CHAPTER 2000-256

Committee Substitute for House Bill No. 2339

An act relating to comprehensive health care; providing a short title; amending s. 400.471, F.S.; deleting the certificate-of-need requirement for licensure of Medicare-certified home health agencies; amending s. 408.032, F.S.; adding definitions of "exemption" and "mental health services"; deleting the definitions of "home health agency," "institutional health service," "intermediate care facility," "multifacility project," and "respite care"; revising the definition of "health services"; amending s. 408.033, F.S.; deleting references to the state health plan; amending s. 408.034, F.S.; deleting a reference to licensing of home health agencies by the Agency for Health Care Administration; amending s. 408.035, F.S.; deleting obsolete certificate-of-need review criteria and revising other criteria; amending s. 408.036, F.S.; revising provisions relating to projects subject to review; deleting references to Medicare-certified home health agencies; deleting the review of certain acquisitions; specifying the types of bed increases subject to review; deleting cost overruns from review; deleting review of combinations or division of nursing home certificates of need; providing for expedited review of certain conversions of licensed hospital beds; deleting the requirement for an exemption for initiation or expansion of obstetric services, provision of respite care services, establishment of a Medicare-certified home health agency, or provision of a health service exclusively on an outpatient basis; providing exemptions for combinations or divisions of nursing home certificates of need and additions of certain hospital beds and nursing home beds within specified limitations; providing exemptions for the addition of temporary acute care beds in certain hospitals and for the establishment of certain types of specialty hospitals through transfer of beds and services from certain existing hospitals; requiring a fee for each request for exemption; amending s. 408.037, F.S.; deleting reference to the state health plan; amending ss. 408.038, 408.039, 408.044, and 408.045, F.S.; replacing "department" with "agency"; clarifying the opportunity to challenge an intended award of a certificate of need; amending s. 408.040, F.S.; deleting an obsolete reference; revising the format of conditions related to Medicaid; creating a certificate-of-need workgroup within the Agency for Health Care Administration; providing for expenses; providing membership, duties, and meetings; requiring reports; providing for termination; amending s. 651.118, F.S.; excluding a specified number of beds from a time limit imposed on extension of authorization for continuing care residential community providers to use sheltered beds for nonresidents; requiring a facility to report such use after the expiration of the extension; amending s. 395.701, F.S.; reducing the annual assessment on hospitals to fund public medical assistance; providing for contingent effect; amending s. 395.7015, F.S.; reducing the annual assessment on certain health care entities; amending s. 408.904, F.S.; increasing certain benefits for hospital outpatient services; amending s. 409.912, F.S.; providing for a contract with reimbursement of an entity in Pasco or Pinellas County

that provides in-home physician services to Medicaid recipients with degenerative neurological diseases; providing for future repeal; providing appropriations; providing for effect of amendments to ss. 395.701 and 395.7015, F.S., contingent on a federal waiver; providing for the transfer of certain unexpended Medicaid funds from the Department of Elderly Affairs to the Agency for Health Care Administration; amending ss. 641.31, 641.315, and 641.3155, F.S.; prohibiting a health maintenance organization from restricting a provider's ability to provide inpatient hospital services to a subscriber; requiring payment for medically necessary inpatient hospital services; providing applicability; amending s. 641.51, F.S.; relating to quality assurance program requirements for certain managed care organizations; allowing the rendering of adverse determinations by physicians licensed in any state; requiring the submission of facts and documentation pertaining to rendered adverse determinations; providing timeframe for organizations to submit facts and documentation to providers and subscribers in writing; requiring an authorized representative to sign the notification; creating s. 381.7351, F.S.; creating the "Reducing Racial and Ethnic Health Disparities: Closing the Gap Act"; creating s. 381.7352, F.S.; providing legislative findings and intent; creating s. 381.7353, F.S.; providing for the creation of the Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program, to be administered by the Department of Health; providing department duties and responsibilities; authorizing appointment of an advisory committee; creating s. 381.7354, F.S.; providing eligibility for grant awards; creating s. 381.7355, F.S.; providing project requirements, an application process, and review criteria; creating s. 381.7356, F.S.; providing for Closing the Gap grant awards; providing for local matching funds; providing factors for determination of the amount of grant awards; providing for award of grants to begin by a specified date, subject to specific appropriation; providing for annual renewal of grants; creating the Florida Commission on Excellence in Health Care; providing legislative findings and intent; providing definitions; providing duties and responsibilities; providing for membership, organization, meetings, procedures, and staff; providing for reimbursement of travel and related expenses of certain members; providing certain evidentiary prohibitions; requiring a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives; providing for termination of the commission; amending s. 408.7056, F.S.; providing additional definitions for the Statewide Provider and Subscriber Assistance Program; amending s. 627.654, F.S.; providing for insuring small employers under policies issued to small employer health alliances; providing requirements for participation; providing limitations; providing for insuring spouses and dependent children; allowing a single master policy to include alternative health plans; amending s. 627.6571, F.S.; including small employer health alliances within policy nonrenewal or discontinuance, coverage modification, and application provisions; amending s. 627.6699, F.S.; revising restrictions relating to premium rates to authorize small employer carriers to modify rates under certain circumstances and to

authorize carriers to issue group health insurance policies to small employer health alliances under certain circumstances; requiring carriers issuing a policy to an alliance to allow appointed agents to sell such a policy; amending ss. 240.2995, 240.2996, 240.512, 381.0406, 395.3035, and 627.4301, F.S.; conforming cross references; defining the term "managed care"; creating s. 641.185, F.S.; providing health maintenance organization subscriber protections; specifying the principles to serve as standards for the Department of Insurance and the Agency for Health Care Administration exercising their duties and responsibilities; requiring that a health maintenance organization observe certain standards in providing health care for subscribers; providing for subscribers to receive quality care from a broad panel of providers, referrals, preventive care, emergency screening services, and second opinions; providing for assurance of independent accreditation by a national review organization and financial security of the organization; providing for continuity of health care; providing for timely, concise information regarding reimbursement to providers and services; providing for flexibility to transfer to another health maintenance organization within the state; providing for eligibility without discrimination based on health status; providing requirements for health maintenance organizations that issue group health contracts relating to preexisting conditions, contract renewability, cancellation, extension, termination, and conversion; providing for timely, urgent grievances and appeals within the organization; providing for timely and urgent review of grievances and appeals by an independent state external review agency; providing for notice of rate changes; providing for information regarding contract provisions, services, medical conditions, providers, and service delivery; providing that no civil cause of action is created; amending s. 641.511, F.S.; requiring posting of certain consumer assistance notices; providing requirements; amending s. 627.6699, F.S.; revising a definition; requiring small employer carriers to begin to offer and issue all small employer benefit plans on a specified date; deleting a requirement that basic and standard small employer health benefit plans be issued; providing additional requirements for determining premium rates for benefit plans; providing for application to plans provided by certain small employer carriers under certain circumstances; amending s. 409.212, F.S.; providing for periodic increase in the optional state supplementation rate; amending s. 409.901, F.S.; amending definitions of terms used in ss. 409.910-409.920, F.S.; amending s. 409.902, F.S.; providing that the Department of Children and Family Services is responsible for Medicaid eligibility determinations; amending s. 409.903, F.S.; providing responsibility for determinations of eligibility for payments for medical assistance and related services; amending s. 409.905, F.S.; increasing the maximum amount that may be paid under Medicaid for hospital outpatient services; amending s. 409.906, F.S.; allowing the Department of Children and Family Services to transfer funds to the Agency for Health Care Administration to cover state match requirements as specified; amending s. 409.907, F.S.; specifying bonding require-

ments for providers; specifying grounds on which provider applications may be denied; amending s. 409.908, F.S.; increasing the maximum amount of reimbursement allowable to Medicaid providers for hospital inpatient care; creating s. 409.9119, F.S.; creating a disproportionate share program for children's hospitals; providing formulas governing payments made to hospitals under the program; providing for withholding payments from a hospital that is not complying with agency rules; amending s. 409.919, F.S.; providing for the adoption and the transfer of certain rules relating to the determination of Medicaid eligibility; authorizing developmental research schools to participate in Medicaid certified school match program; providing for the Agency for Health Care Administration to seek a federal waiver allowing the agency to undertake a pilot project that involves contracting with skilled nursing facilities for the provision of rehabilitation services to adult ventilator dependent patients; providing for evaluation of the pilot program; repealing s. 400.464(3), F.S., relating to home health agency licenses provided to certificate-of-need exempt entities; repealing ss. 408.70(3), 408.701, 408.702, 408.703, 408.704, 408.7041, 408.7042, 408.7045, 408.7055, and 408.706, F.S., relating to community health purchasing alliances; repealing s. 409.912(4)(b), F.S., relating to the authorization of the agency to contract with certain prepaid health care services providers; providing appropriations; reducing certain allocation of positions and funds; providing effective dates.

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

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

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

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

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

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

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

(c) Proof of financial ability to operate.

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

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

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

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

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

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

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

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

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

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

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

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

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

District 5.—Pasco and Pinellas Counties.

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

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

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

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

District 10.—Broward County.

District 11.—Dade and Monroe Counties.

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

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

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

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

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

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

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

~~(12) "Institutional health service" means a health service which is provided by or through a health care facility and which entails an annual operating cost of $500,000 or more. The agency shall, by rule, adjust the annual operating cost threshold annually using an appropriate inflation index.~~

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

(12)~~(14)~~ "Intermediate care facility for the developmentally disabled" means a residential facility licensed under chapter 393 and certified by the Federal Government pursuant to the Social Security Act as a provider of

Medicaid services to persons who are mentally retarded or who have a related condition.

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

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

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

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

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

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

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

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

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

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

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

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

(16)~~(19)~~ "Skilled nursing facility" means an institution, or a distinct part of an institution, which is primarily engaged in providing, to inpatients, skilled nursing care and related services for patients who require medical

or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

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

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

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

408.033 Local and state health planning.—

(1) LOCAL HEALTH COUNCILS.—

(b) Each local health council may:

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

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

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

4. Collect data and conduct analyses and studies related to health care needs of the district, including the needs of medically indigent persons, and

assist the agency and other state agencies in carrying out data collection activities that relate to the functions in this subsection.

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

6. Advise and assist any regional planning councils within each district that have elected to address health issues in their strategic regional policy plans with the development of the health element of the plans to address the health goals and policies in the State Comprehensive Plan.

7. Advise and assist local governments within each district on the development of an optional health plan element of the comprehensive plan provided in chapter 163, to assure compatibility with the health goals and policies in the State Comprehensive Plan and district health plan. To facilitate the implementation of this section, the local health council shall annually provide the local governments in its service area, upon request, with:

a. A copy and appropriate updates of the district health plan;

b. A report of hospital and nursing home utilization statistics for facilities within the local government jurisdiction; and

c. Applicable agency rules and calculated need methodologies for health facilities and services regulated under s. 408.034 for the district served by the local health council.

8. Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of local, state, federal, and private funds distributed to meet the needs of the medically indigent and other underserved population groups.

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

10. Provide technical assistance to encourage and support activities by providers, purchasers, consumers, and local, regional, and state agencies in meeting the health care goals, objectives, and policies adopted by the local health council.

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

(3) DUTIES AND RESPONSIBILITIES OF THE AGENCY.—

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

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

408.034 Duties and responsibilities of agency; rules.—

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

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

408.035 Review criteria.—

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

(1)~~(a)~~ The need for the health care facilities and health services being proposed in relation to the applicable district health plan~~, except in emergency circumstances that pose a threat to the public health~~.

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

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

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

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

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

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

(6)~~(h)~~ The availability of resources, including health personnel, management personnel, and funds for capital and operating expenditures, for project accomplishment and operation.~~; the effects the project will have on clinical needs of health professional training programs in the service district; the extent to which the services will be accessible to schools for health professions in the service district for training purposes if such services are avail-~~

~~able in a limited number of facilities; the availability of alternative uses of such resources for the provision of other health services; and~~

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

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

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

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

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

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

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

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

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

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

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

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

~~(c) In the case of new construction or replacement construction, that alternatives to the construction, for example, modernization or sharing arrangements, have been considered and have been implemented to the maximum extent practicable.~~

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

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

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

408.036 Projects subject to review.—

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

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

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

(c) The conversion from one type of health care facility to another~~, including the conversion from one level of care to another, in a skilled or intermediate nursing facility, if the conversion effects a change in the level of care of 10 beds or 10 percent of total bed capacity of the skilled or intermediate nursing facility within a 2-year period. If the nursing facility is certified for both skilled and intermediate nursing care, the provisions of this paragraph do not apply~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(g) Division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. Such division shall not be approved if it would adversely affect the original certificate's approved cost.~~

(e)~~(h)~~ Replacement of a health care facility when the proposed project site is located in the same district and within a 1-mile radius of the replaced health care facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(i) For the establishment of a Medicare-certified home health agency. This paragraph shall take effect 90 days after the adjournment sine die of the next regular session of the Legislature occurring after the legislative session in which the Legislature receives a report from the Director of Health Care Administration certifying that the federal Health Care Financing Administration has implemented a per-episode prospective pay system for Medicare-certified home health agencies.~~

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

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

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

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

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

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

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

b. The applicant must certify it will meet and continuously maintain the minimum licensure requirements adopted by the agency governing such programs pursuant to subparagraph 2.

c. The applicant must certify it will provide a minimum of 2 percent of its services to charity and Medicaid patients.

2. The agency shall adopt licensure requirements by rule which govern the operation of adult inpatient diagnostic cardiac catheterization programs established pursuant to the exemption provided in this paragraph. The rules shall ensure that such programs:

a. Perform only adult inpatient diagnostic cardiac catheterization services authorized by the exemption and will not provide therapeutic cardiac catheterization or any other services not authorized by the exemption.

b. Maintain sufficient appropriate equipment and health personnel to ensure quality and safety.

c. Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

d. Maintain appropriate program volumes to ensure quality and safety.

e. Provide a minimum of 2 percent of its services to charity and Medicaid patients each year.

3.a. The exemption provided by this paragraph shall not apply unless the agency determines that the program is in compliance with the requirements of subparagraph 1. and that the program will, after beginning operation, continuously comply with the rules adopted pursuant to subparagraph 2. The agency shall monitor such programs to ensure compliance with the requirements of subparagraph 2.

b.(I) The exemption for a program shall expire immediately when the program fails to comply with the rules adopted pursuant to sub-subparagraphs 2.a., b., and c.

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

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

~~4. The agency shall not grant any exemption under this paragraph until the adoption of the rules required under this paragraph, or until March 1,~~

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

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

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

(l) For combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificates of need to be consolidated by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption. The longest validity period among the certificates shall be applicable to each of the combined certificates.

(m) For division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificate of need to be divided by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption.

(n) For the addition of hospital beds licensed under chapter 395 for acute care, mental health services, or a hospital-based distinct part skilled nursing unit in a number that may not exceed 10 total beds or 10 percent of the licensed capacity of the bed category being expanded, whichever is greater. Beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, or at a long-term care hospital, may not be increased under this paragraph.

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

a. Certify that the prior 12-month average occupancy rate for the category of licensed beds being expanded at the facility meets or exceeds 80 percent or, for a hospital-based distinct part skilled nursing unit, the prior 12-month average occupancy rate meets or exceeds 96 percent.

b. Certify that any beds of the same type authorized for the facility under this paragraph before the date of the current request for an exemption have been licensed and operational for at least 12 months.

2. The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.

3. The agency shall count beds authorized under this paragraph as approved beds in the published inventory of hospital beds until the beds are licensed.

(o) For the addition of acute care beds, as authorized by rule consistent with s. 395.003(4), in a number that may not exceed 10 total beds or 10 percent of licensed bed capacity, whichever is greater, for temporary beds in a hospital which has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.

(p) For the addition of nursing home beds licensed under chapter 400 in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater.

1. In addition to any other documentation required by the agency, a request for exemption submitted under this paragraph must:

a. Certify that the facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition.

b. Certify that the prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 96 percent.

c. Certify that any beds authorized for the facility under this paragraph before the date of the current request for an exemption have been licensed and operational for at least 12 months.

2. The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.

3. The agency shall count beds authorized under this paragraph as approved beds in the published inventory of nursing home beds until the beds are licensed.

(q) For establishment of a specialty hospital offering a range of medical service restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county.

(4) A request for exemption under ~~this~~ subsection (3) may be made at any time and is not subject to the batching requirements of this section. The request shall be supported by such documentation as the agency requires by rule. The agency shall assess a fee of $250 for each request for exemption submitted under subsection (3).

Section 8. Paragraph (a) of subsection (1) of section 408.037, Florida Statutes, is amended to read:

408.037 Application content.—

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

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

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

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

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

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

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

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

(3) APPLICATION PROCESSING.—

(a) An applicant shall file an application with the agency ~~department~~, and shall furnish a copy of the application to the local health council and the agency ~~department~~. Within 15 days after the applicable application filing deadline established by agency ~~department~~ rule, the staff of the agency ~~department~~ shall determine if the application is complete. If the application is incomplete, the staff shall request specific information from the applicant necessary for the application to be complete; however, the staff may make only one such request. If the requested information is not filed with the agency ~~department~~ within 21 days of the receipt of the staff's request, the application shall be deemed incomplete and deemed withdrawn from consideration.

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

(4) STAFF RECOMMENDATIONS.—

(a) The agency's ~~department's~~ review of and final agency action on applications shall be in accordance with the district health plan, and statutory

criteria, and the implementing administrative rules. In the application review process, the agency ~~department~~ shall give a preference, as defined by rule of the agency ~~department~~, to an applicant which proposes to develop a nursing home in a nursing home geographically underserved area.

(b) Within 60 days after all the applications in a review cycle are determined to be complete, the agency ~~department~~ shall issue its State Agency Action Report and Notice of Intent to grant a certificate of need for the project in its entirety, to grant a certificate of need for identifiable portions of the project, or to deny a certificate of need. The State Agency Action Report shall set forth in writing its findings of fact and determinations upon which its decision is based. If a finding of fact or determination by the agency ~~department~~ is counter to the district health plan of the local health council, the agency ~~department~~ shall provide in writing its reason for its findings, item by item, to the local health council. If the agency ~~department~~ intends to grant a certificate of need, the State Agency Action Report or the Notice of Intent shall also include any conditions which the agency ~~department~~ intends to attach to the certificate of need. The agency ~~department~~ shall designate by rule a senior staff person, other than the person who issues the final order, to issue State Agency Action Reports and Notices of Intent.

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

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

(5) ADMINISTRATIVE HEARINGS.—

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

(6) JUDICIAL REVIEW.—

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

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

Section 11. Subsections (1) and (2) of section 408.040, Florida Statutes, are amended to read:

408.040 Conditions and monitoring.—

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

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

(b)~~2.~~ The agency may consider, in addition to the other criteria specified in s. 408.035, a statement of intent by the applicant that a specified ~~to designate a~~ percentage of the annual patient days at ~~beds of~~ the facility will be utilized ~~for use~~ by patients eligible for care under Title XIX of the Social Security Act. Any certificate of need issued to a nursing home in reliance upon an applicant's statements that ~~to provide~~ a specified percentage ~~number~~ of annual patient days will be utilized ~~beds for use~~ by residents eligible for care under Title XIX of the Social Security Act must include a statement that such certification is a condition of issuance of the certificate of need. The certificate-of-need program shall notify the Medicaid program office and the Department of Elderly Affairs when it imposes conditions as authorized in this paragraph ~~subparagraph~~ in an area in which a community diversion pilot project is implemented.

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

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

(2)(a) Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 18 months after the date of issuance~~, except in the case of a multifacility project, as defined in s. 408.032, where the certificate of need shall terminate 2 years after the date of issuance~~. The agency shall monitor

the progress of the holder of the certificate of need in meeting the timetable for project development specified in the application with the assistance of the local health council as specified in s. 408.033(1)(b)5., and may revoke the certificate of need, if the holder of the certificate is not meeting such timetable and is not making a good faith effort, as defined by rule, to meet it.

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

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

~~(d) If an application is filed to consolidate two or more certificates as authorized by s. 408.036(2)(f) or to divide a certificate of need into two or more facilities as authorized by s. 408.036(2)(g), the validity period of the certificate or certificates of need to be consolidated or divided shall be extended for the period beginning upon submission of the application and ending when final agency action and any appeal from such action has been concluded. However, no such suspension shall be effected if the application is withdrawn by the applicant.~~

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

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

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

408.045 Certificate of need; competitive sealed proposals.—

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

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

(3) Notification of the decision shall be issued to all applicants not later than 28 calendar days after the date responses to a request for proposal are due.

(4) The procedures provided for under this section are exempt from the batching cycle requirements and the public hearing requirement of s. 408.039.

(5) The agency ~~department~~ may use the competitive sealed proposal procedure for determining a certificate of need for other types of health care facilities and services if the agency ~~department~~ identifies an unmet health care need and when funding in whole or in part for such health care facilities or services is authorized by the Legislature.

Section 14. (1)(a) There is created a certificate-of-need workgroup staffed by the Agency for Health Care Administration.

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

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

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

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

(b) The President of the Senate shall appoint a representative of a for-profit hospital, a representative of a not-for-profit hospital, a representative of a public hospital, two representatives of the nursing home industry, two representatives of the hospice industry, a representative of a consumer organization, a representative from the Department of Elderly Affairs involved with the implementation of a long-term care community diversion program, and a health care market consultant with expertise in health care economics.

(c) The Speaker of the House of Representatives shall appoint a representative from the Florida Hospital Association, a representative of the Association of Community Hospitals and Health Systems of Florida, a representative of the Florida League of Health Systems, a representative of the Florida Health Care Association, a representative of the Florida Association of Homes for the Aging, three representatives of Florida Hospices and Palliative Care, one representative of local health councils, and one representative of a consumer organization.

(4) The workgroup shall study issues pertaining to the certificate-of-need program, including the impact of trends in health care delivery and financing. The workgroup shall study issues relating to implementation of the certificate-of-need program.

(5) The workgroup shall meet at least annually, at the request of the chair. The workgroup shall submit an interim report by December 31, 2001, and a final report by December 31, 2002. The workgroup is abolished effective July 1, 2003.

Section 15. Subsection (7) of section 651.118, Florida Statutes, is amended to read:

651.118 Agency for Health Care Administration; certificates of need; sheltered beds; community beds.—

(7) Notwithstanding the provisions of subsection (2), at the discretion of the continuing care provider, sheltered nursing home beds may be used for persons who are not residents of the facility and who are not parties to a continuing care contract for a period of up to 5 years after the date of issuance of the initial nursing home license. A provider whose 5-year period has expired or is expiring may request the Agency for Health Care Administration for an extension, not to exceed 30 percent of the total sheltered nursing home beds, if the utilization by residents of the facility in the sheltered beds will not generate sufficient income to cover facility expenses, as evidenced by one of the following:

(a) The facility has a net loss for the most recent fiscal year as determined under generally accepted accounting principles, excluding the effects of extraordinary or unusual items, as demonstrated in the most recently audited financial statement; or

(b) The facility would have had a pro forma loss for the most recent fiscal year, excluding the effects of extraordinary or unusual items, if revenues were reduced by the amount of revenues from persons in sheltered beds who were not residents, as reported on by a certified public accountant.

The agency shall be authorized to grant an extension to the provider based on the evidence required in this subsection. The agency may request a facility to use up to 25 percent of the patient days generated by new admissions of nonresidents during the extension period to serve Medicaid recipients for those beds authorized for extended use if there is a demonstrated need in the respective service area and if funds are available. A provider who obtains an extension is prohibited from applying for additional sheltered beds under the provision of subsection (2), unless additional residential units are built or the provider can demonstrate need by facility residents to the Agency for Health Care Administration. The 5-year limit does not apply to up to five sheltered beds designated for inpatient hospice care as part of a contractual arrangement with a hospice licensed under part VI of chapter 400. A facility that uses such beds after the 5-year period shall report such use to the Agency for Health Care Administration. For purposes of this subsection, “resident” means a person who, upon admission to the facility,

initially resides in a part of the facility not licensed under part II of chapter 400.

Section 16. Subsection (2) of section 395.701, Florida Statutes, is amended to read:

395.701 Annual assessments on net operating revenues for inpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.—

(2)(a) There is imposed upon each hospital an assessment in an amount equal to 1.5 percent of the annual net operating revenue for inpatient services for each hospital, such revenue to be determined by the agency, based on the actual experience of the hospital as reported to the agency. Within 6 months after the end of each hospital fiscal year, the agency shall certify the amount of the assessment for each hospital. The assessment shall be payable to and collected by the agency in equal quarterly amounts, on or before the first day of each calendar quarter, beginning with the first full calendar quarter that occurs after the agency certifies the amount of the assessment for each hospital. All moneys collected pursuant to this subsection shall be deposited into the Public Medical Assistance Trust Fund.

(b) There is imposed upon each hospital an assessment in an amount equal to 1 percent of the annual net operating revenue for outpatient services for each hospital, such revenue to be determined by the agency, based on the actual experience of the hospital as reported to the agency. Within 6 months after the end of each hospital fiscal year, the agency shall certify the amount of the assessment for each hospital. The assessment shall be payable to and collected by the agency in equal quarterly amounts, on or before the first day of each calendar quarter, beginning with the first full calendar quarter that occurs after the agency certifies the amount of the assessment for each hospital. All moneys collected pursuant to this subsection shall be deposited into the Public Medical Assistance Trust Fund.

Section 17. Paragraph (a) of subsection (2) of section 395.7015, Florida Statutes, is amended to read:

395.7015 Annual assessment on health care entities.—

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

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

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

408.904 Benefits.—

(2) Covered health services include:

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

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

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

(3) The agency may contract with:

(e) An entity in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases in order to test the cost-effectiveness of enhanced home-based medical care. The entity providing the services shall be reimbursed on a fee-for-service basis at a rate not less than comparable Medicare reimbursement rates. The agency may apply for waivers of federal regulations necessary to implement such program. This paragraph shall be repealed on July 1, 2002.

(9) The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(a) Prior to seeking legislative approval of such a waiver as authorized by this subsection, the agency shall provide notice and an opportunity for public comment. Notice shall be provided to all persons who have made requests of the agency for advance notice and shall be published in the Florida Administrative Weekly not less than 28 days prior to the intended action.

(b) Notwithstanding s. 216.292, funds that are appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver and are not expended shall be transferred to the agency to fund Medicaid-reimbursed nursing home care.

Section 20. The Legislature shall appropriate each fiscal year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund an amount sufficient to replace the funds lost due to reduction by this act of the assessment on other health care entities under s. 395.7015, Florida Statutes, and the reduction by this act in the assessment on hospitals under s. 395.701, Florida Statutes, and to maintain federal approval of the reduced amount of funds deposited into the Public Medical Assistance Trust Fund under s. 395.701, Florida Statutes, as state match for the state's Medicaid program.

Section 21. There is hereby appropriated the sum of $28.3 million from the General Revenue Fund to the Agency for Health Care Administration to implement the provisions of this act relating to the Public Medical Assistance Trust Fund, provided, however, that no portion of this appropriation shall be effective that duplicates a similar appropriation for the same purpose contained in other legislation from the 2000 Legislative Session that becomes law.

Section 22. The amendments to ss. 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 23. Effective July 1, 2000, and applicable to provider contracts entered into or renewed on or after that date, subsection (39) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(39) A health maintenance organization contract may not prohibit or restrict a subscriber from receiving inpatient services in a contracted hospital from a contracted primary care or admitting physician if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 24. Effective July 1, 2000, and applicable to provider contracts entered into or renewed on or after that date, subsection (11) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.—

(11) A contract between a health maintenance organization and a contracted primary care or admitting physician may not contain any provision that prohibits such physician from providing inpatient services in a contracted hospital to a subscriber if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 25. Effective July 1, 2000, and applicable to provider contracts entered into or renewed on or after that date, subsection (5) is added to section 641.3155, Florida Statutes, to read:

641.3155 Provider contracts; payment of claims.—

(5) A health maintenance organization shall pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted hospital to a subscriber, if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 26. Subsections (4) through (10) of section 641.51, Florida Statutes, are renumbered as subsections (5) through (11), respectively, and a new subsection (4) is added to said section to read:

641.51 Quality assurance program; second medical opinion requirement.—

(4) The organization shall ensure that only a physician licensed under chapter 458 or chapter 459, or an allopathic or osteopathic physician with an active, unencumbered license in another state with similar licensing requirements may render an adverse determination regarding a service provided by a physician licensed in this state. The organization shall submit to the treating provider and the subscriber written notification regarding the organization's adverse determination within 2 working days after the subscriber or provider is notified of the adverse determination. The written notification must include the utilization review criteria or benefits provisions used in the adverse determination, identify the physician who rendered the adverse determination, and be signed by an authorized representative of the organization or the physician who rendered the adverse determination. The organization must include with the notification of an adverse determination information concerning the appeal process for adverse determinations.

Section 27. Section 381.7351, Florida Statutes, is created to read:

381.7351 Short title.—Sections 381.7351-381.7356 may be cited as the "Reducing Racial and Ethnic Health Disparities: Closing the Gap Act."

Section 28. Section 381.7352, Florida Statutes, is created to read:

381.7352 Legislative findings and intent.—

(1) The Legislature finds that despite state investments in health care programs, certain racial and ethnic populations in Florida continue to have significantly poorer health outcomes when compared to non-Hispanic whites. The Legislature finds that local solutions to health care problems can have a dramatic and positive effect on the health status of these populations. Local governments and communities are best equipped to identify the health education, health promotion, and disease prevention needs of the racial and ethnic populations in their communities, mobilize the community to address health outcome disparities, enlist and organize local public and private resources, and faith-based organizations to address these disparities, and evaluate the effectiveness of interventions.

(2) It is therefore the intent of the Legislature to provide funds within Florida counties and Front Porch Florida Communities, in the form of Re-

ducing Racial and Ethnic Health Disparities: Closing the Gap grants, to stimulate the development of community-based and neighborhood-based projects which will improve the health outcomes of racial and ethnic populations. Further, it is the intent of the Legislature that these programs foster the development of coordinated, collaborative, and broad-based participation by public and private entities, and faith-based organizations. Finally, it is the intent of the Legislature that the grant program function as a partnership between state and local governments, faith-based organizations, and private-sector health care providers, including managed care, voluntary health care resources, social service providers, and nontraditional partners.

Section 29. Section 381.7353, Florida Statutes, is created to read:

381.7353 Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program; administration; department duties.—

(1) The Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program shall be administered by the Department of Health.

(2) The department shall:

(a) Publicize the availability of funds and establish an application process for submitting a grant proposal.

(b) Provide technical assistance and training, including a statewide meeting promoting best practice programs, as requested, to grant recipients.

(c) Develop uniform data reporting requirements for the purpose of evaluating the performance of the grant recipients and demonstrating improved health outcomes.

(d) Develop a monitoring process to evaluate progress toward meeting grant objectives.

(e) Coordinate with existing community-based programs, such as chronic disease community intervention programs, cancer prevention and control programs, diabetes control programs, the Healthy Start program, the Florida KidCare Program, the HIV/AIDS program, immunization programs, and other related programs at the state and local levels, to avoid duplication of effort and promote consistency.

(3) Pursuant to s. 20.43(6), the secretary may appoint an ad hoc advisory committee to: examine areas where public awareness, public education, research, and coordination regarding racial and ethnic health outcome disparities are lacking; consider access and transportation issues which contribute to health status disparities; and make recommendations for closing gaps in health outcomes and increasing the public's awareness and understanding of health disparities that exist between racial and ethnic populations.

Section 30. Section 381.7354, Florida Statutes, is created to read:

381.7354 Eligibility.—

(1) Any person, entity, or organization within a county may apply for a Closing the Gap grant and may serve as the lead agency to administer and coordinate project activities within the county and develop community partnerships necessary to implement the grant.

(2) Persons, entities, or organizations within adjoining counties with populations of less than 100,000, based on the annual estimates produced by the Population Program of the University of Florida Bureau of Economic and Business Research, may jointly submit a multicounty Closing the Gap grant proposal. However, the proposal must clearly identify a single lead agency with respect to program accountability and administration.

(3) In addition to the grants awarded under subsections (1) and (2), up to 20 percent of the funding for the Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program shall be dedicated to projects that address improving racial and ethnic health status within specific Front Porch Florida Communities, as designated pursuant to s. 14.2015(9)(b).

(4) Nothing in ss. 381.7351-381.7356 shall prevent a person, entity, or organization within a county or group of counties from separately contracting for the provision of racial and ethnic health promotion, health awareness, and disease prevention services.

Section 31. Section 381.7355, Florida Statutes, is created to read:

381.7355 Project requirements; review criteria.—

(1) Closing the Gap grant proposals shall be submitted to the Department of Health for review.

(2) A proposal must include each of the following elements:

(a) The purpose and objectives of the proposal, including identification of the particular racial or ethnic disparity the project will address. The proposal must address one or more of the following priority areas:

1. Decreasing racial and ethnic disparities in maternal and infant mortality rates.

2. Decreasing racial and ethnic disparities in morbidity and mortality rates relating to cancer.

3. Decreasing racial and ethnic disparities in morbidity and mortality rates relating to HIV/AIDS.

4. Decreasing racial and ethnic disparities in morbidity and mortality rates relating to cardiovascular disease.

5. Decreasing racial and ethnic disparities in morbidity and mortality rates relating to diabetes.

6. Increasing adult and child immunization rates in certain racial and ethnic populations.

(b) Identification and relevance of the target population.

(c) Methods for obtaining baseline health status data and assessment of community health needs.

(d) Mechanisms for mobilizing community resources and gaining local commitment.

(e) Development and implementation of health promotion and disease prevention interventions.

(f) Mechanisms and strategies for evaluating the project's objectives, procedures, and outcomes.

(g) A proposed work plan, including a timeline for implementing the project.

(h) Likelihood that project activities will occur and continue in the absence of funding.

(3) Priority shall be given to proposals that:

(a) Represent areas with the greatest documented racial and ethnic health status disparities.

(b) Exceed the minimum local contribution requirements specified in s. 381.7356.

(c) Demonstrate broad-based local support and commitment from entities representing racial and ethnic populations, including non-Hispanic whites. Indicators of support and commitment may include agreements to participate in the program, letters of endorsement, letters of commitment, interagency agreements, or other forms of support.

(d) Demonstrate a high degree of participation by the health care community in clinical preventive service activities and community-based health promotion and disease prevention interventions.

(e) Have been submitted from counties with a high proportion of residents living in poverty and with poor health status indicators.

(f) Demonstrate a coordinated community approach to addressing racial and ethnic health issues within existing publicly financed health care programs.

(g) Incorporate intervention mechanisms which have a high probability of improving the targeted population's health status.

(h) Demonstrate a commitment to quality management in all aspects of project administration and implementation.

Section 32. Section 381.7356, Florida Statutes, is created to read:

381.7356 Local matching funds; grant awards.—

(1) One or more Closing the Gap grants may be awarded in a county, or in a group of adjoining counties from which a multicounty application is submitted. Front Porch Florida Communities grants may also be awarded in a county or group of adjoining counties that are also receiving a grant award.

(2) Closing the Gap grants shall be awarded on a matching basis. One dollar in local matching funds must be provided for each $3 grant payment made by the state, except that:

(a) In counties with populations greater than 50,000, up to 50 percent of the local match may be in kind in the form of free services or human resources. Fifty percent of the local match must be in the form of cash.

(b) In counties with populations of 50,000 or less, the required local matching funds may be provided entirely through in-kind contributions.

(c) Grant awards to Front Porch Florida Communities shall not be required to have a matching requirement.

(3) The amount of the grant award shall be based on the county or neighborhood's population, or on the combined population in a group of adjoining counties from which a multicounty application is submitted, and on other factors, as determined by the department.

(4) Dissemination of grant awards shall begin no later than January 1, 2001.

(5) A Closing the Gap grant shall be funded for 1 year and may be renewed annually upon application to and approval by the department, subject to the achievement of quality standards, objectives, and outcomes and to the availability of funds.

(6) Implementation of the Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program shall be subject to a specific appropriation provided in the General Appropriations Act.

Section 33. Florida Commission on Excellence in Health Care.—

(1) LEGISLATIVE FINDINGS AND INTENT.—The Legislature finds that the health care delivery industry is one of the largest and most complex industries in Florida. The Legislature finds that the current system of regulating health care practitioners and health care providers is one of blame and punishment and does not encourage voluntary admission of errors and immediate corrective action on a large scale. The Legislature finds that previous attempts to identify and address areas which impact the quality of care provided by the health care industry have suffered from a lack of coordination among the industry's stakeholders and regulators. The Legislature finds that additional focus on strengthening health care delivery systems by eliminating avoidable mistakes in the diagnosis and treatment of Floridians holds tremendous promise to increase the quality of health care services available to Floridians, thereby reducing the costs associated with medical mistakes and malpractice and in turn increasing access to health

care in the state. To achieve this enhanced focus, it is the intent of the Legislature to create the Florida Commission on Excellence in Health Care to facilitate the development of a comprehensive statewide strategy for improving health care delivery systems through meaningful reporting standards, data collection and review, and quality measurement.

(2) DEFINITIONS.—As used in this act, the term:

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

(b) "Commission" means the Florida Commission on Excellence in Health Care.

(c) "Department" means the Department of Health.

(d) "Error," with respect to health care, means an unintended act, by omission or commission.

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

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

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

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

(b) Establish guidelines for data sharing and coordination.

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

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

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

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

(g) Evaluate regulatory issues relating to the pharmacy profession and recommend changes necessary to optimize patient safety.

(h) Facilitate open discussion of a process to ensure that comparative information on health care quality is valid, reliable, comprehensive, understandable, and widely available in the public domain.

(i) Sponsor public hearings to share information and expertise, identify "best practices," and recommend methods to promote their acceptance.

(j) Evaluate current regulatory programs to determine what changes, if any, need to be made to facilitate patient safety.

(k) Review public and private health care purchasing systems to determine if there are sufficient mandates and incentives to facilitate continuous improvement in patient safety.

(l) Analyze how effective existing regulatory systems are in ensuring continuous competence and knowledge of effective safety practices.

(m) Develop a framework for organizations that license, accredit, or credential health care practitioners and health care providers to more quickly and effectively identify unsafe providers and practitioners and to take action necessary to remove the unsafe provider or practitioner from practice or operation until such time as the practitioner or provider has proven safe to practice or operate.

(n) Recommend procedures for development of a curriculum on patient safety and methods of incorporating such curriculum into training, licensure, and certification requirements.

(o) Develop a framework for regulatory bodies to disseminate information on patient safety to health care practitioners, health care providers, and consumers through conferences, journal articles and editorials, newsletters, publications, and Internet websites.

(p) Recommend procedures to incorporate recognized patient safety considerations into practice guidelines and into standards related to the introduction and diffusion of new technologies, therapies, and drugs.

(q) Recommend a framework for development of community-based collaborative initiatives for error reporting and analysis and implementation of patient safety improvements.

(r) Evaluate the role of advertising in promoting or adversely affecting patient safety.

(s) Evaluate and make recommendations regarding the need for licensure of additional persons who participate in the delivery of health care to Floridians, including, but not limited to, surgical technologists and pharmacy technicians.

(t) Evaluate the benefits and problems of the current disciplinary systems and make recommendations regarding alternatives and improvements.

(4) MEMBERSHIP, ORGANIZATION, MEETINGS, PROCEDURES, STAFF.—

(a) The commission shall consist of:

1. The Secretary of Health and the Executive Director of the Agency for Health Care Administration.

2. One representative each from the following agencies or organizations: the Board of Medicine, the Board of Osteopathic Medicine, the Board of Pharmacy, the Board of Nursing, the Board of Dentistry, the Florida Dental Association, the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Academy of Physician Assistants, the Florida Chiropractic Society, the Florida Chiropractic Association, the Florida Podiatric Medical Association, the Florida Society of Ambulatory Surgical Centers, the Florida Statutory Teaching Hospital Council, Inc., the Florida Statutory Rural Hospital Council, the Florida Nurses Association, the Florida Organization of Nursing Executives, the Florida Pharmacy Association, the Florida Society of Health System Pharmacists, Inc., the Florida Hospital Association, the Association of Community Hospitals and Health Systems of Florida, Inc., the Florida League of Health Care Systems, the Florida Health Care Risk Management Advisory Council, the Florida Health Care Association, and the Florida Association of Homes for the Aging;

3. One licensed clinical laboratory director, appointed by the Secretary of Health;

4. Two health lawyers, appointed by the Secretary of Health, one of whom shall be a member of The Florida Bar Health Law Section who defends physicians and one of whom shall be a member of the Florida Academy of Trial Lawyers;

5. One representative of the medical malpractice professional liability insurance industry, appointed by the Secretary of Health;

6. One representative of a Florida medical school appointed by the Secretary of Health;

7. Two representatives of the health insurance industry, appointed by the Executive Director of the Agency for Health Care Administration, one of whom shall represent indemnity plans and one of whom shall represent managed care;

8. Five consumer advocates, consisting of one from the Association for Responsible Medicine, two appointed by the Governor, one appointed by the President of the Senate, and one appointed by the Speaker of the House of Representatives; and

9. Two legislators, one appointed by the President of the Senate and one appointed by the Speaker of the House of Representatives.

Commission membership shall reflect the geographic and demographic diversity of the state.

(b) The Secretary of Health and the Executive Director of the Agency for Health Care Administration shall jointly chair the commission. Subcommittees shall be formed by the joint chairs, as needed, to make recommenda-

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

(5) EVIDENTIARY PROHIBITIONS.—

(a) The findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, and actions of the commission shall be available to the public, but may not be introduced into evidence at any civil, criminal, special, or administrative proceeding against a health care practitioner or health care provider arising out of the matters which are the subject of the findings of the commission. Moreover, no member of the commission shall be examined in any civil, criminal, special, or administrative proceeding against a health care practitioner or health care provider as to any evidence or other matters produced or presented during the proceedings of this commission or as to any findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, or other actions of the commission or any members thereof. However, nothing in this section shall be construed to mean that information, documents, or records otherwise available and obtained from original sources are immune from discovery or use in any civil, criminal, special, or administrative proceeding merely because they were presented during proceedings of the commission. Nor shall any person who testifies before the commission or who is a member of the commission be prevented from testifying as to matters within his or her knowledge in a subsequent civil, criminal, special, or administrative proceeding merely because such person testified in front of the commission.

(b) The findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, and actions of the commission shall be used as a guide and resource and shall not be construed as establishing or advocating the standard of care for health care practitioners or health care providers unless subsequently enacted into law or adopted in rule. Nor shall any findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, or actions of the commission be admissible as evidence in any way, directly or indirectly, by introduction of documents or as a basis of an expert opinion as to the standard of care applicable to health care practitioners or health care

providers in any civil, criminal, special, or administrative proceeding unless subsequently enacted into law or adopted in rule.

(c) No person who testifies before the commission or who is a member of the commission may specifically identify any patient, health care practitioner, or health care provider by name. Moreover, the findings, recommendations, evaluations, opinions, investigations, proceedings, records, reports, minutes, testimony, correspondence, work product, and actions of the commission may not specifically identify any patient, health care practitioner, or health care provider by name.

(6) REPORT; TERMINATION.—The commission shall provide a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than February 1, 2001. After submission of the report, the commission shall continue to exist for the purpose of assisting the Department of Health, the Agency for Health Care Administration, and the regulatory boards in their drafting of proposed legislation and rules to implement its recommendations and for the purpose of providing information to the health care industry on its recommendations. The commission shall be terminated June 1, 2001.

Section 34. Effective October 1, 2000, subsection (1) of section 408.7056, Florida Statutes, is amended to read:

408.7056 Statewide Provider and Subscriber Assistance Program.—

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

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

(b) "Department" means the Department of Insurance.

(c) "Grievance procedure" means an established set of rules that specify a process for appeal of an organizational decision.

(d) "Health care provider" or "provider" means a state-licensed or state-authorized facility, a facility principally supported by a local government or by funds from a charitable organization that holds a current exemption from federal income tax under s. 501(c)(3) of the Internal Revenue Code, a licensed practitioner, a county health department established under part I of chapter 154, a prescribed pediatric extended care center defined in s. 400.902, a federally supported primary care program such as a migrant health center or a community health center authorized under s. 329 or s. 330 of the United States Public Health Services Act that delivers health care services to individuals, or a community facility that receives funds from the state under the Community Alcohol, Drug Abuse, and Mental Health Services Act and provides mental health services to individuals.

(e)~~(a)~~ "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(f)~~(b)~~ "Panel" means a statewide provider and subscriber assistance panel selected as provided in subsection (11).

Section 35. Effective October 1, 2000, section 627.654, Florida Statutes, is amended to read:

627.654 Labor union, ~~and~~ association, and small employer health alliance groups.—

(1)(a) A group of individuals may be insured under a policy issued to an association, including a labor union, which association has a constitution and bylaws and not less than 25 individual members and which has been organized and has been maintained in good faith for a period of 1 year for purposes other than that of obtaining insurance, or to the trustees of a fund established by such an association, which association or trustees shall be deemed the policyholder, insuring at least 15 individual members of the association for the benefit of persons other than the officers of the association, the association or trustees.

(b) A small employer, as defined in s. 627.6699 and including the employer's eligible employees and the spouses and dependents of such employees, may be insured under a policy issued to a small employer health alliance by a carrier as defined in s. 627.6699. A small employer health alliance must be organized as a not-for-profit corporation under chapter 617. Notwithstanding any other law, if a small employer member of an alliance loses eligibility to purchase health care through the alliance solely because the business of the small employer member expands to more than 50 and fewer than 75 eligible employees, the small employer member may, at its next renewal date, purchase coverage through the alliance for not more than 1 additional year. A small employer health alliance shall establish conditions of participation in the alliance by a small employer, including, but not limited to:

1. Assurance that the small employer is not formed for the purpose of securing health benefit coverage.

2. Assurance that the employees of a small employer have not been added for the purpose of securing health benefit coverage.

(2) No such policy of insurance as defined in subsection (1) may be issued to any such association or alliance, unless all individual members of such association, or all small employer members of an alliance, or all of any class or classes thereof, are declared eligible and acceptable to the insurer at the time of issuance of the policy.

(3) Any such policy issued under paragraph (1)(a) may insure the spouse or dependent children with or without the member being insured.

(4) A single master policy issued to an association, labor union, or small employer health alliance may include more than one health plan from the same insurer or affiliated insurer group as alternatives for an employer, employee, or member to select.

Section 36. Effective October 1, 2000, paragraph (f) of subsection (2), paragraph (b) of subsection (4), and subsection (6) of section 627.6571, Florida Statutes, are amended to read:

627.6571 Guaranteed renewability of coverage.—

(2) An insurer may nonrenew or discontinue a group health insurance policy based only on one or more of the following conditions:

(f) In the case of health insurance coverage that is made available only through one or more bona fide associations as defined in subsection (5) or through one or more small employer health alliances as described in s. 627.654(1)(b), the membership of an employer in the association or in the small employer health alliance, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor that relates to any covered individuals.

(4) At the time of coverage renewal, an insurer may modify the health insurance coverage for a product offered:

(b) In the small-group market if, for coverage that is available in such market other than only through one or more bona fide associations as defined in subsection (5) or through one or more small employer health alliances as described in s. 627.654(1)(b), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product.

(6) In applying this section in the case of health insurance coverage that is made available by an insurer in the small-group market or large-group market to employers only through one or more associations or through one or more small employer health alliances as described in s. 627.654(1)(b), a reference to "policyholder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

Section 37. Effective October 1, 2000, paragraph (h) of subsection (5), paragraph (b) of subsection (6), and paragraph (a) of subsection (12) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

(h) All health benefit plans issued under this section must comply with the following conditions:

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including require-

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

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

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

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

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

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

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

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

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to department review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the department that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the department. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. Nothing in this subparagraph exempts an alliance or group association from licensure for any activities that require licensure under the Insurance Code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy. ~~Carriers participating in the alliance program, in accordance with ss. 408.70-408.706, may apply a different community rate to business written in that program.~~

(12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.—

(a)1. By May 15, 1993, the commissioner shall appoint a health benefit plan committee composed of four representatives of carriers which shall include at least two representatives of HMOs, at least one of which is a staff model HMO, two representatives of agents, four representatives of small employers, and one employee of a small employer. The carrier members

shall be selected from a list of individuals recommended by the board. The commissioner may require the board to submit additional recommendations of individuals for appointment. ~~As alliances are established under s. 408.702, each alliance shall also appoint an additional member to the committee.~~

2. The committee shall develop changes to the form and level of coverages for the standard health benefit plan and the basic health benefit plan, and shall submit the forms, and levels of coverages to the department by September 30, 1993. The department must approve such forms and levels of coverages by November 30, 1993, and may return the submissions to the committee for modification on a schedule that allows the department to grant final approval by November 30, 1993.

3. The plans shall comply with all of the requirements of this subsection.

4. The plans must be filed with and approved by the department prior to issuance or delivery by any small employer carrier.

5. After approval of the revised health benefit plans, if the department determines that modifications to a plan might be appropriate, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the department for approval.

Section 38. Effective October 1, 2000, subsection (1) of section 240.2995, Florida Statutes, is amended to read:

240.2995 University health services support organizations.—

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

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

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

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

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

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

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

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

(8)

(b) Proprietary confidential business information is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, the Auditor General and Board of Regents, pursuant to their oversight and auditing functions, must be given access to all proprietary confidential business information upon request and without subpoena and must maintain the confidentiality of information so received. As used in this paragraph, the term "proprietary confidential business information" means information, regardless of its form or characteristics, which is owned or controlled by the not-for-profit corporation or its subsidiaries; is intended to be and is treated by the not-for-profit corporation or its subsidiaries as private and the disclosure of which would harm the business operations of the not-for-profit corporation or its subsidiaries; has not been intentionally disclosed by the corporation or its subsidiaries unless pursuant to law, an order of a court or administrative body, a legislative proceeding pursuant to s. 5, Art. III of the State Constitution, or a private agreement that provides that the information may be released to the public; and which is information concerning:

1. Internal auditing controls and reports of internal auditors;

2. Matters reasonably encompassed in privileged attorney-client communications;

3. Contracts for managed-care arrangements, ~~as managed care is defined in s. 408.701,~~ including preferred provider organization contracts, health maintenance organization contracts, and exclusive provider organization contracts, and any documents directly relating to the negotiation, performance, and implementation of any such contracts for managed-care arrangements;

4. Bids or other contractual data, banking records, and credit agreements the disclosure of which would impair the efforts of the not-for-profit corporation or its subsidiaries to contract for goods or services on favorable terms;

5. Information relating to private contractual data, the disclosure of which would impair the competitive interest of the provider of the information;

6. Corporate officer and employee personnel information;

7. Information relating to the proceedings and records of credentialing panels and committees and of the governing board of the not-for-profit corporation or its subsidiaries relating to credentialing;

8. Minutes of meetings of the governing board of the not-for-profit corporation and its subsidiaries, except minutes of meetings open to the public pursuant to subsection (9);

9. Information that reveals plans for marketing services that the corporation or its subsidiaries reasonably expect to be provided by competitors;

10. Trade secrets as defined in s. 688.002, including reimbursement methodologies or rates; or

11. The identity of donors or prospective donors of property who wish to remain anonymous or any information identifying such donors or prospective donors. The anonymity of these donors or prospective donors must be maintained in the auditor's report.

As used in this paragraph, the term “managed care” means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

Section 41. Effective October 1, 2000, subsection (14) of section 381.0406, Florida Statutes, is amended to read:

381.0406 Rural health networks.—

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

Section 42. Effective October 1, 2000, paragraph (a) of subsection (2) of section 395.3035, Florida Statutes, is amended to read:

395.3035 Confidentiality of hospital records and meetings.—

(2) The following records and information of any hospital that is subject to chapter 119 and s. 24(a), Art. I of the State Constitution are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

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

Section 43. Effective October 1, 2000, paragraph (b) of subsection (1) of section 627.4301, Florida Statutes, is amended to read:

627.4301 Genetic information for insurance purposes.—

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

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a self-insured plan as defined in s. 624.031, a multiple-employer welfare arrangement as defined in s. 624.437, a prepaid limited health service organization as defined in s. 636.003, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, a fraternal benefit society as defined in s. 632.601, ~~an accountable health partnership as defined in s. 408.701,~~ or any health care arrangement whereby risk is assumed.

Section 44. Section 641.185, Florida Statutes, is created to read:

641.185 Health maintenance organization subscriber protections.—

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the Department of Insurance and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(a) A health maintenance organization shall ensure that the health care services provided to its subscribers shall be rendered under reasonable standards of quality of care which are at a minimum consistent with the prevailing standards of medical practice in the community pursuant to ss. 641.495(1) and 641.51.

(b) A health maintenance organization subscriber should receive quality health care from a broad panel of providers, including referrals, preventive care pursuant to s. 641.402(1), emergency screening and services pursuant to ss. 641.31(12) and 641.513, and second opinions pursuant to s. 641.51.

(c) A health maintenance organization subscriber should receive assurance that the health maintenance organization has been independently accredited by a national review organization pursuant to s. 641.512, and is financially secure as determined by the state pursuant to ss. 641.221, 641.225, and 641.228.

(d) A health maintenance organization subscriber should receive continuity of health care, even after the provider is no longer with the health maintenance organization pursuant to s. 641.51(7).

(e) A health maintenance organization subscriber should receive timely, concise information regarding the health maintenance organization's reimbursement to providers and services pursuant to ss. 641.31 and 641.31015.

(f) A health maintenance organization subscriber should receive the flexibility to transfer to another Florida health maintenance organization, regardless of health status, pursuant to ss. 641.3104, 641.3107, 641.3111, 641.3921, 641.3922, and 641.228.

(g) A health maintenance organization subscriber should be eligible for coverage without discrimination against individual participants and beneficiaries of group plans based on health status pursuant to s. 641.31073.

(h) A health maintenance organization that issues a group health contract must: provide coverage for preexisting conditions pursuant to s. 641.31071; guarantee renewability of coverage pursuant to s. 641.31074; provide notice of cancellation pursuant to s. 641.3108; provide extension of benefits pursuant to s. 641.3111; provide for conversion on termination of eligibility pursuant to s. 641.3921; and provide for conversion contracts and conditions pursuant to s. 641.3922.

(i) A health maintenance organization subscriber should receive timely, and, if necessary, urgent grievances and appeals within the health maintenance organization pursuant to ss. 641.228, 641.31(5), 641.47, and 641.511.

(j) A health maintenance organization should receive timely and, if necessary, urgent review by an independent state external review organization for unresolved grievances and appeals pursuant to s. 408.7056.

(k) A health maintenance organization subscriber shall be given written notice at least 30 days in advance of a rate change pursuant to s. 641.31(3)(b). In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group pursuant to s. 641.31(3)(b).

(l) A health maintenance organization subscriber shall be given a copy of the applicable health maintenance contract, certificate, or member handbook specifying: all the provisions, disclosure, and limitations required pursuant to s. 641.31(1) and (4); the covered services, including those services, medical conditions, and provider types specified in ss. 641.31, 641.31094, 641.31095, 641.31096, 641.51(10), and 641.513; and where and in what manner services may be obtained pursuant to s. 641.31(4).

(2) This section shall not be construed as creating a civil cause of action by any subscriber or provider against any health maintenance organization.

Section 45. Subsection (11) of section 641.511, Florida Statutes, is renumbered as subsection (12) and a new subsection (11) is added to said section to read:

641.511 Subscriber grievance reporting and resolution requirements.—

(11) Each organization, as part of its contract with any provider, must require the provider to post a consumer assistance notice prominently displayed in the reception area of the provider and clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration, the Statewide Provider and Subscriber Assistance Program, and the Department of Insurance. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization's grievance department shall be provided upon request. The agency is authorized to promulgate rules to implement this section.

Section 46. Paragraph (n) of subsection (3), paragraph (c) of subsection (5), and paragraphs (b) and (d) of subsection (6) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—

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

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

(5) AVAILABILITY OF COVERAGE.—

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

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

2. Beginning August 1, 2000 ~~April 15, 1994~~, offer and issue basic and standard small employer health benefit plans on a guaranteed-issue basis, during an open enrollment period of August 1 through August 31 of each year, to every eligible small employer, with less than ~~one or~~ two eligible employees, which is not formed primarily for purposes of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. Coverage provided pursuant to this subparagraph shall begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children shall constitute a single eligible employee if such person and spouse are employed by the same small employer and either one has a normal work week of less than 25 hours.

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

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j) and may be adjusted as permitted by subparagraphs 5. and 6.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carri-

er's experience. The factors used by carriers are subject to department review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed.

4. Carriers participating in the alliance program, in accordance with ss. 408.70-408.706, may apply a different community rate to business written in that program.

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the department, to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier shall limit the application of such adjustments to only minus adjustments beginning not more than 60 days after the report is sent to the department. For any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 5 percent, the carrier may apply both plus and minus adjustments.

6. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to department review and approval.

7. A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

8. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph a "composite rating methodology" means a rating meth-

odology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

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

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

409.212 Optional supplementation.—

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

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

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

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

(15) "Medicaid program" means the program authorized under Title XIX of the federal Social Security Act which provides for payments for medical items or services, or both, on behalf of any person who is determined by the Department of Children and Family Services, or, for Supplemental Security Income, by the Social Security Administration, to be eligible on the date of service for Medicaid assistance.

(18) "Medicaid recipient" or "recipient" means an individual whom the Department of Children and Family Services, or, for Supplemental Security Income, by the Social Security Administration, determines is eligible, pursuant to federal and state law, to receive medical assistance and related services for which the agency may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

Section 49. Section 409.902, Florida Statutes, is amended to read:

409.902 Designated single state agency; payment requirements; program title.—The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made, subject to any limitations or directions provided for in the General Appropriations Act, only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated the "Medicaid program." The Department of Children and Family Services is responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility.

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

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

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

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

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

(c) The family's countable income and resources do not exceed the applicable Aid to Families with Dependent Children (AFDC) income and resource standards under the AFDC state plan in effect in July 1996, except as amended in the Medicaid state plan to conform as closely as possible to the requirements of the WAGES Program as created in s. 414.015, to the extent permitted by federal law.

(2) A person who receives payments from, who is determined eligible for, or who was eligible for but lost cash benefits from the federal program known as the Supplemental Security Income program (SSI). This category includes a low-income person age 65 or over and a low-income person under age 65 considered to be permanently and totally disabled.

(3) A child under age 21 living in a low-income, two-parent family, and a child under age 7 living with a nonrelative, if the income and assets of the

family or child, as applicable, do not exceed the resource limits under the WAGES Program.

(4) A child who is eligible under Title IV-E of the Social Security Act for subsidized board payments, foster care, or adoption subsidies, and a child for whom the state has assumed temporary or permanent responsibility and who does not qualify for Title IV-E assistance but is in foster care, shelter or emergency shelter care, or subsidized adoption.

(5) A pregnant woman for the duration of her pregnancy and for the post partum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150 percent of the most current federal poverty level, or, effective January 1, 1992, that has an income which is at or below 185 percent of the most current federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.

(6) A child born after September 30, 1983, living in a family that has an income which is at or below 100 percent of the current federal poverty level, who has attained the age of 6, but has not attained the age of 19. In determining the eligibility of such a child, an assets test is not required.

(7) A child living in a family that has an income which is at or below 133 percent of the current federal poverty level, who has attained the age of 1, but has not attained the age of 6. In determining the eligibility of such a child, an assets test is not required.

(8) A person who is age 65 or over or is determined by the agency to be disabled, whose income is at or below 100 percent of the most current federal poverty level and whose assets do not exceed limitations established by the agency. However, the agency may only pay for premiums, coinsurance, and deductibles, as required by federal law, unless additional coverage is provided for any or all members of this group by s. 409.904(1).

Section 51. Subsection (6) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(6) HOSPITAL OUTPATIENT SERVICES.—The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,500 ~~$1,000~~ per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

Section 52. Subsection (5) of section 409.906, Florida Statutes, is amended to read:

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

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

Section 53. Subsection (7), (9), and (10) of section 409.907, Florida Statutes, are amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person

shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(7) The agency may require, as a condition of participating in the Medicaid program and before entering into the provider agreement, that the provider submit information concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform ~~assist in~~ this function. Before entering into the provider agreement, or as a condition of continuing in the Medicaid program, the agency ~~and~~ may also require that Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis which is not cost-based, post a surety bond ~~from the provider~~ not to exceed $50,000 or the total amount billed by the provider to the program during the currant or most recent calendar year, whichever is greater. For new providers, the amount of the surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the provider. A provider's bond shall not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility licensed under part III of chapter 400. The bonds permitted by this section are in addition to the bonds referenced in s. 400.179(4)(d). If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws, rules, or regulations of this state or of any other state or the Federal Government; any prior violation of the laws, rules, or regulations relating to the Medicare program; any prior violation of the rules or regulations of any other public or private insurer; and any prior violation of the laws, rules, or regulations of any regulatory body of this or any other state.

(c) Full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(d) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Medicaid program.

(9) Upon receipt of a completed, signed, and dated application, and completion of any necessary background investigation and criminal history record check, the agency must either:

(a) Enroll the applicant as a Medicaid provider; or

(b) Deny the application if the agency finds that~~, based on the grounds listed in subsection (10),~~ it is in the best interest of the Medicaid program to do so, specifying the reasons for denial. The agency may consider the factors listed in subsection (10), as well as any other factor that could affect the effective and efficient administration of the program, including, but not limited to, the current availability of medical care, services, or supplies to recipients, taking into account geographic location and reasonable travel time.

(10) The agency may consider whether ~~deny enrollment in the Medicaid program to a provider if~~ the provider, or any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder having an ownership interest equal to 5 percent or greater in the provider if the provider is a corporation, partnership, or other business entity, has:

(a) Made a false representation or omission of any material fact in making the application, including the submission of an application that conceals the controlling or ownership interest of any officer, director, agent, managing employee, affiliated person, or partner or shareholder who may not be eligible to participate;

(b) Been or is currently excluded, suspended, terminated from, or has involuntarily withdrawn from participation in, Florida's Medicaid program or any other state's Medicaid program, or from participation in any other governmental or private health care or health insurance program;

(c) Been convicted of a criminal offense relating to the delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance program including the performance of management or administrative services relating to the delivery of goods or services under any such program;

(d) Been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services;

(e) Been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

(f) Been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(g) Been convicted under federal or state law of a crime punishable by imprisonment of a year or more which involves moral turpitude;

(h) Been convicted in connection with the interference or obstruction of any investigation into any criminal offense listed in this subsection;

(i) Been found to have violated federal or state laws, rules, or regulations governing Florida's Medicaid program or any other state's Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program, and been sanctioned accordingly;

(j) Been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or

(k) Failed to pay any fine or overpayment properly assessed under the Medicaid program in which no appeal is pending or after resolution of the proceeding by stipulation or agreement, unless the agency has issued a specific letter of forgiveness or has approved a repayment schedule to which the provider agrees to adhere.

Section 54. Paragraph (a) of subsection (1) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5). Reimbursement for hospital outpatient care is limited to $1,500 ~~$1,000~~ per state fiscal year per recipient, except for:

1. Such care provided to a Medicaid recipient under age 21, in which case the only limitation is medical necessity;

2. Renal dialysis services; and

3. Other exceptions made by the agency.

Section 55. Section 409.9119, Florida Statutes, is created to read:

409.9119 Disproportionate share program for children's hospitals.—In addition to the payments made under s. 409.911, the Agency for Health Care

Administration shall develop and implement a system under which disproportionate share payments are made to those hospitals that are licensed by the state as a children's hospital. This system of payments must conform to federal requirements and must distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals that serve a disproportionate share of low-income patients.

(1) The agency shall use the following formula to calculate the total amount earned for hospitals that participate in the children's hospital disproportionate share program:

$$TAE = DSR \times BMPD \times MD$$

Where:

TAE = total amount earned by a children's hospital.

DSR = disproportionate share rate.

BMPD = base Medicaid per diem.

MD = Medicaid days.

(2) The agency shall calculate the total additional payment for hospitals that participate in the children's hospital disproportionate share program as follows:

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

Where:

TAP = total additional payment for a children's hospital.

TAE = total amount earned by a children's hospital.

STAE = sum of total amount earned by each hospital that participates in the children's hospital disproportionate share program.

TA = total appropriation for the children's hospital disproportionate share program.

(3) A hospital may not receive any payments under this section until it achieves full compliance with the applicable rules of the agency. A hospital that is not in compliance for two or more consecutive quarters may not receive its share of the funds. Any forfeited funds must be distributed to the remaining participating children's hospitals that are in compliance.

Section 56. Section 409.919, Florida Statutes, is amended to read:

409.919 Rules.—The agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements. In addition, the Department of Children and Family Services shall adopt and accept transfer of any rules necessary to

carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering ss. 409.901-409.906 and any other provisions related to responsibility for the determination of Medicaid eligibility.

Section 57. Notwithstanding the provisions of ss. 236.0812, 409.9071, and 409.908(21), Florida Statutes, developmental research schools, as authorized under s. 228.053, Florida Statutes, shall be authorized to participate in the Medicaid certified school match program subject to the provisions of ss. 236.0812, 409.9071, and 409.908(21), Florida Statutes.

Section 58. (1) The Agency for Health Care Administration is directed to submit to the Health Care Financing Administration a request for a waiver that will allow the agency to undertake a pilot project that would implement a coordinated system of care for adult ventilator dependent patients. Under this pilot program, the agency shall identify a network of skilled nursing facilities that have respiratory departments geared towards intensive treatment and rehabilitation of adult ventilator patients and will contract with such a network for respiratory services under a capitation arrangement. The pilot project must allow the agency to evaluate a coordinated and focused system of care for adult ventilator dependent patients to determine the overall cost-effectiveness and improved outcomes for participants.

(2) The agency shall submit the waiver by September 1, 2000. The agency shall forward a preliminary report of the pilot project's findings to the Governor, the Speaker of the House of Representatives, and the President of the Senate 6 months after project implementation. The agency shall submit a final report of the pilot project's findings to the Governor, the Speaker of the House of Representatives, and the President of the Senate no later than February 15, 2002.

Section 59. Subsection (3) of section 400.464 and paragraph (b) of subsection (4) of section 409.912, Florida Statutes, are repealed.

Section 60. Effective October 1, 2000, subsection (3) of section 408.70 and sections 408.701, 408.702, 408.703, 408.704, 408.7041, 408.7042, 408.7045, 408.7055, and 408.706, Florida Statutes, are repealed.

Section 61. The sum of $91,000 in nonrecurring general revenue is hereby appropriated from the General Revenue Fund to the Department of Health to cover costs of the Florida Commission on Excellence in Health Care relating to the travel and related expenses of staff, consumer members, and members appointed by the department or agency; the hiring of consultants, if necessary; and the reproduction and dissemination of documents; however, no portion of this appropriation shall be effective that duplicates a similar appropriation for the same purpose contained in other legislation from the 2000 legislative session that becomes law.

Section 62. The sum of $200,000 is appropriated from the Insurance Commissioner's Regulatory Trust Fund to the Office of Legislative Services for the purpose of implementing the legislative intent expressed in s. 624.215(1), Florida Statutes, for a systematic review of current mandated

health coverages. The review must be conducted by certified actuaries and other appropriate professionals and shall consist of an assessment of the impact, including, but not limited to, the costs and benefits, of current mandated health coverages using the guidelines provided in s. 624.215(2), Florida Statutes. This assessment shall establish the aggregate cost of mandated health coverages.

Section 63. The General Appropriations Act for Fiscal Year 2000-2001 shall be reduced by four full-time-equivalent positions and $260,719 from the Health Care Trust Fund in the Agency for Health Care Administration for purposes of implementing the provisions of this act; however, the reductions shall not be effective if duplicative of similar reductions for the same purpose contained in other legislation from the 2000 legislative session that becomes law.

Section 64. Except as otherwise provided herein, this act shall take effect July 1, 2000.

Approved by the Governor June 8, 2000.

Filed in Office Secretary of State June 8, 2000.