose. The Department of Insurance must adopt rules to govern the use of a consumer's nonpublic financial and health information by health insurers and health maintenance organizations (HMOs) consistent with the National Association of Insurance

Commissioners' Privacy of Consumer and Health Information Regulation adopted September 26, 2000. Such rules must be consistent with, and not more restrictive than, the standards contained in Title V of the Gramm-Leach-Bliley Act of 1999 (Pub. L. No. 106-102).

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 33-0; House 120-0

DEPARTMENT OF HEALTH

CS/HB 475 — Public Health

by Council for Healthy Communities and Rep. Hogan and others (CS/CS/SB 1312 by Judiciary Committee; Health, Aging & Long-Term Care Committee; and Senators Saunders and Crist)

The bill amends various provisions relating to public health as follows:

- Requires a minimum operating reserve in the County Health Department Trust Fund of 8.5 percent of the annual operating budget, requires a public emergency reserve of $500,000, and requires a fixed capital outlay reserve for the renovation, expansion, or construction of new facilities;

- Expands provisions relating to abandoned newborns to apply to paramedics and emergency medical services stations;

- Revises supervision requirements for nonmedical school district personnel performing health-related services;

- Revises background screening of school health services personnel;

- Makes the physical handicap provisions under the Florida Patient's Bill of Rights and Responsibilities applicable to all handicaps;

- Modifies provisions relating to vital records, including amendments to those records;

- Changes the annual reporting date for the child abuse death review report;

- Authorizes use of the Emergency Medical Services Trust Fund monies to fund injury prevention programs;

- Grants the Department of Health rulemaking authority to define the equivalent of cardiopulmonary resuscitation courses for emergency medical technicians and paramedics;

- Limits discovery of emergency medical services personnel examination questions and answers and specifies procedures for a limited review in an administrative proceeding;

- Eliminates outdated requirement for certain soil testing for radon;

- Clarifies the scope of medical consent for a minor under a power of attorney under ch. 743, F.S., to include the power to consent to necessary surgical and general anesthesia services;

- Requires school health programs to be consistent with all provisions governing state school health services;

- Creates an exception to the conflict of interest provisions applicable to public employees for public employees who are licensed medical or osteopathic physicians and who furnish medical services for the Children's Medical Services network under specified conditions;

- Repeals a prospective repeal provision in Chapter 98-171, L.O.F., relating to background screening requirements for licensure, certification and registration of health-related facilities;

- Revises one of the conditions under which a retail pharmacy may engage in wholesale distribution, to include transfers between a modified class II institutional pharmacy and another retail pharmacy or a health care practitioner licensed in Florida and authorized to dispense or prescribe drugs;

- Makes food safety employee training programs subject to the provider's continued compliance with minimum program standards;

- Authorizes the Department of Business and Professional Regulation's Division of Hotels and Restaurants to conduct random audits and to audit any program which it has reason to believe is not in compliance with the statute; and

- Authorizes the Department of Business and Professional Regulation's Division of Hotels and Restaurants to revoke a program's approval if there is finding of noncompliance.

If approved by the Governor, except as otherwise provided, these provisions take effect July 1, 2001.
Vote: Senate 36-0; House 118-0

HB1863 — Onsite Sewage Treatment and Disposal

by Health Regulation Committee and Reps. Farkas and Argenziano (SB 1648 by Senator Mitchell)

The bill amends ss. 381.0065 and 381.0066, F.S., to modify regulatory and permitting requirements for performance-based and aerobic treatment unit onsite sewage treatment systems. The bill requires owners of engineer-designed performance-based systems and aerobic treatment unit systems to have maintenance service agreements with entities permitted by the Department

of Health. The requirement that the owner obtain a system operating permit is removed, and placed instead on the maintenance entity with which the owner contracts, which is required to inspect the system twice annually. Maintenance entities are required to employ a plumbing contractor, septic tank contractor, or state-licensed wastewater plant operator, and obtain an annual system operating permit from the department for each system under service contract. The bill requires the maintenance entity to report quarterly to the department the number of performance-based systems inspected and serviced. The Department of Health is given rule authority to establish minimum qualifying criteria for maintenance entities.

Operating permits for aerobic treatment units are declared valid for 2 years and must be renewed every 2 years. The bill requires the owner of an aerobic treatment unit system to allow the department to inspect the system during reasonable hours at least annually, including the collection and analysis of samples for compliance with performance criteria established by the department.

The operating permit fee for these systems is reduced from the current range of $150 to $300 to not more than $100. A fee of not less than $25 or more than $150 per year is established for a maintenance entity permit for performance-based treatment systems.

The bill requires the Department of Health Technical Review and Advisory Panel to review and advise on the need for licensing the portable restroom industry in the state and submit a report by January 2, 2002. The subjects to be taken into consideration are qualifications, education, training, and the procedure for handling, transporting and disposal of septage. The bill specifies that the intent is not to impact work done by septic tank or master septic tank operators.

If approved by the Governor, these provisions take effect July 1, 2001
Vote: Senate 36-0; House 120-0

MEDICAID

CS/CS/SB 792 — Agency for Health Care Administration

by Appropriations Committee; Health, Aging & Long-Term Care Committee; and Senator Silver

The bill contains substantive provisions of the Appropriations Implementing Bill (SB 2002), as well as other health-related provisions.

Medicaid Eligibility Changes

The bill authorizes Medicaid to make payments for health insurance premiums for Medicaid-eligible individuals who are insured, if the Agency for Health Care Administration (agency or AHCA) determines this to be cost-effective. Certain women screened through the National Breast and Cervical Cancer Early Detection program are made eligible for Medicaid. A Medicaid buy-in program is established pursuant to the "Ticket to Work and Work Incentives Act of 1999"

for persons who are between the ages of 16 and 64, are disabled, and who have assets, income and resources up to and including 250 percent of the federal poverty level. The Agency for Health Care Administration is authorized to seek a federal grant, demonstration project or waiver to implement a Medicaid buy-in program or other programs to assist individuals with disabilities in gaining employment.

Prior Authorization

The agency is authorized to require prior authorization for adult non-emergency hospital inpatient admissions and for adult emergency and urgent-care admissions within 24 hours after admission, and may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempted from requirements for prior authorization. The agency is required to ensure that the process for prior authorization is accessible 24 hours a day, seven days per week. Prior authorization is automatically granted when not denied within 4 hours of request. The agency is to discontinue its hospital retrospective review program upon implementing the prior authorization program for hospital inpatient services. The agency is authorized to implement reimbursement and management reforms for community mental health services to comply with any limitations and directions in the General Appropriations Act including prior authorization of treatment and service plans, prior authorization of services, enhanced use review programs for highly-used services, and limits on services for recipients determined to be abusing their benefit coverage.

Competitive Bidding

The bill requires competitive bidding for home health services, medical supplies and appliances, and independent laboratory services. The agency is authorized to competitively procure transportation services or make changes to permit federal financing of transportation services at the service matching rate rather than the administrative matching rate.

Medicaid Provider Standards and Enrollment

The bill removes the requirement that community mental health or substance abuse providers be licensed by the agency in order to be reimbursed for rehabilitative services. The agency may exclude providers not selected through the competitive bidding process from the Medicaid provider network. The bill establishes "children's provider networks" to provide care coordination and care management for Medicaid-eligible pediatric patients, primary care, authorization of specialist care and other urgent and primary care through organized providers designed to service Medicaid eligibles under 18. The networks are to provide after-hours operation to promote the use of children's networks rather than hospital emergency departments.

The bill removes a requirement that exclusive provider network contracts not cost more than comparable managed care plan contracts.

Reimbursement Changes

The bill specifies that, effective July 1, 2001, the cost of exempting certain hospitals from reimbursement ceilings and the cost of special Medicaid payments are not to be included in premiums paid to HMOs and prepaid health clinics. Each rate semester, the agency is to calculate and publish a Medicaid hospital rate schedule that does not reflect either special Medicaid payments or the elimination of rate reimbursement ceilings to be used by hospitals and Medicaid health maintenance organizations to determine the Medicaid rate for payments to hospitals and physicians outside the entity's geographic service area and for emergency services. The bill deletes the requirement that Medicaid pay deductibles and coinsurance for nursing home and hospital outpatient Medicare part B services.

The agency is authorized to pay for assistive-care services for recipients with functional or cognitive impairments residing in assisted living facilities, adult family-care homes or residential treatment facilities. These services may include health support, assistance with the activities of daily living and instrumental acts of daily living, assistance with medication administration and arrangements for health care.

Hospital inpatient rates are reduced by 6 percent effective July 1, 2001 and restored effective April 1, 2002.

Disproportionate Share

The bill modifies the values for certain elements of the disproportionate share formula used for distributing funds for hospitals providing a disproportionate share of Medicaid or charity care by redefining "base Medicaid per diem" as a facility's Medicaid per diem as of January 1, 1999, rather than the per diem in effect at the beginning of each state fiscal year; requires the use of 1994 audited financial data, rather than most recent calendar year data; and modifies the formula by which disproportionate share percentages are computed, for those hospitals that qualify for the rural hospital disproportionate share program. The bill appropriates disproportionate share funds to the following hospitals:

Jackson Memorial	$13, 937,997
Mount Sinai Medical Center	$285,298
Orlando Regional Medical Center	$313,748
Shands - Jacksonville	$2,734,019
Shands - University of Florida	$1,060,047
Tampa General Hospital	$1,683,415
North Broward Hospital District	$2,231,910

Nursing Home Reimbursement Changes

The bill prohibits increases in nursing home rates associated with changes of ownership or of licensed operator. The agency is required to amend the Title XIX Long-Term Care

Reimbursement plan to provide that the operating, patient care and MAR components associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rates. The agency is required to further amend the long-term care reimbursement plan and the cost reporting system to separate the patient care component of the rates into direct care and indirect care components. These two components together are required to equal the patient care component. The direct care subcomponent is to be limited by the cost-based class ceiling and the indirect care subcomponent is to be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. The patient care component is rebased by a requirement that it be adjusted effective January 1, 2002. The bill specifies that the direct care subcomponent is to include salaries and benefits of direct care staff, including registered nurses, licensed practical nurses, and certified nursing assistants who directly deliver care to residents. Nursing administration, MDS, care plan coordinators, staff development and staffing coordinators are excluded from the direct care subcomponent. All other patient care costs are to be included in the indirect care cost subcomponent. Costs of management companies or home office costs are not to be directly or indirectly allocated to patient care. The agency is to report annually direct and indirect care costs, including average direct care and indirect care cost per resident per facility, and direct care and indirect care salaries and benefits per category of staff member per facility.

The bill continues current policy limiting rate adjustments relating to increases in the cost of general or professional liability insurance for nursing homes.

The agency is authorized to request and implement Medicaid waivers from the federal Health Care Financing Administration to treat a portion of the Medicaid nursing home per diem as capital for creating and operating a risk-retention group for self-insurance purposes, consistent with federal and state laws and rules.

Provisions Pertaining to Local Government

The agency is authorized to certify all local governmental funds used as state match for Medicaid, to the extent that the identified local provider is the benefactor under the Medicaid program as determined in the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. The bill requires the local governmental entity to use a certification form prescribed by the agency which must, at a minimum, include the amount being certified and describe the relationship between the local governmental entity and the health care provider. The agency is to prepare an annual statement to be submitted no later than January 1 annually, documenting activities undertaken pursuant to these provisions.

The bill provides an exemption for counties from contributing toward the cost of the new exemptions on inpatient ceilings for statutory teaching hospitals, specialty hospitals and community hospital education program hospitals, and special Medicaid payments that came into effect July 1, 2000. The provisions relating to county contributions to Medicaid are revised to require county contributions for all Medicaid beneficiaries for inpatient hospitalization in excess of 10 days, rather than 12 days, but not in excess of 45 days. Counties are exempt from

contributing toward certain new exemptions on inpatient ceilings and special Medicaid payments.

Managed Care

The agency is authorized to contract with children's provider networks. The agency is required to disproportionately assign Medicaid-eligible children whose families do not select a provider to a children's network until the children's networks have sufficient numbers to be economically operated. The agency is to disproportionately assign Medicaid-eligible children in families who have failed to choose between managed care or MediPass to the children's networks created in the bill, until the children's networks have sufficient numbers to be economically operated.

Provisions Affecting Medicaid Pharmacy Services

The purpose of the Medicaid Pharmaceutical and Therapeutics Committee is revised to specify development of a preferred-drug list. The committee is to develop its preferred-drug list recommendations by considering the clinical efficacy, safety, and cost effectiveness of a product. Membership of the committee is revised to conform to federal requirements. Four members must be allopathic physicians, one member is to be an osteopathic physician, five members are to be pharmacists and one member is to be a consumer representative. The Governor is to appoint the members of the committee, and is to ensure that at least some of the members represent Medicaid-participating physicians and pharmacies serving all segments and diversity of the Medicaid population and have experience in developing or practicing under a preferred-drug formulary. One pharmacist is to represent the interests of pharmaceutical manufacturers. The agency shall adopt a preferred-drug list upon recommendation from the Medicaid Pharmaceutical and Therapeutics Committee. To the extent feasible, the committee is to review all drug classes included in the formulary at least every 12 months and may recommend additions to and deletions from the formulary so that the formulary provides medically appropriate drug therapies which achieve cost savings contained in the General Appropriations Act.

The committee is to ensure that pharmaceutical manufacturers agreeing to provide supplemental rebates have an opportunity to present evidence supporting inclusion of products in the preferred-drug list. The agency is required, upon timely notice, to ensure that a drug that has been approved or has had any of its uses approved under a priority review classification of the Food and Drug Administration be reviewed at the next regularly scheduled meeting of the committee. The agency is required, to the extent possible, to schedule a product review for any new product at the next regularly scheduled meeting of the committee. Until the committee is appointed and a preferred-drug list adopted, the agency is to use the existing voluntary preferred-drug list.

The committee may also make recommendations to the agency regarding the prior authorization of any prescribed drug covered by Medicaid. Medicaid recipients may appeal agency preferred-drug formulary decisions.

The agency is allowed to establish prior-authorization requirements for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse and possible dangerous interactions. The committee is to make recommendations to the agency on drugs for which prior authorization is required, and the agency is to inform the committee of its decisions regarding drugs subject to prior authorization.

Reimbursement of drugs not included in the formulary are subject to prior authorization, with the exception of mental-health related drugs, anti-retroviral drugs, and drugs for nursing home and other institutional residents. Drugs on the preferred-drug formulary are not exempt from the four-brand limit, however, if a product on the formulary is one of the first four brand-name drugs used by a recipient in a month the drug shall not require prior authorization. The bill removes an exception to the four-brand limit for adults residing in nursing homes and other institutions.

The bill specifies that prior authorization for an exception to the brand name drug restriction is to be sought by the prescriber and not the pharmacy, except for drugs on the restricted formulary for which prior authorization may be sought by an institutional or community pharmacy. Prior authorization for an exception to the brand-name-drug restriction is for 12 months and does not require monthly prior authorization for that patient.

The bill requires the Medicaid drug management program to include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180 day period, and the top 1,000 patients in annual spending. The requirement for use of a counterfeit-proof prescription pad for Medicaid is expanded from only Medicaid-participating prescribers to all prescribers who write prescriptions for Medicaid recipients.

The agency is authorized to establish a preferred-drug formulary and to negotiate supplemental rebates from manufacturers in addition to those required by Title XIX, at no less than 10 percent of the average federally-defined manufacturer price on the last day of the quarter unless the federal or supplemental rebate or both exceed 25 percent. There is no upper limit on the amount of the supplemental rebate the agency may negotiate. The agency may determine that specific products are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred-drug formulary. Inclusion is not guaranteed by payment of a minimum rebate.

Supplemental rebates may include cash, disease management programs, disease management programs, drug product donation programs, drug utilization control programs and other services or investments which guarantee savings to the Medicaid program in the same year the rebate reduction is included in the General Appropriations Act. The agency is authorized to seek federal waivers to implement this initiative. Reimbursement of drugs not on the formulary is subject to prior authorization by the agency. The agency is to establish an advisory committee to study the feasibility of using a restricted formulary for nursing home residents and other institutionalized adults.

The bill appropriates funds to increase the pharmaceutical dispensing fee for prescriptions dispensed to nursing home residents from $4.23 to $4.73 per prescription.

Other

The agency is to provide for development of a demonstration project in Miami-Dade county of a long-term care facility licensed as a hospital to improve access to health care for a predominately minority, medically-underserved and medically-complex population to evaluate alternatives to nursing home care and general acute care for such population. The project is to be located in a health care condominium and co-located with licensed facilities providing a continuum of care, and is not subject to certificate-of-need review.

From the funds in Specific Appropriation 1002 of the General Appropriations Act, $1,750,000 in non-recurring County Health Department Trust Funds is appropriated to:

School Health - Hillsborough County.....$550,000
School Health - Broward County.....$500,000
School Health - Escambia County.....$200,000
School Health - Monroe County.....$200,000
School Health - Dade County.....$300,000

The bill requires the certificate-of-need workgroup to review and make recommendations regarding the appropriateness of current regulations on services provided in ambulatory surgical centers, and prescribes factors to be considered.

The bill provides exemptions from certificate-of-need review for the conversion of hospital-based Medicare and Medicaid certified skilled nursing beds to acute care beds, if the conversion does not involve construction of new facilities; the transfer by a health care system of existing services and not more than 100 beds from a hospital in district 1, subdistrict 1 to another location within the same subdistrict to establish a satellite facility.

The bill makes appropriations to the following Public Guardianship programs:

Dade County.....$150,000
Collier County.....$38,000
Escambia County.....$8,000

The bill amends requirements for the Nursing Student Loan Forgiveness Program to include family practice teaching hospitals and specialty children's hospitals as employing institutions whose employees are eligible to receive loan repayment under the program. The bill extends an exemption to family practice teaching hospitals and specialty children's hospitals from the requirement to match loan forgiveness funding for those nurses employed by those entities. The bill creates a priority listing, by employer, for the disbursement of funds from the Nursing

Student Loan Forgiveness Trust Fund, if insufficient funding prevents the grant of all eligible applicants' requests for awards. The Nursing Scholarship Program requirements are also amended to include nursing homes, family practice teaching hospitals, and specialty children's hospitals in the list of facilities where scholarship recipients can complete their service obligation. The bill transfers by a type two transfer, all statutory powers, duties, functions and the records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Nursing Student Loan Forgiveness Program from the Department of Education to the Department of Health in a type two transfer.

If approved by the Governor, these provisions take effect July 1, 2001 or as otherwise provided. *Vote: Senate 33-0; House 116-0*

CS/SB 1306 — The Mary Brogan Breast and Cervical Cancer Early Detection Program Act

by Health, Aging & Long-Term Care Committee and Senators Sanderson, Miller, and Crist

Establishes the Mary Brogan Breast and Cervical Cancer Screening and Early Detection Program

The bill creates s. 381.93, F.S., to provide legislative intent and to authorize the Department of Health to establish the "Mary Brogan Breast and Cervical Cancer Screening and Early Detection Program" to provide breast and cervical cancer screening, diagnosis, evaluation, treatment, case management and referral to the Agency for Health Care Administration for coverage of treatment services for women who require follow-up. The program is to be funded through grants for such purpose from the federal Centers for Disease Control and Prevention. The Department of Health is to limit enrollment in the program to persons with incomes up to and including 200 percent of the federal poverty level and to establish an eligibility process, which includes income verification to ensure that persons served meet income guidelines. The department is permitted to provide other breast and cervical cancer screening and diagnostic services, however, these services are to be funded separately through other sources than this act.

Expands Medicaid Eligibility for Women Needing Further Medical Care

The bill amends s. 409.904, F.S., to establish a new optional eligibility category under the Florida Medicaid Program consisting of women under 65 years of age who have been screened by a qualified entity under the Mary Brogan Breast and Cervical Cancer Screening and Early Detection Program, need treatment for breast and cervical cancer, and do not have other health care coverage. A "qualified entity" is defined as a county public health department or other entity that has contracted with the Department of Health to provide screening services paid for under this act. An assets test is not required. Women are allowed to be made presumptively eligible for Medicaid, beginning when all eligibility criteria appear to be met and ending when eligibility is determined under the state plan or by the last day of the month following the month the

presumptive eligibility determination is made. A woman is eligible until she gains other health care coverage, no longer needs treatment, or attains 65 years of age. The bill requires the Department of Health and the Agency for Health Care Administration to monitor the total Medicaid expenditures for services under the act. The Department of Health is required to limit the number of screenings to ensure that Medicaid expenditures do not exceed the amount appropriated.

Requires an Annual Report to the Legislature

The annual report is to include the number of women screened, the percentage of positive and negative outcomes, the number of referrals to Medicaid and other providers for treatment services, the estimated number of women who are not screened or not served by Medicaid due to funding limitations (if any), the cost of Medicaid treatment services, and the estimated cost of treatment services for women who were not screened or referred for treatment services due to funding limitations. The report is due March 1 of each year.

If approved by the Governor, these provisions take effect July 1, 2001
Vote: Senate 34-0; House 119-0

CS/SB 2110 — Medicaid Services by Providers in Mobile Units

by Health, Aging & Long-Term Care Committee and Senators Silver and Sanderson

The bill allows the Medicaid program to restrict *mandatory* state plan services rendered by health care providers in mobile units, and to restrict or prohibit *optional* state plan services rendered by providers in mobile units. In the instance of adult denture services and children's dental services, Medicaid may not provide reimbursement for services rendered in mobile units except for: a mobile dental unit owned by or under contract with the Department of Health, complying with Medicaid's county health department clinic services specifications as a county health department clinic services provider; a mobile dental unit owned by or under contract with a federally-qualified health center, complying with Medicaid's federally-qualified health center specifications as a federally-qualified health center provider; a mobile unit providing services at nursing facilities; or a mobile unit owned, operated or under contract with a state-approved dental educational institution.

If approved by the Governor, these provisions take effect July 1, 2001
Vote: Senate 39-0; House 119-0