STORAGE NAME: h2349z.hcs ****AS PASSED BY THE LEGISLATURE****
DATE: August 17, 2000 **CHAPTER #: 2000-367, Laws of Florida**

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH CARE SERVICES
FINAL ANALYSIS

BILL #: HB 2349 (PCB HCS 00-05) (Passed as CS/SB 2034) (Includes HB 1539, HB 1659, SB 2012, HB 2025, HB 2151, HB 2169, HB 2321(PCB HCS 00-04), HB 2385 (PCB HCS 00-03)

RELATING TO: Department of Health

SPONSOR(S): Committee on Health Care Services, Rep. Peaden

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES YEAS 14 NAYS 0
(2) GOVERNMENTAL RULES AND REGULATIONS YEAS 6 NAYS 2
(3) HEALTH AND HUMAN SERVICES APPROPRIATIONS W/D
(4)
(5)

I. SUMMARY:

HB 2349 passed the Legislature as CS/SB 2034. On June 26, 2000, CS/SB 2034 became Ch. 2000-367, Laws of Florida, with the Governor's signature.

HB 2349 relates to a variety of health care issues. The bill:

- Addresses several Department of Health issues, cleaning up several department-related statutes and includes substantive provisions relating to: strategic planning; community service delivery; an immunization registry; clarifying revisions relating to diseases of public health significance, HIV, and school health background screening; and a Hepatitis A public awareness campaign.
- Includes several statutory clean-up provisions relating to last year's transfer of the Brain and Spinal Cord Injury Program from Labor to Health; provides for planning for long-term community based supports for individuals with traumatic brain and spinal cord injuries (HB 2385); and provides for public records protections for the program (HB 2321).
- Provides for a Medicaid preferred prescribed drug spending control program, and a Medicaid Pharmacy and Therapeutics Committee (HB 2151).
- Updates provisions relating to the State Long-Term Care Ombudsman Committee (HB 1539).
- Nullifies a provision in CS/HB 2339 which allowed for the establishment of specialty hospitals through the transfer of existing beds within a county, apart from the Certificate of Need process.
- Entitles the state to a security interest in real property purchased or improved with state funds.
- Establishes the Jesse Trice Cancer Prevention Program (HB 2025).
- Provides additional bonding authority for health facilities authorities (SB 2012).
- Designates February 6 as Florida Alzheimer's Disease Day.
- Creates the Florida Commission on Excellence in Health Care (HB 2169).
- Provides funding for the next phase of the kidney dialysis study (HB 1659).

The bill's effective date is July 1, 2000.

See the FISCAL portion of this analysis for details regarding $401,000 of expenditures for various provisions, and $241 million in reductions relating to Medicaid prescribed drug services.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No [x]	N/A []
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

1. In creating the Medicaid preferred drug spending control program and the Medicaid Pharmacy and Therapeutics Committee, the bill creates more functions for the Florida Medicaid program.

3. In specifying the use of a preferred drug approach to Medicaid prescribed drugs, Medicaid recipients and their prescribing providers will have diminished freedom compared to the current absolutely open formulary under Medicaid.

B. PRESENT SITUATION:

General Background Regarding the Department of Health

Since its creation on January 1, 1997, via ch. 96-403, L.O.F., the Department of Health has had as one of its goals the “clean up” of public health related statutory provisions to ensure that the statutes reflect the priorities and public health mission and functions of the department. Obviously, such a goal is not achieved in a single step. The department is proposing another round of revisions to further refine its statutory basis.

Public Health Planning Functions

Various references in the Florida Statutes require the Department of Health to develop public health planning documents. These requirements include: s. 20.43(1)(l), F.S., which directs the department to biennially publish, and annually update, a state health plan; s. 381.0011(3), F.S., which requires the department to develop a comprehensive public health plan; and s. 381.731, F.S., which requires the department to develop a biennial Healthy Communities, Healthy People plan.

In addition to these separate internal planning requirements, s. 186.021, F.S., requires all state agencies to develop an Agency Strategic Plan. The Agency Strategic Plan for the Department of Health presents the mission statement of the department, and the goals the department is striving to achieve. The plan identifies the department’s highest priority issues, goals, and strategies. The department has indicated that its Agency Strategic Plan is a guide to what the department intends to do to meet its mission.

Primary Care Services

Section 154.011, F.S., is specific to county health department primary care services. When county health department services were funded in the early 1980s, supporting staff positions were established at headquarters. In 1990, the staff responsible for providing oversight and monitoring of county health department primary care programs was eliminated due to budget reductions. Because the department lacks resources to provide oversight to primary care programs, county health department contracts specific to primary care services no longer exist, but rather, such services are part of county health department master contracts. Funds for primary care are now allocated to county health departments by formula. The department's quality assurance process now reviews the quality of programs administered by county health departments, including primary care services.

The department is authorized to adopt rules to govern the operation of primary care programs, specific to quality of care, case management, and Medicaid participation.

Florida Biomedical Research Program

Section 215.5602, F.S., as created in 1999, authorizes funds from the Lawton Chiles Endowment Fund to be appropriated to the Department of Health for operation of the Florida Biomedical Research Program. The statute allows the department to fund research grants only on the diagnosis and treatment of certain smoking-related diseases. As currently written, this section does not allow research on better ways to help people stop using tobacco, nor on screening methodologies, neither of which is “diagnosis and treatment.”

Immunization Registry

Section 381.003(1)(e), F.S., authorizes the department to conduct a vaccine-preventable disease program but does not provide specific authority for electronic transfer of immunization data through a centralized, computerized immunization registry. There is substantial need for such a system and the current national initiative to establish immunization registries in each state has resulted in 21 states with laws or rules authorizing registries. Thirty-four states and the District of Columbia have operating registries at this time. The federal government, through the Centers for Disease Control and Prevention and other funding avenues, has committed considerable federal resources to assist states in the establishment of immunization registries.

Recent statistics indicate that, in Florida, over 60 percent of childhood immunizations are administered by private health care practitioners. Both the public and private sectors continue to experience high mobility of patients between health care providers, which results in fragmented immunization records. Currently, there is no way to consolidate these records. Health care providers must rely on parental recall, parental records, or attempt to contact with previous health care providers to collect the information. There is no way for schools and child care centers to verify the information provided by parents except through contact with a health care provider. An immunization registry would import birth records from Vital Statistics, thereby allowing authorized providers access to all children born in Florida and allowing entry of children who move to Florida. The registry would merge records and make records available to health care providers. Current immunization registry plans have scheduled full implementation of the immunization registry in both the public and private sectors by 2001.

Reports of Diseases of Public Health Significance to the Department

Section 381.0031, F.S., requires health practitioners, hospitals and laboratories to report a diagnosis or suspicion of a disease of public health significance to the Department of Health, and declares such information to be confidential. This section authorizes the adoption of rules to address disease reporting, including what actions the department will take to follow-up on a report and protect the public health. Section 395.3025(5), F.S., gives the Department of Health access to medical records in a licensed facility for the purpose of epidemiological investigation, such as, following-up on reported diseases of public health significance. The statutes have not provided clear access to medical records that are in the possession of other medical providers or laboratories, for the same purpose of following-up on cases of reportable diseases. Review of these records by the Department of Health would save time for the practitioner who is the custodian of the records. Authority to access these records would allow public health workers to get timely access to information about public health aspects of cases, in terms of date of onset, possible sources of infection or exposure, likely date of exposure, period of infectiousness, and so on. This information may be critical to taking effective disease control measures.

Testing for Human Immunodeficiency Virus (HIV)

Section 381.004(3)(d), F.S., prohibits the release of a preliminary HIV test result, without a confirmatory test, except in specified circumstances. One of those circumstances occurs when decisions about the care and treatment of the "person tested" cannot await the results of confirmatory testing. When a pregnant woman presents for childbirth without having had the HIV test as a part of prenatal care, there is no authority to use the preliminary HIV test results of the mother in labor in order to make decisions on the care and treatment of the infant. Most women in Florida are receiving an HIV test as a standard practice of prenatal care. Pregnant women who test HIV positive are given the opportunity to begin drug treatment that will greatly decrease the chance of transmitting the virus to the fetus. Drug therapy can be initiated immediately to the newborn of an infected mother, thereby increasing the effectiveness of the drug therapy.

Section 381.004(3)(h)10., F.S., provides a definition of "medical personnel" who have experienced a significant exposure to HIV in medical treatment situations. Chapter 64D-2, F.A.C., relating to human immunodeficiency virus, also provides a definition for "medical personnel" that is used to describe people who have experienced a significant exposure. The rule expands the definition beyond the statute to include an employee of a health care provider or plasma center and a medical or other student receiving training as a health care professional at a health care facility. It also clarifies that paramedics or emergency medical technicians are those "certified by the department to perform life support procedures." The definition in the rule was developed through rule workshops, with the concurrence of the affected parties, and adopted in 1988. The statute needs to be amended to provide adequate basis for current rule provisions.

Background Screening Requirements for School Health Services Personnel

As created in 1999, s. 381.0059, F.S., provides for background screening of all personnel who provide school health services and was intended to promote increased safety for students by including employees of public/private partnerships. Prior to passage of this legislation, the Florida Department of Law Enforcement would not provide screening for these employees. The unexpected consequence of the legislation has been mass confusion about who needs to be screened and who will pay for it. While health department and school district personnel are generally screened already, there are others who have

contact with students who may not be screened. This includes speakers and presenters of group lectures relating to school health topics, as well as volunteers.

Environmental Health Professionals

Currently, paragraph 381.0101(5)(a), F.S., requires any person who begins employment in a primary environmental health program after September 21, 1994, to be certified in that program within 6 months of employment. The statute allows grandfathering for individuals already employed in primary environmental health programs prior to the effective date of the certification rule. However, this existing language will make it difficult to add new, more current grandfathering allowances for individuals when additional programs are added to the certification process. A change in the statute is needed to allow the Department of Health to set new grandfathering dates when new programs are added.

In addition, paragraph 381.0101(5)(d), F.S., requires certified persons to obtain 24 hours of continuing education units (CEUs) every two years for each program in which they are certified. As the department is looking at adding additional programs to the certification process, the number of CEUs required in total could become burdensome for those environmental health professionals who seek certification in multiple areas of specialty.

Health Promotion and Chronic Disease Control Activities

The department currently promotes the establishment of Healthy Communities, Healthy People programs, as specified in the Healthy Communities, Healthy People Act (ss. 381.731-381.734, F.S.), by providing training to county health departments and their community partners in the Planned Approach to Community Health comprehensive planning process developed by the Centers for Disease Control and Prevention. The department also provides periodic statewide conferences for public health professionals and private health care providers to increase the knowledge of participants in the area of chronic disease prevention, focusing on clinical preventive services to reduce clients and patients' risk factors. Comprehensive Health Improvement Projects (CHIP), developed in county health departments to address chronic diseases, are included in the Healthy Communities, Healthy People program. These programs are increasingly focused on behavior change as a means of prevention. In addition to the ch. 381, F.S., provisions cited above, ch. 385, F.S., more specifically addresses chronic disease control topics.

Epilepsy Program Funding

Section 385.207, F.S., specifically directs the department to conduct a program of care and assistance to persons with epilepsy. These services are, in part, funded with revenue generated as county court civil penalties under s. 318.21(6), F.S., for penalties relating to child restraint requirements (s. 316.613, F.S.) and safety belt usage (s. 316.614, F.S.). Section 318.21, F.S., was formerly s. 318.18, F.S. A conforming cross-reference revision has not been incorporated into s. 385.207, F.S., since this 1996 revision.

Tuberculosis/A.G. Holley State Hospital

Under s. 402.181, F.S., the Departments of Children and Families, Juvenile Justice, and Corrections are covered under the State Institutions Claims Program for damages or injuries caused by children, inmates, or escapees of their state institutions. When the statutes were amended for the divestiture of the Department of Health and Rehabilitative Services, the Department of Health was not included in the amended list of eligible state agencies for this program. The Department of Health is therefore unable to file claims bills

in the event of property damage or direct medical expenses for injuries caused by patients at A.G. Holley Hospital.

Department Rules for Public Swimming and Bathing Places

Section 514.021, F.S., requires the department to review its rules related to public swimming pools and bathing places as needed, but not less than *biannually*, which means twice per year. This is not practical or necessary. The Division of Environmental Health currently reviews these administrative rules once every two years.

Protection of Copyrights, Trademarks, and Service Marks

As the Department of Health implements new initiatives for programs such as anti-tobacco campaigns as part of the tobacco settlements, the department is developing a variety of unique new materials, information, and logos. The same is true for the department's efforts relating to health care provider credentialing. The department, however, lacks specific authority to protect these new "products" via the use of copyrights, trademarks, or service marks.

Brain and Spinal Cord Injury Program

The Brain and Spinal Cord Injury Program was established to provide all eligible injured individuals with the opportunity to obtain the necessary services to enable them to be referred to a vocational rehabilitation program or to an appropriate level of functioning in their community. Last year the program received $13,927,316 in revenue, spent $11,779,392 in expenses. Approximately 68 percent of the funds were spent on client services, 5 percent on administration, 7 percent on centers for independent living, 8 percent on research, and 12 percent on contracts. Last year 2,670 individuals were referred to the program. The program handled 4,822 cases, opening 1,888 cases and closing 2,934 cases.

The Legislature transferred the Brain and Spinal Cord Injury Program to the Department of Health from the Department of Labor and Employment Security effective January 1, 2000, as part of chapter 99-240, Laws of Florida. While much of the statutory language necessary for the program's operations was transferred from chapter 413, F.S., to chapter 381, F.S.; not all statutory authority necessary for the operation of the program was transferred to or replicated in chapter 381 from chapter 413. Specifically, the statutory authority contained in s. 413.012, F.S., relating to the confidentiality of sensitive personal information of applicants or recipients (under the Division of Blind Services, the umbrella program that included the Brain and Spinal Cord Injury Program until last year), was not included in this transfer. The confidentiality of this information is essential to ensuring that applicants and recipients are willing to fully participate in the program.

Long-Term Community-Based Supports

Individuals sustaining traumatic brain and spinal cord injuries have intense, immediate, and ongoing needs from the resulting disability. Due to the lack of services responsive to those needs, such individuals often find themselves placed in inappropriate residential or institutional placements. Individuals and their families often lack the resources to educate themselves as to the existence of programs that could address those needs. Presently, there is no central resource to ease the onerous burden of discovering and coordinating all available services or to step into the gap when resources cannot be found to prevent inappropriate residential or institutional placements.

Hepatitis A

Hepatitis is inflammation of the liver from any cause. Hepatitis can be caused by bacterial or viral infections, infestation with parasites, chemicals (alcohol or drugs), toxins, or immune diseases. Hepatitis commonly results from a virus, particularly one of five hepatitis viruses--A, B, C, D, or E. Less commonly, hepatitis results from other viral infections, such as infectious mononucleosis, yellow fever, and cytomegalovirus infection. The major non-viral causes of hepatitis are alcohol and drugs. Hepatitis can be short-term (acute, lasting less than 6 months), long-term (chronic), or life-threatening (fulminant). Hepatitis occurs commonly throughout the world. The incidence, severity, and means of contagion vary with different forms of hepatitis.

Prevention of hepatitis varies with each type of infection. Some general precautions to reduce the chance of contracting hepatitis or other infections include: avoiding contact with blood or blood products, avoiding sexual contact with a person infected with hepatitis or person with unknown health history, practicing safer sex behaviors, avoiding contact with blood or blood products whenever possible, washing hands thoroughly or clean up extensively after using the restroom if there is contact with anyone's blood, feces, or body fluids, and avoiding IV drug use.

Hepatitis A virus spreads primarily from the stool of one person to the mouth of another. Such transmission is usually the result of poor hygiene. Waterborne and foodborne epidemics are common, especially in developing countries. Eating contaminated raw shellfish is sometimes responsible. Isolated cases, usually arising from person-to-person contact, are also common. Most hepatitis A infections cause no symptoms and go unrecognized.

Hepatitis B vaccine is available for people in high-risk groups. Hepatitis A vaccine is available for people in high risk professions like nursery attendants, institutional care workers, nurses, physicians, and people traveling to parts of the world where the disease is widespread.

The Centers for Disease Control and Prevention estimates that up to 200,000 Americans are infected with Hepatitis A each year, primarily through fecal contaminated food and objects such as toys. The CDC has also recently issued a new recommendation that all children in states identified as having high Hepatitis A infection rates be vaccinated against the disease. The CDC has recently indicated that there are 11 states with more than 20 Hepatitis A infections per 100,000 population, and 6 states with 10 to 20 infections per 100,000 population. All of these states are west of the Mississippi River.

Minority Health Concerns Relating to Cancer

Low income African-Americans and Hispanics in Florida generally have worse outcomes than whites for a wide variety of cancers, partly because of lower probability of early diagnosis through screening. Death rates for some cancers are higher for these populations.

Tobacco use is the major cause of cancer. Tobacco use among youth is being addressed by tobacco-free community partnerships in each county under Florida’s Tobacco Control Program. Eight community-based chronic disease community intervention programs are currently funded with federal block grant dollars awarded to county health departments to address the prevention of lung cancer through prevention of tobacco use or tobacco cessation programs. None of these programs are located in Dade or Lee counties.

The Miami-Dade County Health Department is one of 19 county health departments currently implementing Florida's Breast and Cervical Cancer Early Detection Program. The federal Centers for Disease Control and Prevention currently fund this program at $3.1 million to provide breast and cervical cancer screening exams to uninsured and underinsured women, and to conduct outreach and public and professional education.

The Health Choice Network is a not-for-profit organization formed approximately 8 years ago to foster the philosophies and goals of organizations engaged in the delivery of preventive and primary care services to the underinsured and the uninsured. Organizational members include federally funded health centers in Miami-Dade and southwest Florida. The Health Choice Network currently operates a program designed to prevent asthma that is funded under Specific Appropriation 490A of the 1999-2000 General Appropriations Act.

Jessie Trice

Jessie Trice was a community leader and life-long advocate of improved health care for the poor. She was the first African-American to receive a nursing degree from the University of Miami, to serve as director of the Miami-Dade County Health Department, and to serve as Chairperson of the Florida State Board of Nursing. She was Chief Executive Officer of the Economic Family Health Center. She was also the Founder and Chairperson of the Health Choice Network, which has recently been recognized as a model for integrated service delivery of health care to the poor. She died in October, 1999, from lung cancer.

Medical Errors

State Regulatory Oversight of Health Care and Related Insurance Carriers - The Department of Health was created in 1996 to promote and protect the health of all residents and visitors in the state through organized state and community efforts as provided in s. 20.43, F.S. The duties and responsibilities delegated to the department by the Legislature include: disease and disability prevention; health program design; study of disease causes and formulation of preventive strategies; development of working associations with all agencies and organizations involved in health and health care delivery; analyze trends in the evolution of health systems and identify and promote the use of innovative, cost-effective health delivery systems; serve as the statewide repository of all aggregate data accumulated by state agencies related to health care, analyze that data, and issue periodic reports and policy statements; require that all aggregate data be kept in a manner that promotes easy utilization by the public, state agencies, and all other interested parties; biennially publish and annually update a state health plan that assesses current health programs, systems, and costs; make projections of future problems and opportunities; and recommend changes needed in the health care system to improve the public health.

As set forth in s. 20.43, F.S., the Department of Health and its 26 boards and councils are charged with regulating health care practitioners who provide health care services to the people of Florida in accordance with chapters 455-491, F.S., as necessary for the preservation of the health, safety, and welfare of the public. The department also regulates emergency medical service providers, paramedics, and emergency medical technicians pursuant to chapter 401, F.S.

Moreover, the Department of Health is responsible for the state's public health system pursuant to part I, chapter 154 and chapter 381, F.S., which includes county health departments, comprehensive planning, data collection, technical support, and health resource development functions such as state laboratory and pharmacy services, the state

vital statistics system, emergency medical services coordination and support, and recruitment, retention, and development of preventive and primary health care professionals and managers.

The Agency for Health Care Administration was created in 1992 and regulates health care facilities and managed care organizations which provide delivery mechanisms for health care in Florida in accordance with chapters 395, 627, 636, and 641, F.S. Section 20.42, F.S., sets forth the organizational structure of the agency and lists the responsibilities of each division. The Division of Health Quality Assurance is responsible for the licensure and inspection of health facilities. The Division of Health Policy and Cost Control is responsible for health policy, the State Center for Health Statistics, the development of the Florida Health Plan, certificate of need, and research and analysis.

The Department of Health and the Agency for Health Care Administration have overlapping duties with regard to setting health policy, and researching and analyzing data. The department and agency also work closely together with respect to the licensure and regulation of health care practitioners. Although the statutory responsibility to license and discipline practitioners has been delegated to the Department of Health by the Legislature, the Legislature has also provided in s. 20.43(3), F.S., that the "department may contract with the Agency for Health Care Administration who shall provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils, or boards, as appropriate." Despite the permissive language used in s. 20.43(3), F.S., the funding for the complaint, investigative, and prosecutorial services is appropriated directly to the agency, instead of being appropriate to the department, in an amount of approximately $18 million per fiscal year.

Managed care organizations, indemnity insurers, and medical malpractice professional liability insurance are regulated by the Department of Insurance. There is overlap between the Department of Insurance and the Agency for Health Care Administration with regard to managed care organizations. Chapter 641, F.S., relates to health care services programs. Part I of this chapter, consisting of ss. 641.17-641.3923, F.S., is the "Health Maintenance Organization Act," under which the Department of Insurance regulates the business aspects of HMOs. The Department of Insurance issues a certificate of authority to do business in Florida if the organization applying meets the requirements of s. 641.22, F.S. Specifically, the department reviews the financial and business aspects of HMOs such as actuarial soundness, minimum surplus, insurance and reinsurance, and blanket fidelity bond requirements, as well as managerial aspects of HMOs such as non-discriminatory practices and subscriber grievance procedures.

As a condition of receiving a certificate of authority to do business from the Department of Insurance, an HMO must receive a health care provider certificate from the Agency for Health Care Administration. Part III of chapter 641, F.S., consisting of ss. 641.47-641.75, F.S., authorizes the Agency for Health Care Administration to regulate HMO quality of care by issuing health care provider certificates to HMOs which meet certain requirements. Any entity that is issued a health care provider certificate under part III of chapter 641, F.S., and that is otherwise in compliance with the certificate of authority to do business under part I of chapter 641, F.S., may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.

Insurance carriers are regulated by the Department of Insurance in accordance with chapters 624-651, F.S. Medical malpractice is a tort and is governed by the provisions of chapter 766, F.S.

Private Sector Oversight of Health Care - The professional trade organizations provide ethical standards and goals, and in some instances, resolve conflicts or grievances against their members. For example, the American Medical Association established a Code of Ethics at its first official meeting in 1847 and then in 1996 also added Ethics Standards. The mission of these ethics standards is to promote patient care and the betterment of public health by optimizing ethics in medicine. Other affected health care associations have similar procedures and standards for their members.

The professional associations also are equipped to communicate with members through journals, newsletters, magazines, and other means of communication on a wide scale which is a key component of educating practitioners and providers of changes to statutes, rules, advances in technology, and standards of practice. Any practice changes need recognition and acceptance by, and the support of, the affected organizations in order to become implemented on a broad scale.

Recent Developments and Call for Study - Recent national reports estimate that between 44,000 and 98,000 patients die each year as the result of errors in hospitals. The cost to the nation is estimated to be between $17 billion and $29 billion. Many of these errors could be prevented if the health care delivery system focused on error reduction and instituted quality improvement procedures on a broad scale. However, most efforts to improve the health care system have been fragmented or implemented on a limited scale.

Over the past decade, Florida's health care delivery system has made tremendous strides toward addressing the critical issues of access, quality, and cost containment. Floridians are living longer, healthier lives than ever before. However, the state's health care delivery system is under enormous strain, made evident by the number of documented adverse incidents. The human cost of these adverse incidents is significant and may be avoidable. No single practitioner, provider, or organization is at fault for these adverse incidents. Practitioners and other persons involved in the delivery of health care are human beings, and human beings do make mistakes, especially while under time pressures and other constraints. Therefore, attempting to place blame on any particular component of the health care industry is pointless and destructive. Rather than reducing errors, a system of blame and punishment causes or encourages a system of nondisclosure. The current disciplinary and malpractice systems in Florida are blame and punishment systems which discourage early error detection, discourage admission of fault, and discourage sharing errors and corrective action plans with the entire industry.

The Department of Health and the Agency for Health Care Administration have proposed the formation of a Florida Commission on Excellence in Health Care to serve as the catalyst for the development of a comprehensive statewide strategy for health care delivery process improvement, quality measurement, data collection, and reporting standards. This commission, as envisioned by the department and agency, would consist of key stakeholders in health care, including consumers, health care practitioners and providers, health plans, professional associations, health care regulatory and policy-making bodies, and legislators. The commission would be funded by the Legislature to cover expenses associated with consumer member travel, travel expenses for staff and appointees of the department and agency, meeting costs, consultants, and document production and dissemination. It was anticipated that $100,000 will be necessary to cover the costs of this commission. Costs of the remaining commission members would be paid by the member or the member's sponsoring organization. Employees of the Department of Health and the Agency for Health Care Administration would provide staff expertise relating to meeting planning, research, policy and data analysis, legal issues, and regulatory implementation.

The department and agency recommended that the purpose of the commission should be to study errors in health care, practitioner and provider continuing competency, effectiveness of alternative treatments and services, technology and information systems, and quality of care in all practice settings. The commission would study national reports of medical errors, including but not limited to the Institute of Medicine's report, *To Err is Human: Building a Safer Health System.* The commission would also study our current disciplinary and medical malpractice systems and evaluate alternative systems for reimbursing the injured patient. The commission would be required to provide a report to the Legislature no later than February 1, 2001.

The Ombudsman Concept

According to the Oxford English Dictionary, the English "ombudsman" is derived from the Swedish word, ***ombud***, a commissioner or agent. Further reading provides that ***ombud*** comes from the Old Norse words ***umboð*** meaning charge, commission, and ***umboðsmaðr*** commissary, or manager which means:

> *...a public official appointed to investigate citizens' complaints against local or national government agencies that may be infringing on the rights of individuals.*

In the context of long term care, the Ombudsman program began as a federal demonstration project operated in five states. In 1973, the projects were formally assigned to the Administration on Aging (AoA) within the Department of Health and Human Services (HHS). In 1978, Congress codified the Ombudsman Program in the Older Americans Act. Title VII of the Older Americans Act delineates the following responsibilities for Ombudsmen:

- Identify, investigate, and resolve complaints made by or on behalf of residents;
- Provide information to residents about long-term care services;
- Represent the interests of residents before governmental agencies and seek administrative, legal, and other remedies to protect residents;
- Analyze, comment on, and recommend changes in laws and regulations pertaining to the health, safety, welfare, and rights of residents;
- Educate and inform consumers and the general public regarding issues and concerns related to long-term care and facilitate public comment on laws, regulations, policies, and actions;
- Promote the development of citizen organizations to participate in the program; and
- Provide technical support for the development of resident and family councils to protect the well-being and rights of residents.

Placement of Ombudsman Programs in State-Level Governments

All 50 states, the District of Columbia, and Puerto Rico have long term care ombudsman programs. In each locale, the Ombudsman program has been organized slightly differently. Forty-two states have placed the Office of the State LTC Ombudsman program within the state unit on aging (SUA). In some areas, the Ombudsman programs operate completely outside of the state-level government.

Older American's Act Codified Ombudsman Program

In 1992, Congress reauthorized the Older American's Act and included a directive to the Assistant Secretary for Aging that an in-depth examination of the program was warranted.

The AoA contracted with the Institute of Medicine (IOM). In October 1993, the IOM evaluated and addressed important aspects of the LTC Ombudsman program; specifically, the LTC ombudsmen's ability to deal with problems that affect the care provided to, and the quality of life achieved by, elderly residents of LTC facilities. The IOM concluded its evaluation of the national programs with observations and suggestions that fell into eight broad areas:

- Lack of access to program,
- Lack of program visibility,
- Inadequate legal counsel,
- Conflict of interest,
- Adequate management of volunteers,
- Management of fiscal resources,
- Indirect cost allocations, and
- Cooperative agreements.

The Ombudsman Program in Florida

The State Long-Term Care Ombudsman Program is codified in part I of chapter 400, F.S. The Ombudsman was transferred from the Department of Health and Rehabilitative Services (now called the Department of Children and Family Services) to the Department of Elderly Affairs (DOEA) in 1991. The statute provides that the Ombudsman program "shall be located for administrative purposes in the Department of Elderly Affairs." Further, s. 400.0065(2)(f), F.S., states that the program shall:

> (f) Perform the duties specified in state and federal law without interference by officials of the Department of Elderly Affairs, the Agency for Health Care Administration, or the Department of Children and Family Services. The ombudsman shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives whenever organizational or departmental policy issues threaten the ability of the Office of State Long-Term Care Ombudsman to carry out its duties under state or federal law.

Based on an interim study conducted by the Committee on Elder Affairs & Long-Term Care, issues related to *access, visibility, conflict of interest, and indirect cost allocations* are challenging the Ombudsman program.

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid program. The Agency for Health Care Administration is the single state agency responsible for administering the Florida Medicaid program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S. Section 409.905, F.S., specifies the 12 required services under the Florida Medicaid program, per federal Medicaid regulations. Section 409.906, F.S., lists the 24 "optional" service categories that the State of Florida has chosen to include in the Florida Medicaid program. Among the latter is prescribed drug services, s. 409.906(20), F.S.

The state budget for the Medicaid program for fiscal year 1999-2000 is $7,416,045,061, and the program anticipates serving 1,607,144 clients this year.

Medicaid Prescribed Drug Program

Currently, Medicaid uses an open drug formulary, where recipients may obtain most prescription drugs without restriction. Adult recipients are limited to six prescriptions per month, but additional prescriptions are readily obtained if medically necessary. Many utilization limits are in place to prevent overuse or misuse, but most brand and generic drugs are available within their medically-accepted standards. Medicaid does not employ a Pharmacy and Therapeutics Committee to determine the most cost-effective drugs to include in a Medicaid formulary. In addition, nursing home patients now receive all prescription drugs through the fee-for-service system and are limited to eight drugs per month, with an exception process identical to that used for community residents. Neither the nursing home nor the pharmacy has a financial stake in controlling the costs or utilization of prescriptions by Medicaid recipients.

While the number of recipients and provider reimbursement levels have been relatively stable over the past three years, Medicaid spending for prescription drugs has increased at an annual rate of over 20 percent. The cost of new drugs, effects of direct-to-consumer advertising for new drugs, and increases in utilization are the three pertinent factors to this increase. The increase in cost is being experienced by other states' Medicaid programs. Without intervention, Florida's Medicaid spending for prescription drugs will increase by over $600 million to $2 billion in 2000. Prescription drugs will surpass hospital inpatient expenditures as the second most expensive component of the Medicaid budget in FY 1999-2000, and will be second only to nursing homes. (Source: Social Services Estimating Conference, November 1999).

While the prescription drug benefit is not a federal required service for Medicaid programs, all states provide this benefit as an important part of their overall health care programs. Some states impose a monthly "hard cap" limit, with exceptions, for prescription drugs. For example, Texas has a three prescription cap; California's program is based on a closed formulary with a six prescription limit; and Georgia limits prescriptions to five per month. Prescription costs per member and overall program costs per member are lower than Florida's for all three of these states. (Source: Health Care Financing Administration 64 and 2082 reports, FY 1997).

Title XIX, Section 1927, of the Social Security Act states that a prior authorization program established by a state under paragraph (5) is not a formulary subject to the requirements of a Pharmacy and Therapeutics Committee.

Medicaid Cost Containment Initiatives

Medicaid cost containment initiatives have primarily focused on two fronts: disease management and fraud and abuse initiatives. Beginning in 1997, the Legislature directed the Agency for Health Care Administration to establish disease management programs under the Medicaid program. Initially targeted were disease management programs specific to Medicaid recipients with a diagnosis of diabetes, hemophilia, asthma, and HIV/AIDS. In 1998, the Legislature added end stage renal disease, congestive heart failure, cancer, sickle cell anemia, and hypertension to the targeted disease list. In 1999, legislation was adopted to permit implementation of disease management programs for any condition. The Medicaid budget has already been reduced by $42 million in anticipation of savings resulting from implementation of the disease management initiative.

The Legislature, the Attorney General's Office, and specifically the Medicaid Fraud Control Unit under the Attorney General, the Agency for Health Care Administration, the Office of

Statewide Prosecutor, and the federal government have taken numerous steps over the past several years to combat fraud and abuse within the Florida Medicaid program. Past initiatives have included: claims payment analyses and controls, provider surety bonds and financial background checks, on-site provider visits, Level I and Level II criminal background checks, additional Medicaid Management Information System edits, and improved interagency coordination. Current initiatives include: pharmacy audits, including on-site audits and audits specific to overpayments, an explanation of medical benefits mailing to some recipients; pharmacy lock-in, whereby a federal waiver has been obtained to permit the state to lock-in an abusive Medicaid recipient to a single pharmacy; recipient fingerprinting demonstration project, at approximately 200 pharmacies, to ensure that only the eligible recipient or an authorized representative is picking up prescribed drugs; enhanced claims analysis and automated fraud and abuse detection capabilities; additional pharmacy fraud and abuse controls, including surety bonds and on-site inspections prior to entering provider agreements; fraud detection system enhancements to identify patterns of fraud; and Physician Practice Pattern review, including drug usage evaluation, prescribing profiles, physician education, and outcomes analysis. Budget reductions of $75 million have already been made in expectation of savings from the various fraud and abuse activities and the Practice Pattern Review program.

Medicaid Formulary Study Panel

The 1999 Florida Legislature established the Medicaid Formulary Study Panel by budget proviso to prepare recommendations on the advisability, feasibility, and cost-effectiveness of implementing an appropriate formulary for the Medicaid prescribed drug program. The panel consisted of nine members, three members each appointed by the Governor, the Speaker of the House of Representatives, and the President of the Senate. The Executive Director of the Agency for Health Care Administration served as the panel's chairperson.

The panel's findings were based on its evaluation of reports, Medicaid program data, and information provided by experts and public testimony.

- Since the mid-1990s the rate of increase in overall Medicaid expenditures has not exceeded 6 percent per year. However, the rate of increase for prescribed drugs has continued to grow at double-digit levels. In FY 1999-2000, the rate of increase for the entire Medicaid program will be 6 percent compared to 16.9 percent for prescribed medicines.

- Medicaid prescription drug costs are projected to reach $1.2 billion in FY 1999-2000. Left unchecked, by FY 2000-2001, the prescribed drug line item could exceed $1.5 billion -- outstripping hospital inpatient expenditures for the first time in the program's history, second only to nursing home costs.

- Florida has one of the highest drug costs per person in the country, $999 per drug recipient in 1999.

- Some factors that contribute to increasing costs include direct marketing to consumers, increased marketing to providers, new and more expensive drug therapies for chronic illnesses, higher ingredient costs, multiple drug therapies, an aging population, recognition of new diseases, new uses of existing drugs, and changes in patient demographics.

- The use of formularies is a common practice in the private sector.

- Medicaid is a primary payer of care for severely impaired individuals and people with serious chronic illnesses. Ten percent of Medicaid beneficiaries account for nearly 70 percent of total program expenditures.

The panel considered the following formulary-based and non-formulary-based options during its deliberations:

Formulary-Based Options

- Establish a preferred drug list (formulary) for all major drugs.
- Establish a preferred drug list (formulary) for a select group of therapeutic categories.
- Establish a selective preferred drug list.
- Establish a state drug manufacturer rebate program in conjunction with a preferred drug list.

Non-Formulary-Based Options

- Establish a monthly “hard” limit on *all* drugs for non-institutionalized, adult Medicaid patients.
- Establish a monthly “hard” limit on *brand name* drugs for non-institutionalized, adult Medicaid patients.
- Modify ingredient cost pricing.
- Require a state supplemental rebate in the form of product at best price from manufacturers and based on market share of Medicaid patients by therapeutic class.
- Maintain an open formulary for Medicaid prescribed medicines and strengthen disease management initiatives to control overall health care costs, including prescription drug expenditures.

The panel supported the option to maintain an open formulary for Medicaid prescribed medicines, and to enhance disease management initiatives to control prescription drug expenditures.

The panel voted not to recommend the adoption of any type of preferred drug list for the Florida Medicaid prescribed medicine program by a vote of 6 to 3. Panel members who voted against any of the preferred drug list approaches cited concerns raised during the public testimony and other arguments against these measures as reasons for their decision. Although the panel did not endorse a preferred drug list, they prepared an implementation plan describing how a preferred drug list could be implemented should the Legislature decide to adopt one for the Medicaid program.

The Health Facilities Authority Law

Part III of ch. 154, F.S., the Health Facilities Authorities Law ("the law"), was enacted in 1974. The purpose of the law was to assist counties and municipalities with funding the health facilities and structures needed by the community. The law authorized municipalities and counties to create health facilities authorities, as public corporations and authorized them to be funded through the issuance of special obligation revenue bonds. The projects funded must be designed to enable counties and municipalities to enhance the public's health.

As defined in s. 154.205, F.S., a "health facility" means a private, not-for-profit corporation organized as a state-licensed hospital, nursing home, developmental disabilities facility, mental health facility, or provider of life care services under continuing care contracts.

"Local agency" means a county or municipality created under Florida law. "Project" means any structure, facility, machinery, equipment, or other property suitable for use by a health facility in connection with its operations or proposed operations, including, without limitation, real property therefor; a clinic, computer facility, dining hall, firefighting facility, fire prevention facility, food service and preparation facility, health care facility, long-term care facility, hospital, interns' residence, laboratory, laundry, maintenance facility, nurses' residence, nursing home, nursing school, office, parking area, pharmacy, recreational facility, research facility, storage facility, utility, or X-ray facility, or any combination of the foregoing; and other structures or facilities related thereto or required or useful for health care purposes, the conducting of research, or the operation of a health facility, including facilities or structures essential or convenient for the orderly conduct of such health facility and other similar items necessary or convenient for the operation of a particular facility or structure in the manner to which its use is intended. Specifically excluded from "projects" are items of ongoing operating charges.

The county commission or city council or commission that creates a health facilities authority must designate five persons who are residents of its jurisdiction as members of the authority. Actions taken by an authority may be authorized by resolution at any regular or special meeting. The resolution may have immediate effect and the authority is not required to publish or post it. All meetings of an authority and its records, books, documents, and papers are open and available to the public in accordance with the Public Meetings Law, s. 286.011, F.S.

Section 154.209, F.S., provides for health facilities authorities as public corporations to engage in a variety of business transactions in furtherance of assisting health facilities within the geographic limits of the county or city that created the authority. Health facilities authorities are delegated, among other powers, the power to: sue and be sued; acquire by purchase, lease, gift, or otherwise, or obtain options for the acquisition of, any property, real or personal, improved or unimproved, for the acquisition, construction, operation, or maintenance of any project; construct, acquire, own, lease, repair, maintain, extend, expand, improve, rehabilitate, renovate, furnish, and equip projects and to pay all or any part of the costs of projects from the proceeds of bonds of the authority or from any other funds made available to the authority for such purpose; make and execute agreements of lease, contracts, deeds, mortgages, notes, and other instruments necessary or convenient in the exercise of its powers and functions under part III; pledge or assign any money, rents, charges, fees, or other revenues and any proceeds derived from sales of property, insurance, or condemnation awards; fix, charge, and collect rents, fees, and charges for the use of any project; issue bonds for the purpose of providing funds to pay all or any part of the cost of any project and issue refunding bonds; acquire existing projects and to refund outstanding obligations, mortgages, or advances issued, made, or given by a health facility for the cost of such project; and issue special obligation revenue bonds for the purpose of establishing and maintaining the self-insurance pool and to provide reserve funds in connection with such an insurance pool. In addition to specific authority, health facilities authorities are granted broad general powers to accomplish the purposes of the law, as provided in s. 154.209(19), F.S.

As provided in s. 154.211, F.S., relating to payment of expenses, all expenses incurred by a health facilities authority must be payable solely from funds obtained under the law, and no liability or obligation may be incurred by a health facilities authority, county or municipality, or the state relating to activities permitted under the law beyond the extent to which moneys shall have been provided under the law. Section 154.239, F.S., requires each health facilities authority to submit within the first 90 days of each calendar year to the

county commission or city council or commission that created it a report of its activities that includes a complete operating and financial statement for the preceding calendar year.

Under s. 154.221, F.S., a health facilities authority has the discretion to secure a bond issue through a trust agreement by and between the authority and a corporate trustee which may contain a pledge or assign fees, rents, charges, or proceeds from the sale of any project or part of a project, insurance proceeds, condemnation awards, and other funds and revenues to be received from a condemnation, and may provide for the mortgaging of any project or part of a project as security for repayment of the bond. Revenue bonds issued by a health facilities authority do not constitute debt, liability, or obligation on the part of the county or city that created the authority nor are they a pledge of the faith and credit of the state or the county or city that created the authority, as provided in s. 154.223, F.S.

In 1990, part III of chapter 154, F.S., was amended to allow not-for-profit health care corporations to finance their accounts receivables through the issuance of tax-exempt bonds through any health facilities authority established in the state. Section 154.209(18), F.S., as amended by chapter 98-273, Laws of Florida, authorizes an accounts receivable program to include the financing of accounts receivable acquired by a health facility from other health facilities, whether or not controlled by or affiliated with the health facility and regardless of location within or outside the geographical limits of this state.

Kidney Dialysis Study

In 1999, the Florida Legislature requested that the Agency for Health Care Administration investigate the relationship between dialysis centers, the centers' medical directors, and the laboratories that serve dialysis patients. The agency issued a report on February 1, 2000, on that investigation which concluded that additional review and resources were necessary to complete the study. The estimated cost to contract with a state university to complete the study is $230,000.

State Contracts/Funds for Purchase or Improvement of Real Property

On occasion, subject to public use requirements, the state appropriates funds to local governments and to private nonprofit entities to purchase, improve, and repair real property. This appropriation is known as a fixed capital outlay grants and aids appropriation. In the past, there have been instances where state appropriated capital outlay funds have been used to build buildings for not-for-profit or local government entities which subsequently sold or leased the facilities for profit. There have been other instances where such state- funded buildings were considered business assets and disposed of in bankruptcy proceedings. In the past few years, it has become increasingly common for proviso language of such appropriations made to nonprofit entities to require some form of state security interest in the property in order to ensure compliance with the intent of the grant.

Alzheimer’s Disease

Alzheimer’s disease is a progressively degenerative neurological disorder, and is the most common cause of dementia--the loss of intellectual function (thinking, remembering, and reasoning)--severe enough to interfere with everyday life. Although the disease does strike young people (some as young as age 40), Alzheimer’s is closely associated with advancing age. Ten percent of people over age 65 and nearly 50 percent of those age 85 and older are affected. It is estimated that in excess of 4 million people in the United States, and just

under one-half million people in Florida have Alzheimer's disease. With Florida's aged population, and the aging of the baby boomers, the numbers of Alzheimer's patients are expected to continue to grow.

While being heavily researched, there is as yet no preventive or cure for Alzheimer's disease, nor a way to halt the progression of the disease. Because it is a progressive disease, every person who gets the disease will need different levels of care during the course of the disease, and will ultimately need total care. Such care can be provided in a variety of settings.

The total annual cost of care for those with Alzheimer's disease today is at least $100 billion. The average lifetime cost of care of such persons is estimated at $174,000. Alzheimer's disease costs American business an estimated $33 billion annually, with most of that in lost work of employees who are care givers. Medicare spent an average of $7,682 in 1995 on beneficiaries with Alzheimer's disease, or 70 percent more than the average spent on beneficiaries without a cognitive impairment.

C. EFFECT OF PROPOSED CHANGES:

HB 2349 amends various sections of the Florida Statutes and provides several new provisions of law relating to a variety of health care issues. Background as to the need for these revisions is contained in the PRESENT SITUATION portion of this analysis, and details as to revisions appear in the SECTION-BY-SECTION ANALYSIS which follows.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 20.43(1)(l), F.S., relating to the purposes of the Department of Health, and particularly the department's planning functions, to incorporate a state public health planning requirement into the department's Agency Strategic Plan.

Adds new subsection (8) to provide the department authority to hold copyrights, trademarks, and service marks, and enforcement authority for these, except that such authority does not extend to any public records relating to the department's responsibilities for health care practitioners regulated under pt. II, ch. 455, F.S.

Section 2. Amends the introductory language of s. 39.303, F.S., relating to child protection teams, to specify that the Children's Medical Services Program within the Department of Health is responsible for the teams, and to incorporate technical revisions.

Section 3. Amends subsection (15) of s. 120.80, F.S., relating to exceptions and special requirements of agencies, to provide an exception and special requirements for hearings and authorizing the Department of Health to contract with the Department of Children and Family Services for a hearing officer for hearings relating to the Brain and Spinal Cord Injury Program.

Section 4. Amends s. 154.011(2) and (5), F.S., relating to county health department primary care services, to delete unnecessary detail as to monitoring of certain services and to authorize, in rule, a definition of income used to determine eligibility or sliding fees for services.

Section 5. Amends s. 215.5602(1) and (2), F.S., relating to the Florida Biomedical Research Program, to specify that prevention be an element of research conducted under

the program, and to make consistent reference to diagnostic activities as part of program functions.

Section 6. Amends s. 381.0011(3), F.S., relating to the planning duties of the department, to incorporate a state public health planning requirement into the department's Agency Strategic Plan.

Section 7. Amends s. 381.003(1) and (2), F.S., relating to the department's communicable disease and AIDS responsibilities, to indicate that the department is responsible for ensuring that all children in the state are immunized against vaccine-preventable diseases, and to require the development of an immunization registry. Specifically addressed for the registry are: the purpose of the registry, how the registry will operate, parent or legal guardian's ability to opt out of the registry requirement, electronic transfer of immunization records, registry access by participating immunizing practitioners, and the confidentiality of registry data. The department is granted specific rule-making authority for purposes of operation of the registry.

Section 8. Amends s. 381.0031, F.S., relating to reports of diseases of public health significance to the department, to add as a new subsection (5) language that authorizes the department to obtain and inspect the medical records, records of laboratory tests, and other medical-related information of those practitioners, hospitals, and laboratories that are currently required to report diseases of public health significance to the department under requirements provided in subsection (2) of this same section of statute. The department is authorized to examine the records of a person who has a disease of public health significance only for purposes of preventing and eliminating outbreaks of disease and making epidemiological investigations of reported cases of diseases of public health significance. Also specifically addressed are access to such records, maintenance of confidentiality of such records, and protection from liability or criminal action for the sharing of such records by the holder of such records.

Section 9. Amends s. 381.004(3), F.S., relating to human immunodeficiency virus (HIV) testing, informed consent, counseling, and confidentiality, to: provide an exception to the prohibition on release of preliminary test results specifically in those instances when a pregnant woman's preliminary test result may be particularly relevant in the care or treatment of, or recommendations to, the person tested, and in the case of an intrapartum or postpartum woman, when care, treatment, or recommendations regarding her newborn, cannot await the results of confirmatory testing; and provide further clarification as to the medical professionals who may experience a significant exposure for which HIV testing without patient consent may be conducted. Included are laboratory, blood bank, and plasma center personnel, health professional students, and paramedics and emergency medical technicians certified by the department to perform life-support procedures.

Section 10. Amends s. 381.0059, F.S., relating to background screening requirements for school health services personnel, to provide as a new subsection (5) an exclusion from the definition of "person who provides services under a school health services plan" an unpaid volunteer who lectures students in group settings on health education topics.

Section 11. Amends s. 381.0101(5), F.S., relating to environmental health professionals' standards for certification, to amend the "grandfather" provisions relating to environmental health personnel, to clarify that the provisions only apply to those persons whose primary functions are in a food protection program or onsite sewage treatment and disposal systems, and to specify a maximum of 48 required training hours for those with a multi-program certification.

Section 12. Amends s. 381.731, F.S., relating to the Healthy Communities, Healthy People Plan, to redesignate the title of the section; specify that these planning functions and population-based health promotion strategies be incorporated into the department's Agency Strategic Plan, and to delete obsolete language.

Section 13. Amends s. 381.734, F.S., relating to the Healthy Communities, Healthy People Program, to: reflect the consolidation of planning functions; reflect internal departmental priorities for planning purposes; refer to the Chronic Disease Community Intervention Program; and add as a new element of program focus the importance of a physically active lifestyle.

Section 14. Transfers and renumbers s. 413.46, F.S., as s. 381.7395, F.S., and amends that section to make technical and conforming revisions relating to legislative intent for the Brain and Spinal Cord Injury Program.

Section 15. Creates s. 381.745, F.S., providing definitions for the following terms: activity of daily living, brain and spinal cord injury, emergency medical evacuation system, personal-assistance services, funded services, designated facility, third-party coverage, third-party payment, transitional living facility, and trauma center.

Section 16. Amends s. 381.75, F.S., relating to duties and responsibilities under the Brain and Spinal Cord Injury Program to correct a cross reference, and incorporate technical and conforming revisions.

Section 17. Creates s. 381.755, F.S., specifying the nonassignability of benefits under the Brain and Spinal Cord Injury Program.

Section 18. Amends s. 381.76, F.S., relating to eligibility for the Brain and Spinal Cord Injury Program, to incorporate technical and conforming revisions.

Section 19. Creates s. 381.765, F.S., providing for the retention of title and disposal of property, tools, instruments, training supplies, equipment, or other items of value acquired as program services or for personnel employed in the operation of the program. Provides the department with the exclusive right to develop rules relating to records and record-keeping for department-owned property.

Section 20. Creates s. 381.775, F.S., which provides that oral and written records, information, letters, and reports received, made, or maintained by the department relating to any applicant or recipient of Brain and Spinal Cord Injury Program services are privileged, confidential, and are not subject to the public records provisions of s. 119.07(1), F.S. Provides that release of such records is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, F.S. Provides exceptions for release of records:

- To specified individuals, agencies, or proceedings;
- Whenever an applicant or recipient has declared an intent to harm another person or property;
- To protect the applicant or recipient whenever he or she poses a threat to his or her own safety or to the safety of others; or
- Upon the official request of a law enforcement agency investigating the commission of a crime.

Provides that records that come into the possession of the department and that are confidential by other provisions of law remain confidential and may not be released except as authorized by this act.

[NOTE: While these provisions were contained in a separate public records exemption bill in the House--HB 2321 (PCB HCS 00-04)--the Senate determined that a separate bill was not required for this issue.]

Section 21. Amends s. 381.78, F.S., relating to the Advisory Council on Brain and Spinal Cord Injuries, to: authorize reimbursement for travel and related expenses for council members; prohibit council members from voting on matters of direct financial interest or conflict of interest; to provide for the removal of council members for cause by the Secretary of the Department of Health; delete obsolete provisions; and incorporate technical and conforming revisions.

Section 22. Creates s. 381.785, F.S., providing for the recovery of third-party payments for program services. Requires an applicant to subrogate his or her rights to third-party payments. Authorizes an applicant or recipient of funded services to assign rights of payment for the sole purpose of obtaining reimbursement. Authorizes the program to institute, intervene in, or join any legal proceeding against a third party against whom recovery rights arise. Authorizes statutory liens. Authorizes settlements. Specifies that program payments for services are neither collateral payments nor collateral sources. Provides the program with the same rights and remedies granted under ch. 440, F.S., relating to Workers' Compensation. Provides rulemaking authority.

Section 23. Amends s. 381.79, F.S., relating to the Brain and Spinal Cord Injury Rehabilitation Trust Fund, to provide for expenditures for matching funds for public or private assistance with program-approved expansion of services. Specifies the deposit of certain revenue into the trust fund, and authorizes the department to accept and use gifts made by will or otherwise for the purposes of the program. Updates name of trust fund.

Section 24. Amends s. 385.103, F.S., relating to the department's Chronic Disease Control Program, to: redesignate the section as Community Intervention Programs; expand the topics to be addressed as part of counseling and service capabilities; redesignate the Comprehensive Health Improvement Project as the Community Intervention Program; and incorporate technical and conforming revisions.

Section 25. Amends s. 385.207(3), F.S., relating to Epilepsy Program revenue, to correct a cross-reference to s. 318.21(6), F.S., to conform to revisions previously made to ch. 318, F.S.

Section 26. Amends s. 402.181, F.S., relating to the state institutions claims program, to specify that patients of the Department of Health's institutions [namely, A.G. Holley State Hospital, the state's tuberculosis hospital], be authorized to participate in the payment of restitution under the program.

Section 27. Amends s. 514.021, F.S., relating to the department's rule authority for public swimming pools and bathing places, to specify that rule reviews be conducted *biennially*, not *biannually*.

Section 28. Designates February 6th of each year as Florida Alzheimer's Disease Day.

Section 29. Authorizes the Department of Health, subject to specific appropriations, to create the “long-term community-based supports” program for traumatic brain or spinal cord injured persons.

Subsection (1) requires the department to conduct a study of the long-term needs for community-based supports and services for individuals who have sustained traumatic brain or spinal cord injuries. Provides that the purpose of the study is to prevent inappropriate residential and institutional placement of these individuals and to promote placement in the most cost-effective and least restrictive environment. Requires that any placement recommendations for these individuals must ensure full utilization of and collaboration with other state agencies, programs, and community partners. Requires the study to be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives not later than December 31, 2000.

Subsection (2) requires the department to establish a plan for the implementation of a program of long-term community-based supports and services for individuals who have sustained traumatic brain or spinal cord injuries and who may be subject to inappropriate residential and institutional placement as a direct result of such injuries. The plan is to be based on the results of the study conducted by the department.

Paragraph (a) provides that the program is the payor of last resort for program services. Provides that expenditures for program services are considered funded services for the purposes of s. 381.785, F.S., relating to recovery of third-party payments for Brain and Spinal Cord Injury Program services. Provides that notwithstanding s. 381.79(5), F.S., relating to the Brain and Spinal Cord Injury Trust Fund, proceeds resulting from this section must be used solely for this program.

Paragraph (b) provides the department with rulemaking authority to create procedures to ensure that, in the event the program is unable to directly or indirectly provide the services to all eligible individuals due to lack of funds, the individuals most at risk to suffer the greatest harm from an imminent inappropriate residential or institutional placement are served first.

Paragraph (c) requires that every applicant or recipient of the long-term community-based supports and services program must have been a resident of the state for 1 year immediately preceding the application and be a resident of the state at the time of the application.

Paragraph (d) directs the department to adopt rules to implement this subsection.

Section 30. Provides a severability clause, saving the remainder of the bill should a particular section be voided by a court.

Section 31. Subsection (1) provides legislative intent relating to: a reduction in the rates of illness and death from lung cancer and other cancers among low-income populations; the creation of a faith-based disease-prevention program in conjunction with the Health Choice Network and other community health centers to increase access to health service delivery in South Florida; and the establishment of funding to build upon local private participation to sustain the operation of the program.

Subsection (2) creates the Jessie Trice Cancer Prevention Program within the Department of Health for administrative purposes. Provides that the Jessie Trice Cancer Prevention

Program will be operated from the community health centers within the Health Choice Network in South Florida. Specifies that funds will be provided to develop contracts with community health centers and local faith-based education programs to provide cancer screening, diagnosis, education, and treatment services to low-income populations throughout the state. Provides that the program will be initially created as a pilot program in certain communities in Dade and Lee counties.

Section 32. Specifies that funds to implement the provisions of this act (presumably a reference to section 31) are contingent upon a specific appropriation in the General Appropriations Act.

Section 33. Creates the Florida Commission on Excellence in Health Care, as follows:

Subsection (1) Provides findings and intent, with a focus on improving health care delivery systems through meaningful reporting standards, data collection and review, and quality measurement.

Subsection (2) provides definitions of six relevant terms.

Subsection (3) specifies the duties and responsibilities of the commission. There are twenty specific tasks assigned to the commission.

Subsection (4) specifies the interests to be represented by the 38 commission members. Membership on the commission includes representatives from all facets of health care, including the regulatory boards and agencies, health care practitioner trade associations, health facility trade organizations, managed care organizations, risk management organizations, health care attorney organizations, professional liability insurance industry, consumer advocacy organizations, and the Legislature. The commission will be jointly chaired by the Secretary of the Department of Health and the Director of the Agency for Health Care Administration. Subcommittees are authorized. Commission recommendations must be approved by two-thirds of membership. Alternates may represent appointed members. Staff support will be provided by employees of the Department of Health and the Agency for Health Care Administration.

Subsection (5) addresses evidentiary prohibitions. Specifically included are provisions relating to commission proceedings, standards of care, and patient-identifying information.

Subsection (6) requires a report to the Legislature no later than February 1, 2001, authorizes the commission to assist with any follow-up activities coming out of commission recommendations, and specifies that the commission be terminated June 1, 2001.

Section 34. Appropriates $91,000 in nonrecurring general revenue from the General Revenue Fund to the Department of Health to cover the costs of the commission relating to travel, consultants, and reproduction and dissemination of documents.

Section 35. Appropriates $230,000 from the Agency for Health Care Administration Tobacco Settlement Trust Fund to the agency to contract with the University of South Florida to conduct a review of quality and effectiveness of kidney dialysis treatment as well as the utilization and business arrangements related to kidney dialysis centers. A report on the findings is due to the Legislature no later than February 1, 2001.

Section 36. Creates s. 381.00325, F.S., to direct the Department of Health to develop a Hepatitis A awareness program, which must include information regarding appropriate education of the public and information regarding the availability of the Hepatitis A vaccine. The department is directed to work with private businesses and associations in developing the program and disseminating the information.

Section 37. Creates s. 154.247, F.S., to authorize a health facilities authority, notwithstanding any provision of ch. 154, F.S., to issue bonds for a health facility to finance projects for such health facility, or for another not-for-profit corporation under common control with such health facility, located outside the geographical limits of the local agency or outside this state. Such bond issues are to be premised on the health facilities authority that sponsors the bond issue making a finding that there will be a benefit or cost savings to a health facility located within the issuing authority's jurisdiction.

Section 38. Nullifies a provision contained in CS/HB 2339 (Ch. 2000-256, Laws of Florida) enacted during the 2000 Regular Session of the Legislature, which authorized the establishment of specialty hospitals via the transfer of beds and services from an existing hospital in the same county, apart from the Certificate of Need process.

Section 39. Amends s. 20.41(4), F.S., to rename the long-term care ombudsman councils which operate in each of the Department of Elderly Affairs' (DOEA) Planning & Service Areas (PSAs) from "district councils" to "local councils."

Sections 40-41. Amends s. 395.3025(4)(h), F.S., and s. 400.0063(3)(b), F.S., to make a technical, conforming change.

Section 42. Amends s. 400.0065, F.S., relating to the State Long-Term Care Ombudsman, to specify that the ombudsman annually prepare a budget request that DOEA submits to the Governor for transmittal to the Legislature. Provides that the ombudsman is to enter into a cooperative agreement with the statewide and district human rights advocacy committees and with the office of state government responsible for investigating Medicaid fraud.

Section 43. Creates s. 400.0066, F.S., to specify that the ombudsman perform the duties specified in state and federal law and be free of interference from DOEA, the Agency for Health Care Administration, and the Department of Children and Family Services (DCFS). Specifies that DOEA is to provide administrative support to the ombudsman and delineates that support. Provides that DOEA meet the costs associated with this support from funds appropriated to the department and that those costs be included in the department's annual Legislative budget requests. Authorizes DOEA to divert from the federal ombudsman appropriation an amount not to exceed 10 percent of that appropriation.

Section 44. Amends s. 400.0067, F.S., relating to the State Long-Term Care Ombudsman Council, to specify that the ombudsman, in consultation with the secretary of DOEA and the State Ombudsman Council, prepare the list of nominees from which the Governor selects persons for appointment to the State Long-Term Care Ombudsman Council. Provides that, if the Governor fails to make the appointments within 60 days after receiving the list of nominees, the ombudsman will make the appointments. Provides that members of the state council can serve no more than two consecutive three-year terms. Adds a provision that allows the ombudsman to determine if a member's absence from meetings is "without cause," and makes such a finding final and binding. Makes technical, conforming changes.

Section 45. Amends s. 400.0069, F.S., relating to district ombudsman councils, to provide that local ombudsman councils work under the direction of the state ombudsman and the

State Ombudsman Council. In the case of vacancies and upon expiration of a term of appointment on local councils, the local council shall select a replacement and forward that selection to the state ombudsman. The state ombudsman shall review the selection and recommend approval or disapproval to the Governor for his appointment. If the Governor takes no action within 30 days, the replacement is considered disapproved and the process is repeated. Removes the requirement that DCFS provide office space and administrative support to the ombudsman program. Makes technical, conforming changes.

Sections 46-68. Amend the following sections of statute relating to the indicated topic to incorporate technical, conforming changes:

Bill Section	Statute Section	Topic
46	400.0071	Complaint procedures
47	400.0073	Investigations
48	400.0075	Resolutions
49	400.0077	Confidentiality
50	400.0079	Immunity
51	400.0081	Access
52	400.0083	Interference, retaliation, penalties
53	400.0087	Agency oversight
54	400.0089	Agency reports
55	400.0091	Training
56	400.021	Definitions
57	400.022	Resident's rights
58	400.0255	Resident transfer and discharge
59	400.19	Right of entry and inspection
60	400.191	Availability, distribution, and posting of reports and records
61	400.23	Rules, evaluation and deficiencies, licensure status
62	400.419	Violations, administrative fines
63	400.428	Resident bill of rights
64	400.434	Right of entry and inspection
65	400.435	Maintenance or records and reports
66	400.4415	Assisted living facilities advisory committee
67	400.619	Licensure application and renewal
68	400.628	Residents' bill of rights

Section 69. Subsection (1) provides an appropriation of $40,000 from the General Revenue Fund to the Long-Term Care Ombudsman Program for training members of the state and local long-term care ombudsman councils.

Subsection (2) provides an appropriation of $40,000 from the General Revenue Fund to the Long-Term Care Ombudsman Program to be used for materials to educate residents of long-term care facilities, their families, visitors, facility staff, and the general public about the ombudsman program and to encourage such persons to seek assistance from the ombudsman program.

Section 70. Requires each state agency to include in its standard contract document a requirement that any state funds provided for the purchase of or improvements to real property are contingent upon the contractor or political subdivision granting to the state a

security interest in the property at least to the amount of state funds provided, for at least 5 years from the date of purchase or the completion of the improvements, or as further provided by law.

Section 71. Amends s. 409.912, F.S., relating to cost-effective purchasing of health care under the Medicaid program, to add a new subsection (37) relating to Medicaid prescribed drugs, as follows:

Paragraph (a) directs AHCA to implement a Medicaid preferred prescribed drug spending control program.

Subparagraph 1. specifies that Medicaid prescribed drug coverage for brand name drugs for adult Medicaid recipients not residing in nursing homes or other institutions will be limited to the dispensing of four brand name drugs per month. Children and institutionalized adults are exempt from this restriction. Anti-retroviral agents (used for treating HIV/AIDS) are excluded from this limitation. No requirements for prior authorization or other restrictions on medications used to treat specified mental illnesses may be imposed on Medicaid recipients, and the types of such medications not subject to restrictions are specified.

No more than a 34-day supply of a prescribed drug may be dispensed.

Specifies the provision of unlimited generic drugs, contraceptive drugs and items, and diabetic supplies.

Empowers AHCA to authorize exceptions to the brand-name drug restrictions, based upon the treatment needs of the patient, only when such exceptions are based on prior consultation provided by AHCA or an AHCA contractor, but requires AHCA to establish procedures to ensure that: there will be a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of the request for prior consultation; and a 72-hour supply of the drug prescribed will be provided in an emergency or when the agency does not provide a response within the required 24 hours.

Subparagraph 2. specifies that reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the average wholesale price less 13.25 percent.

Subparagraph 3. directs AHCA to develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers or prescribed drugs each month. This may include, but is not limited to: comprehensive, physician-directed medical records reviews; claims analysis; and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. Authorizes AHCA to contract with a private organization to provide drug program management services.

Subparagraph 4. authorizes AHCA to limit the size of its pharmacy network based on specified factors. Directs AHCA to give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. Elements of a pharmacy credentialing process are specified. Authorizes AHCA to impose a moratorium on Medicaid pharmacy enrollment when it is determined that AHCA has a sufficient number of Medicaid-participating pharmacies.

Subparagraph 5. directs AHCA to develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. Directs AHCA to require the use of such prescription pads.

Subparagraph 6. authorizes AHCA to enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid patients to provide the state a rebate of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. Such rebates may be supplemental to any federal rebate in order to attain the 15.1 percent. Any generic drug manufacturer that raises its price in excess of the Consumer Price Index (Urban) shall include the excess amount in the state rebate.

Paragraph (b) specifies that AHCA implement this subsection to the extent that funds are appropriated to administer the Medicaid drug spending control program.

Authorizes AHCA to contract all or any part of this program to private organizations.

Paragraph (c) requires AHCA to submit a report to the Governor and Legislative leadership by January 15 of each year. The report must include, but not be limited to: the progress made in creating the Medicaid cost containment measures and their effect on Medicaid prescribed drug expenditures.

Section 72. Creates a Medicaid Pharmacy and Therapeutics Committee, to develop and implement a voluntary Medicaid preferred prescribed drug designation program. Specifies that the program provide information to Medicaid providers on medically appropriate and cost efficient prescription drug therapies through the development and publication of a voluntary Medicaid preferred prescribed drug list.

Subsection (1) specifies that the committee be composed of nine members appointed as follows:

- Three Speaker appointees representing allopathic physicians, osteopathic physicians, and trauma surgeons;
- Three Senate President appointees representing family practice physicians, podiatric physicians, and dentists; and
- Three Governor appointees representing pharmacists, institutional pharmacists, and clinical pharmacology.

Members are to serve 2-year terms, from the date of their appointment. Members may be appointed to more than one term.

The Agency for Health Care Administration is to serve as staff for the committee, and assist with all ministerial duties.

Subsection (2) specifies that, upon recommendation from the committee, AHCA shall establish a voluntary Medicaid preferred prescribed drug list. Upon further recommendation of the committee, AHCA is to add to, delete from, or modify the list. The committee is required to review requests for additions to, deletions from, or modifications to the list.

The list is to be adopted by the committee in conjunction with medical specialists, when appropriate, using the following criteria: use of the list shall be voluntary by providers,

and the list must provide for medically appropriate drug therapies for Medicaid patients which achieve cost savings in the Medicaid program

Subsection (3) directs AHCA to publish and disseminate the voluntary Medicaid preferred prescribed drug list to all Medicaid providers in the state.

Section 73. Provides for a July 1, 2000, effective date.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The following indicates the specific Medicaid prescribed drug spending reductions specified in this bill and in Specific Appropriation 230 in the FY 2000-2001 General Appropriations Act:

Ingredient costs at AWP minus 13.25%	
General Revenue	$10,470,851
Medical Care TF	$13,656,142

Monthly limit on recipient drugs	
General Revenue	$30,373,000
Medical Care TF	$39,627,000
Secure prescription program	
General Revenue	$7,810,200
Medical Care TF	$10,189,800
Generic drug rebates	
General Revenue	$1,300,000
Medical Care TF	$1,696,082
Pharmacy network controls	
General Revenue	$9,800,000
Medical Care TF	$12,785,849
Drug plan management program	
General Revenue	$17,789,900
Medical Care TF	$23,210,100
Voluntary preferred drug list	
General Revenue	$10,847,500
Medical Care TF	$14,152,500
Restore certain full dosage limits	
General Revenue	$3,601,370
Grants & Donations TF	$1,459,600
Medical Care TF	$4,698,630
Drug therapy limits	
General Revenue	$4,339,000
Medical Care TF	$5,661,000
Drug usage guidelines -- FDA	
General Revenue	$7,593,250
Medical Care TF	$9,906,750
Total -- Medicaid Prescribed Drug Spending Reductions	
General Revenue	$103,925,071
Grants & Donations TF	$1,459,600
Medical Care TF	$135,583,853
TOTAL REDUCTIONS	$240,968,524

2. Expenditures:
As specified in various provisions of this bill:

Florida Commission on Excellence on Health Care	
General Revenue	$91,000
Contract -- review of kidney dialysis treatment	
AHCA Tobacoo Settlement TF	$230,000

Long-Term Care Ombudsman Program -- member training

General Revenue	$40,000
Long-Term Care Ombudsman Program -- education	
General Revenue	$40,000
Total expenditures	
General Revenue	$171,000
AHCA Tobacoo Settlement TF	$230,000
TOTAL	$401,000

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

Under section 37 of the bill, health facilities authorities will be able to generate revenues from the management of bond issues. Such bond issues are not obligations of any governmental jurisdiction other than the involved health facilities authority.

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Not-for-profit corporations, within the state and outside the state, may have an additional source of debt financing via the section 37 provisions relating to health facilities authorities.

D. FISCAL COMMENTS:

According to the Department of Health, this bill has no fiscal impact, other than specified above. However, the department indicates that absent the passage of this bill and lien authorization relating to the Brain and Spinal Cord Injury Program, the program would not be able to collect upon its statutory liens, and potentially forego over $300,000 each year in funding. This additional funding has allowed the program to serve hundreds of additional brain or spinal cord injured citizens over the past decade.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

Comments of the Committee on Health Care Services

Section 37 of the bill, in providing additional authority for health facilities authorities, prefaces the new authority with the nullifying clause: notwithstanding any provision of this part to the contrary. This appears to be intended to enable a health facilities authority to issue bonds for an affiliated not-for-profit corporation outside the authority's geographic limits. Under a broader interpretation, this may be intended to create an exception to requirements otherwise provided under part III of chapter 154, F.S., that under current law limit a health facilities authority to financing by bond issue for specified purposes.

The bill is silent on guidelines for the borrowers and other pertinent factors relating to the use of debt instruments as authorized by section 37 of the bill. It would appear that this provision creates a substantial departure from the public policy purpose of part III of chapter 154, F.S. Furthermore, the bill does not provide safeguards against a health facilities authority abusing the newly created bond financing authority provided in the bill nor does it provide guidelines to minimize the ability of a health facilities authority to overextend itself as a credit financier.

In addition to the requirement granting a security interest contained in section 70 of this bill, HB 2377 (ch. 2000-371, Laws of Florida), relating to the state budgeting process, among other provisions, also contains requirements to provide preconditions to the receipt of grants and aids appropriations in excess of a certain amount that are to be used by nonpublic entities to acquire, construct, alter, or maintain real property. Section 35 of HB 2377, which creates s. 216.348, F.S., provides restrictions on assignment or transfer of interests in the property and requires investment of funds and return of earned interest under certain circumstances.

There is some question as to the need for a public records exemption specific to the information to be obtained and retained by the Department of Health for purposes of the immunization registry as required by section 7 of the bill. This issue was addressed via a separate Department of Health public health public records exemption bill, CS/HB 1479, which was not adopted during the 2000 Session.

Comments of the Committee on Governmental Rules and Regulations

There is also a question as to the need to immunize health care practitioners and facilities, and laboratories from civil penalties or criminal conviction when being statutorily directed to provide immunization information to the department.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 30, 2000, the Committee on Health Care Services approved the following Proposed Committee Bills, relating to the indicated topic, and these were filed and numbered as indicated:

PCB HCS 00-03	HB 2385	Transfer/Brain and Spinal Cord Injury Program
PCB HCS 00-04	HB 2321	Confidentiality of Patient and Applicant Records in the Brain and Spinal Cord Injury Program
PCB HCS 00-05	HB 2349	Department of Health/Public Health

[NOTE: On the Senate side, SB 2034 was the companion bill for these 3 House bills.]

The Committee on Governmental Rules and Regulations adopted three amendments to HB 2349 at its April 19, 2000, meeting. One amendment provided that notwithstanding any provision of chapter 154 to the contrary, an authority may, if it finds that there will be a benefit or a cost savings to a health facility located within its jurisdiction, issue bonds for such health facility to finance projects for such health facility, or for another not-for-profit corporation under common control with such health facility, located outside the geographical limits of the local agency or outside this state.

Another amendment clarified that it is the child that a parent or guardian may refuse to have participate in the immunization registry. The final amendment directed the department to develop a hepatitis A awareness and immunization program for business settings in which contraction of hepatitis A threatens the public health and safety; directed that the program shall be offered through the county public health units and shall be self-supporting; directed the department to work with pharmaceutical manufacturers and private associations in developing the program and securing the hepatitis A vaccine at the lowest possible costs; and directed the department to distribute materials to potentially affected businesses and individuals. The latter amendment also directed the Department of Revenue, in conjunction with the department and other agencies, to examine and report to the Legislative officers by January 1, 2001, on the feasibility of providing a state refund to participating businesses and individuals.

On April 17, 2000, HB 2321 was heard in the Governmental Operations Committee, which incorporated a technical amendment, and reported the bill favorably as amended. On April 19, 2000, HB 2321 was placed on the House calendar.

On May 1, 2000, HB 2385 and HB 2349 were withdrawn from the Health and Human Services Appropriations Committee, and placed on the House calendar.

On May 3, 2000, CS/SB 2034 was taken up on second reading on the Senate floor. Amendments were adopted addressing:

- The Department of Health’s authority to hold and enforce copyrights, trademarks, and service marks;
- Clarifying language for the immunization registry;
- The designation of February 6 as Florida Alzheimer's Disease Day;
- Long-term community based supports for traumatic brain and spinal cord injured persons;

- The Jesse Trice Cancer Prevention Program;
- The Florida Commission on Excellence in Health Care;
- Funding for the next phase of the kidney dialysis study;
- Hepatitis A awareness initiative; and
- Health facilities authority bonding capability.

The bill then moved to third reading.

On May 5, 2000, CS/SB 2034 was taken up by the Senate on third reading and further amended to include language which:

- Nullified a provision in CS/HB 2339 which allowed the establishment of specialty hospitals through the transfer of existing beds and services within a county, exempt from Certificate of Need;
- Incorporated provisions relating to the state long-term care ombudsman program;
- Provided the state with a security interest with real property purchased or renovated with state funds; and
- Directed the Agency for Health Care Administration to implement a Medicaid prescribed drug spending control program, and created the Medicaid Pharmaceuticals and Therapeutics Committee.

As amended, the bill was unanimously approved by the Senate.

On May 5, 2000, CS/SB 2034 was amended by the House, the amendment was reconsidered and removed, and the House unanimously approved the bill.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Staff Director:

Phil E. Williams Phil E. Williams

AS REVISED BY THE COMMITTEE ON GOVERNMENTAL RULES AND REGULATIONS:

Prepared by: Staff Director:

David M. Greenbaum David M. Greenbaum

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Staff Director:

Phil E. Williams Phil E. Williams