CHAPTER 99-356

House Bill No. 2231

An act relating to health care; amending s. 455.654, F.S.; providing definitions; providing requirements for accepting outside referrals for diagnostic imaging; providing for disciplinary procedures against a group practice or sole provider that accepts an outside referral for diagnostic imaging services in violation of such requirements; requiring the Agency for Health Care Administration to study issues relating to quality care in providing diagnostic imaging services; requiring the agency to convene a technical advisory panel; providing for registration of all group practices; prescribing registration information; providing for the technical advisory panel to submit recommendations for agency rules; requiring the agency to adopt rules; providing a date for the adoption and publication of rules; authorizing group practices and sole providers to accept a prescribed percentage of their patients from outside referrals; requiring the Agency for Health Care Administration in conjunction with the Medicaid Fraud Unit of the Office of the Attorney General to study certain specified business activities and arrangements of providers of clinical laboratory services for kidney dialysis; requiring a report; amending s. 4, ch. 98-192, Laws of Florida; eliminating requirement that the agency receive written confirmation from the federal Health Care Financing Administration that amendments to ss. 395.701 and 395.7015, F.S., will not adversely affect assessments or state match for the state's Medicaid program; providing duties for the agency and the Secretary of State; providing for a study and analysis of services for kidney dialysis patients; requiring providers of diagnostic cardiac catheterization services to comply with certain laws and rules adopted by the Agency for Health Care Administration; amending s. 155.40, F.S.; providing construction with respect to a transaction involving the sale or lease of a public hospital; providing construction with respect to specified hospital lessees; amending s. 455.651, F.S.; providing for a cause of action, damages, attorney's fees, and costs; amending s. 409.910, F.S.; clarifying that the state may recover and retain damages in excess of Medicaid payments made under certain circumstances; providing for retroactive application; creating s. 381.100, F.S.; creating the "Florida Community Health Protection Act"; creating s. 381.102, F.S.; providing for Community Health Program pilot projects; establishing pilot projects in designated counties; creating s. 381.103, F.S.; providing duties of the Department of Health; requiring a report; amending s. 627.6472, F.S.; requiring exclusive provider organizations to provide, without prior authorization, female subscribers one annual visit to an obstetrician/gynecologist; requiring coordination of medical care; amending s. 641.51, F.S.; requiring a health maintenance organization to provide, without prior authorization, female subscribers one annual visit to an obstetrician/gynecologist; requiring coordination of medical care; providing for application; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 455.654, Florida Statutes, 1998 Supplement, is amended to read:

455.654 Financial arrangements between referring health care providers and providers of health care services.—

(1) SHORT TITLE.—This section may be cited as the "Patient Self-Referral Act of 1992."

(2) LEGISLATIVE INTENT.—It is recognized by the Legislature that the referral of a patient by a health care provider to a provider of health care services in which the referring health care provider has an investment interest represents a potential conflict of interest. The Legislature finds these referral practices may limit or eliminate competitive alternatives in the health care services market, may result in overutilization of health care services, may increase costs to the health care system, and may adversely affect the quality of health care. The Legislature also recognizes, however, that it may be appropriate for providers to own entities providing health care services, and to refer patients to such entities, as long as certain safeguards are present in the arrangement. It is the intent of the Legislature to provide guidance to health care providers regarding prohibited patient referrals between health care providers and entities providing health care services and to protect the people of Florida from unnecessary and costly health care expenditures.

(3) DEFINITIONS.—For the purpose of this section, the word, phrase, or term:

(a) "Board" means any of the following boards relating to the respective professions: the Board of Medicine as created in s. 458.307; the Board of Osteopathic Medicine as created in s. 459.004; the Board of Chiropractic Medicine as created in s. 460.404; the Board of Podiatric Medicine as created in s. 461.004; the Board of Optometry as created in s. 463.003; the Board of Pharmacy as created in s. 465.004; and the Board of Dentistry as created in s. 466.004.

(b) "Comprehensive rehabilitation services" means services that are provided by health care professionals licensed under part I or part III of chapter 468 or chapter 486 to provide speech, occupational, or physical therapy services on an outpatient or ambulatory basis.

(c) "Designated health services" means, for purposes of this section, clinical laboratory services, physical therapy services, comprehensive rehabilitative services, diagnostic-imaging services, and radiation therapy services.

(d) "Diagnostic imaging services" means magnetic resonance imaging, nuclear medicine, angiography, arteriography, computed tomography, positron emission tomography, digital vascular imaging, bronchography, lymphangiography, splenography, ultrasound, EEG, EKG, nerve conduction studies, and evoked potentials.

(e) "Direct supervision" means supervision by a physician who is present in the office suite and immediately available to provide assistance and direction throughout the time services are being performed.

(f)~~(d)~~ "Entity" means any individual, partnership, firm, corporation, or other business entity.

(g)~~(e)~~ "Fair market value" means value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use, and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(h)~~(f)~~ "Group practice" means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:

1. In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;

2. For which substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and

3. In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group.

(i)~~(g)~~ "Health care provider" means any physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or any health care provider licensed under chapter 463 or chapter 466.

(j)~~(h)~~ "Immediate family member" means a health care provider's spouse, child, child's spouse, grandchild, grandchild's spouse, parent, parent-in-law, or sibling.

(k)~~(i)~~ "Investment interest" means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity interests or debt instruments. The following investment interests shall be excepted from this definition:

1. An investment interest in an entity that is the sole provider of designated health services in a rural area;

2. An investment interest in notes, bonds, debentures, or other debt instruments issued by an entity which provides designated health services,

as an integral part of a plan by such entity to acquire such investor's equity investment interest in the entity, provided that the interest rate is consistent with fair market value, and that the maturity date of the notes, bonds, debentures, or other debt instruments issued by the entity to the investor is not later than October 1, 1996.

3. An investment interest in real property resulting in a landlord-tenant relationship between the health care provider and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant or exceeds fair market value; or

4. An investment interest in an entity which owns or leases and operates a hospital licensed under chapter 395 or a nursing home facility licensed under chapter 400.

(l)~~(j)~~ "Investor" means a person or entity owning a legal or beneficial ownership or investment interest, directly or indirectly, including, without limitation, through an immediate family member, trust, or another entity related to the investor within the meaning of 42 C.F.R... s. 413.17, in an entity.

(m) "Outside referral for diagnostic imaging services" means a referral of a patient to a group practice or sole provider for diagnostic imaging services by a physician who is not a member of the group practice or of the sole provider's practice and who does not have an investment interest in the group practice or sole provider's practice, for which the group practice or sole provider billed for both the technical and the professional fee for the patient, and the patient did not become a patient of the group practice or sole provider's practice.

(n) "Patient of a group practice" or "patient of a sole provider" means a patient who receives a physical examination, evaluation, diagnosis, and development of a treatment plan if medically necessary by a physician who is a member of the group practice or the sole provider's practice.

(o)~~(k)~~ "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service; or

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

3. The following orders, recommendations, or plans of care shall not constitute a referral by a health care provider:

a. By a radiologist for diagnostic-imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.

d. By a cardiologist for cardiac catheterization services.

e. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice; provided, however, that effective July 1, 1999, a physician licensed pursuant to chapter 458, chapter 459, chapter 460, or chapter 461 may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for which the sole provider or group practice billed both the technical and the professional fee for or on behalf of the patient, if the referring physician has no investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more that 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 395.

h. By a health care provider for diagnostic clinical laboratory services where such services are directly related to renal dialysis.

i. By a urologist for lithotripsy services.

j. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

k. By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

l. By a nephrologist for renal dialysis services and supplies.

(p) "Present in the office suite" means that the physician is actually physically present; provided, however, that the health care provider is considered physically present during brief unexpected absences as well as during routine absences of a short duration if the absences occur during time periods in which the health care provider is otherwise scheduled and ordinarily expected to be present and the absences do not conflict with any other requirement in the Medicare program for a particular level of health care provider supervision.

~~(q)(l)~~ "Rural area" means a county with a population density of no greater than 100 persons per square mile, as defined by the United States Census.

(r) "Sole provider" means one health care provider licensed under chapter 458, chapter 459, chapter 460, or chapter 461, who maintains a separate medical office and a medical practice separate from any other health care provider and who bills for his or her services separately from the services provided by any other health care provider. A sole provider shall not share overhead expenses or professional income with any other person or group practice.

(4) REQUIREMENTS FOR ACCEPTING OUTSIDE REFERRALS FOR DIAGNOSTIC IMAGING.—

(a) A group practice or sole provider accepting outside referrals for diagnostic imaging services is required to comply with the following conditions:

1. Diagnostic imaging services must be provided exclusively by a group practice physician or by a full-time or part-time employee of the group practice or of the sole provider's practice.

2. All equity in the group practice or sole provider's practice accepting outside referrals for diagnostic imaging must be held by the physicians comprising the group practice or the sole provider's practice, each of which must provide at least 75 percent of his professional services to the group. Alternatively, the group must be incorporated under chapter 617, Florida Statutes, and must be exempt under the provisions of the Internal Revenue Code 501(c)(3) and be part of a foundation in existence prior to January 1, 1999 that is created for the purpose of patient care, medical education, and research.

3. A group practice or sole provider may not enter into, extend or renew any contract with a practice management company that provides any financial incentives, directly or indirectly, based on an increase in outside referrals for diagnostic imaging services from any group or sole provider managed by the same practice management company.

4. The group practice or sole provider accepting outside referrals for diagnostic imaging services must bill for both the professional and technical component of the service on behalf of the patient and no portion of the payment, or any type of consideration, either directly or indirectly, may be shared with the referring physician.

5. Group practices or sole providers that have a Medicaid provider agreement with the Agency for Health Care Administration must furnish diagnostic imaging services to their Medicaid patients and may not refer a Medicaid recipient to a hospital for outpatient diagnostic imaging services unless the physician furnishes the hospital with documentation demonstrating the medical necessity for such a referral. If necessary, the Agency for Health Care Administration may apply for a federal waiver to implement this subparagraph.

6. All group practices and sole providers accepting outside referrals for diagnostic imaging shall report annually to the Agency for Health Care

Administration providing the number of outside referrals accepted for diagnostic imaging services and the total number of all patients receiving diagnostic imaging services.

(b) If a group practice or sole provider accepts an outside referral for diagnostic imaging services in violation of this subsection or if a group practice or sole provider accepts outside referrals for diagnostic imaging services in excess of the percentage limitation established in subparagraph (a)2. of this subsection, the group practice or the sole provider shall be subject to the penalties in subsection (5).

(c) Each managing physician member of a group practice and each sole provider who accepts outside referrals for diagnostic imaging services shall submit an annual attestation signed under oath to the Agency for Health Care Administration which shall include the annual report required under s. 455.654(4)(a)6. and which shall further confirm that each group practice or sole provider is in compliance with the percentage limitations for accepting outside referrals and the requirements for accepting outside referrals listed in s. 455.654(4)(a). The agency may verify the report submitted by group practices and sole providers.

(5)~~(4)~~ PROHIBITED REFERRALS AND CLAIMS FOR PAYMENT.—Except as provided in this section:

(a) A health care provider may not refer a patient for the provision of designated health services to an entity in which the health care provider is an investor or has an investment interest.

(b) A health care provider may not refer a patient for the provision of any other health care item or service to an entity in which the health care provider is an investor unless:

1. The provider's investment interest is in registered securities purchased on a national exchange or over-the-counter market and issued by a publicly held corporation:

a. Whose shares are traded on a national exchange or on the over-the-counter market; and

b. Whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million; or

2. With respect to an entity other than a publicly held corporation described in subparagraph 1., and a referring provider's investment interest in such entity, each of the following requirements are met:

a. No more than 50 percent of the value of the investment interests are held by investors who are in a position to make referrals to the entity.

b. The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are no different from the terms offered to investors who are not in a position to make such referrals.

c. The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are not related to the previous or expected volume of referrals from that investor to the entity.

d. There is no requirement that an investor make referrals or be in a position to make referrals to the entity as a condition for becoming or remaining an investor.

3. With respect to either such entity or publicly held corporation:

a. The entity or corporation does not loan funds to or guarantee a loan for an investor who is in a position to make referrals to the entity or corporation if the investor uses any part of such loan to obtain the investment interest.

b. The amount distributed to an investor representing a return on the investment interest is directly proportional to the amount of the capital investment, including the fair market value of any preoperational services rendered, invested in the entity or corporation by that investor.

4. Each board and, in the case of hospitals, the Agency for Health Care Administration, shall encourage the use by licensees of the declaratory statement procedure to determine the applicability of this section or any rule adopted pursuant to this section as it applies solely to the licensee. Boards shall submit to the Agency for Health Care Administration the name of any entity in which a provider investment interest has been approved pursuant to this section, and the Agency for Health Care Administration shall adopt rules providing for periodic quality assurance and utilization review of such entities.

(c) No claim for payment may be presented by an entity to any individual, third-party payor, or other entity for a service furnished pursuant to a referral prohibited under this section.

(d) If an entity collects any amount that was billed in violation of this section, the entity shall refund such amount on a timely basis to the payor or individual, whichever is applicable.

(e) Any person that presents or causes to be presented a bill or a claim for service that such person knows or should know is for a service for which payment may not be made under paragraph (c), or for which a refund has not been made under paragraph (d), shall be subject to a civil penalty of not more than $15,000 for each such service to be imposed and collected by the appropriate board.

(f) Any health care provider or other entity that enters into an arrangement or scheme, such as a cross-referral arrangement, which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil penalty of not more than $100,000 for each such circumvention arrangement or scheme to be imposed and collected by the appropriate board.

(g) A violation of this section by a health care provider shall constitute grounds for disciplinary action to be taken by the applicable board pursuant to s. 458.331(2), s. 459.015(2), s. 460.413(2), s. 461.013(2), s. 463.016(2), or s. 466.028(2). Any hospital licensed under chapter 395 found in violation of this section shall be subject to the rules adopted by the Agency for Health Care Administration pursuant to s. 395.0185(2).

(h) Any hospital licensed under chapter 395 that discriminates against or otherwise penalizes a health care provider for compliance with this act.

(i) The provision of paragraph (a) shall not apply to referrals to the offices of radiation therapy centers managed by an entity or subsidiary or general partner thereof, which performed radiation therapy services at those same offices prior to April 1, 1991, and shall not apply also to referrals for radiation therapy to be performed at no more than one additional office of any entity qualifying for the foregoing exception which, prior to February 1, 1992, had a binding purchase contract on and a nonrefundable deposit paid for a linear accelerator to be used at the additional office. The physical site of the radiation treatment centers affected by this provision may be relocated as a result of the following factors: acts of God; fire; strike; accident; war; eminent domain actions by any governmental body; or refusal by the lessor to renew a lease. A relocation for the foregoing reasons is limited to relocation of an existing facility to a replacement location within the county of the existing facility upon written notification to the Office of Licensure and Certification.

(j) A health care provider who meets the requirements of paragraphs (b) and (i) must disclose his or her investment interest to his or her patients as provided in s. 455.701.

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

Section 3. Section 4 of chapter 98-192, Laws of Florida, is amended to read:

Section 4. This act shall take effect July 1, 1998. However, if the Agency for Health Care Administration between April 15, 1999 and November 15, 1999 receives written certification from the federal Health Care Financing Administration that the amendments enacted herein to s. 395.701, F.S. or s. 395.7015, F.S., violate federal regulations regarding permissible state health care taxes which would cause the state to be denied federal Medicaid funds, then the amendment to the individual section contained herein and so identified by the Health Care Financing Administration as violating federal law hereby stands repealed. Upon receipt of written certification from the Health Care Financing Administration, the Agency for Health Care Administration shall forward such certification to the Secretary of State, the President of the Senate and the Speaker of the House of Representatives

with a letter identifying the section or sections which stand repealed consistent with this section. The Secretary of State shall delete the amendment to the section so identified in the official records of the Florida Statutes consistent with this section. The effective date of the repeal of the section contained in the federal certification shall be the date that the notice is received by the Secretary of State., ~~except that the amendment of sections 395.701 and 395.7015, Florida Statutes, by this act shall take effect only upon 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~~.

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

Section 5. Each provider of diagnostic cardiac catheterization services shall comply with the requirements of section 408.036(3)(n)2.a.-d., Florida Statutes, and rules of the Agency for Health Care Administration governing the operation of adult inpatient diagnostic cardiac catheterization programs, including the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories.

Section 6. Subsections (6) and (7) of section 155.40, Florida Statutes, are added to said section, to read:

155.40 Sale or lease of county, district, or municipal hospital.—

(6) Unless otherwise expressly stated in the lease documents, the transaction involving the sale or lease of a hospital shall not be construed as:

(a) a transfer of a governmental function from the county, district, or municipality to the private purchaser or lessee;

(b) constituting a financial interest of the public lessor in the private lessee; or

(c) making a private lessee an integral part of the public lessor's decision-making process.

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

Section 7. Subsection (3) is added to section 455.651, Florida Statutes, 1998 Supplement, to read:

455.651 Disclosure of confidential information.—

(3) Any person injured as a result of a willful violation of this section shall have a civil cause of action for treble damages, reasonable attorney's fees, and costs.

Section 8. Subsections (4) and (7) of section 409.910, Florida Statutes, 1998 Supplement, are amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(4) After the department has provided medical assistance under the Medicaid program, it shall seek recovery of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid, as to:

(a) Claims for which the department has a waiver pursuant to federal law; or

(b) Situations in which the department learns of the existence of a liable third party or in which third-party benefits are discovered or become available after medical assistance has been provided by Medicaid.

(7) The department shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits.

(a) Recovery of such benefits shall be collected directly from:

1. Any third party;

2. The recipient or legal representative, if he or she has received third-party benefits;

3. The provider of a recipient's medical services if third-party benefits have been recovered by the provider; notwithstanding any provision of this section, to the contrary, however, no provider shall be required to refund or pay to the department any amount in excess of the actual third-party benefits received by the provider from a third-party payor for medical services provided to the recipient; or

4. Any person who has received the third-party benefits.

(b) Upon receipt of any recovery or other collection pursuant to this section, the department shall distribute the amount collected as follows:

1. To itself, an amount equal to the state Medicaid expenditures for the recipient plus any incentive payment made in accordance with paragraph (14)(a).

2. To the Federal Government, the federal share of the state Medicaid expenditures minus any incentive payment made in accordance with paragraph (14)(a) and federal law, and minus any other amount permitted by federal law to be deducted.

3. To the recipient, after deducting any known amounts owed to the department for any related medical assistance or to health care providers, any remaining amount. This amount shall be treated as income or resources in determining eligibility for Medicaid.

The provisions of this subsection do not apply to any proceeds received by the state, or any agency thereof, pursuant to a final order, judgment, or settlement agreement, in any matter in which the state asserts claims brought on its own behalf, and not as a subrogee of a recipient, or under other theories of liability. The provisions of this subsection do not apply to any proceeds received by the state, or an agency thereof, pursuant to a final order, judgment, or settlement agreement, in any matter in which the state asserted both claims as a subrogee and additional claims, except as to those sums specifically identified in the final order, judgment, or settlement agreement as reimbursements to the recipient as expenditures for the named recipient on the subrogation claim.

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

Section 10. Section 381.100, Florida Statutes, is created to read:

381.100 Short title.—Sections 381.100-381.103 may be cited as the "Florida Community Health Protection Act."

Section 11. Section 381.102, Florida Statutes, is created to read:

381.102 Community Health pilot projects.—

(1) The Legislature has determined that:

(a) The state is committed to the economic, environmental, and public health revitalization of its communities;

(b) Measures to address the public health needs of low-income communities in urban and rural areas must be implemented in order to ensure the sustainability of these communities;

(c) The implementation of these measures will enhance cooperative efforts among the private sector, government, and nonprofit organizations in this state to ensure the sustainability of Florida; and

(d) It would be beneficial to provide resources in this state to undertake a series of pilot projects that demonstrate techniques and approaches to ensure health care for disease prevention and health promotion for low-income persons who are living in urban and rural communities.

(2) Community Health pilot projects are hereby established to promote disease prevention and health promotion among low-income persons living in urban and rural communities.

(3) The pilot projects may form partnerships with existing health care providers and units, contribute to a health care needs assessment, provide research capacity to improve health status, and serve as the basis for health care capacity in urban and rural communities.

(4) The following pilot projects are created:

(a) In Pinellas County, for the Greenwood Community Health Center in Clearwater.

(b) In Escambia County, for the low-income communities within the Palafox Redevelopment Area.

(c) In Hillsborough, Pasco, Pinellas, and Manatee counties for the Urban League of Pinellas County, to operate its mobile health screening unit to provide public health care to persons living in low-income urban and rural communities.

(d) In Palm Beach County, for the low-income communities within the City of Riviera Beach.

(e) In the City of St. Petersburg, for the low-income communities within the Challenge 2001 Area.

(f) In Broward County, the communities immediately surrounding the Miles Health Center in Ft. Lauderdale.

Section 12. Section 381.103, Florida Statutes, is created to read:

381.103 Community Health Pilot Projects; duties of department.—To the extent feasible, the department may:

(1) Assist the pilot projects in development and implementation of their community programs by acting as the granting agency and contracting with the pilot projects.

(2) Facilitate the integration of the pilot projects with ongoing departmental programs, so that duplication of services is avoided and synergy between the programs enhanced.

(3) Develop educational and outreach programs for health care providers and communities that increase awareness of health care needs for low-income persons living in urban and rural communities.

(4) Assist the pilot projects in obtaining low-cost health care services designed to prevent disease and promote health in low-income communities.

(5) Prepare a report to be submitted to the President of the Senate, the Speaker of the House of Representatives, and the Governor on the findings, accomplishments, and recommendations of the Community Health pilot projects by or on January 1, 2001.

(6) Facilitate cooperation between affected communities, appropriate agencies, and ongoing initiatives, such as Front Porch Florida.

Section 13. Subsection (18) is added to section 627.6472, Florida Statutes, 1998 Supplement, to read:

627.6472 Exclusive provider organizations.—

(18) Each organization shall allow, without prior authorization, a female subscriber to visit a contracted obstetrician/gynecologist for one annual visit and medically necessary follow-up care detected at that visit. Nothing in this subsection shall prevent an organization from requiring that an obstetrician/gynecologist treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.

Section 14. Subsection (11) is added to section 641.51, Florida Statutes, to read:

641.51 Quality assurance program; second medical opinion requirement.—

(11) Each organization shall allow, without prior authorization, a female subscriber, to visit a contracted obstetrician/gynecologist for one annual visit and for medically necessary follow-up care detected at that visit. Nothing in this subsection shall prevent an organization from requiring that an obstetrician/gynecologist treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.

Section 15. This act shall take effect July 1, 1999, except that sections 10 and 11 of this act shall take effect October 1, 1999, and shall apply to contracts issued or renewed on or after that date.

Approved by the Governor June 11, 1999.

Filed in Office Secretary of State June 11, 1999.