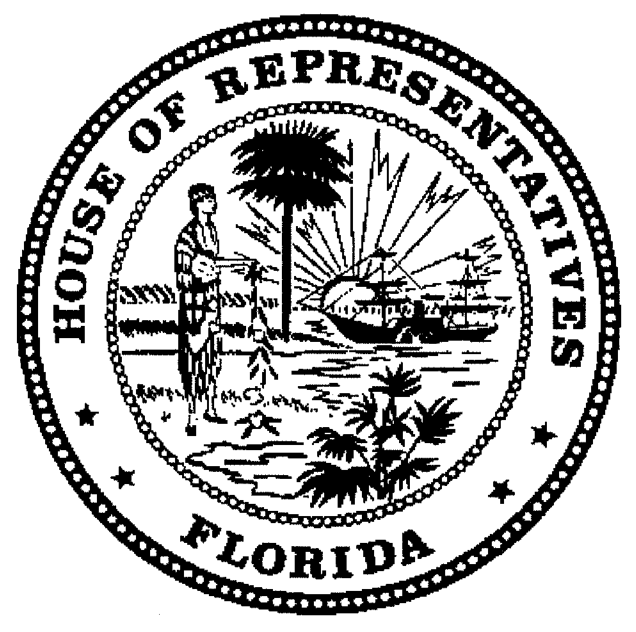


# Health & Human Services Quality Subcommittee

**Tuesday, March 15, 2011**
**9:00 AM**
**306 HOB**

**Dean Cannon**
**Speaker**

**John Wood**
**Chair**

# Committee Meeting Notice

## HOUSE OF REPRESENTATIVES

### Health & Human Services Quality Subcommittee

**Start Date and Time:** Tuesday, March 15, 2011 09:00 am

**End Date and Time:** Tuesday, March 15, 2011 10:30 am

**Location:** 306 HOB
**Duration:** 1.50 hrs

**Consideration of the following bill(s):**

HB 119 Health Care by Hudson
HB 367 Health Care Provider Contracts by Hooper
HB 467 Entities Contracting with the Medicaid Program by Albritton

**Consideration of the following proposed committee bill(s):**

PCB HSQS 11-01 -- Repeals Obsolete Language relating to the Department of Health

**NOTICE FINALIZED on 03/11/2011 16:19 by Villar.Melissa**

HB 119

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 119 Health Care
**SPONSOR(S):** Hudson
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health & Human Services Quality Subcommittee | | Guzzo | Calamas |
| 2) Appropriations Committee | | | |
| 3) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS


The bill amends the Health Care Licensing Procedures Act (Act) and the various authorizing statutes of entities regulated by the Agency for Health Care Administration (AHCA) to reduce, streamline, and clarify regulations for those providers.

- The bill eliminates the Limited Nursing Services specialty license type for assisted living facilities (ALFs) to allow a licensed nurse to provide such services in a standard licensed ALF. The bill replaces the requirement to monitor specialty license facilities with a requirement to monitor all ALFs based upon citation of serious violations and allows a fee to be charged for monitoring visits. The bill modifies AHCA consultation duties related to ALFs, and requires the adoption of rules for data submission by ALFs related to the numbers of residents receiving mental health or nursing services, resident funding sources, and staffing.
- The bill limits the frequency of fire safety inspections by the State Fire Marshal for nursing homes, and expands the ability of nursing homes to provide respite services and provides criteria for the provision of such services.
- The bill amends the Health Care Clinic Act to exempt from licensure entities owned by a corporation generating more than $250 million in annual sales and which have at least one owner who is a health care practitioner, and entities owned or controlled, directly or indirectly, by a publically traded entity with $100 million or more in total annual revenues derived from providing health care services by employed or contracted health care practitioners.
- The bill amends various licensure provisions, including those related to bankruptcy notifications, licensure renewal notices, billing complaints, accrediting organizations, licensure application document submissions, staffing in geriatric outpatient clinics, medical records, property statements, AHCA inspection staff, litigation notices, and health care clinic licensure exemptions.
- The bill repeals obsolete or duplicative provisions in licensing and related statutes, including expired reports and regulations and provisions that exist in other sections of law. The bill resolves conflicts among and between provisions in the Act and various authorizing statutes for individual provider types. The bill also makes various revisions to update terminology and conforms current law to prior legislative changes.
- The bill requires prescribed drugs billed as 340B prescribed medication to meet the requirements of the Deficit Reduction Act of 2005 and the federal 340B program; contain a national drug code and be billed at the actual acquisition cost or payment will be denied.
- The bill transfers administrative duties of the expansion program for federally qualified health centers from the Department of Health (DOH) to AHCA.
- The bill allows for the creation of voluntary wellness programs offering rewards and incentives to program participants.

The bill adds orthotic, pedorthic and prosthetic licensees to the list of "health care providers" for purposes of medical malpractice lawsuits.

The bill has an insignificant negative fiscal impact on the Agency for Health Care Administration. (See Fiscal Comments.)

The bill has an effective date of July 1, 2011.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

The Agency for Health Care Administration (AHCA) regulates over 41,000 health care providers under various regulatory programs. Regulated providers include:

- Laboratories authorized to perform testing under the Drug-Free Workplace Act (ss. 112.0455, 440.102, F.S.).
- Birth centers (Ch. 383, F.S.).
- Abortion clinics (Ch. 390, F.S.).
- Crisis stabilization units (Pts. I and IV of Ch. 394, F.S.).
- Short-term residential treatment facilities (Pt. I and IV of Ch. 394, F.S.).
- Residential treatment facilities (Pt. IV of Ch. 394, F.S.).
- Residential treatment centers for children and adolescents (Pt. IV of Ch. 394, F.S.).
- Hospitals (Part I of Ch. 395, F.S.).
- Ambulatory surgical centers (Pt. I of Ch. 395, F.S.).
- Mobile surgical facilities (Pt. I of Ch. 395, F.S.).
- Health care risk managers (Pt. I of Ch. 395, F.S.).
- Nursing homes (Pt. II of Ch. 400, F.S.).
- Assisted living facilities (Pt. I of Ch. 429, F.S.).
- Home health agencies (Pt. III of Ch. 400, F.S.).
- Nurse registries (Pt. III of Ch. 400, F.S.).
- Companion services or homemaker services providers (Pt. III of Ch. 400, F.S.).
- Adult day care centers (Pt. III of Ch. 429, F.S.).
- Hospices (Pt. IV of Ch. 400, F.S.).
- Adult family-care homes (Pt. II of Ch. 429, F.S.).
- Homes for special services (Pt. V of Ch. 400, F.S.).
- Transitional living facilities (Pt. V of Ch. 400, F.S.).
- Prescribed pediatric extended care centers (Pt. VI of Ch. 400, F.S.).
- Home medical equipment providers (Pt. VII of Ch. 400, F.S.).
- Intermediate care facilities for persons with developmental disabilities (Pt. VIII of Ch. 400, F.S.).
- Health care services pools (Pt. IX of Ch. 400, F.S.).
- Health care clinics (Pt. X of Ch. 400, F.S.).
- Clinical laboratories (Pt. I of Ch. 483, F.S.).
- Multiphasic health testing centers (Pt. II of Ch. 483, F.S.).
- Organ, tissue, and eye procurement organizations (Pt. V of Ch. 765, F.S.).

**Health Care Licensing Procedures Act**

Providers are regulated under the Health Care Licensing Procedures Act (Act) in part II of chapter 408, F.S. The Act provides uniform licensing procedures and standards applicable to most AHCA-regulated entities. The Act contains basic licensing standards for 29 provider types in areas such as licensure application requirements, ownership disclosure, staff background screening, inspections, administrative sanctions, license renewal notices, and bankruptcy and eviction notices.

In addition to the Act, each provider type has an authorizing statute which includes unique provisions for licensure beyond the uniform criteria. Pursuant to s. 408.832, F.S., in the case of conflict between the Act and an individual authorizing statute, the Act prevails. There are several references in authorizing statutes that

conflict with or duplicate provisions in the Act, including references to the classification of deficiencies, penalties for an intentional or negligent act by a provider, provisional licenses, proof of financial ability to operate, inspection requirements and plans of corrections from providers. Chapter 2009-223, L.O.F., made changes to part II of chapter 408, F.S., which supersede components of the specific licensing statutes.

This bill repeals obsolete or duplicative provisions in licensing and related statutes, including expired reports and regulations and provisions that exist in other sections of law like the Act. The bill also makes changes to the Act to reduce, streamline, or clarify regulations for all providers regulated by AHCA.

The bill changes individual licensing statutes to reflect updates to the uniform standards in the Act. The bill makes corresponding changes to provider licensing statutes to reflect the changes made to the Act to eliminate conflicts and obsolete language.

License Renewal Notices

Section 408.806, F.S., requires AHCA to notify licensees by mail or electronically when it is time to renew their licenses. AHCA mails renewal notices to over 30,000 providers every two years. While the statute does not specify the manner of mailing notices, AHCA sends them by certified mail to verify receipt by the providers. The cost of certified mail is approximately $78,000 annually. According to AHCA, some certified mail is returned, as providers do not pick it up or the post office is unable to obtain necessary signatures for delivery. AHCA has also encountered situations in which licensees did not timely renew their licenses and claimed that their lack of receipt of a renewal reminder was a reason for that failure.

The bill clarifies that renewal notices are courtesy reminders only and do not excuse the licensees from the requirement to file timely licensure applications. The revised language gives AHCA clear flexibility to use or not use certified mail to send courtesy renewal reminders.

Classification and Fines for Violations

Section 408.813, F.S., includes criteria for the classification of deficiencies for all providers licensed by AHCA. Some authorizing statutes also contain criteria for the classification of deficiencies, some of which do not match the provisions contained in the Act. The provisions in the Act legally supersede conflicting provisions in the authorizing statutes. However, the dual provisions may be confusing, and some conflicts still exist. Additionally, authorizing statutes are inconsistent related to fines for unclassified deficiencies such as failure to maintain insurance or exceeding licensed bed capacity.

The bill modifies the classification of licensure violations related to nursing homes, home health agencies, intermediate care facilities for the developmentally disabled, and adult family care homes to refer to the scope and severity in s. 408.813, F.S. Fine amounts for violations are unchanged. For intermediate care facilities for the developmentally disabled, the amount of fines for Class I, II, and III violations are unchanged, but a new Class IV is added for consistency with s. 408.813, F.S., with a fine not to exceed $500. The addition of the Class IV violation creates a lower category for minor violations by those facilities. This resolves conflicting or confusing differences between the Act and the authorizing statutes, and resolves inconsistencies between these three authorizing statutes.

In addition, the bill establishes uniform sanction authority for unclassified deficiencies of up to $500 per violation. Examples of unclassified deficiencies include failure to maintain insurance and other administrative requirements, exceeding licensed capacity, or violating a moratorium. Without fine authority, AHCA would be required to initiate revocation action for violations against those providers that do not have general fine authority. These violations may not warrant such a severe sanction.

Licensure Denial and Revocation

An action by AHCA to deny or revoke a license is subject to challenge under the Administrative Procedures Act (chapter 120, F.S.) If a licensee challenges the agency action, s. 408.815(2), F.S., allows the license to continue to exist and the provider to continue to operate during the pendency of the case. Once a final order is issued on the denial or revocation, if the original licensure expiration date has passed, there is no valid license

and the provider must cease operations immediately. According to AHCA, this can be problematic for residents or clients who must immediately be moved to another facility or find another health care provider.

The bill amends s. 408.815, F.S., to authorize AHCA to extend a license expiration date up to 30 days beyond the final order date in the event of a licensure denial or revocation to allow for the orderly transfer of residents or patients.

Billing Complaint Authority

The Act provides authority to review billing complaints across all programs and gives the impression that AHCA can take licensure action regarding billing practices. Section 408.10(2), F.S., requires AHCA to investigate consumer complaints regarding billing practices and determine if the facility has engaged in billing practices which are unreasonable and unfair to the consumer. However, the Act does not provide specific standards for billing practices which AHCA can use to cite violations and discipline a provider's license. Nor does the Act define what activities would be unreasonable and unfair. Several providers' authorizing statutes do include billing standards, including nursing homes and assisted living facilities.[1] However, other authorizing statutes are silent on billing standards, including hospitals, labs, crisis stabilization units and residential treatment facilities.

For calendar year 2010, AHCA received 473 complaints that alleged billing-related issues. Of those, 74 were for providers that have billing standards in their licensure statutes. The remaining 399 were related to billing issues for which no regulatory authority existed for billing matters. When the agency receives a billing complaint regarding one of the providers which does not have statutory billing standards, it is the agency's policy to review the complaint and encourage the parties to work together to resolve the problem. However, the provider is not cited or disciplined due to lack of authority.

The bill repeals AHCA's independent authority related to billing complaints in the Act. However, a review for regulatory compliance will continue to be conducted when a complaint is received for one of the providers over which AHCA has well-defined statutory billing authority. This review could possibly result in citations and discipline.

License Display

Section 408.804, F.S., makes it unlawful to provide or offer services that require licensure without first obtaining a license. This section of law also makes licenses valid only for entities and locations for which they are issued. Licensees are required to display licenses in a conspicuous place readily visible to the clients. The Act does not currently address falsification or ill-usage of license documents.

The bill makes it a second degree misdemeanor to knowingly alter, deface, or falsify a license and is punishable by up to 60 days in jail and a fine of up to $500. The bill makes it an administrative violation for a licensee to display an altered, defaced, or falsified license. Such violations are subject to licensure revocation and a fine of up to $1,000 per day.

**Hospital Licensure**

Accreditation Organizations

Currently, Florida law allows AHCA to consider and use hospital accreditation by certain accrediting organizations for various purposes, including accepting accreditation surveys in lieu of AHCA surveys, requiring accreditation for designation as certain specialty hospitals, and setting standards for quality improvement programs. Section 395.002, F.S., defines "accrediting organizations" as the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care, Inc.

[1] S. 400.23, F.S., (Nursing Homes) and s. 429.19, F.S., (Assisted Living Facilities).

The bill broadens the definition of "accrediting organizations" for hospitals and ambulatory surgery centers to include any nationally recognized accrediting organization whose standards incorporate comparable licensure requirements as determined by AHCA. This gives AHCA and providers greater flexibility to accept new or improving accrediting organizations and reconsider existing organizations based on current statutory and rule-based standards.

Complaint Investigation Procedures

Complaint investigation procedures for hospitals exist in the hospital authorizing statutes as well as in the Act. Section 395.1046, F.S., provides special procedures for hospital complaints regarding emergency access issues. AHCA may investigate emergency access complaints even if the complaint is withdrawn. When the investigation is complete, AHCA shall prepare an investigative report that makes a probable cause determination. AHCA reports that the federal process for emergency access complaints dictates that these complaints should not be handled any differently from other types of complaints.

The bill repeals s. 395.1046, F.S., which eliminates the special procedures for investigating hospital emergency access complaints and would allow AHCA to employ existing hospital complaint investigation procedures used for all other types of complaints.

**Nursing Home Licensure**

Nursing Home License Application

An application for nursing home licensure must include the following:

- A signed affidavit disclosing financial or ownership interest of a nursing home controlling interest in the last five years in any health or residential facility which has closed, filed bankruptcy, has a receiver appointed or an injunction placed against it, or been denied, suspended, or revoked by a regulatory agency. This information is also required in s. 400.111, F.S.
- A plan for quality assurance and risk management. This plan is also reviewed during onsite inspections by AHCA.
- The total number of beds including those certified for Medicare and Medicaid. This information is also required by s. 408.806(1) (d), F.S.

The bill eliminates routine submission of documents at licensure by amending ss. 400.071, 400.111, and 400.1183, 400.141, F.S., to substitute the requirement for nursing homes to routinely submit certain documents at the time of licensure with the ability for AHCA to request the documents, if needed.

Nursing Home Geriatric Outpatient Clinics

Currently, nursing homes may establish a geriatric outpatient clinic as authorized in s. 400.021, F.S., to provide outpatient health care to persons 60 years of age or older. The clinic can be staffed by a registered nurse or a physician's assistant.

The bill expands the health care professionals that may staff a geriatric outpatient clinic in a nursing home to include licensed practical nurses under the direct supervision of registered nurses or advanced registered nurse practitioners.

Nursing Home Records

Section 400.141(1)(j), F.S., requires licensees to maintain full patient records. AHCA Rule 59A-4.118, F.A.C., establishes certain requirements regarding the credentials of nursing home records personnel. Specifically, the rule requires nursing homes to employ or contract with a person who is eligible for certification as a registered record administrator or an accredited record technician by the American Health Information Management Association is a graduate of a school of medical record science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Health Information Management Association. AHCA Rule 59A-4.118, F.A.C., was promulgated in 1994 and the credentialing

organizations referred to in the rule presently do not exist as listed. There is also no authorizing statute that requires nursing homes to contract with a medical records consultant.

The bill amends s. 440.141(1)(j), F.S., to include federal language regarding maintenance of medical records consistent with federal medical records regulations contained in Title 42, Code of Federal Regulations. Specifically, the federal regulations require nursing homes to maintain medical records in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.[2] The addition of these federal standards will require the repeal of AHCA Rule 59A-4.118, F.A.C., related to the credentials of medical records personnel.

Nursing homes are required to maintain records of all grievances, and to report to the agency, upon licensure renewal, various data regarding those grievances. The bill retains the requirement for nursing homes to maintain all grievance records, but removes the requirement that nursing homes report the grievance information at the time of relicensure. The bill requires nursing homes to retain a log to be made available for inspection by AHCA.

Nursing Home Staffing Ratios - General

Nursing homes must comply with staff-to-resident ratios requirements. Under s. 400.141(1)(o), F.S., nursing homes are required to semiannually submit to AHCA information regarding facility staff-to-resident ratios, staff turnover, and staff stability, including information regarding certified nursing assistants, licensed nurses, the director of nursing, and the facility administrator. The ratio must be reported as an average of the most recent calendar quarter. Staff turnover must be reported for the most recent 12-month period. The formula for determining staff stability is the total number of employees that have been employed for more than 12 months, divided by the total number of employees employed at the end of the most recent calendar quarter, and expressed as a percentage.

If a nursing home fails to comply with minimum staffing requirements for two consecutive days, the facility must cease new admissions until the staffing ratio has been achieved for six consecutive days. Failure to self-impose this moratorium on admissions results in a Class II deficiency cited by AHCA. All other citations for a Class II deficiency represent current ongoing non-compliance that AHCA determines has compromised a resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being. Use of the Class II deficiency for a failure to cease admissions is an inconsistent use of a "Class II" deficiency in comparison to all other violations. No nursing homes were cited for this violation in 2010.

The bill removes the requirements under s. 400.141(1)(o), F.S., for reporting staff-to-resident ratio information semiannually to AHCA.

The bill modifies the penalty for nursing homes that fail to self impose an admissions moratorium for insufficient staffing to a fine of $1,000 instead of a Class II deficiency.

Nursing Home Staffing Requirements

Section 400.23(5), F.S., requires AHCA, in collaboration with the Division of Children's Medical Services within the Department of Health (DOH), to adopt rules for minimum standards of care for persons under 21 years of age who reside in nursing home facilities. In 1997, Rule 59A-4.1295, F.A.C., was adopted to provide these additional standards of care for pediatric nursing homes which consist of the following:

- For residents who require **skilled care**, each nursing home must provide an average of 3.5 hours of nursing care per patient per day. A maximum of 1.5 hours may be provided by a certified nursing assistant (CNA), and no less than 1 hour of care must be provided by a licensed nurse.
- For residents who are **fragile** each nursing home must provide an average of 5 hours of direct care per patient per day. A maximum of 1.5 hours of care may be provided by a CNA, and no less than 1.7 hours of care must be provided by a licensed nurse.

[2] 42 C.F.R. 483.75.

Section 400.23(3)(a), F.S., establishes general nursing home staffing standards. Until 2001, s. 400.23(3)(a) did not require a minimum number of licensed nurses or certified nursing assistants. When Rule 59A-4.1295, F.A.C., was adopted in 1997, it was in compliance with s. 400.23(3)(a), F.S., because there were no minimum staffing standards required in the statute at that time. However, the minimum staffing requirements in s. 400.23(3)(a), F.S., have changed since the Rule language above was adopted.

In 2001 s. 400.23(3)(a) was amended to include a minimum staffing standard, which is still in effect today. Currently, s. 400.23(3)(a), F.S., establishes general nursing home staffing standards and requires at least 3.9 hours of licensed nursing and CNA direct care per resident per day. Minimums of 2.7 hours of direct care by a CNA and 1 hour of direct care by a licensed nurse are required. The minimum staffing requirements for pediatric nursing homes in Rule 59A-4.1295, F.A.C. are inconsistent with those required for general nursing homes in s. 400.23(3)(a). The rule limits CNA care to no more than 1.5 hours per day for both fragile and skilled patients, while the statute allows a minimum of 2.7 hours of CNA care per day.

AHCA has tried several times to amend the pediatric staffing ratios in Rule 59A-4.1295, F.A.C. In their most recent proposal, AHCA attempted to delete the rule requirements for skilled and fragile residents detailed above in an effort to comply with s. 400.23(3)(a), F.S. However, the proposed rule has since been withdrawn. During this process, the Joint Administrative Procedures Committee informed the agency that according to s. 120.52(8)(c), F.S., a rule which "enlarges, modifies or contravenes the specific provisions of law implemented" is an "invalid exercise of delegated legislative authority." [3] AHCA has been unsuccessful as of yet in amending language in the rule to comply with the current version of s. 400.23, F.S.

The bill requires AHCA and the Children's Medical Services Network to adopt rules for minimum staffing requirements for nursing homes that serve individuals less than 21 years of age. Further, the bill provides that these rules are to apply in lieu of the standards contained in s. 400.23(3)(a), F.S. The staffing requirements are as follows:

- For individuals under age 21 who require **skilled** care, each nursing home facility must provide a minimum combined average of licensed nurses, respiratory therapists, and certified nursing assistants of 3.9 hours of direct care per resident per day.
- For individuals under age 21 who are **fragile**, each nursing home must include a minimum combined average of licensed nurses, respiratory therapists, and certified nursing assistances of 5.0 hours of direct care per resident per day.

| **Current General 400.23(3)(a)** | **Current Pediatric Skilled 59A-4.1295(8)(a)** | **HB 119 Pediatric Skilled** | **Current Pediatric Medically Fragile 59A-4.1295(8)(b)** | **HB 119 Pediatric Medically Fragile** |
|---|---|---|---|---|
| Nurse – 1 hr. | Nurse – 1 hr. minimum | 3.9 hrs. | Nurse – 1.7 hrs. minimum | 5 hrs. |
| CNAs – 2.7 hrs. minimum | CNAs – 1.5 hrs. maximum | Can be all CNAs | CNAs – 1.5 hrs. maximum | Can be all CNAs |

Nursing Home Do Not Resuscitate Orders

Section 400.142, F.S., requires AHCA to develop rules relating to implementation of do not resuscitate orders (DNRs) for nursing home residents. Criteria for DNRs are found in s. 401.45, F.S., which allows for emergency pre-hospital treatment to be provided by any licensee and provides that resuscitation may be withheld from a patient by an emergency medical technician (EMT) or paramedic if evidence of a DNR is presented.[4] Section 401.45, F.S., also provides rule making authority to DOH to implement this section and requires DOH, in consultation with the Department of Elderly Affairs and AHCA, to develop a standardized DNR identification

[3] Oates, Jowanna. "To Bernard Hudson." 14 September 2010. Joint Administrative Procedures Committee.
[4] Section 401.45, F.S.

system with devices that signify, when carried or worn, that the patient has been issued an order not to administer cardiopulmonary resuscitation by a physician.[5]

DOH developed rule 64J-2.018, F.A.C., which became effective October, 1 2008, while AHCA has yet to promulgate any rules relating to the implementation of DNRs. Rule 64J-2.018, F.A.C., provides the following:[6]

- An EMT or paramedic must withhold or withdraw cardiopulmonary resuscitation if presented with an original or completed copy of DH Form 1896 (Florida DNR Form).
- The DNR Order form must be printed on yellow paper and have the words "DO NOT RESUSCITATE ORDER" printed in black.
- A patient identification device is a miniature version of DH Form 1896 and is a voluntary device intended to provide and portable and convenient DNR order form.
- The DNR order form and patient identification device must be signed by the patient's physician.
- An EMT or paramedic must verify the identity of the patient in possession of the DNR order form or patient identification device by means of the patient's driver license or a witness in the presence of the patient.
- During transport, the EMT must ensure that a copy of the DNR order form or the patient identification device accompanies the live patient.
- A DNR may be revoked at any time by the patient.

The bill removes the requirement for AHCA to promulgate rules related to the implementation of DNRs for nursing home residents. This requirement appears to be duplicative of DOH rulemaking authority in s. 401.45(5), F.S.

<u>Nursing Home Inspections and Surveys</u>

AHCA employs surveyors to inspect nursing homes. Pursuant to s. 400.275, F.S., newly hired nursing home surveyors must spend two days in a nursing home as part of basic training in a non-regulatory role. Federal regulations prescribe an extensive training process for nursing home inspection staff. Staff must pass the federal Surveyor Minimum Qualifications Test. Federal regulations prohibit an AHCA staff person who formerly worked in a nursing home from inspecting a nursing home within two years of employment with that home; state law requires a five year lapse.

The bill removes the requirement for new AHCA nursing home inspection staff to spend two days in a nursing home as part of basic training and aligns staff requirements with federal regulations. AHCA nursing home staff must still be fully qualified under federal requirements for the Surveyor Minimum Qualifications Test.

<u>Nursing Home Litigation Notices</u>

Sections 400.147(10) and 400.0233, F.S., require nursing homes to report civil notices of intent tolitigate and civil complaints filed with clerks of courts by a resident or representative of a resident. This information has been used to produce the Semi-Annual Report on Nursing Homes required by s. 400.195, F.S. However, s. 400.195, F.S., was repealed in 2010.

The bill eliminates the requirement to report notices of intent to litigate and civil complaints.

<u>Nursing Home Respite Care</u>

Section 400.141(1)(f), F.S., allows nursing homes to provide respite care for people needing short-term or temporary nursing home services. Only nursing homes with standard licensure status with no Class I or Class II deficiencies in the past two years or having Gold Seal status may provide respite services. AHCA is authorized to promulgate rules for the provision of respite services.

---

[5] Id.
[6] Florida Department of Health Rule 64J-2.018, F.A.C.

The bill amends s. 400.141, F.S., to expand the ability of nursing homes to provide respite services not exceeding 60 days per year and individual stays may not exceed 14 days. The bill allows all licensed nursing homes to provide respite services without limitations based on prior deficiencies. The bill provides additional criteria for the provision of respite services. For each patient, the nursing home must:

- Have an abbreviated plan of care for each respite patient, covering nutrition, medication, physician orders, nursing assessments and dietary preferences;
- Have a contract that covers the services to be provided;
- Ensure patient release to the proper person; and
- Assume the duties of the patient's primary care giver.

The bill provides that respite patients are exempt from discharge planning requirements, allowed to use his or her personal medication with a physician's order, and covered by the resident rights as delineated in s. 400.022, F.S., except those related to transfer, choice of physician, bed reservation policies, and discharge challenges. The bill requires prospective respite patients to provide certain medical information to the nursing home and entitles the patient to retain his or her personal physician.

Nursing Home Kitchen Inspections

DOH operates a food safety program pursuant to s. 381.0072, F.S. DOH issues food establishment licenses or permits, conducts food safety inspections and enforces regulations through fines and other disciplinary actions.[7] A food service establishment includes the following:[8]

- Detention facilities.
- Public or private schools.
- Migrant labor camps.
- ALFs.
- Adult family-care homes.
- Adult day care centers.
- Short-term residential facilities.
- Residential treatment facilities.
- Homes for special services.
- Transitional living facilities.
- Crisis stabilization units.
- Hospices.
- Prescribed pediatric extended care centers.
- Intermediate care facilities for people with developmental disabilities.
- Boarding schools.
- Civic or fraternal organizations.
- Bars and lounges.
- Vending machines that dispense potentially hazardous foods.
- Mobile units at any of the facilities named above, where food is prepared and intended for individual portion service, including the site at which individual portions are provided, regardless of whether consumption is on or off the premises and regardless of whether there is a charge for the food.

In 2010, HB 5311 was passed and repealed DOH's regulatory authority to perform kitchen inspections for certain entities licensed by other state agencies:

- Hospitals licensed under chapter 395.
- Nursing homes licensed under part II of chapter 400.
- Child care facilities as defined in s. 402.301, F.S.
- Residential facilities collocated with a nursing home or hospital.

---

[7] Office of Program Policy Analysis & Government Accountability, State Food Safety Programs Should Improve Performance and Financial Self-Sufficiency, Report No. 08-67 (December 2008).
[8] Section 381.0072(1)(b), F.S.

The bill reinstates the department's authority to inspect nursing homes and limits kitchen inspections of nursing homes by DOH to twice a year. DOH may make additional inspections in response to a complaint. The bill requires DOH to coordinate inspection timing with AHCA, such that a DOH inspection occurs at least 60 days after an AHCA inspection.

Nursing Home Fire Inspections

The Florida Fire Prevention Code is established in chapter 633, F.S., which also establishes the duties and responsibilities of the Florida Fire Marshal and his agents, who are housed within the Department of Financial Services (DFS). Currently, s. 633.081, F.S., requires the Fire Marshal to inspect nursing homes when DFS has "reasonable cause" to believe that a violation of the Florida Fire Code, any rules promulgated under the Florida Fire Code, or of a fire safety code established by a local authority, exists.

The bill amends s. 633.081 to limit fire inspections of nursing homes by the State Fire Marshal or his agent to once a year. The Fire Marshal may make additional inspections in response to a complaint giving rise to "reasonable cause" for believing a violation exists. The Fire Marshal may also make additional inspections upon identifying violations when accessing a nursing home facility for orientation or training activities.

Notice of Bankruptcy and Eviction

Currently, nursing homes are required to notify AHCA of bankruptcy filing pursuant to s. 400.141(1)(r), F.S. However, nursing homes are not required to notify AHCA of eviction, and there is no statutory requirement for other types of facility providers to notify AHCA if served with an eviction notice or of bankruptcy filing. AHCA reports that it has recently been made aware of several eviction and bankruptcy orders affecting regulated facilities.[9]

The bill amends s. 408.810, F.S., to require providers' controlling interests to notify AHCA within 10 days after a court action to initiate bankruptcy, foreclosure, or eviction proceedings. This applies to any such action to which the controlling interest is a petitioner or defendant. According to AHCA, this new requirement would allow the agency to monitor the facility to ensure patient protection and safe transfer, if necessary.[10] If the property upon which a licensed provider operates is encumbered by a mortgage or is leased, the bill requires the licensee to notify the mortgage holder or landlord that the property will provide services that require licensure and instruct the mortgage holder or landlord to notify AHCA if action is initiated against the licensee, such as eviction or foreclosure.

**Hospice Licensure**

Section 408.810(8) F.S., requires any hospice initial or change of ownership applicant show anticipated provider revenue and expenditures, the basis for financing anticipated cash flow requirements and access to contingency financing. Section 400.606(1)(l), F.S., requires that an annual operating budget be submitted, which duplicates the financial information now required in the Act.

The hospice authorizing statutes and federal regulations require that hospices have inpatient beds for pain control, symptom management, and respite care. Inpatient beds may be in a hospital, skilled nursing facility or a freestanding inpatient facility operated by a hospice. Section 408.043, F.S., requires that there be a certificate of need for a hospice freestanding facility "primarily engaged in providing inpatient care and related services." This provision is repeated in the Act.

The bill removes the requirement for hospice licensure applicants to submit a projected annual operating budget. Financial projections are already submitted as part of the proof of financial ability to operate as required in the Act; therefore, this removes duplicative requirements.

---

[9] AHCA, *Staff Analysis and Economic Impact, House Bill Number 119* (February 7, 2011).
[10] Id.

The bill amends both the Act and the hospice authorizing statutes related to certificates of need for inpatient hospice facilities. The bill eliminates the modifier "primarily" to provide that any provision of inpatient hospice care, in any facility not already licensed as a health care facility (like a hospital or nursing home), requires a certificate of need. In effect, the bill provides that no exemptions to this requirement exist.

**Home Medical Equipment Licensure**

Section 400.931(2), F.S., allows a bond be posted as an alternative to submitting proof of financial ability to operate for a home medical equipment provider. Section 408.8065, F.S., requires the submission of financial statements demonstrating the ability to fund start up costs, working capital, and contingency requirements.

The bill deletes the provisions of s. 400.931, F.S., related to the ability to submit a bond as an alternative to submitting proof of financial ability to operate. Due to 2009 legislative changes, financial oversight is now addressed in the Act.

**Health Care Clinic Licensure**

Part X of ch. 400, F.S., contains the Health Care Clinic Act. This act was passed in 2003 to reduce fraud and abuse in the personal injury protection (PIP) insurance system. Florida's Motor Vehicle No-Fault Law[11] requires motor vehicle owners to maintain $10,000 of personal injury protection (PIP) insurance. PIP benefits are available for certain express damages sustained in a motor vehicle accident, regardless of fault.

Pursuant to the Health Care Clinic Act, AHCA licenses entities that meet the definition of a "clinic": "an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services…".[12] Licensure applications must identify the owners, medical director, and medical providers employed by the clinic. Applicants must provide proof of compliance with applicable rules and financial ability to operate. A level two background screening is required of each applicant for clinic licensure, and certain criminal offenses bar licensure. Each clinic must have a medical director or clinic director who agrees in writing to accept legal responsibility pursuant to s. 400.9935, F.S., for the following activities on behalf of the clinic:

- Ensuring that all practitioners providing health care services or supplies to patients maintain a current, active, and unencumbered Florida license;
- Reviewing patient referral contracts or agreements made by the clinic;
- Ensuring that all health care practitioners at the clinic have active appropriate certification or licensure for the level of care being provided;
- Serving as the clinic records owner;
- Ensuring compliance with the recordkeeping, office surgery, and adverse incident reporting requirements of ch. 456, F.S., the respective practice acts, and rules adopted under the Health Care Clinic Act; and
- Conducting systematic reviews of clinic billings to ensure billings are not fraudulent or unlawful. If an unlawful charge is discovered, immediate corrective action must be taken.

AHCA may deny, revoke, or suspend a health care clinic license and impose administrative fines of up to $5,000 per violation pursuant to s. 400.995, F.S.

Although all clinics must be licensed, s. 400.9905(4), F.S., contains a listing of entities that are not considered a "clinic" for purposes of licensure, including:

- Entities licensed or registered by the state under one or more specified practice acts and that only provide services within the scope of their license, and entities that own such entities, and entities under common ownership with such entities;
- Entities that are exempt from federal taxation under 26 U.S.C. sec. 501(c)(3) or sec. 501(c)(4);

[11] Sections 627.730-627.7405, F.S., the Florida Motor Vehicle No-Fault Law, were repealed on October 1, 2007 pursuant to s. 19, ch. 2003-411 L.O.F. The No-Fault Law was revived and reenacted effective January 1, 2008 pursuant to ch. 2007-324 L.O.F.
[12] Section 400.9905(4), F.S.

- Community college and university clinics;
- Entities owned or operated by the federal or state government;
- Clinical facilities affiliated with an accredited medical school which provides certain training;
- Entities that provide only oncology or radiation therapy services by physicians and are owned by publicly-traded corporations;
- Clinical facilities affiliated with an accredited certain college of chiropractic which provides certain training;
- Entities that provide a certain amount of practitioner staffing or anesthesia services to hospitals; and
- Orthotic or prosthetic facilities owned by publicly-traded corporations.

The bill expands an existing exemption from health care clinic licensure for clinics that are wholly owned, directly or indirectly, by a publicly traded corporation to include pediatric cardiology or perinatology clinics. The bill also creates exemptions from licensure for entities:

- Owned by a corporation generating more than $250 million in annual sales and which have at least one owner who is a health care practitioner;
- Owned directly or indirectly by a publically traded entity with $100 million or more in total annual revenues derived from providing health care services by employed or contracted licensed health care practitioners.

Licensure for health care clinics includes mobile clinics and portable equipment providers. The bill provides that portable service providers, such as mobile ultrasound providers, are subject to health care clinic licensure even though they do not deliver care at the clinic's location.

Section 400.991(4), F.S., allows a bond to be posted as an alternative to submitting proof of financial ability to operate for health care clinics. The bill deletes provisions in s. 400.991(4), F.S., related to the ability to submit a bond as an alternative to submitting proof of financial ability to operate. Due to 2009 legislative changes, financial oversight is now addressed in the Act.

**Assisted Living Facility Licensure**

Currently, an ALF that wishes to provide certain nursing services must also have a limited nursing services (LNS) license or extended congregate care (ECC) specialty license to provide certain nursing services. These specialty licenses allow facilities to provide a variety of additional services beyond those allowed in a standard licensed ALF.

With a LNS specialty license, a facility may provide nursing assessment; care and application of routine dressings; care of casts, braces and splints; administration and regulation of portable oxygen; catheter, colostomy, and ileostomy care; maintenance and the application of cold or heat treatments; passive range of motion exercises; and ear and eye irrigations.

Facilities with the ECC specialty license may provide additional services, including total help with activities of daily living (bathing, dressing, toileting); dietary management (special diets and nutrition monitoring); administering medication and prescribed treatments; rehabilitative services; and escort to health services. Additionally, licensed nursing staff in an ECC program may provide any nursing service permitted within the scope of their license consistent with residency requirements and the facility's written policies and procedures. A facility is required to pay an additional licensure fee for the LNS and ECC specialty license.

In accordance with current law, LNS facilities must be monitored at least twice a year and ECC facilities must be monitored quarterly. Additional fees required for these programs cover the costs of monitoring visits and the additional oversight during routine inspections and licensure due to the higher acuity of residents and services. As of January 2011, there are a total of 2,919 ALFs with standard licenses with a total of 82,176 beds. Of the 2,919 ALFs in Florida, 1,038 have a LNS specialty license and 285 have an ECC specialty license; Of these 48 have both a LNS and an ECC license.[13]

[13] AHCA, *Staff Analysis and Economic Impact, House Bill Number 119* (February 7, 2011).

ALFs are not currently required to submit resident population data to AHCA. However, chapter 2009-223, L.O.F., requires the submission of disaster/emergency information electronically via AHCA's Emergency Status System (ESS) in conjunction with the licensure renewal process. Currently, 42.1 percent (1,197) of ALFs are enrolled in this system.

Section 429.23, F.S., requires each ALF to submit a monthly report on civil liability claims filed against the facility and provides that the reports are not discoverable on civil or administrative actions. Section 429.35, F.S., requires AHCA to forward the results of biennial licensure surveys to various entities, including a local public library, the local ombudsman council, and the district Adult Services and Mental Health Program Office.

The bill eliminates the LNS specialty license for ALFs and allows a licensed nurse to provide limited nursing services in a standard licensed ALF without additional licensure. The bill repeals the requirement to monitor ECCs, and replaces it with a requirement to monitor based upon citation of serious violations (Class I or Class II) in any ALF. The bill increases ALF licensure fees to compensate for the loss of LNS licensure fees and maintain the licensure program. The bill authorizes $356 for a standard license fee, $67.50 per private pay bed and $18,000 for a total fee cap.

The bill allows AHCA to charge a fee for monitoring visits equal to the lesser of one half of the facility's biennial license and bed fee or $500. During Fiscal Year 2009-2010, AHCA conducted a total of 667 monitoring visits for LNS and ECC licensure. Under the new monitoring proposed in the bill, AHCA expects to conduct 726 monitoring visits per year, assuming an average monitoring of three times per year. AHCA expects the monitoring based upon citation of violations proposed in the bill to have a neutral effect on the number of visits conducted per year despite the elimination of the LNS license.[14]

The bill modifies AHCA's consultation duties by removing the required provision of a checklist of necessary general, local and state approvals prior to the construction of a facility; and an explanation of benefits and financial assistance options available to a facility resident who is a recipient of supplemental security income.

The bill requires AHCA to adopt rules for data submission by ALFs related to staffing and numbers of residents receiving certain services. The bill requires facilities to electronically submit resident population data to AHCA semi-annually. Licensees will be required to report ALF resident information not currently required and requires the Department of Elder Affairs (DOEA), in consultation with AHCA, to adopt rules. According to AHCA, this resident information will be useful for health planning and regulatory purposes.[15]

The bill also eliminates the requirement that ALFs report civil liability claims to AHCA and allows AHCA to provide biennial survey results to the public electronically or via the AHCA website.

**Multi-Phasic Health Testing Centers**

Multi-phasic health testing centers (centers) are facilities which take human specimens for delivery to clinical laboratories for testing and may perform other basic human measurement functions. Centers are licensed and regulated under part II of chapter 483, F.S. Section 483.294, F.S., requires AHCA to inspect centers at least annually. The bill amends the inspection schedule requiring AHCA to inspect centers biennially.

**Brain and Spinal Cord Injury Trust Fund**

Under current law, specified traffic fines may be used to provide an enhanced Medicaid rate to nursing homes that serve clients with brain and spinal cord injuries. According to AHCA, funds collected from these fines have not been sufficient to support a Medicaid nursing home supplemental rate for the estimated 100 adult ventilator-dependent patients.

---

[14] AHCA email dated 02,22,11, on file with subcommittee staff.
[15] AHCA, *Staff Analysis and Economic Impact, House Bill Number 119* (February 7, 2011).

The bill redirects the revenue to the Brain and Spinal Cord Injury Trust Fund within DOH, to be used for Medicaid recipients who have sustained a spinal cord injury and who are technologically and respiratory dependent.

**"Up-or-Out" Program**

The Medicaid "Up-or-Out" Quality of Care Contract Management Program authorized in s. 400.148, F.S., was created as a pilot program in 2001. The purpose of the program was to improve care in poor performing nursing homes and assisted living facilities by assigning trained medical personnel to facilities in select counties similar to Medicare models for managing the medical and supportive-care needs of long-term nursing home residents. The pilot was subject to appropriation; however, an appropriation was not allocated. Therefore, the program was never implemented. According to AHCA, the criteria specified to identify poor performing facilities has been replaced by more comprehensive information for consumers to make informed choices for care.

The bill repeals the Medicaid Up-or-Out Pilot Quality of Care Contract Management Program.

**Medical Malpractice**

Sections 766.201-766.212, F.S., establish a process for prompt resolution of medical malpractice lawsuits including presuit investigation and arbitration. These sections apply to malpractice lawsuits against health care providers, which are:

- Hospitals, ambulatory surgical centers and mobile surgical facilities as defined and licensed under ch. 395;
- Birth centers licensed under ch. 383;
- Physicians licensed under ch. 458 or 459;
- Chiropractors licensed under ch. 460;
- Podiatrists licensed under ch. 461;
- Naturopaths licensed under ch. 462;
- Optometrists licensed under ch. 463;
- Nurses licensed under pt. I of ch. 464;
- Dentists, dental hygienists and dental labs licensed under ch. 466;
- Midwives licensed under ch. 467; or
- Physical therapists licensed under ch. 486;
- Clinical laboratories licensed under ch. 483;
- Health maintenance organization certified under pt. I of ch. 641;
- Blood banks;
- Plasma centers;
- Industrial clinics;
- Renal dialysis facilities; or
- Professional association partnerships, corporations, joint ventures, or other associations for professional activity by health care providers.

The bill adds orthotic, pedorthic and prosthetic providers licensed under pt. XIV of ch. 468 to the definition of "health care providers" for purposes of medical malpractice lawsuits governed by ss. 766.201-766.212, F.S.

**Medicaid Prescribed Drug Spending-Control Program**

Section 499.003(54), F.S., defines "wholesale distribution" as distribution of prescription drugs to people other than consumers or patients. It expressly excludes certain activities, which effectively excludes these activities from wholesale drug distribution regulation.

One such excluded activity is the sale, purchase, trade or transfer of prescription drugs from or for entities able to purchase drugs at discount prices pursuant to the federal "340B" program. The 340B program limits the cost of certain drugs to certain federal grantees, federally-qualified health center look-alikes and qualified

disproportionate share hospitals.[16] To qualify for exclusion from state wholesale distribution regulation, s. 499.003(54)(a)4.d., F.S., requires such entities to maintain separate inventories for drugs purchased under the 340B program and other drugs.

Under federal statute, 340B purchased drugs must be billed to Medicaid at actual acquisition cost. The Medicaid agency must then carve these claims out of the rebate pool so that state Medicaid programs can collect federal rebates on the non-340B purchased drugs. Collection of rebates requires the addition of national drug code (NDC) numbers.[17] The requirement for an NDC number on a claim means that the State Medicaid program must reject claims that lack NDC numbers.[18]

The bill amends s. 409.912(39)(a), F.S., stipulating that a claim billed as a 340B prescribed medication must :

- Meet the requirements of the Deficit Reduction Act of 2005;
- Meet the requirements of the federal 340B program;
- Contain a national drug code; and
- Be billed at the actual acquisition cost.

If a claim does not meet all of these requirements the claim will be denied by the state Medicaid program.

**Federally Qualified Health Center Access Program**

Federally qualified health center (FQHC) is a federal designation from the Bureau of Primary Health Care and the Center for Medicare and Medicaid Services that is assigned to private non-profit or public health care organizations that serve predominantly uninsured or medically underserved areas. A high percentage of community health center patients are uninsured and live at or near the federal poverty level (FPL). Many are recipients of Medicaid. Fifty-four percent of Florida FQHC patients live at or below 100% of the FPL. Another 16% of Florida FQHC patients live between 100% and 200% of the FPL.[19]

Section 409.91255, F.S., requires DOH to develop a program for the expansion of FQHC's to provide comprehensive primary and preventive health care and urgent care services that may reduce the morbidity, mortality, and cost of care among the uninsured population of the state. In selecting centers to receive this financial assistance DOH must:

- Give preference to communities that have few or no community-based primary care services or in which the current services are unable to meet the community's needs.
- Require primary care services to be provided to the medically indigent using a sliding fee schedule based on income.
- Promote innovative and creative uses of federal, state, and local health care resources.
- Require funds provided be used to pay for operating costs of a projected expansion in patient caseloads, services or for capital improvement projects.
- Require in-kind support from other sources.
- Promote coordination among federally qualified health centers, other private sector providers, and publicly supported programs.
- Promote the development of community emergency room diversion programs in conjunction with local resources.[20]

Applications for financial assistance under the program are reviewed by a seven-member panel, four of whom are appointed by the State Surgeon General and three of whom are appointed by the CEO of the Florida Association of Community Health Centers.

---

[16] *See*, Introduction to 340B Drug Pricing Program, U.S. Department of Health and Human Services, Health Resources and Services Administration, *available at* http://www.hrsa.gov/opa/introduction.htm (last viewed February 14, 2011).
[17] Drug products are identified and reported using a national drug code: a unique, three-segment number, which is a universal product identifier for human drugs.
[18] AHCA, *Staff Analysis and Economic Impact, House Bill Number 119* (February 7, 2011).
[19] Florida Association of Community Health Centers, Inc., *2010 FQHC Facts.*
[20] Section 409.91255(3), F.S.

The bill amends s. 409.91255, F.S., to transfer the program authority from DOH to AHCA. In addition, the bill requires the Florida Association of Community Health Centers to develop a FQHC based statewide assessment and strategic plan to assist in the assessment and identification of areas of critical need every five years beginning January 1, 2012. The bill also transfers the authority to select the four panel members who review applications from the State Surgeon General to the Secretary of AHCA. The other three members of the panel are still appointed by the CEO of the Florida Association of Community Health Centers.

**Wellness Programs**

Section 626.9541(1)(h), F.S., prohibits unlawful rebates as inducement to enter into an insurance contract and allows for rebates when they are expressly provides by law. Presently, s. 626.9541, F.S., does not prohibit or provide for wellness programs with reward incentives.

The bill amends s. 626.9541, F.S., to provide health insurers the authority to offer a voluntary wellness or health improvement program that provides rewards and incentives to benefit plan members in an effort to encourage or reward participation in a health insurer's wellness program. These rewards and incentives include, but are not limited to:

- Merchandise
- Gift cards
- Debit cards
- Premium discounts or rebates
- Contributions towards a member's health savings account
- Modifications to copayment, deductible or coinsurance amounts

Additionally, the bill provides authority to health insurers to request health benefit plan members to provide documentation stating that they have a medical condition which makes it unreasonably difficult or medically inadvisable to participate in a wellness program. The bill provides that rewards or incentives are not insurance benefits.

**Statutory Revisions**

The bill updates the name of the Statewide Advocacy Council, formerly known as The Human Rights Advocacy Committee, The Joint Commission, formerly known as the Joint Commission of the Accreditation of Healthcare Organizations, and the Commission on Accreditation on Rehabilitation Facilities, formerly known as CARF - the Rehabilitation Accreditation Commission.

The bill deletes definitions for and references to private review agents and utilization review in s. 395.002, F.S., to conform to the repeal made in chapter 2009-223, L.O.F. The bill repeals unused or unnecessary definitions, including definitions for "department" and "agency".

The bill makes technical corrections and repeals requested by the Division of Statutory Revision, such as repealing obsolete dates, amending cross-references, and updating the reference to an obsolete rule.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 112.0455, F.S., relating to the Drug-Free Workplace Act.
**Section 2:** Amends s. 154.11, F.S., relating to powers of the board of trustees.
**Section 3:** Amends s. 318.21, F.S., relating to the disposition of civil penalties by county courts.
**Section 4:** Amends s. 381.0072, F.S., relating to food service protection.
**Section 5:** Repeals s. 383.325, F.S., relating to inspection reports.
**Section 6:** Amends s. 394.4787, F.S., relating to specialty psychiatric hospitals.
**Section 7:** Amends s. 394.741, F.S., relating to accreditation requirements for providers of behavioral health care services.
**Section 8:** Amends s. 395.002, F.S., relating to accrediting organizations and specialty hospitals.
**Section 9:** Amends s. 395.003, F.S., relating to licensure; denial suspension, and revocation.

**Section 10:** Amends s. 395.0193, F.S., relating to licensed facilities; peer review; disciplinary powers; agency or partnership with physicians.
**Section 11:** Amends s. 395.1023, F.S., relating to child abuse and neglect cases.
**Section 12:** Amends s. 395.1041, F.S., relating to access to emergency services and care.
**Section 13:** Repeals s. 395.1046, F.S., relating to complaint investigation procedures.
**Section 14:** Amends s. 395.1055, F.S., relating to rules and enforcement.
**Section 15:** Amends s. 395.10972, F.S., relating to the Health Care Risk Manager Advisory Council.
**Section 16:** Amends s. 395.2050, F.S., relating to routine inquiry for organ and tissue donation.
**Section 17:** Amends s. 395.3036, F.S., relating to confidentiality of records and meetings of corporations that lease public hospitals or other public health care facilities.
**Section 18:** Repeals s. 395.3037, F.S., relating to definitions of "department" and "agency".
**Section 19:** Amends s. 395.3038, F.S., relating to state-listed primary stroke centers and comprehensive stroke centers, and notification of hospitals.
**Section 20:** Amends s. 395.602, F.S., relating to rural hospitals.
**Section 21:** Amends s. 400.021, F.S., relating to geriatric outpatient clinics.
**Section 22:** Amends s. 400.0239, F.S., relating to the quality of long-term care facility improvement trust fund.
**Section 23:** Amends s. 400.0255, F.S., relating to resident transfer or discharge.
**Section 24:** Amends s. 400.063, F.S., relating to resident protection.
**Section 25:** Amends s. 400.071, F.S., relating to applications for licensure.
**Section 26:** Amends s. 400.0712, F.S., relating to applications for inactive licenses.
**Section 27:** Amends s. 400.111, F.S., relating to disclosure of controlling interest.
**Section 28:** Amends s. 400.1183, F.S., relating to resident grievance procedures.
**Section 29:** Repeals s. 400.141, F.S., relating to administration and management of nursing home facilities.
**Section 30:** Amends s. 400.142, F.S., relating to emergency medication kits and orders not to resuscitate.
**Section 31:** Amends s. 400.147, F.S., relating to internal risk management and the quality assurance program.
**Section 32:** Repeals s. 400.148, F.S., relating to the Medicaid "Up-or-Out" quality of care contract management program.
**Section 33:** Amends s. 400.179, F.S., relating to liability for Medicaid underpayments and overpayments.
**Section 34:** Amends s. 400.19, F.S., relating to right of entry and inspection.
**Section 35:** Amends s. 400.23, F.S., relating to rules, evaluation and deficiencies and licensure status.
**Section 36:** Amends s. 400.275, F.S., relating to agency duties.
**Section 37:** Amends s. 400.484, F.S., relating to right of inspection, violation and fines.
**Section 38:** Amends s. 400.606, F.S., relating to license application, renewal, conditional license or permits and certificates of need.
**Section 39:** Amends s. 400.607, F.S., relating to denial, suspension and revocation of a license; emergency actions and imposition of administrative fines.
**Section 40:** Amends s. 400.915, F.S., relating to construction and renovation requirements.
**Section 41:** Amends s. 400.925, F.S., relating to accrediting organizations.
**Section 42:** Amends s. 400.931, F.S., relating to application for licensure.
**Section 43:** Amends s. 400.932, F.S., relating to administrative penalties.
**Section 44:** Amends s. 400.967, F.S., relating to rules and classification of violations.
**Section 45:** Amends s. 400.9905, F.S., relating to clinics and portable health service or equipment providers.
**Section 46:** Amends s. 400.991, F.S., relating to license requirements, background screenings and prohibitions.
**Section 47:** Amends s. 400.9935, F.S., relating to clinic responsibilities.
**Section 48:** Amends s. 408.034, F.S., relating to agency duties and responsibilities.
**Section 49:** Amends s. 408.036, F.S., relating to projects subject to review and exemption.
**Section 50:** Amends s. 408.043, F.S., relating to special provisions for Hospice applications for certificates of need.
**Section 51:** Amends s. 408.05, F.S., relating to the Florida Center for Health Information and Policy Analysis.

**Section 52:** Amends s. 408.061, F.S., relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.
**Section 53:** Amends s. 408.07, F.S., relating to rural hospitals.
**Section 54:** Amends s. 408.10, F.S., relating to consumer complaints.
**Section 55:** Amends s. 408.802, F.S., relating to applicability.
**Section 56:** Amends s. 408.804, F.S., relating to displaying of a license.
**Section 57:** Amends s. 408.806, F.S., relating to the license application process.
**Section 58:** Amends s. 408.810, F.S., relating to minimum licensure requirements.
**Section 59:** Amends s. 408.813, F.S., relating to administrative fines and violations.
**Section 60:** Amends s. 408.815, F.S., relating to license or application denial and revocation.
**Section 61:** Amends s. 408.820, F.S., relating to exemptions.
**Section 62:** Amends s. 409.91196, F.S., relating to supplemental rebate agreements and public records and public meetings exemption.
**Section 63:** Amends s. 409.912, F.S., relating to cost-effective purchasing of health care.
**Section 64:** Amends s. 409.91255, F.S., relating to the Federally Qualified Health Center Access Program.
**Section 65:** Amends s. 429.07, F.S., relating to license requirements, fees and inspections.
**Section 66:** Amends s. 429.11, F.S., relating to initial applications for licensure.
**Section 67:** Amends s. 429.12, F.S., relating to sale or transfer of ownership of a facility.
**Section 68:** Amends s. 429.14, F.S., relating to administrative penalties.
**Section 69:** Amends s. 429.17, F.S., relating to license expiration, renewal and conditional licenses.
**Section 70:** Amends s. 429.19, F.S., relating to violations and the imposition of administrative fines.
**Section 71:** Amends s. 429.23, F.S., relating to the internal risk management and quality assurance program.
**Section 72:** Amends s. 429.255, F.S., relating to the use of personnel and emergency care.
**Section 73:** Amends s. 429.28, F.S., relating to the resident bill of rights.
**Section 74:** Amends s. 429.35, F.S., relating to the maintenance of records and reports.
**Section 75:** Amends s. 429.41, F.S., relating to rules establishing standards.
**Section 76:** Amends s. 429.53, F.S., relating to consultation by the agency.
**Section 77:** Amends s. 429.54, F.S., relating to collection of information; local subsidy.
**Section 78:** Amends s. 429.71, F.S., relating to classification of violations and administrative fines.
**Section 79:** Amends s. 429.911, F.S., relating to the denial, suspension, or revocation of a license; emergency action; administrative fines; investigations and inspections.
**Section 80:** Amends s. 429.915, F.S., relating to conditional licensure.
**Section 81:** Amends s. 430.80, F.S., relating to the implementation of a teaching nursing home pilot project.
**Section 82:** Amends s. 440.13, F.S., relating to medical services and supplies; penalty for violations and limitations.
**Section 83:** Amends s. 483.294, F.S., relating to the inspection of centers.
**Section 84:** Amends s. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices.
**Section 85:** Amends s. 627.645, F.S., relating to the restriction of denied health insurance claims.
**Section 86:** Amends s. 627.668, F.S., relating to optional coverage for mental and nervous disorders.
**Section 87:** Amends s. 627.669, F.S., relating to optional coverage requirement for substance abuse impaired persons.
**Section 88:** Amends s. 627.736, F.S., relating to required personal injury protection benefits.
**Section 89:** Amends s. 633.081, F.S., relating to the inspection of buildings and equipment; orders; fire safety inspection training requirements; certification and disciplinary action.
**Section 90:** Amends s. 641.495, F.S., relating to the requirements for issuance and maintenance of certificates.
**Section 91:** Amends s. 651.118, F.S., relating to the Agency for Health Care Administration; certificates of need; sheltered beds; and community beds.
**Section 92:** Amends s. 766.1015, F.S., relating to civil immunity for members of or consultants to certain boards, committees, or other entities.
**Section 93:** Amends s. 766.202, F.S., relating to health care providers.
**Section 94:** Provides an effective date of July 1, 2011.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Assisted living facility provider fees will be increased to offset the elimination of the LNS license fee and to reflect the Consumer Price Index adjustment, as authorized in s. 408.805, F.S. This will result in a neutral net impact to the industry as a whole; the per-resident fees will go up for all licensees and LNS licensees will no longer have a LNS license fee. (See Fiscal Comments.)

D. FISCAL COMMENTS:

**License Renewal Notices**

AHCA estimates that the bill will result in savings of $78,000 in administrative costs annually in the Health Care Trust Fund through the discontinuation of certified mail service to deliver license renewal notices.

**License Display**

The bill grants AHCA the authority to impose a fine of up to $1,000 per day when a licensee displays an altered, defaced or falsified license. However, AHCA reports that it does not anticipate that this fine will generate any additional revenues, but instead act as a deterrent.[21]

**Assisted Living Facility Limited Nursing Specialty License**

Fees

The bill increases the biennial license fee for standard ALFs to offset the elimination of the LNS specialty licensure fees. ALF fees are adjusted each year by the Consumer Price Index, as authorized by s. 408.805, F.S. AHCA reports that the adjustment in fees for ALF licensure has a neutral fiscal impact on fee collections.[22]

Based on the number of LNS specialty licenses (995) and beds (25,883) in February 2010, the LNS specialty license is projected to generate approximately $554,000 in revenues biennially. The revenues are calculated as follows:

$296 per license plus $10 per bed = $553,350 based on current numbers
($294,520 + $258,830) = $553,350

[21] AHCA email dated 02,08,11, on file with subcommittee staff.
[22] AHCA, *Staff Analysis and Economic Impact, House Bill Number 119* (February 7, 2011).

The additional fee increase in the bill is intended to offset the loss in revenues from the elimination of the specialty license fee. The fee increase is calculated as follows:

$553,350 divided by 65,298 beds = $8.47/bed
(81,038 total beds less 15,740 OSS)

The proposed fee is calculated as follows:

$59 per bed + $8.50 per bed = $67.50 per bed.

However, the calculation above is based on outdated fee amounts (2010). The fees are adjusted annually by the agency to reflect the Consumer Price Index adjustment, as authorized in s. 408.805, F.S. The current LNS fees are slightly greater than the fees used to calculate the fee adjustment in the bill, which means the loss of revenue from the elimination of the LNS license is also greater.

AHCA reports an expected annual loss of revenue of $131,261 resulting from the use of outdated fees to calculate the fee increase in the bill.[23]

Monitoring

The bill replaces the specialty license monitoring for ECC and LNS licensees with monitoring based on the citation of class I or II deficiencies in the last two years. As of February 20, 2011, there were 242 ALFs that had been cited for a Class I or II deficiency in the prior two years. Assuming an average monitoring of three times per year for these facilities, AHCA expects to make 726 monitor visits per year. In comparison, AHCA conducted a total of 667 monitoring visits during Fiscal Year 2009-2010. The monitoring workload of LNS and ECC licensees lost as a result of the bill will be replaced by the monitoring workload of ALFs with a class I or II deficiency in the last two years.[24]

**Federally Qualified Health Centers**

The bill transfers the administration of duties for expansion of federally qualified health centers (FQHC) from DOH to AHCA. AHCA has requested one full-time equivalent position with a salary of $51,215; standard expense package and $4,000 in additional expenses to cover statewide travel requirements. The Agency is also requesting $150,000 (with half coming from General Revenue and the other half from the Medical Care Trust Fund) to contract for professional services relating to evaluation of grant application and management of contracting, lien and security requirements.

There is no expected fiscal impact for DOH. The general revenue supporting the program is currently appropriated to AHCA. The DOH, Office of Health Professional Recruitment currently administers the Program in support of the AHCA.

Below is a table (provided by AHCA) detailing the total net expected revenues and expenditures to result from the bill:

| FISCAL IMPACT ON AHCA/FUNDS: | Amount Year 1 FY 11-12 | Amount Year 2 FY 12-13 |
|---|---|---|
| **1. Non-Recurring Impact:** | | |
| **Revenues:** | | |
| Licenses | $0 | $0 |
| Fees | $0 | $0 |
| Grants | $0 | $0 |
| | $0 | $0 |
| Transfers In / Another | $0 | $0 |

[23] AHCA, *Staff Analysis and Economic Impact, House Bill Number 119* (February 7, 2011).
[24] AHCA email dated 02,22,11, on file with subcommittee staff.

| | | | | | | |
|---|---|---|---|---|---|---|
| Agency | | | | | | |
| **Total Non-Recurring Revenues** | | | | | **$0** | **$0** |
| **Expenditures:** | | | | | | |
| **Salaries** | | | | | $0 | $0 |
| **OPS** | | | | | | |
| Other Personal Services | | 0.00 | @ | $0 | $0 | $0 |
| | | 0.00 | @ | $0 | $0 | $0 |
| **Total Non-Recurring OPS** | | | | | $0 | $0 |
| **Expense (Agency Standard Expense & Operating Capital Outlay Package)** | | | | | | |
| Professional Staff | | 0.00 | @ | $3,898 | $3,898 | $0 |
| Support Staff | | 0.00 | @ | $0 | $0 | $0 |
| | | 0.00 | @ | $0 | $0 | $0 |
| Additional Travel Expense | | 0.00 | @ | $0 | $0 | $0 |
| | | 0.00 | | | $0 | $0 |
| **Total Non-Recurring Expense** | | | | | **$3,898** | **$0** |
| **Operating Capital Outlay (Agency Standard Expense & Operating Capital Outlay Package)** | | | | | | |
| Laptop Computers | | 0.00 | @ | $0 | $0 | $0 |
| | | 0.00 | @ | $0 | $0 | $0 |
| **Total Operating Capital Outlay** | | | | | **$0** | **$0** |
| **Special Categories** | | | | | | |
| Contracted Services | | | | | $0 | $0 |
| **Total Non-Recurring Special Categories** | | | | | **$0** | **$0** |
| **Total Non-Recurring Expenditures** | | | | | **$3,898** | **$0** |

**2. Recurring Impact:**

| | Class Code | FTEs | Pay Grade | Rate | | |
|---|---|---|---|---|---|---|
| **Revenues:** | | | | | | |
| Licenses | | | | | $0 | $0 |
| Fees | | | | | ($131,261) | ($131,261) |
| Grants | | | | | $0 | $0 |
| Cost Savings – Mailing | | | | | $78,000 | $78,000 |
| Transfers In/Another Agency | | | | | $0 | $0 |
| **Total Recurring Revenues** | | | | | ($53,261) | ($53,261) |
| **Expenditures:** | | | | | | |
| **Salaries** | | | | | | |
| Government Analyst II | 2225 | 1.00 | **26** | $51,215 | $71,164 | $71,164 |
| | | 0.00 | **0** | 0 | $0 | $0 |
| **Total Salary and Benefits** | | 1.00 | **FTEs** | $51,215 | $71,164 | $71,164 |
| **OPS** | | | | | | |
| Other Personal Services | | 0.00 | @ | $0 | $0 | $0 |
| | | 0.00 | @ | $0 | $0 | $0 |
| **Total OPS** | | | | | $0 | $0 |
| **Expenses** | | | | | | |
| Professional Staff | | 1.00 | @ | $6,555 | $6,555 | $6,555 |
| Support Staff | | 0.00 | @ | $0 | $0 | $0 |
| Additional Travel | | 1.00 | @ | $4,000 | $4,000 | $4,000 |

| | | | | | |
|---|---|---|---|---|---|
| Expenses | | | | | |
| | | | | $0 | $0 |
| **Total Expenses** | | | | $10,555 | $10,555 |
| **Contracted Services** | 0.00 | | $0 | $0 | $0 |
| **Human Resources Services** | | | | | |
| FTE Positions | 1.00 | @ | $356 | $356 | $356 |
| OPS Positions | 0.00 | @ | $0 | $0 | $0 |
| **Total Human Resources Services** | | | | $356 | $356 |
| **Special Categories** | | | | | |
| Contracted Services | | | | $150,000 | $150,000 |
| | | | | $0 | $0 |
| | | | | $0 | $0 |
| **Total Special Categories** | | | | $150,000 | $150,000 |
| **Total Recurring Expenditures** | **1.00** | **FTEs** | **51,215** | **$232,075** | **$232,075** |

***3. Long Run Effects Other Than Normal Growth:***

***4. Total Revenues and Expenditures:***

| | | | | |
|---|---|---|---|---|
| Sub-Total Non-Recurring Revenues | | | $0 | $0 |
| Sub-Total Recurring Revenues | | | ($53,261) | ($53,261) |
| **Total Revenues** | | | **($53,261)** | **($53,261)** |
| Sub-Total Non-Recurring Expenditures | | | $3,898 | $0 |
| Sub-Total Recurring Expenditures | | | $232,075 | $232,075 |
| **Total Expenditures** | **1.00** | **FTEs** | **$235,973** | **$232,075** |
| **Difference (Total Revenues minus Total Expenditures)** | | | **$289,233** | **$285,336** |

***5. Funding of Expenditures:***

| | | | |
|---|---|---|---|
| General Revenue Fund | 50% | $117,986 | $116,037 |
| MCTF | 50% | $117,986 | $116,037 |
| **Total** | **100%** | **$235,972** | **$232,074** |

***6. Impact of Revenue:***

| | | |
|---|---|---|
| HCTF | ($131,261) | ($131,261) |
| **HCTF** | **$78,000** | **$78,000** |
| **Total** | **$53,261** | **$53,261** |

***7. Issue TOTAL:***

| | | | |
|---|---|---|---|
| Funding of Expenditures | 64% | $235,972 | $232,074 |
| Loss of Revenue | **36%** | $53,261 | $53,261 |
| **Total** | **100%** | **$289,233** | **$285,336** |

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to AHCA, DOH, and DOEA to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to health care; amending s. 112.0455,
3 F.S., relating to the Drug-Free Workplace Act; deleting an
4 obsolete provision; amending s. 318.21, F.S.; revising
5 distribution of funds from civil penalties imposed for
6 traffic infractions by county courts; amending s.
7 381.0072, F.S.; limiting Department of Health food service
8 inspections in nursing homes; requiring the department to
9 coordinate inspections with the Agency for Health Care
10 Administration; repealing s. 383.325, F.S., relating to
11 confidentiality of inspection reports of licensed birth
12 center facilities; amending s. 395.002, F.S.; revising and
13 deleting definitions applicable to regulation of hospitals
14 and other licensed facilities; conforming a cross-
15 reference; amending s. 395.003, F.S.; deleting an obsolete
16 provision; conforming a cross-reference; amending s.
17 395.0193, F.S.; requiring a licensed facility to report
18 certain peer review information and final disciplinary
19 actions to the Division of Medical Quality Assurance of
20 the Department of Health rather than the Division of
21 Health Quality Assurance of the Agency for Health Care
22 Administration; amending s. 395.1023, F.S.; providing for
23 the Department of Children and Family Services rather than
24 the Department of Health to perform certain functions with
25 respect to child protection cases; requiring certain
26 hospitals to notify the Department of Children and Family
27 Services of compliance; amending s. 395.1041, F.S.,
28 relating to hospital emergency services and care; deleting

29 obsolete provisions; repealing s. 395.1046, F.S., relating
30 to complaint investigation procedures; amending s.
31 395.1055, F.S.; requiring licensed facility beds to
32 conform to standards specified by the Agency for Health
33 Care Administration, the Florida Building Code, and the
34 Florida Fire Prevention Code; amending s. 395.10972, F.S.;
35 revising a reference to the Florida Society of Healthcare
36 Risk Management to conform to the current designation;
37 amending s. 395.2050, F.S.; revising a reference to the
38 federal Health Care Financing Administration to conform to
39 the current designation; amending s. 395.3036, F.S.;
40 correcting a reference; repealing s. 395.3037, F.S.,
41 relating to redundant definitions; amending ss. 154.11,
42 394.741, 395.3038, 400.925, 400.9935, 408.05, 440.13,
43 627.645, 627.668, 627.669, 627.736, 641.495, and 766.1015,
44 F.S.; revising references to the Joint Commission on
45 Accreditation of Healthcare Organizations, the Commission
46 on Accreditation of Rehabilitation Facilities, and the
47 Council on Accreditation to conform to their current
48 designations; amending s. 395.602, F.S.; revising the
49 definition of the term "rural hospital" to delete an
50 obsolete provision; amending s. 400.021, F.S.; revising
51 the definition of the term "geriatric outpatient clinic";
52 amending s. 400.0255, F.S.; correcting an obsolete cross-
53 reference to administrative rules; amending s. 400.063,
54 F.S.; deleting an obsolete provision; amending ss. 400.071
55 and 400.0712, F.S.; revising applicability of general
56 licensure requirements under part II of ch. 408, F.S., to

57 applications for nursing home licensure; revising
58 provisions governing inactive licenses; amending s.
59 400.111, F.S.; providing for disclosure of controlling
60 interest of a nursing home facility upon request by the
61 Agency for Health Care Administration; amending s.
62 400.1183, F.S.; revising grievance record maintenance and
63 reporting requirements for nursing homes; amending s.
64 400.141, F.S.; providing criteria for the provision of
65 respite services by nursing homes; requiring a written
66 plan of care; requiring a contract for services; requiring
67 resident release to caregivers to be designated in
68 writing; providing an exemption to the application of
69 discharge planning rules; providing for residents' rights;
70 providing for use of personal medications; providing terms
71 of respite stay; providing for communication of patient
72 information; requiring a physician's order for care and
73 proof of a physical examination; providing for services
74 for respite patients and duties of facilities with respect
75 to such patients; conforming a cross-reference; requiring
76 facilities to maintain clinical records that meet
77 specified standards; providing a fine relating to an
78 admissions moratorium; deleting requirement for facilities
79 to submit certain information related to management
80 companies to the agency; deleting a requirement for
81 facilities to notify the agency of certain bankruptcy
82 filings to conform to changes made by the act; amending s.
83 400.142, F.S.; deleting language relating to agency
84 adoption of rules; amending 400.147, F.S.; revising

85 reporting requirements for licensed nursing home
86 facilities relating to adverse incidents; repealing s.
87 400.148, F.S., relating to the Medicaid "Up-or-Out"
88 Quality of Care Contract Management Program; amending s.
89 400.179, F.S.; deleting an obsolete provision; amending s.
90 400.19, F.S.; revising inspection requirements; amending
91 s. 400.23, F.S.; deleting an obsolete provision;
92 correcting a reference; directing the agency to adopt
93 rules for minimum staffing standards in nursing homes that
94 serve persons under 21 years of age; providing minimum
95 staffing standards; amending s. 400.275, F.S.; revising
96 agency duties with regard to training nursing home
97 surveyor teams; revising requirements for team members;
98 amending s. 400.484, F.S.; revising the schedule of home
99 health agency inspection violations; amending s. 400.606,
100 F.S.; revising the content requirements of the plan
101 accompanying an initial or change-of-ownership application
102 for licensure of a hospice; revising requirements relating
103 to certificates of need for certain hospice facilities;
104 amending s. 400.607, F.S.; revising grounds for agency
105 action against a hospice; amending s. 400.915, F.S.;
106 correcting an obsolete cross-reference to administrative
107 rules; amending s. 400.931, F.S.; deleting a requirement
108 that an applicant for a home medical equipment provider
109 license submit a surety bond to the agency; amending s.
110 400.932, F.S.; revising grounds for the imposition of
111 administrative penalties for certain violations by an
112 employee of a home medical equipment provider; amending s.

113 400.967, F.S.; revising the schedule of inspection
114 violations for intermediate care facilities for the
115 developmentally disabled; providing a penalty for certain
116 violations; amending s. 400.9905, F.S.; revising the
117 definitions of the terms "clinic" and "portable equipment
118 provider"; providing that part X of ch, 400, F.S., the
119 Health Care Clinic Act, does not apply to certain clinical
120 facilities, an entity owned by a corporation with a
121 specified amount of annual sales of health care services
122 under certain circumstances, or an entity owned or
123 controlled by a publicly traded entity with a specified
124 amount of annual revenues; amending s. 400.991, F.S.;
125 conforming terminology; revising application requirements
126 relating to documentation of financial ability to operate
127 a mobile clinic; amending s. 408.034, F.S.; revising
128 agency authority relating to licensing of intermediate
129 care facilities for the developmentally disabled; amending
130 s. 408.036, F.S.; deleting an exemption from certain
131 certificate-of-need review requirements for a hospice or a
132 hospice inpatient facility; amending s. 408.043, F.S.;
133 revising requirements for certain freestanding inpatient
134 hospice care facilities to obtain a certificate of need;
135 amending s. 408.061, F.S.; revising health care facility
136 data reporting requirements; amending s. 408.10, F.S.;
137 removing agency authority to investigate certain consumer
138 complaints; amending s. 408.802, F.S.; removing
139 applicability of part II of ch. 408, F.S., relating to
140 general licensure requirements, to private review agents;

141 amending s. 408.804, F.S.; providing penalties for
142 altering, defacing, or falsifying a license certificate
143 issued by the agency or displaying such an altered,
144 defaced, or falsified certificate; amending s. 408.806,
145 F.S.; revising agency responsibilities for notification of
146 licensees of impending expiration of a license; requiring
147 payment of a late fee for a license application to be
148 considered complete under certain circumstances; amending
149 s. 408.810, F.S.; revising provisions relating to
150 information required for licensure; requiring proof of
151 submission of notice to a mortgagor or landlord regarding
152 provision of services requiring licensure; requiring
153 disclosure of information by a controlling interest of
154 certain court actions relating to financial instability
155 within a specified time period; amending s. 408.813, F.S.;
156 authorizing the agency to impose fines for unclassified
157 violations of part II of ch. 408, F.S.; amending s.
158 408.815, F.S.; authorizing the agency to extend a license
159 expiration date under certain circumstances; conforming a
160 cross-reference; amending s. 408.820, F.S.; conforming a
161 cross-reference; amending s. 409.91196, F.S.; conforming a
162 cross-reference; amending s. 409.912, F.S.; revising
163 procedures for implementation of a Medicaid prescribed-
164 drug spending-control program; amending s. 409.91255,
165 F.S.; transferring administrative responsibility for the
166 application procedure for federally qualified health
167 centers from the Department of Health to the Agency for
168 Health Care Administration; requiring the Florida

169 Association of Community Health Centers, Inc., to provide
170 support and assume administrative costs for the program;
171 amending s. 429.07, F.S.; deleting the requirement for an
172 assisted living facility to obtain an additional license
173 in order to provide limited nursing services; deleting the
174 requirement for the agency to conduct quarterly monitoring
175 visits of facilities that hold a license to provide
176 extended congregate care services; deleting the
177 requirement for the department to report annually on the
178 status of and recommendations related to extended
179 congregate care; deleting the requirement for the agency
180 to conduct monitoring visits at least twice a year to
181 facilities providing limited nursing services; increasing
182 the licensure fees and the maximum fee required for the
183 standard license; increasing the licensure fees for the
184 extended congregate care license; eliminating the license
185 fee for the limited nursing services license; transferring
186 from another provision of law the requirement that a
187 biennial survey of an assisted living facility include
188 specific actions to determine whether the facility is
189 adequately protecting residents' rights; providing that
190 under specified conditions an assisted living facility
191 that has a class I or class II violation is subject to
192 periodic unannounced monitoring; requiring a registered
193 nurse to participate in certain monitoring visits;
194 amending s. 429.11, F.S.; revising licensure application
195 requirements for assisted living facilities to eliminate
196 provisional licenses; amending s. 429.12, F.S.; deleting a

197 requirement that a transferor of an assisted living
198 facility advise the transferee to submit a plan for
199 correction of certain deficiencies to the Agency for
200 Health Care Administration before ownership of the
201 facility is transferred; amending s. 429.14, F.S.;
202 removing a ground for the imposition of an administrative
203 penalty; clarifying provisions relating to a facility's
204 request for a hearing under certain circumstances;
205 authorizing the agency to provide certain information
206 relating to the licensure status of assisted living
207 facilities electronically or through the agency's Internet
208 website; amending s. 429.17, F.S.; deleting provisions
209 relating to the limited nursing services license; revising
210 agency responsibilities regarding the issuance of
211 conditional licenses; amending s. 429.19, F.S.; clarifying
212 that a monitoring fee may be assessed in addition to an
213 administrative fine; amending s. 429.23, F.S.; deleting
214 reporting requirements for assisted living facilities
215 relating to liability claims; amending s. 429.255, F.S.;
216 eliminating provisions authorizing the use of volunteers
217 to provide certain health-care-related services in
218 assisted living facilities; authorizing assisted living
219 facilities to provide limited nursing services; requiring
220 an assisted living facility to be responsible for certain
221 recordkeeping and staff to be trained to monitor residents
222 receiving certain health-care-related services; amending
223 s. 429.28, F.S.; deleting a requirement for a biennial
224 survey of an assisted living facility, to conform to

225 changes made by the act; conforming a cross-reference;
226 amending s. 429.35, F.S.; authorizing the agency to
227 provide certain information relating to the inspections of
228 assisted living facilities electronically or through the
229 agency's Internet website; amending s. 429.41, F.S.,
230 relating to rulemaking; conforming provisions to changes
231 made by the act; amending s. 429.53, F.S.; revising
232 provisions relating to consultation by the agency;
233 revising a definition; amending s. 429.54, F.S.; requiring
234 licensed assisted living facilities to electronically
235 report certain data semiannually to the agency in
236 accordance with rules adopted by the department; amending
237 s. 429.71, F.S.; revising schedule of inspection
238 violations for adult family-care homes; amending s.
239 429.911, F.S.; deleting a ground for agency action against
240 an adult day care center; amending s. 429.915, F.S.;
241 revising agency responsibilities regarding the issuance of
242 conditional licenses; amending s. 483.294, F.S.; revising
243 frequency of agency inspections of multiphasic health
244 testing centers; amending s. 626.9541, F.S.; authorizing
245 an insurer offering a group or individual health benefit
246 plan to offer a wellness program; authorizing rewards or
247 incentives; providing for verification of a member's
248 inability to participate for medical reasons; providing
249 that such rewards or incentives are not insurance
250 benefits; amending s. 633.081, F.S.; limiting State Fire
251 Marshal inspections of nursing homes to once a year;
252 providing for additional inspections based on complaints

253 and violations identified in the course of orientation or
254 training activities; amending s. 766.202, F.S.; adding
255 persons licensed under part XIV of ch. 468, F.S., to the
256 definition of "health care provider"; amending ss.
257 394.4787, 400.0239, 408.07, 430.80, and 651.118, F.S.;
258 conforming terminology and references to changes made by
259 the act; revising a reference; providing an effective
260 date.
261
262 Be It Enacted by the Legislature of the State of Florida:
263
264 Section 1. Paragraphs (f) through (k) of subsection (10)
265 of section 112.045, Florida Statutes, are redesignated as
266 paragraphs (e) through (j), respectively, and present paragraph
267 (e) of subsection (10) and paragraph (e) of subsection (14) of
268 that section are amended to read:
269 112.0455 Drug-Free Workplace Act.—
270 (10) EMPLOYER PROTECTION.—
271 ~~(e) Nothing in this section shall be construed to operate~~
272 ~~retroactively, and nothing in this section shall abrogate the~~
273 ~~right of an employer under state law to conduct drug tests prior~~
274 ~~to January 1, 1990. A drug test conducted by an employer prior~~
275 ~~to January 1, 1990, is not subject to this section.~~
276 (14) DISCIPLINE REMEDIES.—
277 (e) Upon resolving an appeal filed pursuant to paragraph
278 (c), and finding a violation of this section, the commission may
279 order the following relief:

280 1. Rescind the disciplinary action, expunge related
281 records from the personnel file of the employee or job applicant
282 and reinstate the employee.
283 2. Order compliance with paragraph (10)(f)~~(g)~~.
284 3. Award back pay and benefits.
285 4. Award the prevailing employee or job applicant the
286 necessary costs of the appeal, reasonable attorney's fees, and
287 expert witness fees.
288 Section 2. Paragraph (n) of subsection (1) of section
289 154.11, Florida Statutes, is amended to read:
290 154.11 Powers of board of trustees.—
291 (1) The board of trustees of each public health trust
292 shall be deemed to exercise a public and essential governmental
293 function of both the state and the county and in furtherance
294 thereof it shall, subject to limitation by the governing body of
295 the county in which such board is located, have all of the
296 powers necessary or convenient to carry out the operation and
297 governance of designated health care facilities, including, but
298 without limiting the generality of, the foregoing:
299 (n) To appoint originally the staff of physicians to
300 practice in any designated facility owned or operated by the
301 board and to approve the bylaws and rules to be adopted by the
302 medical staff of any designated facility owned and operated by
303 the board, such governing regulations to be in accordance with
304 the standards of the Joint Commission ~~on the Accreditation of~~
305 ~~Hospitals~~ which provide, among other things, for the method of
306 appointing additional staff members and for the removal of staff
307 members.



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

308 Section 3. Subsection (15) of section 318.21, Florida
309 Statutes, is amended to read:
310 318.21 Disposition of civil penalties by county courts.—
311 All civil penalties received by a county court pursuant to the
312 provisions of this chapter shall be distributed and paid monthly
313 as follows:
314 (15) Of the additional fine assessed under s. 318.18(3)(e)
315 for a violation of s. 316.1893, 50 percent of the moneys
316 received from the fines shall be remitted to the Department of
317 Revenue and deposited into the Brain and Spinal Cord Injury
318 Trust Fund of Department of Health and shall be appropriated to
319 the Department of Health ~~Agency for Health Care Administration~~
320 as general revenue to ~~provide an enhanced Medicaid payment to~~
321 ~~nursing homes that~~ serve Medicaid recipients with ~~brain and~~
322 spinal cord injuries that are medically complex and who are
323 technologically and respiratory dependent. The remaining 50
324 percent of the moneys received from the enhanced fine imposed
325 under s. 318.18(3)(e) shall be remitted to the Department of
326 Revenue and deposited into the Department of Health Emergency
327 Medical Services Trust Fund to provide financial support to
328 certified trauma centers in the counties where enhanced penalty
329 zones are established to ensure the availability and
330 accessibility of trauma services. Funds deposited into the
331 Emergency Medical Services Trust Fund under this subsection
332 shall be allocated as follows:
333 (a) Fifty percent shall be allocated equally among all
334 Level I, Level II, and pediatric trauma centers in recognition
335 of readiness costs for maintaining trauma services.

336 (b) Fifty percent shall be allocated among Level I, Level
337 II, and pediatric trauma centers based on each center's relative
338 volume of trauma cases as reported in the Department of Health
339 Trauma Registry.
340 Section 4. Paragraph (f) is added to subsection (2) of
341 section 381.0072, Florida Statutes, to read:
342 381.0072 Food service protection.—It shall be the duty of
343 the Department of Health to adopt and enforce sanitation rules
344 consistent with law to ensure the protection of the public from
345 food-borne illness. These rules shall provide the standards and
346 requirements for the storage, preparation, serving, or display
347 of food in food service establishments as defined in this
348 section and which are not permitted or licensed under chapter
349 500 or chapter 509.
350 (2) DUTIES.—
351 (f) The department shall inspect food service
352 establishments in nursing homes licensed under part II of
353 chapter 400 twice each year. The department may make additional
354 inspections only in response to complaints. The department shall
355 coordinate inspections with the Agency for Health Care
356 Administration, such that the department's inspection is at
357 least 60 days after a recertification visit by the Agency for
358 Health Care Administration.
359 Section 5. Section 383.325, Florida Statutes, is repealed.
360 Section 6. Subsection (7) of section 394.4787, Florida
361 Statutes, is amended to read:

362 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788,
363 and 394.4789.—As used in this section and ss. 394.4786,
364 394.4788, and 394.4789:
365 (7) "Specialty psychiatric hospital" means a hospital
366 licensed by the agency pursuant to s. 395.002(26) ~~(28)~~ and part
367 II of chapter 408 as a specialty psychiatric hospital.
368 Section 7. Subsection (2) of section 394.741, Florida
369 Statutes, is amended to read:
370 394.741 Accreditation requirements for providers of
371 behavioral health care services.—
372 (2) Notwithstanding any provision of law to the contrary,
373 accreditation shall be accepted by the agency and department in
374 lieu of the agency's and department's facility licensure onsite
375 review requirements and shall be accepted as a substitute for
376 the department's administrative and program monitoring
377 requirements, except as required by subsections (3) and (4),
378 for:
379 (a) Any organization from which the department purchases
380 behavioral health care services that is accredited by the Joint
381 Commission ~~on Accreditation of Healthcare Organizations~~ or the
382 Council on Accreditation ~~for Children and Family Services~~, or
383 has those services that are being purchased by the department
384 accredited by the Commission on Accreditation of Rehabilitation
385 Facilities ~~CARF—the Rehabilitation Accreditation Commission~~.
386 (b) Any mental health facility licensed by the agency or
387 any substance abuse component licensed by the department that is
388 accredited by the Joint Commission ~~on Accreditation of~~
389 ~~Healthcare Organizations~~, the Commission on Accreditation of

390 Rehabilitation Facilities ~~CARF-the Rehabilitation Accreditation~~
391 ~~Commission~~, or the Council on Accreditation ~~of Children and~~
392 ~~Family Services~~.
393 (c) Any network of providers from which the department or
394 the agency purchases behavioral health care services accredited
395 by the Joint Commission ~~on Accreditation of Healthcare~~
396 ~~Organizations~~, <u>the Commission on Accreditation of Rehabilitation</u>
397 <u>Facilities</u> ~~CARF-the Rehabilitation Accreditation Commission~~, the
398 Council on Accreditation ~~of Children and Family Services~~, or the
399 National Committee for Quality Assurance. A provider
400 organization, which is part of an accredited network, is
401 afforded the same rights under this part.
402 Section 8. Present subsections (15) through (32) of
403 section 395.002, Florida Statutes, are renumbered as subsections
404 (14) through (28), respectively, and present subsections (1),
405 (14), (24), (30), and (31) and paragraph (c) of present
406 subsection (28) of that section are amended to read:
407 395.002 Definitions.—As used in this chapter:
408 (1) "Accrediting organizations" means <u>nationally</u>
409 <u>recognized or approved accrediting organizations whose standards</u>
410 <u>incorporate comparable licensure requirements as determined by</u>
411 <u>the agency</u> ~~the Joint Commission on Accreditation of Healthcare~~
412 ~~Organizations, the American Osteopathic Association, the~~
413 ~~Commission on Accreditation of Rehabilitation Facilities, and~~
414 ~~the Accreditation Association for Ambulatory Health Care, Inc~~.
415 ~~(14) "Initial denial determination" means a determination~~
416 ~~by a private review agent that the health care services~~



CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

hb0119-00

417 ~~furnished or proposed to be furnished to a patient are~~
418 ~~inappropriate, not medically necessary, or not reasonable.~~
419 ~~(24) "Private review agent" means any person or entity~~
420 ~~which performs utilization review services for third-party~~
421 ~~payors on a contractual basis for outpatient or inpatient~~
422 ~~services. However, the term shall not include full-time~~
423 ~~employees, personnel, or staff of health insurers, health~~
424 ~~maintenance organizations, or hospitals, or wholly owned~~
425 ~~subsidiaries thereof or affiliates under common ownership, when~~
426 ~~performing utilization review for their respective hospitals,~~
427 ~~health maintenance organizations, or insureds of the same~~
428 ~~insurance group. For this purpose, health insurers, health~~
429 ~~maintenance organizations, and hospitals, or wholly owned~~
430 ~~subsidiaries thereof or affiliates under common ownership,~~
431 ~~include such entities engaged as administrators of self-~~
432 ~~insurance as defined in s. 624.031.~~
433 (26)~~(28)~~ "Specialty hospital" means any facility which
434 meets the provisions of subsection (12), and which regularly
435 makes available either:
436 (c) Intensive residential treatment programs for children
437 and adolescents as defined in subsection (14) ~~(15)~~.
438 ~~(30) "Utilization review" means a system for reviewing the~~
439 ~~medical necessity or appropriateness in the allocation of health~~
440 ~~care resources of hospital services given or proposed to be~~
441 ~~given to a patient or group of patients.~~
442 ~~(31) "Utilization review plan" means a description of the~~
443 ~~policies and procedures governing utilization review activities~~
444 ~~performed by a private review agent.~~

445 Section 9. Paragraph (c) of subsection (1) and paragraph
446 (b) of subsection (2) of section 395.003, Florida Statutes, are
447 amended to read:
448 395.003 Licensure; denial, suspension, and revocation.—
449 (1)
450 ~~(c) Until July 1, 2006, additional emergency departments~~
451 ~~located off the premises of licensed hospitals may not be~~
452 ~~authorized by the agency.~~
453 (2)
454 (b) The agency shall, at the request of a licensee that is
455 a teaching hospital as defined in s. 408.07(45), issue a single
456 license to a licensee for facilities that have been previously
457 licensed as separate premises, provided such separately licensed
458 facilities, taken together, constitute the same premises as
459 defined in s. 395.002(22)~~(23)~~. Such license for the single
460 premises shall include all of the beds, services, and programs
461 that were previously included on the licenses for the separate
462 premises. The granting of a single license under this paragraph
463 shall not in any manner reduce the number of beds, services, or
464 programs operated by the licensee.
465 Section 10. Paragraph (e) of subsection (2) and subsection
466 (4) of section 395.0193, Florida Statutes, are amended to read:
467 395.0193 Licensed facilities; peer review; disciplinary
468 powers; agency or partnership with physicians.—
469 (2) Each licensed facility, as a condition of licensure,
470 shall provide for peer review of physicians who deliver health
471 care services at the facility. Each licensed facility shall

472 develop written, binding procedures by which such peer review
473 shall be conducted. Such procedures shall include:
474 (e) Recording of agendas and minutes which do not contain
475 confidential material, for review by the Division of <u>Medical</u>
476 <u>Quality Assurance of the department</u> ~~Health Quality Assurance of~~
477 ~~the agency~~.
478 (4) Pursuant to ss. 458.337 and 459.016, any disciplinary
479 actions taken under subsection (3) shall be reported in writing
480 to the Division of <u>Medical Quality Assurance of the department</u>
481 ~~Health Quality Assurance of the agency~~ within 30 working days
482 after its initial occurrence, regardless of the pendency of
483 appeals to the governing board of the hospital. The notification
484 shall identify the disciplined practitioner, the action taken,
485 and the reason for such action. All final disciplinary actions
486 taken under subsection (3), if different from those which were
487 reported to the <u>department</u> ~~agency~~ within 30 days after the
488 initial occurrence, shall be reported within 10 working days to
489 the Division of <u>Medical Quality Assurance of the department</u>
490 ~~Health Quality Assurance of the agency~~ in writing and shall
491 specify the disciplinary action taken and the specific grounds
492 therefor. The division shall review each report and determine
493 whether it potentially involved conduct by the licensee that is
494 subject to disciplinary action, in which case s. 456.073 shall
495 apply. The reports are not subject to inspection under s.
496 119.07(1) even if the division's investigation results in a
497 finding of probable cause.
498 Section 11. Section 395.1023, Florida Statutes, is amended
499 to read:

500 395.1023 Child abuse and neglect cases; duties.—Each
501 licensed facility shall adopt a protocol that, at a minimum,
502 requires the facility to:
503 (1) Incorporate a facility policy that every staff member
504 has an affirmative duty to report, pursuant to chapter 39, any
505 actual or suspected case of child abuse, abandonment, or
506 neglect; and
507 (2) In any case involving suspected child abuse,
508 abandonment, or neglect, designate, at the request of the
509 Department <u>of Children and Family Services</u>, a staff physician to
510 act as a liaison between the hospital and the Department of
511 Children and Family Services office which is investigating the
512 suspected abuse, abandonment, or neglect, and the child
513 protection team, as defined in s. 39.01, when the case is
514 referred to such a team.
515
516 Each general hospital and appropriate specialty hospital shall
517 comply with the provisions of this section and shall notify the
518 agency and the Department <u>of Children and Family Services</u> of its
519 compliance by sending a copy of its policy to the agency and the
520 Department <u>of Children and Family Services</u> as required by rule.
521 The failure by a general hospital or appropriate specialty
522 hospital to comply shall be punished by a fine not exceeding
523 $1,000, to be fixed, imposed, and collected by the agency. Each
524 day in violation is considered a separate offense.
525 Section 12. Subsection (2) and paragraph (d) of subsection
526 (3) of section 395.1041, Florida Statutes, are amended to read:
527 395.1041 Access to emergency services and care.—



CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

528 (2) INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The agency
529 shall establish and maintain an inventory of hospitals with
530 emergency services. The inventory shall list all services within
531 the service capability of the hospital, and such services shall
532 appear on the face of the hospital license. Each hospital having
533 emergency services shall notify the agency of its service
534 capability in the manner and form prescribed by the agency. The
535 agency shall use the inventory to assist emergency medical
536 services providers and others in locating appropriate emergency
537 medical care. The inventory shall also be made available to the
538 general public. ~~On or before August 1, 1992, the agency shall~~
539 ~~request that each hospital identify the services which are~~
540 ~~within its service capability. On or before November 1, 1992,~~
541 ~~the agency shall notify each hospital of the service capability~~
542 ~~to be included in the inventory. The hospital has 15 days from~~
543 ~~the date of receipt to respond to the notice. By December 1,~~
544 ~~1992, the agency shall publish a final inventory.~~ Each hospital
545 shall reaffirm its service capability when its license is
546 renewed and shall notify the agency of the addition of a new
547 service or the termination of a service prior to a change in its
548 service capability.
549 (3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF
550 FACILITY OR HEALTH CARE PERSONNEL.—
551 (d)1. Every hospital shall ensure the provision of
552 services within the service capability of the hospital, at all
553 times, either directly or indirectly through an arrangement with
554 another hospital, through an arrangement with one or more
555 physicians, or as otherwise made through prior arrangements. A

556 hospital may enter into an agreement with another hospital for
557 purposes of meeting its service capability requirement, and
558 appropriate compensation or other reasonable conditions may be
559 negotiated for these backup services.
560 2. If any arrangement requires the provision of emergency
561 medical transportation, such arrangement must be made in
562 consultation with the applicable provider and may not require
563 the emergency medical service provider to provide transportation
564 that is outside the routine service area of that provider or in
565 a manner that impairs the ability of the emergency medical
566 service provider to timely respond to prehospital emergency
567 calls.
568 3. A hospital shall not be required to ensure service
569 capability at all times as required in subparagraph 1. if, prior
570 to the receiving of any patient needing such service capability,
571 such hospital has demonstrated to the agency that it lacks the
572 ability to ensure such capability and it has exhausted all
573 reasonable efforts to ensure such capability through backup
574 arrangements. In reviewing a hospital's demonstration of lack of
575 ability to ensure service capability, the agency shall consider
576 factors relevant to the particular case, including the
577 following:
578 a. Number and proximity of hospitals with the same service
579 capability.
580 b. Number, type, credentials, and privileges of
581 specialists.
582 c. Frequency of procedures.
583 d. Size of hospital.

584 4. The agency shall publish ~~proposed~~ rules implementing a
585 reasonable exemption procedure ~~by November 1, 1992~~. ~~Subparagraph~~
586 ~~1. shall become effective upon the effective date of said rules~~
587 ~~or January 31, 1993, whichever is earlier. For a period not to~~
588 ~~exceed 1 year from the effective date of subparagraph 1., a~~
589 ~~hospital requesting an exemption shall be deemed to be exempt~~
590 ~~from offering the service until the agency initially acts to~~
591 ~~deny or grant the original request.~~ The agency has 45 days <u>after</u>
592 ~~from~~ the date of receipt of the request to approve or deny the
593 request. ~~After the first year from the effective date of~~
594 ~~subparagraph 1.,~~ If the agency fails to initially act within
595 <u>that</u> ~~the~~ time period, the hospital is deemed to be exempt from
596 offering the service until the agency initially acts to deny the
597 request.
598 Section 13. <u>Section 395.1046, Florida Statutes, is</u>
599 <u>repealed.</u>
600 Section 14. Paragraph (e) of subsection (1) of section
601 395.1055, Florida Statutes, is amended to read:
602 395.1055 Rules and enforcement.—
603 (1) The agency shall adopt rules pursuant to ss.
604 120.536(1) and 120.54 to implement the provisions of this part,
605 which shall include reasonable and fair minimum standards for
606 ensuring that:
607 (e) Licensed facility beds conform to minimum space,
608 equipment, and furnishings standards as specified by the <u>agency,</u>
609 <u>the Florida Building Code, and the Florida Fire Prevention Code</u>
610 ~~department~~.



CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

611 Section 15. Subsection (1) of section 395.10972, Florida
612 Statutes, is amended to read:
613 395.10972 Health Care Risk Manager Advisory Council.—The
614 Secretary of Health Care Administration may appoint a seven-
615 member advisory council to advise the agency on matters
616 pertaining to health care risk managers. The members of the
617 council shall serve at the pleasure of the secretary. The
618 council shall designate a chair. The council shall meet at the
619 call of the secretary or at those times as may be required by
620 rule of the agency. The members of the advisory council shall
621 receive no compensation for their services, but shall be
622 reimbursed for travel expenses as provided in s. 112.061. The
623 council shall consist of individuals representing the following
624 areas:
625 (1) Two shall be active health care risk managers,
626 including one risk manager who is recommended by and a member of
627 the Florida Society for ~~of~~ Healthcare Risk Management and
628 Patient Safety.
629 Section 16. Subsection (3) of section 395.2050, Florida
630 Statutes, is amended to read:
631 395.2050 Routine inquiry for organ and tissue donation;
632 certification for procurement activities; death records review.—
633 (3) Each organ procurement organization designated by the
634 federal Centers for Medicare and Medicaid Services ~~Health Care~~
635 ~~Financing Administration~~ and licensed by the state shall conduct
636 an annual death records review in the organ procurement
637 organization's affiliated donor hospitals. The organ procurement
638 organization shall enlist the services of every Florida licensed

639 tissue bank and eye bank affiliated with or providing service to
640 the donor hospital and operating in the same service area to
641 participate in the death records review.
642 Section 17. Subsection (2) of section 395.3036, Florida
643 Statutes, is amended to read:
644 395.3036 Confidentiality of records and meetings of
645 corporations that lease public hospitals or other public health
646 care facilities.—The records of a private corporation that
647 leases a public hospital or other public health care facility
648 are confidential and exempt from the provisions of s. 119.07(1)
649 and s. 24(a), Art. I of the State Constitution, and the meetings
650 of the governing board of a private corporation are exempt from
651 s. 286.011 and s. 24(b), Art. I of the State Constitution when
652 the public lessor complies with the public finance
653 accountability provisions of s. 155.40(5) with respect to the
654 transfer of any public funds to the private lessee and when the
655 private lessee meets at least three of the five following
656 criteria:
657 (2) The public lessor and the private lessee do not
658 commingle any of their funds in any account maintained by either
659 of them, other than the payment of the rent and administrative
660 fees or the transfer of funds pursuant to s. 155.40 ~~subsection~~
661 ~~(2)~~.
662 Section 18. Section 395.3037, Florida Statutes, is
663 repealed.
664 Section 19. Subsections (1), (4), and (5) of section
665 395.3038, Florida Statutes, are amended to read:



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

666 395.3038 State-listed primary stroke centers and
667 comprehensive stroke centers; notification of hospitals.—
668 (1) The agency shall make available on its website and to
669 the department a list of the name and address of each hospital
670 that meets the criteria for a primary stroke center and the name
671 and address of each hospital that meets the criteria for a
672 comprehensive stroke center. The list of primary and
673 comprehensive stroke centers shall include only those hospitals
674 that attest in an affidavit submitted to the agency that the
675 hospital meets the named criteria, or those hospitals that
676 attest in an affidavit submitted to the agency that the hospital
677 is certified as a primary or a comprehensive stroke center by
678 the Joint Commission ~~on Accreditation of Healthcare~~
679 ~~Organizations~~.
680 (4) The agency shall adopt by rule criteria for a primary
681 stroke center which are substantially similar to the
682 certification standards for primary stroke centers of the Joint
683 Commission ~~on Accreditation of Healthcare Organizations~~.
684 (5) The agency shall adopt by rule criteria for a
685 comprehensive stroke center. However, if the Joint Commission ~~on~~
686 ~~Accreditation of Healthcare Organizations~~ establishes criteria
687 for a comprehensive stroke center, the agency shall establish
688 criteria for a comprehensive stroke center which are
689 substantially similar to those criteria established by the Joint
690 Commission ~~on Accreditation of Healthcare Organizations~~.
691 Section 20. Paragraph (e) of subsection (2) of section
692 395.602, Florida Statutes, is amended to read:
693 395.602 Rural hospitals.—

694 (2) DEFINITIONS.—As used in this part:
695 (e) "Rural hospital" means an acute care hospital licensed
696 under this chapter, having 100 or fewer licensed beds and an
697 emergency room, which is:
698 1. The sole provider within a county with a population
699 density of no greater than 100 persons per square mile;
700 2. An acute care hospital, in a county with a population
701 density of no greater than 100 persons per square mile, which is
702 at least 30 minutes of travel time, on normally traveled roads
703 under normal traffic conditions, from any other acute care
704 hospital within the same county;
705 3. A hospital supported by a tax district or subdistrict
706 whose boundaries encompass a population of 100 persons or fewer
707 per square mile;
708 ~~4. A hospital in a constitutional charter county with a~~
709 ~~population of over 1 million persons that has imposed a local~~
710 ~~option health service tax pursuant to law and in an area that~~
711 ~~was directly impacted by a catastrophic event on August 24,~~
712 ~~1992, for which the Governor of Florida declared a state of~~
713 ~~emergency pursuant to chapter 125, and has 120 beds or less that~~
714 ~~serves an agricultural community with an emergency room~~
715 ~~utilization of no less than 20,000 visits and a Medicaid~~
716 ~~inpatient utilization rate greater than 15 percent;~~
717 4.~~5.~~ A hospital with a service area that has a population
718 of 100 persons or fewer per square mile. As used in this
719 subparagraph, the term "service area" means the fewest number of
720 zip codes that account for 75 percent of the hospital's
721 discharges for the most recent 5-year period, based on

722 information available from the hospital inpatient discharge
723 database in the Florida Center for Health Information and Policy
724 Analysis at the Agency for Health Care Administration; or
725 5.~~6.~~ A hospital designated as a critical access hospital,
726 as defined in s. 408.07(15).
727
728 Population densities used in this paragraph must be based upon
729 the most recently completed United States census. A hospital
730 that received funds under s. 409.9116 for a quarter beginning no
731 later than July 1, 2002, is deemed to have been and shall
732 continue to be a rural hospital from that date through June 30,
733 2015, if the hospital continues to have 100 or fewer licensed
734 beds and an emergency room~~, or meets the criteria of~~
735 ~~subparagraph 4~~. An acute care hospital that has not previously
736 been designated as a rural hospital and that meets the criteria
737 of this paragraph shall be granted such designation upon
738 application, including supporting documentation to the Agency
739 for Health Care Administration.
740 Section 21. Subsection (8) of section 400.021, Florida
741 Statutes, is amended to read:
742 400.021 Definitions.—When used in this part, unless the
743 context otherwise requires, the term:
744 (8) "Geriatric outpatient clinic" means a site for
745 providing outpatient health care to persons 60 years of age or
746 older, which is staffed by a registered nurse or a physician
747 assistant, or a licensed practical nurse under the direct
748 supervision of a registered nurse, advanced registered nurse
749 practitioner, or physician.

750 Section 22. Paragraph (g) of subsection (2) of section
751 400.0239, Florida Statutes, is amended to read:
752 400.0239 Quality of Long-Term Care Facility Improvement
753 Trust Fund.—
754 (2) Expenditures from the trust fund shall be allowable
755 for direct support of the following:
756 (g) Other initiatives authorized by the Centers for
757 Medicare and Medicaid Services for the use of federal civil
758 monetary penalties~~, including projects recommended through the~~
759 ~~Medicaid "Up-or-Out" Quality of Care Contract Management Program~~
760 ~~pursuant to s. 400.148~~.
761 Section 23. Subsection (15) of section 400.0255, Florida
762 Statutes, is amended to read
763 400.0255 Resident transfer or discharge; requirements and
764 procedures; hearings.—
765 (15)(a) The department's Office of Appeals Hearings shall
766 conduct hearings under this section. The office shall notify the
767 facility of a resident's request for a hearing.
768 (b) The department shall, by rule, establish procedures to
769 be used for fair hearings requested by residents. These
770 procedures shall be equivalent to the procedures used for fair
771 hearings for other Medicaid cases appearing in s. 409.285 and
772 applicable rules~~, chapter 10-2, part VI, Florida Administrative~~
773 ~~Code~~. The burden of proof must be clear and convincing evidence.
774 A hearing decision must be rendered within 90 days after receipt
775 of the request for hearing.

776 (c) If the hearing decision is favorable to the resident
777 who has been transferred or discharged, the resident must be
778 readmitted to the facility's first available bed.
779 (d) The decision of the hearing officer shall be final.
780 Any aggrieved party may appeal the decision to the district
781 court of appeal in the appellate district where the facility is
782 located. Review procedures shall be conducted in accordance with
783 the Florida Rules of Appellate Procedure.
784 Section 24. Subsection (2) of section 400.063, Florida
785 Statutes, is amended to read:
786 400.063 Resident protection.—
787 (2) The agency is authorized to establish for each
788 facility, subject to intervention by the agency, a separate bank
789 account for the deposit to the credit of the agency of any
790 moneys received from the Health Care Trust Fund or any other
791 moneys received for the maintenance and care of residents in the
792 facility, and the agency is authorized to disburse moneys from
793 such account to pay obligations incurred for the purposes of
794 this section. The agency is authorized to requisition moneys
795 from the Health Care Trust Fund in advance of an actual need for
796 cash on the basis of an estimate by the agency of moneys to be
797 spent under the authority of this section. Any bank account
798 established under this section need not be approved in advance
799 of its creation as required by s. 17.58, but shall be secured by
800 depository insurance equal to or greater than the balance of
801 such account or by the pledge of collateral security ~~in~~
802 ~~conformance with criteria established in s. 18.11~~. The agency
803 shall notify the Chief Financial Officer of any such account so

804 established and shall make a quarterly accounting to the Chief
805 Financial Officer for all moneys deposited in such account.
806 Section 25. Subsections (1) and (5) of section 400.071,
807 Florida Statutes, are amended to read:
808 400.071 Application for license.—
809 (1) In addition to the requirements of part II of chapter
810 408, the application for a license shall be under oath and must
811 contain the following:
812 (a) The location of the facility for which a license is
813 sought and an indication, as in the original application, that
814 such location conforms to the local zoning ordinances.
815 ~~(b) A signed affidavit disclosing any financial or~~
816 ~~ownership interest that a controlling interest as defined in~~
817 ~~part II of chapter 408 has held in the last 5 years in any~~
818 ~~entity licensed by this state or any other state to provide~~
819 ~~health or residential care which has closed voluntarily or~~
820 ~~involuntarily; has filed for bankruptcy; has had a receiver~~
821 ~~appointed; has had a license denied, suspended, or revoked; or~~
822 ~~has had an injunction issued against it which was initiated by a~~
823 ~~regulatory agency. The affidavit must disclose the reason any~~
824 ~~such entity was closed, whether voluntarily or involuntarily.~~
825 ~~(c) The total number of beds and the total number of~~
826 ~~Medicare and Medicaid certified beds.~~
827 (b) ~~(d)~~ Information relating to the applicant and employees
828 which the agency requires by rule. The applicant must
829 demonstrate that sufficient numbers of qualified staff, by
830 training or experience, will be employed to properly care for

831 the type and number of residents who will reside in the
832 facility.
833 (c) ~~(e)~~ Copies of any civil verdict or judgment involving
834 the applicant rendered within the 10 years preceding the
835 application, relating to medical negligence, violation of
836 residents' rights, or wrongful death. As a condition of
837 licensure, the licensee agrees to provide to the agency copies
838 of any new verdict or judgment involving the applicant, relating
839 to such matters, within 30 days after filing with the clerk of
840 the court. The information required in this paragraph shall be
841 maintained in the facility's licensure file and in an agency
842 database which is available as a public record.
843 (5) As a condition of licensure, each facility must
844 establish ~~and submit with its application~~ a plan for quality
845 assurance and for conducting risk management.
846 Section 26. Section 400.0712, Florida Statutes, is amended
847 to read:
848 400.0712 Application for inactive license.—
849 ~~(1) As specified in this section, the agency may issue an~~
850 ~~inactive license to a nursing home facility for all or a portion~~
851 ~~of its beds. Any request by a licensee that a nursing home or~~
852 ~~portion of a nursing home become inactive must be submitted to~~
853 ~~the agency in the approved format. The facility may not initiate~~
854 ~~any suspension of services, notify residents, or initiate~~
855 ~~inactivity before receiving approval from the agency; and a~~
856 ~~licensee that violates this provision may not be issued an~~
857 ~~inactive license.~~

858 (1) ~~(2)~~ In addition to the powers granted under part II of
859 chapter 408, the agency may issue an inactive license for a
860 portion of the total beds to a nursing home that chooses to use
861 an unoccupied contiguous portion of the facility for an
862 alternative use to meet the needs of elderly persons through the
863 use of less restrictive, less institutional services.
864 (a) An inactive license issued under this subsection may
865 be granted for a period not to exceed the current licensure
866 expiration date but may be renewed by the agency at the time of
867 licensure renewal.
868 (b) A request to extend the inactive license must be
869 submitted to the agency in the approved format and approved by
870 the agency in writing.
871 (c) Nursing homes that receive an inactive license to
872 provide alternative services shall not receive preference for
873 participation in the Assisted Living for the Elderly Medicaid
874 waiver.
875 (2) ~~(3)~~ The agency shall adopt rules pursuant to ss.
876 120.536(1) and 120.54 necessary to implement this section.
877 Section 27. Section 400.111, Florida Statutes, is amended
878 to read:
879 400.111 Disclosure of controlling interest.—In addition to
880 the requirements of part II of chapter 408, when requested by
881 the agency, the licensee shall submit a signed affidavit
882 disclosing any financial or ownership interest that a
883 controlling interest has held within the last 5 years in any
884 entity licensed by the state or any other state to provide
885 health or residential care which entity has closed voluntarily

886 or involuntarily; has filed for bankruptcy; has had a receiver
887 appointed; has had a license denied, suspended, or revoked; or
888 has had an injunction issued against it which was initiated by a
889 regulatory agency. The affidavit must disclose the reason such
890 entity was closed, whether voluntarily or involuntarily.

891 Section 28. Subsection (2) of section 400.1183, Florida
892 Statutes, is amended to read:

893 400.1183 Resident grievance procedures.—

894 (2) Each facility shall maintain records of all grievances
895 and shall retain a log for agency inspection of ~~report to the~~
896 ~~agency at the time of relicensure~~ the total number of grievances
897 handled ~~during the prior licensure period~~, a categorization of
898 the cases underlying the grievances, and the final disposition
899 of the grievances.

900 Section 29. Paragraphs (o) through (w) of subsection (1)
901 of section 400.141, Florida Statutes, are redesignated as
902 paragraphs (n) through (u), respectively, and present paragraphs
903 (f), (g), (j), (n), (o), and (r) of that subsection are amended,
904 to read:

905 400.141 Administration and management of nursing home
906 facilities.—

907 (1) Every licensed facility shall comply with all
908 applicable standards and rules of the agency and shall:

909 (f) Be allowed and encouraged by the agency to provide
910 other needed services under certain conditions. If the facility
911 has a standard licensure status~~, and has had no class I or class~~
912 ~~II deficiencies during the past 2 years~~ or has been awarded a
913 Gold Seal under the program established in s. 400.235, it may ~~be~~

914 ~~encouraged by the agency to~~ provide services, including, but not
915 limited to, respite and adult day services, which enable
916 individuals to move in and out of the facility. A facility is
917 not subject to any additional licensure requirements for
918 providing these services, under the following conditions:~~.~~
919 1. Respite care may be offered to persons in need of
920 short-term or temporary nursing home services. For each person
921 admitted under the respite care program, the facility licensee
922 must:
923 a. Have a written abbreviated plan of care that, at a
924 minimum, includes nutritional requirements, medication orders,
925 physician orders, nursing assessments, and dietary preferences.
926 The nursing or physician assessments may take the place of all
927 other assessments required for full-time residents.
928 b. Have a contract that, at a minimum, specifies the
929 services to be provided to the respite resident, including
930 charges for services, activities, equipment, emergency medical
931 services, and the administration of medications. If multiple
932 respite admissions for a single person are anticipated, the
933 original contract is valid for 1 year after the date of
934 execution.
935 c. Ensure that each resident is released to his or her
936 caregiver or an individual designated in writing by the
937 caregiver.
938 2. A person admitted under the respite care program is:
939 a. Exempt from requirements in rule related to discharge
940 planning.

941 b. Covered by the residents' rights set forth in s.
942 400.022(1)(a)-(o) and (r)-(t). Funds or property of the resident
943 shall not be considered trust funds subject to the requirements
944 of s. 400.022(1)(h) until the resident has been in the facility
945 for more than 14 consecutive days.
946 c. Allowed to use his or her personal medications for the
947 respite stay if permitted by facility policy. The facility must
948 obtain a physician's order for the medications. The caregiver
949 may provide information regarding the medications as part of the
950 nursing assessment and that information must agree with the
951 physician's order. Medications shall be released with the
952 resident upon discharge in accordance with current physician's
953 orders.
954 3. A person receiving respite care is entitled to reside
955 in the facility for a total of 60 days within a contract year or
956 within a calendar year if the contract is for less than 12
957 months. However, each single stay may not exceed 14 days. If a
958 stay exceeds 14 consecutive days, the facility must comply with
959 all assessment and care planning requirements applicable to
960 nursing home residents.
961 4. A person receiving respite care must reside in a
962 licensed nursing home bed.
963 5. A prospective respite resident must provide medical
964 information from a physician, a physician assistant, or a nurse
965 practitioner and other information from the primary caregiver as
966 may be required by the facility prior to or at the time of
967 admission to receive respite care. The medical information must
968 include a physician's order for respite care and proof of a

969 physical examination by a licensed physician, physician
970 assistant, or nurse practitioner. The physician's order and
971 physical examination may be used to provide intermittent respite
972 care for up to 12 months after the date the order is written.
973 6. The facility must assume the duties of the primary
974 caregiver. To ensure continuity of care and services, the
975 resident is entitled to retain his or her personal physician and
976 must have access to medically necessary services such as
977 physical therapy, occupational therapy, or speech therapy, as
978 needed. The facility must arrange for transportation to these
979 services if necessary. Respite care must be provided in
980 accordance with this part and rules adopted by the agency.
981 However, the agency shall, by rule, adopt modified requirements
982 for resident assessment, resident care plans, resident
983 contracts, physician orders, and other provisions, as
984 appropriate, for short-term or temporary nursing home services.
985 7. The agency shall allow for shared programming and staff
986 in a facility which meets minimum standards and offers services
987 pursuant to this paragraph, but, if the facility is cited for
988 deficiencies in patient care, may require additional staff and
989 programs appropriate to the needs of service recipients. A
990 person who receives respite care may not be counted as a
991 resident of the facility for purposes of the facility's licensed
992 capacity unless that person receives 24-hour respite care. A
993 person receiving either respite care for 24 hours or longer or
994 adult day services must be included when calculating minimum
995 staffing for the facility. Any costs and revenues generated by a
996 nursing home facility from nonresidential programs or services



CODING: Words stricken are deletions; words underlined are additions.

997 shall be excluded from the calculations of Medicaid per diems
998 for nursing home institutional care reimbursement.
999 (g) If the facility has a standard license or is a Gold
1000 Seal facility, exceeds the minimum required hours of licensed
1001 nursing and certified nursing assistant direct care per resident
1002 per day, and is part of a continuing care facility licensed
1003 under chapter 651 or a retirement community that offers other
1004 services pursuant to part III of this chapter or part I or part
1005 III of chapter 429 on a single campus, be allowed to share
1006 programming and staff. At the time of inspection and in the
1007 semiannual report required pursuant to paragraph (n) ~~(o)~~, a
1008 continuing care facility or retirement community that uses this
1009 option must demonstrate through staffing records that minimum
1010 staffing requirements for the facility were met. Licensed nurses
1011 and certified nursing assistants who work in the nursing home
1012 facility may be used to provide services elsewhere on campus if
1013 the facility exceeds the minimum number of direct care hours
1014 required per resident per day and the total number of residents
1015 receiving direct care services from a licensed nurse or a
1016 certified nursing assistant does not cause the facility to
1017 violate the staffing ratios required under s. 400.23(3)(a).
1018 Compliance with the minimum staffing ratios shall be based on
1019 total number of residents receiving direct care services,
1020 regardless of where they reside on campus. If the facility
1021 receives a conditional license, it may not share staff until the
1022 conditional license status ends. This paragraph does not
1023 restrict the agency's authority under federal or state law to
1024 require additional staff if a facility is cited for deficiencies

1025 in care which are caused by an insufficient number of certified
1026 nursing assistants or licensed nurses. The agency may adopt
1027 rules for the documentation necessary to determine compliance
1028 with this provision.
1029 (j) Keep full records of resident admissions and
1030 discharges; medical and general health status, including medical
1031 records, personal and social history, and identity and address
1032 of next of kin or other persons who may have responsibility for
1033 the affairs of the residents; and individual resident care plans
1034 including, but not limited to, prescribed services, service
1035 frequency and duration, and service goals. The records shall be
1036 open to inspection by the agency. The facility must maintain
1037 clinical records on each resident in accordance with accepted
1038 professional standards and practices that are complete,
1039 accurately documented, readily accessible, and systematically
1040 organized.
1041 ~~(n) Submit to the agency the information specified in s.~~
1042 ~~400.071(1)(b) for a management company within 30 days after the~~
1043 ~~effective date of the management agreement.~~
1044 (n)~~(o)~~1. ~~Submit semiannually to the agency, or more~~
1045 ~~frequently if requested by the agency, information regarding~~
1046 ~~facility staff-to-resident ratios, staff turnover, and staff~~
1047 ~~stability, including information regarding certified nursing~~
1048 ~~assistants, licensed nurses, the director of nursing, and the~~
1049 ~~facility administrator. For purposes of this reporting:~~
1050 ~~a. Staff-to-resident ratios must be reported in the~~
1051 ~~categories specified in s. 400.23(3)(a) and applicable rules.~~

1052 ~~The ratio must be reported as an average for the most recent~~
1053 ~~calendar quarter.~~
1054 ~~b. Staff turnover must be reported for the most recent 12-~~
1055 ~~month period ending on the last workday of the most recent~~
1056 ~~calendar quarter prior to the date the information is submitted.~~
1057 ~~The turnover rate must be computed quarterly, with the annual~~
1058 ~~rate being the cumulative sum of the quarterly rates. The~~
1059 ~~turnover rate is the total number of terminations or separations~~
1060 ~~experienced during the quarter, excluding any employee~~
1061 ~~terminated during a probationary period of 3 months or less,~~
1062 ~~divided by the total number of staff employed at the end of the~~
1063 ~~period for which the rate is computed, and expressed as a~~
1064 ~~percentage.~~
1065 ~~c. The formula for determining staff stability is the~~
1066 ~~total number of employees that have been employed for more than~~
1067 ~~12 months, divided by the total number of employees employed at~~
1068 ~~the end of the most recent calendar quarter, and expressed as a~~
1069 ~~percentage.~~
1070 ~~d.~~ A nursing facility that has failed to comply with state
1071 minimum-staffing requirements for 2 consecutive days is
1072 prohibited from accepting new admissions until the facility has
1073 achieved the minimum-staffing requirements for a period of 6
1074 consecutive days. For the purposes of this sub-subparagraph, any
1075 person who was a resident of the facility and was absent from
1076 the facility for the purpose of receiving medical care at a
1077 separate location or was on a leave of absence is not considered
1078 a new admission. Failure to impose such an admissions moratorium
1079 is subject to a $1,000 fine ~~constitutes a class II deficiency~~.



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1080 2.~~e.~~ A nursing facility which does not have a conditional
1081 license may be cited for failure to comply with the standards in
1082 s. 400.23(3)(a)1.b. and c. only if it has failed to meet those
1083 standards on 2 consecutive days or if it has failed to meet at
1084 least 97 percent of those standards on any one day.
1085 3.~~f.~~ A facility which has a conditional license must be in
1086 compliance with the standards in s. 400.23(3)(a) at all times.
1087 (r)~~2.~~ This subsection ~~paragraph~~ does not limit the
1088 agency's ability to impose a deficiency or take other actions if
1089 a facility does not have enough staff to meet the residents'
1090 needs.
1091 ~~(r) Report to the agency any filing for bankruptcy~~
1092 ~~protection by the facility or its parent corporation,~~
1093 ~~divestiture or spin-off of its assets, or corporate~~
1094 ~~reorganization within 30 days after the completion of such~~
1095 ~~activity.~~
1096 Section 30. Subsection (3) of section 400.142, Florida
1097 Statutes, is amended to read:
1098 400.142 Emergency medication kits; orders not to
1099 resuscitate.—
1100 (3) Facility staff may withhold or withdraw
1101 cardiopulmonary resuscitation if presented with an order not to
1102 resuscitate executed pursuant to s. 401.45. ~~The agency shall~~
1103 ~~adopt rules providing for the implementation of such orders.~~
1104 Facility staff and facilities shall not be subject to criminal
1105 prosecution or civil liability, nor be considered to have
1106 engaged in negligent or unprofessional conduct, for withholding
1107 or withdrawing cardiopulmonary resuscitation pursuant to such an

1108 order and rules adopted by the agency. The absence of an order
1109 not to resuscitate executed pursuant to s. 401.45 does not
1110 preclude a physician from withholding or withdrawing
1111 cardiopulmonary resuscitation as otherwise permitted by law.
1112 Section 31. Subsections (11) through (15) of section
1113 400.147, Florida Statutes, are renumbered as subsections (10)
1114 through (14), respectively, and present subsection (10) is
1115 amended to read:
1116 400.147 Internal risk management and quality assurance
1117 program.—
1118 ~~(10) By the 10th of each month, each facility subject to~~
1119 ~~this section shall report any notice received pursuant to s.~~
1120 ~~400.0233(2) and each initial complaint that was filed with the~~
1121 ~~clerk of the court and served on the facility during the~~
1122 ~~previous month by a resident or a resident's family member,~~
1123 ~~guardian, conservator, or personal legal representative. The~~
1124 ~~report must include the name of the resident, the resident's~~
1125 ~~date of birth and social security number, the Medicaid~~
1126 ~~identification number for Medicaid-eligible persons, the date or~~
1127 ~~dates of the incident leading to the claim or dates of~~
1128 ~~residency, if applicable, and the type of injury or violation of~~
1129 ~~rights alleged to have occurred. Each facility shall also submit~~
1130 ~~a copy of the notices received pursuant to s. 400.0233(2) and~~
1131 ~~complaints filed with the clerk of the court. This report is~~
1132 ~~confidential as provided by law and is not discoverable or~~
1133 ~~admissible in any civil or administrative action, except in such~~
1134 ~~actions brought by the agency to enforce the provisions of this~~
1135 ~~part.~~

1136 Section 32. Section 400.148, Florida Statutes, is
1137 repealed.
1138 Section 33. Paragraph (e) of subsection (2) of section
1139 400.179, Florida Statutes, is amended to read:
1140 400.179 Liability for Medicaid underpayments and
1141 overpayments.—
1142 (2) Because any transfer of a nursing facility may expose
1143 the fact that Medicaid may have underpaid or overpaid the
1144 transferor, and because in most instances, any such underpayment
1145 or overpayment can only be determined following a formal field
1146 audit, the liabilities for any such underpayments or
1147 overpayments shall be as follows:
1148 ~~(e) For the 2009-2010 fiscal year only, the provisions of~~
1149 ~~paragraph (d) shall not apply. This paragraph expires July 1,~~
1150 ~~2010.~~
1151 Section 34. Subsection (3) of section 400.19, Florida
1152 Statutes, is amended to read:
1153 400.19 Right of entry and inspection.—
1154 (3) The agency shall every 15 months conduct at least one
1155 unannounced inspection to determine compliance by the licensee
1156 with statutes, and with rules promulgated under the provisions
1157 of those statutes, governing minimum standards of construction,
1158 quality and adequacy of care, and rights of residents. The
1159 survey shall be conducted every 6 months for the next 2-year
1160 period if the facility has been cited for a class I deficiency,
1161 has been cited for two or more class II deficiencies arising
1162 from separate surveys or investigations within a 60-day period,
1163 or has had three or more substantiated complaints within a 6-

1164 month period, each resulting in at least one class I or class II
1165 deficiency. In addition to any other fees or fines in this part,
1166 the agency shall assess a fine for each facility that is subject
1167 to the 6-month survey cycle. The fine for the 2-year period
1168 shall be $6,000, one-half to be paid at the completion of each
1169 survey. The agency may adjust this fine by the change in the
1170 Consumer Price Index, based on the 12 months immediately
1171 preceding the increase, to cover the cost of the additional
1172 surveys. The agency shall verify through subsequent inspection
1173 that any deficiency identified during inspection is corrected.
1174 However, the agency may verify the correction of a class III or
1175 class IV deficiency ~~unrelated to resident rights or resident~~
1176 ~~care~~ without reinspecting the facility if adequate written
1177 documentation has been received from the facility, which
1178 provides assurance that the deficiency has been corrected. The
1179 giving or causing to be given of advance notice of such
1180 unannounced inspections by an employee of the agency to any
1181 unauthorized person shall constitute cause for suspension of not
1182 fewer than 5 working days according to the provisions of chapter
1183 110.
1184 Section 35. Subsection (5) of section 400.23, Florida
1185 Statutes, is amended to read:
1186 400.23 Rules; evaluation and deficiencies; licensure
1187 status.—
1188 (5)(a) The agency, in collaboration with the Division of
1189 Children's Medical Services Network of the Department of Health,
1190 must~~, no later than December 31, 1993,~~ adopt rules for minimum
1191 standards of care for persons under 21 years of age who reside



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1192 in nursing home facilities. The rules must include a methodology
1193 for reviewing a nursing home facility under ss. 408.031-408.045
1194 which serves only persons under 21 years of age. A facility may
1195 be exempt from these standards for specific persons between 18
1196 and 21 years of age, if the person's physician agrees that
1197 minimum standards of care based on age are not necessary.
1198 (b) The agency, in collaboration with the Division of
1199 Children's Medical Services Network, shall adopt rules for
1200 minimum staffing requirements for nursing home facilities that
1201 serve persons under 21 years of age, which shall apply in lieu
1202 of the standards contained in subsection (3).
1203 1. For persons under 21 years of age who require skilled
1204 care, the requirements shall include a minimum combined average
1205 of licensed nurses, respiratory therapists, respiratory care
1206 practitioners, and certified nursing assistants of 3.9 hours of
1207 direct care per resident per day for each nursing home facility.
1208 2. For persons under 21 years of age who are fragile, the
1209 requirements shall include a minimum combined average of
1210 licensed nurses, respiratory therapists, respiratory care
1211 practitioners, and certified nursing assistants of 5 hours of
1212 direct care per resident per day for each nursing home facility.
1213 Section 36. Subsection (1) of section 400.275, Florida
1214 Statutes, is amended to read:
1215 400.275 Agency duties.—
1216 (1) ~~The agency shall ensure that each newly hired nursing~~
1217 ~~home surveyor, as a part of basic training, is assigned full-~~
1218 ~~time to a licensed nursing home for at least 2 days within a 7-~~
1219 ~~day period to observe facility operations outside of the survey~~



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1220 ~~process before the surveyor begins survey responsibilities. Such~~
1221 ~~observations may not be the sole basis of a deficiency citation~~
1222 ~~against the facility.~~ The agency may not assign an individual to
1223 be a member of a survey team for purposes of a survey,
1224 evaluation, or consultation visit at a nursing home facility in
1225 which the surveyor was an employee within the preceding 2 ~~5~~
1226 years.
1227 Section 37. Subsection (2) of section 400.484, Florida
1228 Statutes, is amended to read:
1229 400.484 Right of inspection; violations ~~deficiencies~~;
1230 fines.—
1231 (2) The agency shall impose fines for various classes of
1232 violations ~~deficiencies~~ in accordance with the following
1233 schedule:
1234 (a) Class I violations are defined in s. 408.813. ~~A class~~
1235 ~~I deficiency is any act, omission, or practice that results in a~~
1236 ~~patient's death, disablement, or permanent injury, or places a~~
1237 ~~patient at imminent risk of death, disablement, or permanent~~
1238 ~~injury.~~ Upon finding a class I violation ~~deficiency~~, the agency
1239 shall impose an administrative fine in the amount of $15,000 for
1240 each occurrence and each day that the violation ~~deficiency~~
1241 exists.
1242 (b) Class II violations are defined in s. 408.813. ~~A class~~
1243 ~~II deficiency is any act, omission, or practice that has a~~
1244 ~~direct adverse effect on the health, safety, or security of a~~
1245 ~~patient.~~ Upon finding a class II violation ~~deficiency~~, the
1246 agency shall impose an administrative fine in the amount of

1247 $5,000 for each occurrence and each day that the violation
1248 ~~deficiency~~ exists.
1249 (c) Class III violations are defined in s. 408.813. ~~A~~
1250 ~~class III deficiency is any act, omission, or practice that has~~
1251 ~~an indirect, adverse effect on the health, safety, or security~~
1252 ~~of a patient.~~ Upon finding an uncorrected or repeated class III
1253 violation ~~deficiency~~, the agency shall impose an administrative
1254 fine not to exceed $1,000 for each occurrence and each day that
1255 the uncorrected or repeated violation ~~deficiency~~ exists.
1256 (d) Class IV violations are defined in s. 408.813. ~~A class~~
1257 ~~IV deficiency is any act, omission, or practice related to~~
1258 ~~required reports, forms, or documents which does not have the~~
1259 ~~potential of negatively affecting patients. These violations are~~
1260 ~~of a type that the agency determines do not threaten the health,~~
1261 ~~safety, or security of patients.~~ Upon finding an uncorrected or
1262 repeated class IV violation ~~deficiency~~, the agency shall impose
1263 an administrative fine not to exceed $500 for each occurrence
1264 and each day that the uncorrected or repeated violation
1265 ~~deficiency~~ exists.
1266 Section 38. Paragraph (i) of subsection (1) and subsection
1267 (4) of section 400.606, Florida Statutes, are amended to read:
1268 400.606 License; application; renewal; conditional license
1269 or permit; certificate of need.—
1270 (1) In addition to the requirements of part II of chapter
1271 408, the initial application and change of ownership application
1272 must be accompanied by a plan for the delivery of home,
1273 residential, and homelike inpatient hospice services to

1274 terminally ill persons and their families. Such plan must
1275 contain, but need not be limited to:
1276 ~~(i) The projected annual operating cost of the hospice.~~
1277
1278 If the applicant is an existing licensed health care provider,
1279 the application must be accompanied by a copy of the most recent
1280 profit-loss statement and, if applicable, the most recent
1281 licensure inspection report.
1282 (4) A freestanding hospice facility that is ~~primarily~~
1283 engaged in providing inpatient and related services and that is
1284 not otherwise licensed as a health care facility shall be
1285 required to obtain a certificate of need. However, a
1286 freestanding hospice facility with six or fewer beds shall not
1287 be required to comply with institutional standards such as, but
1288 not limited to, standards requiring sprinkler systems, emergency
1289 electrical systems, or special lavatory devices.
1290 Section 39. Subsection (2) of section 400.607, Florida
1291 Statutes, is amended to read:
1292 400.607 Denial, suspension, revocation of license;
1293 emergency actions; imposition of administrative fine; grounds.—
1294 (2) A violation of this part, part II of chapter 408, or
1295 applicable rules ~~Any of the following actions~~ by a licensed
1296 hospice or any of its employees shall be grounds for
1297 administrative action by the agency against a hospice.~~:~~
1298 ~~(a) A violation of the provisions of this part, part II of~~
1299 ~~chapter 408, or applicable rules.~~
1300 ~~(b) An intentional or negligent act materially affecting~~
1301 ~~the health or safety of a patient.~~

1302 Section 40. Section 400.915, Florida Statutes, is amended
1303 to read:
1304 400.915 Construction and renovation; requirements.—The
1305 requirements for the construction or renovation of a PPEC center
1306 shall comply with:
1307 (1) The provisions of chapter 553, which pertain to
1308 building construction standards, including plumbing, electrical
1309 code, glass, manufactured buildings, accessibility for the
1310 physically disabled;
1311 (2) The provisions of s. 633.022 and applicable rules
1312 pertaining to physical ~~minimum~~ standards for nonresidential
1313 child care ~~physical~~ facilities ~~in rule 10M-12.003, Florida~~
1314 ~~Administrative Code, Child Care Standards~~; and
1315 (3) The standards or rules adopted pursuant to this part
1316 and part II of chapter 408.
1317 Section 41. Subsection (1) of section 400.925, Florida
1318 Statutes, is amended to read:
1319 400.925 Definitions.—As used in this part, the term:
1320 (1) "Accrediting organizations" means the Joint Commission
1321 ~~on Accreditation of Healthcare Organizations~~ or other national
1322 accreditation agencies whose standards for accreditation are
1323 comparable to those required by this part for licensure.
1324 Section 42. Subsections (3) through (6) of section
1325 400.931, Florida Statutes, are renumbered as subsections (2)
1326 through (5), respectively, and present subsection (2) of that
1327 section is amended to read:
1328 400.931 Application for license; fee~~; provisional license;~~
1329 ~~temporary permit~~.—



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1330 ~~(2) As an alternative to submitting proof of financial~~
1331 ~~ability to operate as required in s. 408.810(8), the applicant~~
1332 ~~may submit a $50,000 surety bond to the agency.~~
1333 Section 43. Subsection (2) of section 400.932, Florida
1334 Statutes, is amended to read:
1335 400.932 Administrative penalties.—
1336 (2) A violation of this part, part II of chapter 408, or
1337 applicable rules ~~Any of the following actions~~ by an employee of
1338 a home medical equipment provider shall be ~~are~~ grounds for
1339 administrative action or penalties by the agency.~~:~~
1340 ~~(a) Violation of this part, part II of chapter 408, or~~
1341 ~~applicable rules.~~
1342 ~~(b) An intentional, reckless, or negligent act that~~
1343 ~~materially affects the health or safety of a patient.~~
1344 Section 44. Subsection (3) of section 400.967, Florida
1345 Statutes, is amended to read:
1346 400.967 Rules and classification of violations
1347 ~~deficiencies~~.—
1348 (3) The agency shall adopt rules to provide that, when the
1349 criteria established under this part and part II of chapter 408
1350 are not met, such violations ~~deficiencies~~ shall be classified
1351 according to the nature of the violation ~~deficiency~~. The agency
1352 shall indicate the classification on the face of the notice of
1353 deficiencies as follows:
1354 (a) Class I violations ~~deficiencies~~ are defined in s.
1355 408.813 ~~those which the agency determines present an imminent~~
1356 ~~danger to the residents or guests of the facility or a~~
1357 ~~substantial probability that death or serious physical harm~~



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1358 ~~would result therefrom~~. ~~The condition or practice constituting a~~
1359 ~~class I violation must be abated or eliminated immediately,~~
1360 ~~unless a fixed period of time, as determined by the agency, is~~
1361 ~~required for correction.~~ A class I violation ~~deficiency~~ is
1362 subject to a civil penalty in an amount not less than $5,000 and
1363 not exceeding $10,000 for each violation ~~deficiency~~. A fine may
1364 be levied notwithstanding the correction of the violation
1365 ~~deficiency~~.
1366 (b) Class II violations ~~deficiencies~~ are defined in s.
1367 408.813 ~~those which the agency determines have a direct or~~
1368 ~~immediate relationship to the health, safety, or security of the~~
1369 ~~facility residents, other than class I deficiencies~~. A class II
1370 violation ~~deficiency~~ is subject to a civil penalty in an amount
1371 not less than $1,000 and not exceeding $5,000 for each violation
1372 ~~deficiency~~. A citation for a class II violation ~~deficiency~~ shall
1373 specify the time within which the violation ~~deficiency~~ must be
1374 corrected. If a class II violation ~~deficiency~~ is corrected
1375 within the time specified, no civil penalty shall be imposed,
1376 unless it is a repeated offense.
1377 (c) Class III violations ~~deficiencies~~ are defined in s.
1378 408.813 ~~those which the agency determines to have an indirect or~~
1379 ~~potential relationship to the health, safety, or security of the~~
1380 ~~facility residents, other than class I or class II deficiencies~~.
1381 A class III violation ~~deficiency~~ is subject to a civil penalty
1382 of not less than $500 and not exceeding $1,000 for each
1383 deficiency. A citation for a class III violation ~~deficiency~~
1384 shall specify the time within which the violation ~~deficiency~~
1385 must be corrected. If a class III violation ~~deficiency~~ is

1386 corrected within the time specified, no civil penalty shall be
1387 imposed, unless it is a repeated offense.
1388 (d) Class IV violations are defined in s. 408.813. Upon
1389 finding an uncorrected or repeated class IV violation, the
1390 agency shall impose an administrative fine not to exceed $500
1391 for each occurrence and each day that the uncorrected or
1392 repeated violation exists.
1393 Section 45. Subsections (4) and (7) of section 400.9905,
1394 Florida Statutes, are amended to read:
1395 400.9905 Definitions.—
1396 (4) "Clinic" means an entity at which health care services
1397 are provided to individuals and which tenders charges for
1398 reimbursement for such services, including a mobile clinic and a
1399 portable health service or equipment provider. For purposes of
1400 this part, the term does not include and the licensure
1401 requirements of this part do not apply to:
1402 (a) Entities licensed or registered by the state under
1403 chapter 395; or entities licensed or registered by the state and
1404 providing only health care services within the scope of services
1405 authorized under their respective licenses granted under ss.
1406 383.30-383.335, chapter 390, chapter 394, chapter 397, this
1407 chapter except part X, chapter 429, chapter 463, chapter 465,
1408 chapter 466, chapter 478, part I of chapter 483, chapter 484, or
1409 chapter 651; end-stage renal disease providers authorized under
1410 42 C.F.R. part 405, subpart U; or providers certified under 42
1411 C.F.R. part 485, subpart B or subpart H; or any entity that
1412 provides neonatal or pediatric hospital-based health care

1413 services or other health care services by licensed practitioners
1414 solely within a hospital licensed under chapter 395.
1415 (b) Entities that own, directly or indirectly, entities
1416 licensed or registered by the state pursuant to chapter 395; or
1417 entities that own, directly or indirectly, entities licensed or
1418 registered by the state and providing only health care services
1419 within the scope of services authorized pursuant to their
1420 respective licenses granted under ss. 383.30-383.335, chapter
1421 390, chapter 394, chapter 397, this chapter except part X,
1422 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
1423 part I of chapter 483, chapter 484, chapter 651; end-stage renal
1424 disease providers authorized under 42 C.F.R. part 405, subpart
1425 U; or providers certified under 42 C.F.R. part 485, subpart B or
1426 subpart H; or any entity that provides neonatal or pediatric
1427 hospital-based health care services by licensed practitioners
1428 solely within a hospital licensed under chapter 395.
1429 (c) Entities that are owned, directly or indirectly, by an
1430 entity licensed or registered by the state pursuant to chapter
1431 395; or entities that are owned, directly or indirectly, by an
1432 entity licensed or registered by the state and providing only
1433 health care services within the scope of services authorized
1434 pursuant to their respective licenses granted under ss. 383.30-
1435 383.335, chapter 390, chapter 394, chapter 397, this chapter
1436 except part X, chapter 429, chapter 463, chapter 465, chapter
1437 466, chapter 478, part I of chapter 483, chapter 484, or chapter
1438 651; end-stage renal disease providers authorized under 42
1439 C.F.R. part 405, subpart U; or providers certified under 42
1440 C.F.R. part 485, subpart B or subpart H; or any entity that

1441 provides neonatal or pediatric hospital-based health care
1442 services by licensed practitioners solely within a hospital
1443 under chapter 395.
1444 (d) Entities that are under common ownership, directly or
1445 indirectly, with an entity licensed or registered by the state
1446 pursuant to chapter 395; or entities that are under common
1447 ownership, directly or indirectly, with an entity licensed or
1448 registered by the state and providing only health care services
1449 within the scope of services authorized pursuant to their
1450 respective licenses granted under ss. 383.30-383.335, chapter
1451 390, chapter 394, chapter 397, this chapter except part X,
1452 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
1453 part I of chapter 483, chapter 484, or chapter 651; end-stage
1454 renal disease providers authorized under 42 C.F.R. part 405,
1455 subpart U; or providers certified under 42 C.F.R. part 485,
1456 subpart B or subpart H; or any entity that provides neonatal or
1457 pediatric hospital-based health care services by licensed
1458 practitioners solely within a hospital licensed under chapter
1459 395.
1460 (e) An entity that is exempt from federal taxation under
1461 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
1462 under 26 U.S.C. s. 409 that has a board of trustees not less
1463 than two-thirds of which are Florida-licensed health care
1464 practitioners and provides only physical therapy services under
1465 physician orders, any community college or university clinic,
1466 and any entity owned or operated by the federal or state
1467 government, including agencies, subdivisions, or municipalities
1468 thereof.

1469 (f) A sole proprietorship, group practice, partnership, or
1470 corporation that provides health care services by physicians
1471 covered by s. 627.419, that is directly supervised by one or
1472 more of such physicians, and that is wholly owned by one or more
1473 of those physicians or by a physician and the spouse, parent,
1474 child, or sibling of that physician.
1475 (g) A sole proprietorship, group practice, partnership, or
1476 corporation that provides health care services by licensed
1477 health care practitioners under chapter 457, chapter 458,
1478 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
1479 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
1480 chapter 490, chapter 491, or part I, part III, part X, part
1481 XIII, or part XIV of chapter 468, or s. 464.012, which are
1482 wholly owned by one or more licensed health care practitioners,
1483 or the licensed health care practitioners set forth in this
1484 paragraph and the spouse, parent, child, or sibling of a
1485 licensed health care practitioner, so long as one of the owners
1486 who is a licensed health care practitioner is supervising the
1487 business activities and is legally responsible for the entity's
1488 compliance with all federal and state laws. However, a health
1489 care practitioner may not supervise services beyond the scope of
1490 the practitioner's license, except that, for the purposes of
1491 this part, a clinic owned by a licensee in s. 456.053(3)(b) that
1492 provides only services authorized pursuant to s. 456.053(3)(b)
1493 may be supervised by a licensee specified in s. 456.053(3)(b).
1494 (h) Clinical facilities affiliated with an accredited
1495 medical school at which training is provided for medical
1496 students, residents, or fellows.

1497 (i) Entities that provide only oncology or radiation
1498 therapy services by physicians licensed under chapter 458 or
1499 chapter 459 or entities that provide oncology or radiation
1500 therapy services by physicians licensed under chapter 458 or
1501 chapter 459 which are owned by a corporation whose shares are
1502 publicly traded on a recognized stock exchange.
1503 (j) Clinical facilities affiliated with a college of
1504 chiropractic accredited by the Council on Chiropractic Education
1505 at which training is provided for chiropractic students.
1506 (k) Entities that provide licensed practitioners to staff
1507 emergency departments or to deliver anesthesia services in
1508 facilities licensed under chapter 395 and that derive at least
1509 90 percent of their gross annual revenues from the provision of
1510 such services. Entities claiming an exemption from licensure
1511 under this paragraph must provide documentation demonstrating
1512 compliance.
1513 (l) Orthotic, ~~or~~ prosthetic, pediatric cardiology, or
1514 perinatology clinical facilities that are a publicly traded
1515 corporation or that are wholly owned, directly or indirectly, by
1516 a publicly traded corporation. As used in this paragraph, a
1517 publicly traded corporation is a corporation that issues
1518 securities traded on an exchange registered with the United
1519 States Securities and Exchange Commission as a national
1520 securities exchange.
1521 (m) Entities that are owned by a corporation that has $250
1522 million or more in total annual sales of health care services
1523 provided by licensed health care practitioners if one or more of
1524 the owners of the entity is a health care practitioner who is



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1525 licensed in this state, is responsible for supervising the
1526 business activities of the entity, and is legally responsible
1527 for the entity's compliance with state law for purposes of this
1528 section.
1529 (n) Entities that are owned or controlled, directly or
1530 indirectly, by a publicly traded entity with $100 million or
1531 more, in the aggregate, in total annual revenues derived from
1532 providing health care services by licensed health care
1533 practitioners that are employed or contracted by an entity
1534 described in this paragraph.
1535 (7) "Portable health service or equipment provider" means
1536 an entity that contracts with or employs persons to provide
1537 portable health care services or equipment to multiple locations
1538 ~~performing treatment or diagnostic testing of individuals~~, that
1539 bills third-party payors for those services, and that otherwise
1540 meets the definition of a clinic in subsection (4).
1541 Section 46. Paragraph (b) of subsection (1) and paragraph
1542 (c) of subsection (4) of section 400.991, Florida Statutes, are
1543 amended to read:
1544 400.991 License requirements; background screenings;
1545 prohibitions.—
1546 (1)
1547 (b) Each mobile clinic must obtain a separate health care
1548 clinic license and must provide to the agency, at least
1549 quarterly, its projected street location to enable the agency to
1550 locate and inspect such clinic. A portable health service or
1551 equipment provider must obtain a health care clinic license for

1552 a single administrative office and is not required to submit
1553 quarterly projected street locations.
1554 (4) In addition to the requirements of part II of chapter
1555 408, the applicant must file with the application satisfactory
1556 proof that the clinic is in compliance with this part and
1557 applicable rules, including:
1558 (c) Proof of financial ability to operate as required
1559 under <u>ss.</u> ~~s.~~ 408.810(8) <u>and 408.8065</u>. ~~As an alternative to~~
1560 ~~submitting proof of financial ability to operate as required~~
1561 ~~under s. 408.810(8), the applicant may file a surety bond of at~~
1562 ~~least $500,000 which guarantees that the clinic will act in full~~
1563 ~~conformity with all legal requirements for operating a clinic,~~
1564 ~~payable to the agency. The agency may adopt rules to specify~~
1565 ~~related requirements for such surety bond.~~
1566 Section 47. Paragraph (g) of subsection (1) and paragraph
1567 (a) of subsection (7) of section 400.9935, Florida Statutes, are
1568 amended to read:
1569 400.9935 Clinic responsibilities.—
1570 (1) Each clinic shall appoint a medical director or clinic
1571 director who shall agree in writing to accept legal
1572 responsibility for the following activities on behalf of the
1573 clinic. The medical director or the clinic director shall:
1574 (g) Conduct systematic reviews of clinic billings to
1575 ensure that the billings are not fraudulent or unlawful. Upon
1576 discovery of an unlawful charge, the medical director or clinic
1577 director shall take immediate corrective action. If the clinic
1578 performs only the technical component of magnetic resonance
1579 imaging, static radiographs, computed tomography, or positron

1580 emission tomography, and provides the professional
1581 interpretation of such services, in a fixed facility that is
1582 accredited by the Joint Commission ~~on Accreditation of~~
1583 ~~Healthcare Organizations~~ or the Accreditation Association for
1584 Ambulatory Health Care, and the American College of Radiology;
1585 and if, in the preceding quarter, the percentage of scans
1586 performed by that clinic which was billed to all personal injury
1587 protection insurance carriers was less than 15 percent, the
1588 chief financial officer of the clinic may, in a written
1589 acknowledgment provided to the agency, assume the responsibility
1590 for the conduct of the systematic reviews of clinic billings to
1591 ensure that the billings are not fraudulent or unlawful.
1592 (7)(a) Each clinic engaged in magnetic resonance imaging
1593 services must be accredited by the Joint Commission ~~on~~
1594 ~~Accreditation of Healthcare Organizations~~, the American College
1595 of Radiology, or the Accreditation Association for Ambulatory
1596 Health Care, within 1 year after licensure. A clinic that is
1597 accredited by the American College of Radiology or is within the
1598 original 1-year period after licensure and replaces its core
1599 magnetic resonance imaging equipment shall be given 1 year after
1600 the date on which the equipment is replaced to attain
1601 accreditation. However, a clinic may request a single, 6-month
1602 extension if it provides evidence to the agency establishing
1603 that, for good cause shown, such clinic cannot be accredited
1604 within 1 year after licensure, and that such accreditation will
1605 be completed within the 6-month extension. After obtaining
1606 accreditation as required by this subsection, each such clinic
1607 must maintain accreditation as a condition of renewal of its



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1608 license. A clinic that files a change of ownership application
1609 must comply with the original accreditation timeframe
1610 requirements of the transferor. The agency shall deny a change
1611 of ownership application if the clinic is not in compliance with
1612 the accreditation requirements. When a clinic adds, replaces, or
1613 modifies magnetic resonance imaging equipment and the
1614 accreditation agency requires new accreditation, the clinic must
1615 be accredited within 1 year after the date of the addition,
1616 replacement, or modification but may request a single, 6-month
1617 extension if the clinic provides evidence of good cause to the
1618 agency.
1619 Section 48. Subsection (2) of section 408.034, Florida
1620 Statutes, is amended to read:
1621 408.034 Duties and responsibilities of agency; rules.—
1622 (2) In the exercise of its authority to issue licenses to
1623 health care facilities and health service providers, as provided
1624 under chapters 393 and 395 and parts II, ~~and~~ IV, and VIII of
1625 chapter 400, the agency may not issue a license to any health
1626 care facility or health service provider that fails to receive a
1627 certificate of need or an exemption for the licensed facility or
1628 service.
1629 Section 49. Paragraph (d) of subsection (1) of section
1630 408.036, Florida Statutes, is amended to read:
1631 408.036 Projects subject to review; exemptions.—
1632 (1) APPLICABILITY.—Unless exempt under subsection (3), all
1633 health-care-related projects, as described in paragraphs (a)-
1634 (g), are subject to review and must file an application for a
1635 certificate of need with the agency. The agency is exclusively

1636 responsible for determining whether a health-care-related
1637 project is subject to review under ss. 408.031-408.045.
1638 (d) The establishment of a hospice or hospice inpatient
1639 facility~~, except as provided in s. 408.043~~.
1640 Section 50. Subsection (2) of section 408.043, Florida
1641 Statutes, is amended to read:
1642 408.043 Special provisions.—
1643 (2) HOSPICES.—When an application is made for a
1644 certificate of need to establish or to expand a hospice, the
1645 need for such hospice shall be determined on the basis of the
1646 need for and availability of hospice services in the community.
1647 The formula on which the certificate of need is based shall
1648 discourage regional monopolies and promote competition. The
1649 inpatient hospice care component of a hospice which is a
1650 freestanding facility, or a part of a facility, ~~which is~~
1651 ~~primarily engaged in providing inpatient care and related~~
1652 ~~services~~ and is not licensed as a health care facility shall
1653 also be required to obtain a certificate of need. Provision of
1654 hospice care by any current provider of health care is a
1655 significant change in service and therefore requires a
1656 certificate of need for such services.
1657 Section 51. Paragraph (k) of subsection (3) of section
1658 408.05, Florida Statutes, is amended to read:
1659 408.05 Florida Center for Health Information and Policy
1660 Analysis.—
1661 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to
1662 produce comparable and uniform health information and statistics
1663 for the development of policy recommendations, the agency shall

1664 perform the following functions:
1665 (k) Develop, in conjunction with the State Consumer Health
1666 Information and Policy Advisory Council, and implement a long-
1667 range plan for making available health care quality measures and
1668 financial data that will allow consumers to compare health care
1669 services. The health care quality measures and financial data
1670 the agency must make available shall include, but is not limited
1671 to, pharmaceuticals, physicians, health care facilities, and
1672 health plans and managed care entities. The agency shall update
1673 the plan and report on the status of its implementation
1674 annually. The agency shall also make the plan and status report
1675 available to the public on its Internet website. As part of the
1676 plan, the agency shall identify the process and timeframes for
1677 implementation, any barriers to implementation, and
1678 recommendations of changes in the law that may be enacted by the
1679 Legislature to eliminate the barriers. As preliminary elements
1680 of the plan, the agency shall:
1681 1. Make available patient-safety indicators, inpatient
1682 quality indicators, and performance outcome and patient charge
1683 data collected from health care facilities pursuant to s.
1684 408.061(1)(a) and (2). The terms "patient-safety indicators" and
1685 "inpatient quality indicators" shall be as defined by the
1686 Centers for Medicare and Medicaid Services, the National Quality
1687 Forum, the Joint Commission ~~on Accreditation of Healthcare~~
1688 ~~Organizations~~, the Agency for Healthcare Research and Quality,
1689 the Centers for Disease Control and Prevention, or a similar
1690 national entity that establishes standards to measure the
1691 performance of health care providers, or by other states. The

1692 agency shall determine which conditions, procedures, health care
1693 quality measures, and patient charge data to disclose based upon
1694 input from the council. When determining which conditions and
1695 procedures are to be disclosed, the council and the agency shall
1696 consider variation in costs, variation in outcomes, and
1697 magnitude of variations and other relevant information. When
1698 determining which health care quality measures to disclose, the
1699 agency:
1700 a. Shall consider such factors as volume of cases; average
1701 patient charges; average length of stay; complication rates;
1702 mortality rates; and infection rates, among others, which shall
1703 be adjusted for case mix and severity, if applicable.
1704 b. May consider such additional measures that are adopted
1705 by the Centers for Medicare and Medicaid Studies, National
1706 Quality Forum, the Joint Commission ~~on Accreditation of~~
1707 ~~Healthcare Organizations~~, the Agency for Healthcare Research and
1708 Quality, Centers for Disease Control and Prevention, or a
1709 similar national entity that establishes standards to measure
1710 the performance of health care providers, or by other states.
1711
1712 When determining which patient charge data to disclose, the
1713 agency shall include such measures as the average of
1714 undiscounted charges on frequently performed procedures and
1715 preventive diagnostic procedures, the range of procedure charges
1716 from highest to lowest, average net revenue per adjusted patient
1717 day, average cost per adjusted patient day, and average cost per
1718 admission, among others.
1719 2. Make available performance measures, benefit design,

1720 and premium cost data from health plans licensed pursuant to
1721 chapter 627 or chapter 641. The agency shall determine which
1722 health care quality measures and member and subscriber cost data
1723 to disclose, based upon input from the council. When determining
1724 which data to disclose, the agency shall consider information
1725 that may be required by either individual or group purchasers to
1726 assess the value of the product, which may include membership
1727 satisfaction, quality of care, current enrollment or membership,
1728 coverage areas, accreditation status, premium costs, plan costs,
1729 premium increases, range of benefits, copayments and
1730 deductibles, accuracy and speed of claims payment, credentials
1731 of physicians, number of providers, names of network providers,
1732 and hospitals in the network. Health plans shall make available
1733 to the agency any such data or information that is not currently
1734 reported to the agency or the office.
1735 3. Determine the method and format for public disclosure
1736 of data reported pursuant to this paragraph. The agency shall
1737 make its determination based upon input from the State Consumer
1738 Health Information and Policy Advisory Council. At a minimum,
1739 the data shall be made available on the agency's Internet
1740 website in a manner that allows consumers to conduct an
1741 interactive search that allows them to view and compare the
1742 information for specific providers. The website must include
1743 such additional information as is determined necessary to ensure
1744 that the website enhances informed decisionmaking among
1745 consumers and health care purchasers, which shall include, at a
1746 minimum, appropriate guidance on how to use the data and an
1747 explanation of why the data may vary from provider to provider.

1748 4. Publish on its website undiscounted charges for no
1749 fewer than 150 of the most commonly performed adult and
1750 pediatric procedures, including outpatient, inpatient,
1751 diagnostic, and preventative procedures.
1752 Section 52. Paragraph (a) of subsection (1) of section
1753 408.061, Florida Statutes, is amended to read:
1754 408.061 Data collection; uniform systems of financial
1755 reporting; information relating to physician charges;
1756 confidential information; immunity.—
1757 (1) The agency shall require the submission by health care
1758 facilities, health care providers, and health insurers of data
1759 necessary to carry out the agency's duties. Specifications for
1760 data to be collected under this section shall be developed by
1761 the agency with the assistance of technical advisory panels
1762 including representatives of affected entities, consumers,
1763 purchasers, and such other interested parties as may be
1764 determined by the agency.
1765 (a) Data submitted by health care facilities, including
1766 the facilities as defined in chapter 395, shall include, but are
1767 not limited to: case-mix data, patient admission and discharge
1768 data, hospital emergency department data which shall include the
1769 number of patients treated in the emergency department of a
1770 licensed hospital reported by patient acuity level, data on
1771 hospital-acquired infections as specified by rule, data on
1772 complications as specified by rule, data on readmissions as
1773 specified by rule, with patient and provider-specific
1774 identifiers included, actual charge data by diagnostic groups,
1775 financial data, accounting data, operating expenses, expenses

1776 incurred for rendering services to patients who cannot or do not
1777 pay, interest charges, depreciation expenses based on the
1778 expected useful life of the property and equipment involved, and
1779 demographic data. The agency shall adopt nationally recognized
1780 risk adjustment methodologies or software consistent with the
1781 standards of the Agency for Healthcare Research and Quality and
1782 as selected by the agency for all data submitted as required by
1783 this section. Data may be obtained from documents such as, but
1784 not limited to: leases, contracts, debt instruments, itemized
1785 patient bills, medical record abstracts, and related diagnostic
1786 information. Reported data elements shall be reported
1787 electronically <u>and</u> ~~in accordance with rule 59E-7.012, Florida~~
1788 ~~Administrative Code. Data submitted shall be~~ certified by the
1789 chief executive officer or an appropriate and duly authorized
1790 representative or employee of the licensed facility that the
1791 information submitted is true and accurate.
1792 Section 53. Subsection (43) of section 408.07, Florida
1793 Statutes, is amended to read:
1794 408.07 Definitions.—As used in this chapter, with the
1795 exception of ss. 408.031-408.045, the term:
1796 (43) "Rural hospital" means an acute care hospital
1797 licensed under chapter 395, having 100 or fewer licensed beds
1798 and an emergency room, and which is:
1799 (a) The sole provider within a county with a population
1800 density of no greater than 100 persons per square mile;
1801 (b) An acute care hospital, in a county with a population
1802 density of no greater than 100 persons per square mile, which is
1803 at least 30 minutes of travel time, on normally traveled roads



CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

1804 under normal traffic conditions, from another acute care
1805 hospital within the same county;
1806 (c) A hospital supported by a tax district or subdistrict
1807 whose boundaries encompass a population of 100 persons or fewer
1808 per square mile;
1809 (d) A hospital with a service area that has a population
1810 of 100 persons or fewer per square mile. As used in this
1811 paragraph, the term "service area" means the fewest number of
1812 zip codes that account for 75 percent of the hospital's
1813 discharges for the most recent 5-year period, based on
1814 information available from the hospital inpatient discharge
1815 database in the Florida Center for Health Information and Policy
1816 Analysis at the Agency for Health Care Administration; or
1817 (e) A critical access hospital.
1818
1819 Population densities used in this subsection must be based upon
1820 the most recently completed United States census. A hospital
1821 that received funds under s. 409.9116 for a quarter beginning no
1822 later than July 1, 2002, is deemed to have been and shall
1823 continue to be a rural hospital from that date through June 30,
1824 2015, if the hospital continues to have 100 or fewer licensed
1825 beds and an emergency room~~, or meets the criteria of s.~~
1826 ~~395.602(2)(e)4~~. An acute care hospital that has not previously
1827 been designated as a rural hospital and that meets the criteria
1828 of this subsection shall be granted such designation upon
1829 application, including supporting documentation, to the Agency
1830 for Health Care Administration.

1831 Section 54. Section 408.10, Florida Statutes, is amended
1832 to read:
1833 408.10 Consumer complaints.—The agency shall~~:~~
1834 ~~(1)~~ publish and make available to the public a toll-free
1835 telephone number for the purpose of handling consumer complaints
1836 and shall serve as a liaison between consumer entities and other
1837 private entities and governmental entities for the disposition
1838 of problems identified by consumers of health care.
1839 ~~(2) Be empowered to investigate consumer complaints~~
1840 ~~relating to problems with health care facilities' billing~~
1841 ~~practices and issue reports to be made public in any cases where~~
1842 ~~the agency determines the health care facility has engaged in~~
1843 ~~billing practices which are unreasonable and unfair to the~~
1844 ~~consumer.~~
1845 Section 55. Subsections (12) through (30) of section
1846 408.802, Florida Statutes, are renumbered as subsections (11)
1847 through (29), respectively, and present subsection (11) of that
1848 section is amended to read:
1849 408.802 Applicability.—The provisions of this part apply
1850 to the provision of services that require licensure as defined
1851 in this part and to the following entities licensed, registered,
1852 or certified by the agency, as described in chapters 112, 383,
1853 390, 394, 395, 400, 429, 440, 483, and 765:
1854 ~~(11) Private review agents, as provided under part I of~~
1855 ~~chapter 395.~~
1856 Section 56. Subsection (3) is added to section 408.804,
1857 Florida Statutes, to read:
1858 408.804 License required; display.—



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1859 (3) Any person who knowingly alters, defaces, or falsifies
1860 a license certificate issued by the agency, or causes or
1861 procures any person to commit such an offense, commits a
1862 misdemeanor of the second degree, punishable as provided in s.
1863 775.082 or s 775.083. Any licensee or provider who displays an
1864 altered, defaced, or falsified license certificate is subject to
1865 the penalties set forth in s. 408.815 and an administrative fine
1866 of $1,000 for each day of illegal display.
1867 Section 57. Paragraph (d) of subsection (2) of section
1868 408.806, Florida Statutes, is amended, present subsections (3)
1869 through (8) are renumbered as subsections (4) through (9),
1870 respectively, and a new subsection (3) is added to that section,
1871 to read:
1872 408.806 License application process.—
1873 (2)
1874 (d) ~~The agency shall notify the licensee by mail or~~
1875 ~~electronically at least 90 days before the expiration of a~~
1876 ~~license that a renewal license is necessary to continue~~
1877 ~~operation.~~ The licensee's failure to timely file ~~submit~~ a
1878 renewal application and license application fee with the agency
1879 shall result in a $50 per day late fee charged to the licensee
1880 by the agency; however, the aggregate amount of the late fee may
1881 not exceed 50 percent of the licensure fee or $500, whichever is
1882 less. The agency shall provide a courtesy notice to the licensee
1883 by United States mail, electronically, or by any other manner at
1884 its address of record or mailing address, if provided, at least
1885 90 days prior to the expiration of a license informing the
1886 licensee of the expiration of the license. If the agency does

1887 not provide the courtesy notice or the licensee does not receive
1888 the courtesy notice, the licensee continues to be legally
1889 obligated to timely file the renewal application and license
1890 application fee with the agency and is not excused from the
1891 payment of a late fee. If an application is received after the
1892 required filing date and exhibits a hand-canceled postmark
1893 obtained from a United States post office dated on or before the
1894 required filing date, no fine will be levied.
1895 (3) Payment of the late fee is required to consider any
1896 late application complete, and failure to pay the late fee is
1897 considered an omission from the application.
1898 Section 58. Subsections (6) and (9) of section 408.810,
1899 Florida Statutes, are amended to read:
1900 408.810 Minimum licensure requirements.—In addition to the
1901 licensure requirements specified in this part, authorizing
1902 statutes, and applicable rules, each applicant and licensee must
1903 comply with the requirements of this section in order to obtain
1904 and maintain a license.
1905 (6)(a) An applicant must provide the agency with proof of
1906 the applicant's legal right to occupy the property before a
1907 license may be issued. Proof may include, but need not be
1908 limited to, copies of warranty deeds, lease or rental
1909 agreements, contracts for deeds, quitclaim deeds, or other such
1910 documentation.
1911 (b) In the event the property is encumbered by a mortgage
1912 or is leased, an applicant must provide the agency with proof
1913 that the mortgagor or landlord has been provided written notice
1914 of the applicant's intent as mortgagee or tenant to provide

1915 services that require licensure and instruct the mortgagor or
1916 landlord to serve the agency by certified mail with copies of
1917 any foreclosure or eviction actions initiated by the mortgagor
1918 or landlord against the applicant.
1919 (9) A controlling interest may not withhold from the
1920 agency any evidence of financial instability, including, but not
1921 limited to, checks returned due to insufficient funds,
1922 delinquent accounts, nonpayment of withholding taxes, unpaid
1923 utility expenses, nonpayment for essential services, or adverse
1924 court action concerning the financial viability of the provider
1925 or any other provider licensed under this part that is under the
1926 control of the controlling interest. A controlling interest
1927 shall notify the agency within 10 days after a court action to
1928 initiate bankruptcy, foreclosure, or eviction proceedings
1929 concerning the provider, in which the controlling interest is a
1930 petitioner or defendant. Any person who violates this subsection
1931 commits a misdemeanor of the second degree, punishable as
1932 provided in s. 775.082 or s. 775.083. Each day of continuing
1933 violation is a separate offense.
1934 Section 59. Subsection (3) is added to section 408.813,
1935 Florida Statutes, to read:
1936 408.813 Administrative fines; violations.—As a penalty for
1937 any violation of this part, authorizing statutes, or applicable
1938 rules, the agency may impose an administrative fine.
1939 (3) The agency may impose an administrative fine for a
1940 violation that does not qualify as a class I, class II, class
1941 III, or class IV violation. Unless otherwise specified by law,

1942 the amount of the fine shall not exceed $500 for each violation.
1943 Unclassified violations may include:
1944 (a) Violating any term or condition of a license.
1945 (b) Violating any provision of this part, authorizing
1946 statutes, or applicable rules.
1947 (c) Exceeding licensed capacity.
1948 (d) Providing services beyond the scope of the license.
1949 (e) Violating a moratorium imposed pursuant to s. 408.814.
1950 Section 60. Subsection (2) of section 408.815, Florida
1951 Statutes, is amended, and subsection (5) is added to that
1952 section, to read:
1953 408.815 License or application denial; revocation.—
1954 (2) If a licensee lawfully continues to operate while a
1955 denial or revocation is pending in litigation, the licensee must
1956 continue to meet all other requirements of this part,
1957 authorizing statutes, and applicable rules and must file
1958 subsequent renewal applications for licensure and pay all
1959 licensure fees. The provisions of ss. 120.60(1) and 408.806(4)
1960 ~~(3)~~(c) shall not apply to renewal applications filed during the
1961 time period in which the litigation of the denial or revocation
1962 is pending until that litigation is final.
1963 (5) In order to ensure the health, safety, and welfare of
1964 clients when a license has been denied, revoked, or is set to
1965 terminate, the agency may extend the license expiration date for
1966 a period of up to 30 days for the sole purpose of allowing the
1967 safe and orderly discharge of clients. The agency may impose
1968 conditions on the extension, including, but not limited to,
1969 prohibiting or limiting admissions, expedited discharge

1970 planning, required status reports, and mandatory monitoring by
1971 the agency or third parties. When imposing these conditions, the
1972 agency shall take into consideration the nature and number of
1973 clients, the availability and location of acceptable alternative
1974 placements, and the ability of the licensee to continue
1975 providing care to the clients. The agency may terminate the
1976 extension or modify the conditions at any time. This authority
1977 is in addition to any other authority granted to the agency
1978 under chapter 120, this part, and authorizing statutes but
1979 creates no right or entitlement to an extension of a license
1980 expiration date.
1981 Section 61. Subsection (11) of section 408.820, Florida
1982 Statutes, is amended to read:
1983 408.820 Exemptions.—Except as prescribed in authorizing
1984 statutes, the following exemptions shall apply to specified
1985 requirements of this part:
1986 (11) Health care risk managers, as provided under part I
1987 of chapter 395, are exempt from ss. 408.806(8) ~~(7)~~, 408.810(4)-
1988 (10), and 408.811.
1989 Section 62. Subsection (1) of section 409.91196, Florida
1990 Statutes, is amended to read:
1991 409.91196 Supplemental rebate agreements; public records
1992 and public meetings exemption.—
1993 (1) The rebate amount, percent of rebate, manufacturer's
1994 pricing, and supplemental rebate, and other trade secrets as
1995 defined in s. 688.002 that the agency has identified for use in
1996 negotiations, held by the Agency for Health Care Administration



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1997 under s. 409.912(39)(a)8. ~~7.~~ are confidential and exempt from s.
1998 119.07(1) and s. 24(a), Art. I of the State Constitution.
1999 Section 63. Paragraph (a) of subsection (39) of section
2000 409.912, Florida Statutes, is amended to read:
2001 409.912 Cost-effective purchasing of health care.—The
2002 agency shall purchase goods and services for Medicaid recipients
2003 in the most cost-effective manner consistent with the delivery
2004 of quality medical care. To ensure that medical services are
2005 effectively utilized, the agency may, in any case, require a
2006 confirmation or second physician's opinion of the correct
2007 diagnosis for purposes of authorizing future services under the
2008 Medicaid program. This section does not restrict access to
2009 emergency services or poststabilization care services as defined
2010 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2011 shall be rendered in a manner approved by the agency. The agency
2012 shall maximize the use of prepaid per capita and prepaid
2013 aggregate fixed-sum basis services when appropriate and other
2014 alternative service delivery and reimbursement methodologies,
2015 including competitive bidding pursuant to s. 287.057, designed
2016 to facilitate the cost-effective purchase of a case-managed
2017 continuum of care. The agency shall also require providers to
2018 minimize the exposure of recipients to the need for acute
2019 inpatient, custodial, and other institutional care and the
2020 inappropriate or unnecessary use of high-cost services. The
2021 agency shall contract with a vendor to monitor and evaluate the
2022 clinical practice patterns of providers in order to identify
2023 trends that are outside the normal practice patterns of a
2024 provider's professional peers or the national guidelines of a

2025 provider's professional association. The vendor must be able to
2026 provide information and counseling to a provider whose practice
2027 patterns are outside the norms, in consultation with the agency,
2028 to improve patient care and reduce inappropriate utilization.
2029 The agency may mandate prior authorization, drug therapy
2030 management, or disease management participation for certain
2031 populations of Medicaid beneficiaries, certain drug classes, or
2032 particular drugs to prevent fraud, abuse, overuse, and possible
2033 dangerous drug interactions. The Pharmaceutical and Therapeutics
2034 Committee shall make recommendations to the agency on drugs for
2035 which prior authorization is required. The agency shall inform
2036 the Pharmaceutical and Therapeutics Committee of its decisions
2037 regarding drugs subject to prior authorization. The agency is
2038 authorized to limit the entities it contracts with or enrolls as
2039 Medicaid providers by developing a provider network through
2040 provider credentialing. The agency may competitively bid single-
2041 source-provider contracts if procurement of goods or services
2042 results in demonstrated cost savings to the state without
2043 limiting access to care. The agency may limit its network based
2044 on the assessment of beneficiary access to care, provider
2045 availability, provider quality standards, time and distance
2046 standards for access to care, the cultural competence of the
2047 provider network, demographic characteristics of Medicaid
2048 beneficiaries, practice and provider-to-beneficiary standards,
2049 appointment wait times, beneficiary use of services, provider
2050 turnover, provider profiling, provider licensure history,
2051 previous program integrity investigations and findings, peer
2052 review, provider Medicaid policy and billing compliance records,

2053 clinical and medical record audits, and other factors. Providers
2054 shall not be entitled to enrollment in the Medicaid provider
2055 network. The agency shall determine instances in which allowing
2056 Medicaid beneficiaries to purchase durable medical equipment and
2057 other goods is less expensive to the Medicaid program than long-
2058 term rental of the equipment or goods. The agency may establish
2059 rules to facilitate purchases in lieu of long-term rentals in
2060 order to protect against fraud and abuse in the Medicaid program
2061 as defined in s. 409.913. The agency may seek federal waivers
2062 necessary to administer these policies.
2063 (39)(a) The agency shall implement a Medicaid prescribed-
2064 drug spending-control program that includes the following
2065 components:
2066 1. A Medicaid preferred drug list, which shall be a
2067 listing of cost-effective therapeutic options recommended by the
2068 Medicaid Pharmacy and Therapeutics Committee established
2069 pursuant to s. 409.91195 and adopted by the agency for each
2070 therapeutic class on the preferred drug list. At the discretion
2071 of the committee, and when feasible, the preferred drug list
2072 should include at least two products in a therapeutic class. The
2073 agency may post the preferred drug list and updates to the
2074 preferred drug list on an Internet website without following the
2075 rulemaking procedures of chapter 120. Antiretroviral agents are
2076 excluded from the preferred drug list. The agency shall also
2077 limit the amount of a prescribed drug dispensed to no more than
2078 a 34-day supply unless the drug products' smallest marketed
2079 package is greater than a 34-day supply, or the drug is
2080 determined by the agency to be a maintenance drug in which case

2081 a 100-day maximum supply may be authorized. The agency is
2082 authorized to seek any federal waivers necessary to implement
2083 these cost-control programs and to continue participation in the
2084 federal Medicaid rebate program, or alternatively to negotiate
2085 state-only manufacturer rebates. The agency may adopt rules to
2086 implement this subparagraph. The agency shall continue to
2087 provide unlimited contraceptive drugs and items. The agency must
2088 establish procedures to ensure that:
2089 a. There is a response to a request for prior consultation
2090 by telephone or other telecommunication device within 24 hours
2091 after receipt of a request for prior consultation; and
2092 b. A 72-hour supply of the drug prescribed is provided in
2093 an emergency or when the agency does not provide a response
2094 within 24 hours as required by sub-subparagraph a.
2095 2. Reimbursement to pharmacies for Medicaid prescribed
2096 drugs shall be set at the lesser of: the average wholesale price
2097 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
2098 plus 4.75 percent, the federal upper limit (FUL), the state
2099 maximum allowable cost (SMAC), or the usual and customary (UAC)
2100 charge billed by the provider.
2101 3. For a prescribed drug billed as a 340B prescribed
2102 medication, the claim must meet the requirements of the Deficit
2103 Reduction Act of 2005 and the federal 340B program, contain a
2104 national drug code, and be billed at the actual acquisition cost
2105 or payment shall be denied.
2106 4.~~3.~~ The agency shall develop and implement a process for
2107 managing the drug therapies of Medicaid recipients who are using
2108 significant numbers of prescribed drugs each month. The

2109 management process may include, but is not limited to,
2110 comprehensive, physician-directed medical-record reviews, claims
2111 analyses, and case evaluations to determine the medical
2112 necessity and appropriateness of a patient's treatment plan and
2113 drug therapies. The agency may contract with a private
2114 organization to provide drug-program-management services. The
2115 Medicaid drug benefit management program shall include
2116 initiatives to manage drug therapies for HIV/AIDS patients,
2117 patients using 20 or more unique prescriptions in a 180-day
2118 period, and the top 1,000 patients in annual spending. The
2119 agency shall enroll any Medicaid recipient in the drug benefit
2120 management program if he or she meets the specifications of this
2121 provision and is not enrolled in a Medicaid health maintenance
2122 organization.

2123 5.~~4.~~ The agency may limit the size of its pharmacy network
2124 based on need, competitive bidding, price negotiations,
2125 credentialing, or similar criteria. The agency shall give
2126 special consideration to rural areas in determining the size and
2127 location of pharmacies included in the Medicaid pharmacy
2128 network. A pharmacy credentialing process may include criteria
2129 such as a pharmacy's full-service status, location, size,
2130 patient educational programs, patient consultation, disease
2131 management services, and other characteristics. The agency may
2132 impose a moratorium on Medicaid pharmacy enrollment when it is
2133 determined that it has a sufficient number of Medicaid-
2134 participating providers. The agency must allow dispensing
2135 practitioners to participate as a part of the Medicaid pharmacy
2136 network regardless of the practitioner's proximity to any other

2137 entity that is dispensing prescription drugs under the Medicaid
2138 program. A dispensing practitioner must meet all credentialing
2139 requirements applicable to his or her practice, as determined by
2140 the agency.
2141 6.~~5.~~ The agency shall develop and implement a program that
2142 requires Medicaid practitioners who prescribe drugs to use a
2143 counterfeit-proof prescription pad for Medicaid prescriptions.
2144 The agency shall require the use of standardized counterfeit-
2145 proof prescription pads by Medicaid-participating prescribers or
2146 prescribers who write prescriptions for Medicaid recipients. The
2147 agency may implement the program in targeted geographic areas or
2148 statewide.
2149 7.~~6.~~ The agency may enter into arrangements that require
2150 manufacturers of generic drugs prescribed to Medicaid recipients
2151 to provide rebates of at least 15.1 percent of the average
2152 manufacturer price for the manufacturer's generic products.
2153 These arrangements shall require that if a generic-drug
2154 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2155 at a level below 15.1 percent, the manufacturer must provide a
2156 supplemental rebate to the state in an amount necessary to
2157 achieve a 15.1-percent rebate level.
2158 8.~~7.~~ The agency may establish a preferred drug list as
2159 described in this subsection, and, pursuant to the establishment
2160 of such preferred drug list, it is authorized to negotiate
2161 supplemental rebates from manufacturers that are in addition to
2162 those required by Title XIX of the Social Security Act and at no
2163 less than 14 percent of the average manufacturer price as
2164 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless

2165 the federal or supplemental rebate, or both, equals or exceeds
2166 29 percent. There is no upper limit on the supplemental rebates
2167 the agency may negotiate. The agency may determine that specific
2168 products, brand-name or generic, are competitive at lower rebate
2169 percentages. Agreement to pay the minimum supplemental rebate
2170 percentage will guarantee a manufacturer that the Medicaid
2171 Pharmaceutical and Therapeutics Committee will consider a
2172 product for inclusion on the preferred drug list. However, a
2173 pharmaceutical manufacturer is not guaranteed placement on the
2174 preferred drug list by simply paying the minimum supplemental
2175 rebate. Agency decisions will be made on the clinical efficacy
2176 of a drug and recommendations of the Medicaid Pharmaceutical and
2177 Therapeutics Committee, as well as the price of competing
2178 products minus federal and state rebates. The agency is
2179 authorized to contract with an outside agency or contractor to
2180 conduct negotiations for supplemental rebates. For the purposes
2181 of this section, the term "supplemental rebates" means cash
2182 rebates. Effective July 1, 2004, value-added programs as a
2183 substitution for supplemental rebates are prohibited. The agency
2184 is authorized to seek any federal waivers to implement this
2185 initiative.
2186 9.~~8.~~ The Agency for Health Care Administration shall
2187 expand home delivery of pharmacy products. To assist Medicaid
2188 patients in securing their prescriptions and reduce program
2189 costs, the agency shall expand its current mail-order-pharmacy
2190 diabetes-supply program to include all generic and brand-name
2191 drugs used by Medicaid patients with diabetes. Medicaid
2192 recipients in the current program may obtain nondiabetes drugs

2193 on a voluntary basis. This initiative is limited to the
2194 geographic area covered by the current contract. The agency may
2195 seek and implement any federal waivers necessary to implement
2196 this subparagraph.
2197 10.~~9.~~ The agency shall limit to one dose per month any
2198 drug prescribed to treat erectile dysfunction.
2199 11.~~10.~~a. The agency may implement a Medicaid behavioral
2200 drug management system. The agency may contract with a vendor
2201 that has experience in operating behavioral drug management
2202 systems to implement this program. The agency is authorized to
2203 seek federal waivers to implement this program.
2204 b. The agency, in conjunction with the Department of
2205 Children and Family Services, may implement the Medicaid
2206 behavioral drug management system that is designed to improve
2207 the quality of care and behavioral health prescribing practices
2208 based on best practice guidelines, improve patient adherence to
2209 medication plans, reduce clinical risk, and lower prescribed
2210 drug costs and the rate of inappropriate spending on Medicaid
2211 behavioral drugs. The program may include the following
2212 elements:
2213 (I) Provide for the development and adoption of best
2214 practice guidelines for behavioral health-related drugs such as
2215 antipsychotics, antidepressants, and medications for treating
2216 bipolar disorders and other behavioral conditions; translate
2217 them into practice; review behavioral health prescribers and
2218 compare their prescribing patterns to a number of indicators
2219 that are based on national standards; and determine deviations
2220 from best practice guidelines.



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

2221 (II) Implement processes for providing feedback to and
2222 educating prescribers using best practice educational materials
2223 and peer-to-peer consultation.
2224 (III) Assess Medicaid beneficiaries who are outliers in
2225 their use of behavioral health drugs with regard to the numbers
2226 and types of drugs taken, drug dosages, combination drug
2227 therapies, and other indicators of improper use of behavioral
2228 health drugs.
2229 (IV) Alert prescribers to patients who fail to refill
2230 prescriptions in a timely fashion, are prescribed multiple same-
2231 class behavioral health drugs, and may have other potential
2232 medication problems.
2233 (V) Track spending trends for behavioral health drugs and
2234 deviation from best practice guidelines.
2235 (VI) Use educational and technological approaches to
2236 promote best practices, educate consumers, and train prescribers
2237 in the use of practice guidelines.
2238 (VII) Disseminate electronic and published materials.
2239 (VIII) Hold statewide and regional conferences.
2240 (IX) Implement a disease management program with a model
2241 quality-based medication component for severely mentally ill
2242 individuals and emotionally disturbed children who are high
2243 users of care.
2244 12. ~~11.~~a. The agency shall implement a Medicaid
2245 prescription drug management system. The agency may contract
2246 with a vendor that has experience in operating prescription drug
2247 management systems in order to implement this system. Any
2248 management system that is implemented in accordance with this

2249 subparagraph must rely on cooperation between physicians and
2250 pharmacists to determine appropriate practice patterns and
2251 clinical guidelines to improve the prescribing, dispensing, and
2252 use of drugs in the Medicaid program. The agency may seek
2253 federal waivers to implement this program.
2254 b. The drug management system must be designed to improve
2255 the quality of care and prescribing practices based on best
2256 practice guidelines, improve patient adherence to medication
2257 plans, reduce clinical risk, and lower prescribed drug costs and
2258 the rate of inappropriate spending on Medicaid prescription
2259 drugs. The program must:
2260 (I) Provide for the development and adoption of best
2261 practice guidelines for the prescribing and use of drugs in the
2262 Medicaid program, including translating best practice guidelines
2263 into practice; reviewing prescriber patterns and comparing them
2264 to indicators that are based on national standards and practice
2265 patterns of clinical peers in their community, statewide, and
2266 nationally; and determine deviations from best practice
2267 guidelines.
2268 (II) Implement processes for providing feedback to and
2269 educating prescribers using best practice educational materials
2270 and peer-to-peer consultation.
2271 (III) Assess Medicaid recipients who are outliers in their
2272 use of a single or multiple prescription drugs with regard to
2273 the numbers and types of drugs taken, drug dosages, combination
2274 drug therapies, and other indicators of improper use of
2275 prescription drugs.

2276 (IV) Alert prescribers to patients who fail to refill
2277 prescriptions in a timely fashion, are prescribed multiple drugs
2278 that may be redundant or contraindicated, or may have other
2279 potential medication problems.
2280 (V) Track spending trends for prescription drugs and
2281 deviation from best practice guidelines.
2282 (VI) Use educational and technological approaches to
2283 promote best practices, educate consumers, and train prescribers
2284 in the use of practice guidelines.
2285 (VII) Disseminate electronic and published materials.
2286 (VIII) Hold statewide and regional conferences.
2287 (IX) Implement disease management programs in cooperation
2288 with physicians and pharmacists, along with a model quality-
2289 based medication component for individuals having chronic
2290 medical conditions.
2291 13. ~~12.~~ The agency is authorized to contract for drug
2292 rebate administration, including, but not limited to,
2293 calculating rebate amounts, invoicing manufacturers, negotiating
2294 disputes with manufacturers, and maintaining a database of
2295 rebate collections.
2296 14. ~~13.~~ The agency may specify the preferred daily dosing
2297 form or strength for the purpose of promoting best practices
2298 with regard to the prescribing of certain drugs as specified in
2299 the General Appropriations Act and ensuring cost-effective
2300 prescribing practices.
2301 15. ~~14.~~ The agency may require prior authorization for
2302 Medicaid-covered prescribed drugs. The agency may, but is not
2303 required to, prior-authorize the use of a product:

2304 a. For an indication not approved in labeling;
2305 b. To comply with certain clinical guidelines; or
2306 c. If the product has the potential for overuse, misuse,
2307 or abuse.
2308
2309 The agency may require the prescribing professional to provide
2310 information about the rationale and supporting medical evidence
2311 for the use of a drug. The agency may post prior authorization
2312 criteria and protocol and updates to the list of drugs that are
2313 subject to prior authorization on an Internet website without
2314 amending its rule or engaging in additional rulemaking.
2315 16.~~15.~~ The agency, in conjunction with the Pharmaceutical
2316 and Therapeutics Committee, may require age-related prior
2317 authorizations for certain prescribed drugs. The agency may
2318 preauthorize the use of a drug for a recipient who may not meet
2319 the age requirement or may exceed the length of therapy for use
2320 of this product as recommended by the manufacturer and approved
2321 by the Food and Drug Administration. Prior authorization may
2322 require the prescribing professional to provide information
2323 about the rationale and supporting medical evidence for the use
2324 of a drug.
2325 17.~~16.~~ The agency shall implement a step-therapy prior
2326 authorization approval process for medications excluded from the
2327 preferred drug list. Medications listed on the preferred drug
2328 list must be used within the previous 12 months prior to the
2329 alternative medications that are not listed. The step-therapy
2330 prior authorization may require the prescriber to use the
2331 medications of a similar drug class or for a similar medical

2332 indication unless contraindicated in the Food and Drug
2333 Administration labeling. The trial period between the specified
2334 steps may vary according to the medical indication. The step-
2335 therapy approval process shall be developed in accordance with
2336 the committee as stated in s. 409.91195(7) and (8). A drug
2337 product may be approved without meeting the step-therapy prior
2338 authorization criteria if the prescribing physician provides the
2339 agency with additional written medical or clinical documentation
2340 that the product is medically necessary because:
2341 a. There is not a drug on the preferred drug list to treat
2342 the disease or medical condition which is an acceptable clinical
2343 alternative;
2344 b. The alternatives have been ineffective in the treatment
2345 of the beneficiary's disease; or
2346 c. Based on historic evidence and known characteristics of
2347 the patient and the drug, the drug is likely to be ineffective,
2348 or the number of doses have been ineffective.
2349
2350 The agency shall work with the physician to determine the best
2351 alternative for the patient. The agency may adopt rules waiving
2352 the requirements for written clinical documentation for specific
2353 drugs in limited clinical situations.
2354 18.~~17.~~ The agency shall implement a return and reuse
2355 program for drugs dispensed by pharmacies to institutional
2356 recipients, which includes payment of a $5 restocking fee for
2357 the implementation and operation of the program. The return and
2358 reuse program shall be implemented electronically and in a
2359 manner that promotes efficiency. The program must permit a

2360 pharmacy to exclude drugs from the program if it is not
2361 practical or cost-effective for the drug to be included and must
2362 provide for the return to inventory of drugs that cannot be
2363 credited or returned in a cost-effective manner. The agency
2364 shall determine if the program has reduced the amount of
2365 Medicaid prescription drugs which are destroyed on an annual
2366 basis and if there are additional ways to ensure more
2367 prescription drugs are not destroyed which could safely be
2368 reused. The agency's conclusion and recommendations shall be
2369 reported to the Legislature by December 1, 2005.
2370 Section 64. Section 409.91255, Florida Statutes, is
2371 amended to read:
2372 409.91255 Federally qualified health center access
2373 program.—
2374 (1) SHORT TITLE.—This section may be cited as the
2375 "Community Health Center Access Program Act."
2376 (2) LEGISLATIVE FINDINGS AND INTENT.—
2377 (a) The Legislature finds that, despite significant
2378 investments in health care programs, nearly 6 ~~more than 2~~
2379 million low-income Floridians, primarily the working poor and
2380 minority populations, continue to lack access to basic health
2381 care services. Further, the Legislature recognizes that
2382 federally qualified health centers have a proven record of
2383 providing cost-effective, comprehensive primary and preventive
2384 health care and are uniquely qualified to address the lack of
2385 adequate health care services for the uninsured.
2386 (b) It is the intent of the Legislature to recognize the
2387 significance of increased federal investments in federally

2388 qualified health centers and to leverage that investment through
2389 the creation of a program to provide for the expansion of the
2390 primary and preventive health care services offered by federally
2391 qualified health centers. Further, such a program will support
2392 the coordination of federal, state, and local resources to
2393 assist such health centers in developing an expanded community-
2394 based primary care delivery system.
2395 (3) ASSISTANCE TO FEDERALLY QUALIFIED HEALTH CENTERS.—The
2396 agency shall administer ~~Department of Health shall develop~~ a
2397 program for the expansion of federally qualified health centers
2398 for the purpose of providing comprehensive primary and
2399 preventive health care and urgent care services that may reduce
2400 the morbidity, mortality, and cost of care among the uninsured
2401 population of the state. The program shall provide for
2402 distribution of financial assistance to federally qualified
2403 health centers that apply and demonstrate a need for such
2404 assistance in order to sustain or expand the delivery of primary
2405 and preventive health care services. In selecting centers to
2406 receive this financial assistance, the program:
2407 (a) Shall give preference to communities that have few or
2408 no community-based primary care services or in which the current
2409 services are unable to meet the community's needs. To assist in
2410 the assessment and identification of areas of critical need, the
2411 Florida Association of Community Health Centers, Inc., shall
2412 develop, every 5 years, beginning January 1, 2012, a federally
2413 qualified health center based statewide assessment and strategic
2414 plan.
2415 (b) Shall require that primary care services be provided

2416 to the medically indigent using a sliding fee schedule based on
2417 income.
2418 (c) Shall promote ~~allow~~ innovative and creative uses of
2419 federal, state, and local health care resources.
2420 (d) Shall require that the funds provided be used to pay
2421 for operating costs of a projected expansion in patient
2422 caseloads or services or for capital improvement projects.
2423 Capital improvement projects may include renovations to existing
2424 facilities or construction of new facilities, provided that an
2425 expansion in patient caseloads or services to a new patient
2426 population will occur as a result of the capital expenditures.
2427 The agency ~~department~~ shall include in its standard contract
2428 document a requirement that any state funds provided for the
2429 purchase of or improvements to real property are contingent upon
2430 the contractor granting to the state a security interest in the
2431 property at least to the amount of the state funds provided for
2432 at least 5 years from the date of purchase or the completion of
2433 the improvements or as further required by law. The contract
2434 must include a provision that, as a condition of receipt of
2435 state funding for this purpose, the contractor agrees that, if
2436 it disposes of the property before the agency's ~~department's~~
2437 interest is vacated, the contractor will refund the
2438 proportionate share of the state's initial investment, as
2439 adjusted by depreciation.
2440 (e) Shall ~~May~~ require in-kind support from other sources.
2441 (f) Shall promote ~~May encourage~~ coordination among
2442 federally qualified health centers, other private sector
2443 providers, and publicly supported programs.

2444 (g) Shall promote ~~allow~~ the development of community
2445 emergency room diversion programs in conjunction with local
2446 resources, providing extended hours of operation to urgent care
2447 patients. Diversion programs shall include case management for
2448 emergency room followup care.
2449 (4) EVALUATION OF APPLICATIONS.—A review panel shall be
2450 established, consisting of four persons appointed by the
2451 Secretary of Health Care Administration ~~State Surgeon General~~
2452 and three persons appointed by the chief executive officer of
2453 the Florida Association of Community Health Centers, Inc., to
2454 review all applications for financial assistance under the
2455 program. Applicants shall specify in the application whether the
2456 program funds will be used for the expansion of patient
2457 caseloads or services or for capital improvement projects to
2458 expand and improve patient facilities. The panel shall use the
2459 following elements in reviewing application proposals and shall
2460 determine the relative weight for scoring and evaluating these
2461 elements:
2462 (a) The target population to be served.
2463 (b) The health benefits to be provided.
2464 (c) The methods that will be used to measure cost-
2465 effectiveness.
2466 (d) How patient satisfaction will be measured.
2467 (e) The proposed internal quality assurance process.
2468 (f) Projected health status outcomes.
2469 (g) How data will be collected to measure cost-
2470 effectiveness, health status outcomes, and overall achievement
2471 of the goals of the proposal.

2472 (h) All resources, including cash, in-kind, voluntary, or
2473 other resources that will be dedicated to the proposal.
2474 (5) ADMINISTRATION AND TECHNICAL ASSISTANCE.—The agency
2475 shall ~~Department of Health may~~ contract with the Florida
2476 Association of Community Health Centers, Inc., to develop and
2477 coordinate ~~administer~~ the program and provide technical
2478 assistance to the federally qualified health centers selected to
2479 receive financial assistance. The contracted entity shall be
2480 responsible for program support and assume all costs related to
2481 administration of this program.
2482 Section 65. Subsections (3) and (4) of section 429.07,
2483 Florida Statutes, are amended, and subsections (6) and (7) are
2484 added to that section, to read:
2485 429.07 License required; fee; inspections.—
2486 (3) In addition to the requirements of s. 408.806, each
2487 license granted by the agency must state the type of care for
2488 which the license is granted. Licenses shall be issued for one
2489 or more of the following categories of care: standard, extended
2490 congregate care, ~~limited nursing services,~~ or limited mental
2491 health.
2492 (a) A standard license shall be issued to a facility
2493 ~~facilities~~ providing one or more of the personal services
2494 identified in s. 429.02. Such licensee ~~facilities~~ may also
2495 employ or contract with a person ~~licensed under part I of~~
2496 ~~chapter 464~~ to ~~administer medications and~~ perform other tasks as
2497 specified in s. 429.255.
2498 (b) An extended congregate care license shall be issued to
2499 a licensee ~~facilities~~ providing, directly or through contract,

2500 services beyond those authorized in paragraph (a), including
2501 services performed by persons licensed under part I of chapter
2502 464 and supportive services, as defined by rule, to persons who
2503 would otherwise be disqualified from continued residence in a
2504 facility licensed under this part.
2505 1. In order for extended congregate care services to be
2506 provided, the agency must first determine that all requirements
2507 established in law and rule are met and must specifically
2508 designate, on the ~~facility's~~ license, that such services may be
2509 provided and whether the designation applies to all or part of
2510 the facility. Such designation may be made at the time of
2511 initial licensure or relicensure, or upon request in writing by
2512 a licensee under this part and part II of chapter 408. The
2513 notification of approval or the denial of the request shall be
2514 made in accordance with part II of chapter 408. An existing
2515 licensee ~~facilities~~ qualifying to provide extended congregate
2516 care services must have maintained a standard license and ~~may~~
2517 not ~~have~~ been subject to administrative sanctions during the
2518 previous 2 years, or since initial licensure if ~~the facility has~~
2519 ~~been~~ licensed for less than 2 years, for any of the following
2520 reasons:
2521 a. A class I or class II violation;
2522 b. Three or more repeat or recurring class III violations
2523 of identical or similar resident care standards from which a
2524 pattern of noncompliance is found by the agency;
2525 c. Three or more class III violations that were not
2526 corrected in accordance with the corrective action plan approved
2527 by the agency;



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

2528 d. Violation of resident care standards which results in
2529 requiring the facility to employ the services of a consultant
2530 pharmacist or consultant dietitian;
2531 e. Denial, suspension, or revocation of a license for
2532 another facility licensed under this part in which the applicant
2533 for an extended congregate care license has at least 25 percent
2534 ownership interest; or
2535 f. Imposition of a moratorium pursuant to this part or
2536 part II of chapter 408 or initiation of injunctive proceedings.
2537 2. A facility that is licensed to provide extended
2538 congregate care services shall maintain a written progress
2539 report for ~~on~~ each person who receives services which describes
2540 the type, amount, duration, scope, and outcome of services that
2541 are rendered and the general status of the resident's health. ~~A~~
2542 ~~registered nurse, or appropriate designee, representing the~~
2543 ~~agency shall visit the facility at least quarterly to monitor~~
2544 ~~residents who are receiving extended congregate care services~~
2545 ~~and to determine if the facility is in compliance with this~~
2546 ~~part, part II of chapter 408, and relevant rules. One of the~~
2547 ~~visits may be in conjunction with the regular survey. The~~
2548 ~~monitoring visits may be provided through contractual~~
2549 ~~arrangements with appropriate community agencies. A registered~~
2550 ~~nurse shall serve as part of the team that inspects the~~
2551 ~~facility. The agency may waive one of the required yearly~~
2552 ~~monitoring visits for a facility that has been licensed for at~~
2553 ~~least 24 months to provide extended congregate care services,~~
2554 ~~if, during the inspection, the registered nurse determines that~~
2555 ~~extended congregate care services are being provided~~

2556 ~~appropriately, and if the facility has no class I or class II~~
2557 ~~violations and no uncorrected class III violations. The agency~~
2558 ~~must first consult with the long-term care ombudsman council for~~
2559 ~~the area in which the facility is located to determine if any~~
2560 ~~complaints have been made and substantiated about the quality of~~
2561 ~~services or care. The agency may not waive one of the required~~
2562 ~~yearly monitoring visits if complaints have been made and~~
2563 ~~substantiated.~~
2564 3. A facility that is licensed to provide extended
2565 congregate care services must:
2566 a. Demonstrate the capability to meet unanticipated
2567 resident service needs.
2568 b. Offer a physical environment that promotes a homelike
2569 setting, provides for resident privacy, promotes resident
2570 independence, and allows sufficient congregate space as defined
2571 by rule.
2572 c. Have sufficient staff available, taking into account
2573 the physical plant and firesafety features of the building, to
2574 assist with the evacuation of residents in an emergency.
2575 d. Adopt and follow policies and procedures that maximize
2576 resident independence, dignity, choice, and decisionmaking to
2577 permit residents to age in place, so that moves due to changes
2578 in functional status are minimized or avoided.
2579 e. Allow residents or, if applicable, a resident's
2580 representative, designee, surrogate, guardian, or attorney in
2581 fact to make a variety of personal choices, participate in
2582 developing service plans, and share responsibility in
2583 decisionmaking.

2584 f. Implement the concept of managed risk.
2585 g. Provide, directly or through contract, the services of
2586 a person licensed under part I of chapter 464.
2587 h. In addition to the training mandated in s. 429.52,
2588 provide specialized training as defined by rule for facility
2589 staff.
2590 4. A facility that is licensed to provide extended
2591 congregate care services is exempt from the criteria for
2592 continued residency set forth in rules adopted under s. 429.41.
2593 A licensed facility must adopt its own requirements within
2594 guidelines for continued residency set forth by rule. However,
2595 the facility may not serve residents who require 24-hour nursing
2596 supervision. A licensed facility that provides extended
2597 congregate care services must also provide each resident with a
2598 written copy of facility policies governing admission and
2599 retention.
2600 5. The primary purpose of extended congregate care
2601 services is to allow residents, as they become more impaired,
2602 the option of remaining in a familiar setting from which they
2603 would otherwise be disqualified for continued residency. A
2604 facility licensed to provide extended congregate care services
2605 may also admit an individual who exceeds the admission criteria
2606 for a facility with a standard license, if the individual is
2607 determined appropriate for admission to the extended congregate
2608 care facility.
2609 6. Before the admission of an individual to a facility
2610 licensed to provide extended congregate care services, the
2611 individual must undergo a medical examination as provided in s.

2612 429.26(4) and the facility must develop a preliminary service
2613 plan for the individual.
2614 7. When a <u>licensee</u> ~~facility~~ can no longer provide or
2615 arrange for services in accordance with the resident's service
2616 plan and needs and the <u>licensee's</u> ~~facility's~~ policy, the
2617 <u>licensee</u> ~~facility~~ shall make arrangements for relocating the
2618 person in accordance with s. 429.28(1)(k).
2619 8. Failure to provide extended congregate care services
2620 may result in denial of extended congregate care license
2621 renewal.
2622 ~~(c) A limited nursing services license shall be issued to~~
2623 ~~a facility that provides services beyond those authorized in~~
2624 ~~paragraph (a) and as specified in this paragraph.~~
2625 ~~1. In order for limited nursing services to be provided in~~
2626 ~~a facility licensed under this part, the agency must first~~
2627 ~~determine that all requirements established in law and rule are~~
2628 ~~met and must specifically designate, on the facility's license,~~
2629 ~~that such services may be provided. Such designation may be made~~
2630 ~~at the time of initial licensure or relicensure, or upon request~~
2631 ~~in writing by a licensee under this part and part II of chapter~~
2632 ~~408. Notification of approval or denial of such request shall be~~
2633 ~~made in accordance with part II of chapter 408. Existing~~
2634 ~~facilities qualifying to provide limited nursing services shall~~
2635 ~~have maintained a standard license and may not have been subject~~
2636 ~~to administrative sanctions that affect the health, safety, and~~
2637 ~~welfare of residents for the previous 2 years or since initial~~
2638 ~~licensure if the facility has been licensed for less than 2~~
2639 ~~years.~~



CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

2640 ~~2. Facilities that are licensed to provide limited nursing~~
2641 ~~services shall maintain a written progress report on each person~~
2642 ~~who receives such nursing services, which report describes the~~
2643 ~~type, amount, duration, scope, and outcome of services that are~~
2644 ~~rendered and the general status of the resident's health. A~~
2645 ~~registered nurse representing the agency shall visit such~~
2646 ~~facilities at least twice a year to monitor residents who are~~
2647 ~~receiving limited nursing services and to determine if the~~
2648 ~~facility is in compliance with applicable provisions of this~~
2649 ~~part, part II of chapter 408, and related rules. The monitoring~~
2650 ~~visits may be provided through contractual arrangements with~~
2651 ~~appropriate community agencies. A registered nurse shall also~~
2652 ~~serve as part of the team that inspects such facility.~~
2653 ~~3. A person who receives limited nursing services under~~
2654 ~~this part must meet the admission criteria established by the~~
2655 ~~agency for assisted living facilities. When a resident no longer~~
2656 ~~meets the admission criteria for a facility licensed under this~~
2657 ~~part, arrangements for relocating the person shall be made in~~
2658 ~~accordance with s. 429.28(1)(k), unless the facility is licensed~~
2659 ~~to provide extended congregate care services.~~
2660 (4) In accordance with s. 408.805, an applicant or
2661 licensee shall pay a fee for each license application submitted
2662 under this part, part II of chapter 408, and applicable rules.
2663 The amount of the fee shall be established by rule.
2664 (a) The biennial license fee required of a facility is
2665 <u>$356</u> ~~$300~~ per license, with an additional fee of <u>$67.50</u> ~~$50~~ per
2666 resident based on the total licensed resident capacity of the
2667 facility, except that no additional fee will be assessed for



CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

2668 beds designated for recipients of optional state supplementation
2669 payments provided for in s. 409.212. The total fee may not
2670 exceed $18,000 ~~$10,000~~.
2671 (b) In addition to the total fee assessed under paragraph
2672 (a), the agency shall require facilities that are licensed to
2673 provide extended congregate care services under this part to pay
2674 an additional fee per licensed facility. The amount of the
2675 biennial fee shall be $501 ~~$400~~ per license, with an additional
2676 fee of $10 per resident based on the total licensed resident
2677 capacity of the facility.
2678 ~~(c) In addition to the total fee assessed under paragraph~~
2679 ~~(a), the agency shall require facilities that are licensed to~~
2680 ~~provide limited nursing services under this part to pay an~~
2681 ~~additional fee per licensed facility. The amount of the biennial~~
2682 ~~fee shall be $250 per license, with an additional fee of $10 per~~
2683 ~~resident based on the total licensed resident capacity of the~~
2684 ~~facility.~~
2685 (6) In order to determine whether the facility is
2686 adequately protecting residents' rights as provided in s.
2687 429.28, the agency shall conduct a biennial survey, which shall
2688 include private informal conversations with a sample of
2689 residents and consultation with the ombudsman council in the
2690 planning and service area in which the facility is located to
2691 discuss residents' experiences within the facility.
2692 (7) An assisted living facility that has been cited within
2693 the previous 24-month period for a class I or class II
2694 violation, regardless of the status of any enforcement or
2695 disciplinary action, is subject to periodic unannounced

2696 monitoring to determine if the facility is in compliance with
2697 this part, part II of chapter 408, and applicable rules.
2698 Monitoring may occur through a desk review or an onsite
2699 assessment. If the class I or class II violation relates to
2700 providing or failing to provide nursing care, a registered nurse
2701 must participate in at least two onsite monitoring visits within
2702 a 12-month period.
2703 Section 66. Subsection (7) of section 429.11, Florida
2704 Statutes, is renumbered as subsection (6), and present
2705 subsection (6) of that section is amended to read:
2706 429.11 Initial application for license~~; provisional~~
2707 ~~license~~.—
2708 ~~(6) In addition to the license categories available in s.~~
2709 ~~408.808, a provisional license may be issued to an applicant~~
2710 ~~making initial application for licensure or making application~~
2711 ~~for a change of ownership. A provisional license shall be~~
2712 ~~limited in duration to a specific period of time not to exceed 6~~
2713 ~~months, as determined by the agency.~~
2714 Section 67. Section 429.12, Florida Statutes, is amended
2715 to read:
2716 429.12 Sale or transfer of ownership of a facility.—It is
2717 the intent of the Legislature to protect the rights of the
2718 residents of an assisted living facility when the facility is
2719 sold or the ownership thereof is transferred. Therefore, in
2720 addition to the requirements of part II of chapter 408, whenever
2721 a facility is sold or the ownership thereof is transferred,
2722 including leasing,~~:~~



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

2723 ~~(1)~~ the transferee shall notify the residents, in writing,
2724 of the change of ownership within 7 days after receipt of the
2725 new license.
2726 ~~(2) The transferor of a facility the license of which is~~
2727 ~~denied pending an administrative hearing shall, as a part of the~~
2728 ~~written change-of-ownership contract, advise the transferee that~~
2729 ~~a plan of correction must be submitted by the transferee and~~
2730 ~~approved by the agency at least 7 days before the change of~~
2731 ~~ownership and that failure to correct the condition which~~
2732 ~~resulted in the moratorium pursuant to part II of chapter 408 or~~
2733 ~~denial of licensure is grounds for denial of the transferee's~~
2734 ~~license.~~
2735 Section 68. Paragraphs (b) through (l) of subsection (1)
2736 of section 429.14, Florida Statutes, are redesignated as
2737 paragraphs (a) through (k), respectively, and present paragraph
2738 (a) of subsection (1) and subsections (5) and (6) of that
2739 section are amended to read:
2740 429.14 Administrative penalties.—
2741 (1) In addition to the requirements of part II of chapter
2742 408, the agency may deny, revoke, and suspend any license issued
2743 under this part and impose an administrative fine in the manner
2744 provided in chapter 120 against a licensee for a violation of
2745 any provision of this part, part II of chapter 408, or
2746 applicable rules, or for any of the following actions by a
2747 licensee, for the actions of any person subject to level 2
2748 background screening under s. 408.809, or for the actions of any
2749 facility employee:

2750 ~~(a) An intentional or negligent act seriously affecting~~
2751 ~~the health, safety, or welfare of a resident of the facility.~~
2752 (5) An action taken by the agency to suspend, deny, or
2753 revoke a facility's license under this part or part II of
2754 chapter 408, in which the agency claims that the facility owner
2755 or an employee of the facility has threatened the health,
2756 safety, or welfare of a resident of the facility shall be heard
2757 by the Division of Administrative Hearings of the Department of
2758 Management Services within 120 days after receipt of the
2759 facility's request for a hearing, unless that time limitation is
2760 waived by both parties. The administrative law judge must render
2761 a decision within 30 days after receipt of a proposed
2762 recommended order.
2763 (6) The agency shall provide to the Division of Hotels and
2764 Restaurants of the Department of Business and Professional
2765 Regulation, on a monthly basis, a list of those assisted living
2766 facilities that have had their licenses denied, suspended, or
2767 revoked or that are involved in an appellate proceeding pursuant
2768 to s. 120.60 related to the denial, suspension, or revocation of
2769 a license. This information may be provided electronically or
2770 through the agency's Internet website.
2771 Section 69. Subsections (1), (4), and (5) of section
2772 429.17, Florida Statutes, are amended to read:
2773 429.17 Expiration of license; renewal; conditional
2774 license.—
2775 (1) ~~Limited nursing,~~ Extended congregate care~~,~~ and limited
2776 mental health licenses shall expire at the same time as the
2777 facility's standard license, regardless of when issued.

2778 (4) In addition to the license categories available in s.
2779 408.808, a conditional license may be issued to an applicant for
2780 license renewal if the applicant fails to meet all standards and
2781 requirements for licensure. A conditional license issued under
2782 this subsection shall be limited in duration to a specific
2783 period of time not to exceed 6 months, as determined by the
2784 agency~~, and shall be accompanied by an agency-approved plan of~~
2785 ~~correction~~.
2786 (5) When an extended congregate care ~~or limited nursing~~
2787 ~~license~~ is requested during a facility's biennial license
2788 period, the fee shall be prorated in order to permit the
2789 additional license to expire at the end of the biennial license
2790 period. The fee shall be calculated as of the date the
2791 additional license application is received by the agency.
2792 Section 70. Subsection (7) of section 429.19, Florida
2793 Statutes, is amended to read:
2794 429.19 Violations; imposition of administrative fines;
2795 grounds.—
2796 (7) In addition to any administrative fines imposed, the
2797 agency may assess a survey or monitoring fee, equal to the
2798 lesser of one half of the facility's biennial license and bed
2799 fee or $500, to cover the cost of conducting initial complaint
2800 investigations that result in the finding of a violation that
2801 was the subject of the complaint or to monitor the health,
2802 safety, or security of residents under s. 429.07(7) ~~monitoring~~
2803 ~~visits conducted under s. 429.28(3)(c) to verify the correction~~
2804 ~~of the violations~~.



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

2805 Section 71. Subsections (6) through (10) of section
2806 429.23, Florida Statutes, are renumbered as subsections (5)
2807 through (9), respectively, and present subsection (5) of that
2808 section is amended to read:
2809 429.23 Internal risk management and quality assurance
2810 program; adverse incidents and reporting requirements.—
2811 ~~(5) Each facility shall report monthly to the agency any~~
2812 ~~liability claim filed against it. The report must include the~~
2813 ~~name of the resident, the dates of the incident leading to the~~
2814 ~~claim, if applicable, and the type of injury or violation of~~
2815 ~~rights alleged to have occurred. This report is not discoverable~~
2816 ~~in any civil or administrative action, except in such actions~~
2817 ~~brought by the agency to enforce the provisions of this part.~~
2818 Section 72. Paragraph (a) of subsection (1) and subsection
2819 (2) of section 429.255, Florida Statutes, are amended to read:
2820 429.255 Use of personnel; emergency care.—
2821 (1)(a) Persons under contract to the facility or~~,~~ facility
2822 staff~~, or volunteers,~~ who are licensed according to part I of
2823 chapter 464, or those persons exempt under s. 464.022(1), and
2824 others as defined by rule, may administer medications to
2825 residents, take residents' vital signs, manage individual weekly
2826 pill organizers for residents who self-administer medication,
2827 give prepackaged enemas ordered by a physician, observe
2828 residents, document observations on the appropriate resident's
2829 record, report observations to the resident's physician, and
2830 contract or allow residents or a resident's representative,
2831 designee, surrogate, guardian, or attorney in fact to contract
2832 with a third party, provided residents meet the criteria for

2833 appropriate placement as defined in s. 429.26. Persons under
2834 contract to the facility or facility staff who are licensed
2835 according to part I of chapter 464 may provide limited nursing
2836 services. Nursing assistants certified pursuant to part II of
2837 chapter 464 may take residents' vital signs as directed by a
2838 licensed nurse or physician. The facility is responsible for
2839 maintaining documentation of services provided under this
2840 paragraph as required by rule and ensuring that staff are
2841 adequately trained to monitor residents receiving these
2842 services.
2843 (2) In facilities licensed to provide extended congregate
2844 care, persons under contract to the facility or, facility staff,
2845 or volunteers, who are licensed according to part I of chapter
2846 464, or those persons exempt under s. 464.022(1), or those
2847 persons certified as nursing assistants pursuant to part II of
2848 chapter 464, may also perform all duties within the scope of
2849 their license or certification, as approved by the facility
2850 administrator and pursuant to this part.
2851 Section 73. Subsections (4), (5), (6), and (7) of section
2852 429.28, Florida Statutes, are renumbered as subsections (3),
2853 (4), (5), and (6), respectively, and present subsections (3) and
2854 (6) of that section are amended to read:
2855 429.28 Resident bill of rights.—
2856 ~~(3)(a) The agency shall conduct a survey to determine~~
2857 ~~general compliance with facility standards and compliance with~~
2858 ~~residents' rights as a prerequisite to initial licensure or~~
2859 ~~licensure renewal.~~

2860 ~~(b) In order to determine whether the facility is~~
2861 ~~adequately protecting residents' rights, the biennial survey~~
2862 ~~shall include private informal conversations with a sample of~~
2863 ~~residents and consultation with the ombudsman council in the~~
2864 ~~planning and service area in which the facility is located to~~
2865 ~~discuss residents' experiences within the facility.~~
2866 ~~(c) During any calendar year in which no survey is~~
2867 ~~conducted, the agency shall conduct at least one monitoring~~
2868 ~~visit of each facility cited in the previous year for a class I~~
2869 ~~or class II violation, or more than three uncorrected class III~~
2870 ~~violations.~~
2871 ~~(d) The agency may conduct periodic followup inspections~~
2872 ~~as necessary to monitor the compliance of facilities with a~~
2873 ~~history of any class I, class II, or class III violations that~~
2874 ~~threaten the health, safety, or security of residents.~~
2875 ~~(e) The agency may conduct complaint investigations as~~
2876 ~~warranted to investigate any allegations of noncompliance with~~
2877 ~~requirements required under this part or rules adopted under~~
2878 ~~this part.~~
2879 (5)~~(6)~~ Any facility which terminates the residency of an
2880 individual who participated in activities specified in
2881 subsection (4) ~~(5)~~ shall show good cause in a court of competent
2882 jurisdiction.
2883 Section 74. Subsection (2) of section 429.35, Florida
2884 Statutes, is amended to read:
2885 429.35 Maintenance of records; reports.—
2886 (2) Within 60 days after the date of the biennial
2887 inspection visit required under s. 408.811 or within 30 days

2888 after the date of any interim visit, the agency shall forward
2889 the results of the inspection to the local ombudsman council in
2890 whose planning and service area, as defined in part II of
2891 chapter 400, the facility is located; to at least one public
2892 library or, in the absence of a public library, the county seat
2893 in the county in which the inspected assisted living facility is
2894 located; and, when appropriate, to the district Adult Services
2895 and Mental Health Program Offices. This information may be
2896 provided electronically or through the agency's Internet
2897 website.
2898 Section 75. Paragraphs (i) and (j) of subsection (1) of
2899 section 429.41, Florida Statutes, are amended to read:
2900 429.41 Rules establishing standards.—
2901 (1) It is the intent of the Legislature that rules
2902 published and enforced pursuant to this section shall include
2903 criteria by which a reasonable and consistent quality of
2904 resident care and quality of life may be ensured and the results
2905 of such resident care may be demonstrated. Such rules shall also
2906 ensure a safe and sanitary environment that is residential and
2907 noninstitutional in design or nature. It is further intended
2908 that reasonable efforts be made to accommodate the needs and
2909 preferences of residents to enhance the quality of life in a
2910 facility. The agency, in consultation with the department, may
2911 adopt rules to administer the requirements of part II of chapter
2912 408. In order to provide safe and sanitary facilities and the
2913 highest quality of resident care accommodating the needs and
2914 preferences of residents, the department, in consultation with
2915 the agency, the Department of Children and Family Services, and

2916 the Department of Health, shall adopt rules, policies, and
2917 procedures to administer this part, which must include
2918 reasonable and fair minimum standards in relation to:
2919 (i) Facilities holding an ~~a limited nursing,~~ extended
2920 congregate care~~,~~ or limited mental health license.
2921 (j) The establishment of specific criteria to define
2922 appropriateness of resident admission and continued residency in
2923 a facility holding a standard, ~~limited nursing,~~ extended
2924 congregate care, and limited mental health license.
2925 Section 76. Subsections (1) and (2) of section 429.53,
2926 Florida Statutes, are amended to read:
2927 429.53 Consultation by the agency.—
2928 (1) The ~~area offices of licensure and certification of the~~
2929 agency shall provide consultation to the following upon request:
2930 (a) A licensee of a facility.
2931 (b) A person interested in obtaining a license to operate
2932 a facility under this part.
2933 (2) As used in this section, "consultation" includes:
2934 (a) An explanation of the requirements of this part and
2935 rules adopted pursuant thereto;
2936 (b) An explanation of the license application and renewal
2937 procedures; and
2938 ~~(c) The provision of a checklist of general local and~~
2939 ~~state approvals required prior to constructing or developing a~~
2940 ~~facility and a listing of the types of agencies responsible for~~
2941 ~~such approvals;~~



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

2942 ~~(d) An explanation of benefits and financial assistance~~
2943 ~~available to a recipient of supplemental security income~~
2944 ~~residing in a facility;~~
2945 (c) ~~(e)~~ Any other information which the agency deems
2946 necessary to promote compliance with the requirements of this
2947 part~~; and~~
2948 ~~(f) A preconstruction review of a facility to ensure~~
2949 ~~compliance with agency rules and this part~~.
2950 Section 77. Subsections (1) and (2) of section 429.54,
2951 Florida Statutes, are renumbered as subsections (2) and (3),
2952 respectively, and a new subsection (1) is added to that section
2953 to read:
2954 429.54 Collection of information; local subsidy.—
2955 (1) A facility that is licensed under this part must
2956 report electronically to the agency semiannually data related to
2957 the facility, including, but not limited to, the total number of
2958 residents, the number of residents who are receiving limited
2959 mental health services, the number of residents who are
2960 receiving extended congregate care services, the number of
2961 residents who are receiving limited nursing services, and
2962 professional staffing employed by or under contract with the
2963 licensee to provide resident services. The department, in
2964 consultation with the agency, shall adopt rules to administer
2965 this subsection.
2966 Section 78. Subsections (1) and (5) of section 429.71,
2967 Florida Statutes, are amended to read:
2968 429.71 Classification of violations ~~deficiencies~~;
2969 administrative fines.—

2970 (1) In addition to the requirements of part II of chapter
2971 408 and in addition to any other liability or penalty provided
2972 by law, the agency may impose an administrative fine on a
2973 provider according to the following classification:
2974 (a) Class I violations are defined in s. 408.813 ~~those~~
2975 ~~conditions or practices related to the operation and maintenance~~
2976 ~~of an adult family-care home or to the care of residents which~~
2977 ~~the agency determines present an imminent danger to the~~
2978 ~~residents or guests of the facility or a substantial probability~~
2979 ~~that death or serious physical or emotional harm would result~~
2980 ~~therefrom. The condition or practice that constitutes a class I~~
2981 ~~violation must be abated or eliminated within 24 hours, unless a~~
2982 ~~fixed period, as determined by the agency, is required for~~
2983 ~~correction~~. A class I violation ~~deficiency~~ is subject to an
2984 administrative fine in an amount not less than $500 and not
2985 exceeding $1,000 for each violation. ~~A fine may be levied~~
2986 ~~notwithstanding the correction of the deficiency.~~
2987 (b) Class II violations are defined in s. 408.813 ~~those~~
2988 ~~conditions or practices related to the operation and maintenance~~
2989 ~~of an adult family-care home or to the care of residents which~~
2990 ~~the agency determines directly threaten the physical or~~
2991 ~~emotional health, safety, or security of the residents, other~~
2992 ~~than class I violations~~. A class II violation is subject to an
2993 administrative fine in an amount not less than $250 and not
2994 exceeding $500 for each violation. ~~A citation for a class II~~
2995 ~~violation must specify the time within which the violation is~~
2996 ~~required to be corrected. If a class II violation is corrected~~

2997 ~~within the time specified, no civil penalty shall be imposed,~~
2998 ~~unless it is a repeated offense.~~
2999 (c) Class III violations are defined in s. 408.813 ~~those~~
3000 ~~conditions or practices related to the operation and maintenance~~
3001 ~~of an adult family-care home or to the care of residents which~~
3002 ~~the agency determines indirectly or potentially threaten the~~
3003 ~~physical or emotional health, safety, or security of residents,~~
3004 ~~other than class I or class II violations~~. A class III violation
3005 is subject to an administrative fine in an amount not less than
3006 $100 and not exceeding $250 for each violation. ~~A citation for a~~
3007 ~~class III violation shall specify the time within which the~~
3008 ~~violation is required to be corrected.~~ If a class III violation
3009 is corrected within the time specified, no civil penalty shall
3010 be imposed, unless it is a repeated violation ~~offense~~.
3011 (d) Class IV violations are defined in s. 408.813 ~~those~~
3012 ~~conditions or occurrences related to the operation and~~
3013 ~~maintenance of an adult family-care home, or related to the~~
3014 ~~required reports, forms, or documents, which do not have the~~
3015 ~~potential of negatively affecting the residents~~. ~~A provider that~~
3016 ~~does not correct~~ A class IV violation ~~within the time limit~~
3017 ~~specified by the agency~~ is subject to an administrative fine in
3018 an amount not less than $50 and not exceeding $100 for each
3019 violation. Any class IV violation that is corrected during the
3020 time the agency survey is conducted will be identified as an
3021 agency finding and not as a violation, unless it is a repeat
3022 violation.
3023 ~~(5) As an alternative to or in conjunction with an~~
3024 ~~administrative action against a provider, the agency may request~~

3025 ~~a plan of corrective action that demonstrates a good faith~~
3026 ~~effort to remedy each violation by a specific date, subject to~~
3027 ~~the approval of the agency.~~
3028 Section 79. Paragraphs (b) through (e) of subsection (2)
3029 of section 429.911, Florida Statutes, are redesignated as
3030 paragraphs (a) through (d), respectively, and present paragraph
3031 (a) of that subsection is amended to read:
3032 429.911 Denial, suspension, revocation of license;
3033 emergency action; administrative fines; investigations and
3034 inspections.—
3035 (2) Each of the following actions by the owner of an adult
3036 day care center or by its operator or employee is a ground for
3037 action by the agency against the owner of the center or its
3038 operator or employee:
3039 ~~(a) An intentional or negligent act materially affecting~~
3040 ~~the health or safety of center participants.~~
3041 Section 80. Section 429.915, Florida Statutes, is amended
3042 to read:
3043 429.915 Conditional license.—In addition to the license
3044 categories available in part II of chapter 408, the agency may
3045 issue a conditional license to an applicant for license renewal
3046 or change of ownership if the applicant fails to meet all
3047 standards and requirements for licensure. A conditional license
3048 issued under this subsection must be limited to a specific
3049 period not exceeding 6 months, as determined by the agency~~, and~~
3050 ~~must be accompanied by an approved plan of correction~~.
3051 Section 81. Paragraphs (b) and (g) of subsection (3) of
3052 section 430.80, Florida Statutes, are amended to read:

3053 430.80 Implementation of a teaching nursing home pilot
3054 project.—
3055 (3) To be designated as a teaching nursing home, a nursing
3056 home licensee must, at a minimum:
3057 (b) Participate in a nationally recognized accreditation
3058 program and hold a valid accreditation, such as the
3059 accreditation awarded by the Joint Commission ~~on Accreditation~~
3060 ~~of Healthcare Organizations~~, or, at the time of initial
3061 designation, possess a Gold Seal Award as conferred by the state
3062 on its licensed nursing home;
3063 (g) Maintain insurance coverage pursuant to s.
3064 400.141(1)(q) ~~(s)~~ or proof of financial responsibility in a
3065 minimum amount of $750,000. Such proof of financial
3066 responsibility may include:
3067 1. Maintaining an escrow account consisting of cash or
3068 assets eligible for deposit in accordance with s. 625.52; or
3069 2. Obtaining and maintaining pursuant to chapter 675 an
3070 unexpired, irrevocable, nontransferable and nonassignable letter
3071 of credit issued by any bank or savings association organized
3072 and existing under the laws of this state or any bank or savings
3073 association organized under the laws of the United States that
3074 has its principal place of business in this state or has a
3075 branch office which is authorized to receive deposits in this
3076 state. The letter of credit shall be used to satisfy the
3077 obligation of the facility to the claimant upon presentment of a
3078 final judgment indicating liability and awarding damages to be
3079 paid by the facility or upon presentment of a settlement
3080 agreement signed by all parties to the agreement when such final



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

3081 judgment or settlement is a result of a liability claim against
3082 the facility.
3083 Section 82. Paragraph (a) of subsection (2) of section
3084 440.13, Florida Statutes, is amended to read:
3085 440.13 Medical services and supplies; penalty for
3086 violations; limitations.—
3087 (2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—
3088 (a) Subject to the limitations specified elsewhere in this
3089 chapter, the employer shall furnish to the employee such
3090 medically necessary remedial treatment, care, and attendance for
3091 such period as the nature of the injury or the process of
3092 recovery may require, which is in accordance with established
3093 practice parameters and protocols of treatment as provided for
3094 in this chapter, including medicines, medical supplies, durable
3095 medical equipment, orthoses, prostheses, and other medically
3096 necessary apparatus. Remedial treatment, care, and attendance,
3097 including work-hardening programs or pain-management programs
3098 accredited by the Commission on Accreditation of Rehabilitation
3099 Facilities or the Joint Commission ~~on the Accreditation of~~
3100 ~~Health Organizations~~ or pain-management programs affiliated with
3101 medical schools, shall be considered as covered treatment only
3102 when such care is given based on a referral by a physician as
3103 defined in this chapter. Medically necessary treatment, care,
3104 and attendance does not include chiropractic services in excess
3105 of 24 treatments or rendered 12 weeks beyond the date of the
3106 initial chiropractic treatment, whichever comes first, unless
3107 the carrier authorizes additional treatment or the employee is
3108 catastrophically injured.

3109

3110 Failure of the carrier to timely comply with this subsection
3111 shall be a violation of this chapter and the carrier shall be
3112 subject to penalties as provided for in s. 440.525.
3113 Section 83. Section 483.294, Florida Statutes, is amended
3114 to read:
3115 483.294 Inspection of centers.—In accordance with s.
3116 408.811, the agency shall biennially~~, at least once annually,~~
3117 inspect the premises and operations of all centers subject to
3118 licensure under this part.
3119 Section 84. Subsection (4) is added to section 626.9541,
3120 Florida Statutes, to read:
3121 626.9541 Unfair methods of competition and unfair or
3122 deceptive acts or practices defined; alternative rates of
3123 payment; wellness programs.—
3124 (4) WELLNESS PROGRAMS.—An insurer issuing a group or
3125 individual health benefit plan may offer a voluntary wellness or
3126 health-improvement program that allows for rewards or
3127 incentives, including, but not limited to, merchandise, gift
3128 cards, debit cards, premium discounts or rebates, contributions
3129 towards a member's health savings account, modifications to
3130 copayment, deductible, or coinsurance amounts, or any
3131 combination of these incentives, to encourage or reward
3132 participation in the program. The health plan member may be
3133 required to provide verification, such as a statement from his
3134 or her physician, that a medical condition makes it unreasonably
3135 difficult or medically inadvisable for the individual to
3136 participate in the wellness program. Any reward or incentive

3137 established under this subsection is not an insurance benefit
3138 and does not violate this section. This subsection does not
3139 prohibit an insurer from offering incentives or rewards to
3140 members for adherence to wellness or health improvement programs
3141 if otherwise allowed by state or federal law. Notwithstanding
3142 any provision of this subsection, no insurer, nor its agent, may
3143 use any incentive authorized by this subsection for the purpose
3144 of redirecting patients from one health care insurance plan to
3145 another.
3146 Section 85. Subsection (1) of section 627.645, Florida
3147 Statutes, is amended to read:
3148 627.645 Denial of health insurance claims restricted.—
3149 (1) No claim for payment under a health insurance policy
3150 or self-insured program of health benefits for treatment, care,
3151 or services in a licensed hospital which is accredited by the
3152 Joint Commission ~~on the Accreditation of Hospitals~~, the American
3153 Osteopathic Association, or the Commission on the Accreditation
3154 of Rehabilitative Facilities shall be denied because such
3155 hospital lacks major surgical facilities and is primarily of a
3156 rehabilitative nature, if such rehabilitation is specifically
3157 for treatment of physical disability.
3158 Section 86. Paragraph (c) of subsection (2) of section
3159 627.668, Florida Statutes, is amended to read:
3160 627.668 Optional coverage for mental and nervous disorders
3161 required; exception.—
3162 (2) Under group policies or contracts, inpatient hospital
3163 benefits, partial hospitalization benefits, and outpatient
3164 benefits consisting of durational limits, dollar amounts,



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

3165 deductibles, and coinsurance factors shall not be less favorable
3166 than for physical illness generally, except that:
3167 (c) Partial hospitalization benefits shall be provided
3168 under the direction of a licensed physician. For purposes of
3169 this part, the term "partial hospitalization services" is
3170 defined as those services offered by a program accredited by the
3171 Joint Commission ~~on Accreditation of Hospitals (JCAH)~~ or in
3172 compliance with equivalent standards. Alcohol rehabilitation
3173 programs accredited by the Joint Commission ~~on Accreditation of~~
3174 ~~Hospitals~~ or approved by the state and licensed drug abuse
3175 rehabilitation programs shall also be qualified providers under
3176 this section. In any benefit year, if partial hospitalization
3177 services or a combination of inpatient and partial
3178 hospitalization are utilized, the total benefits paid for all
3179 such services shall not exceed the cost of 30 days of inpatient
3180 hospitalization for psychiatric services, including physician
3181 fees, which prevail in the community in which the partial
3182 hospitalization services are rendered. If partial
3183 hospitalization services benefits are provided beyond the limits
3184 set forth in this paragraph, the durational limits, dollar
3185 amounts, and coinsurance factors thereof need not be the same as
3186 those applicable to physical illness generally.
3187 Section 87. Subsection (3) of section 627.669, Florida
3188 Statutes, is amended to read:
3189 627.669 Optional coverage required for substance abuse
3190 impaired persons; exception.—
3191 (3) The benefits provided under this section shall be
3192 applicable only if treatment is provided by, or under the

3193 supervision of, or is prescribed by, a licensed physician or
3194 licensed psychologist and if services are provided in a program
3195 accredited by the Joint Commission ~~on Accreditation of Hospitals~~
3196 or approved by the state.
3197 Section 88. Paragraph (a) of subsection (1) of section
3198 627.736, Florida Statutes, is amended to read:
3199 627.736 Required personal injury protection benefits;
3200 exclusions; priority; claims.—
3201 (1) REQUIRED BENEFITS.—Every insurance policy complying
3202 with the security requirements of s. 627.733 shall provide
3203 personal injury protection to the named insured, relatives
3204 residing in the same household, persons operating the insured
3205 motor vehicle, passengers in such motor vehicle, and other
3206 persons struck by such motor vehicle and suffering bodily injury
3207 while not an occupant of a self-propelled vehicle, subject to
3208 the provisions of subsection (2) and paragraph (4)(e), to a
3209 limit of $10,000 for loss sustained by any such person as a
3210 result of bodily injury, sickness, disease, or death arising out
3211 of the ownership, maintenance, or use of a motor vehicle as
3212 follows:
3213 (a) *Medical benefits.*—Eighty percent of all reasonable
3214 expenses for medically necessary medical, surgical, X-ray,
3215 dental, and rehabilitative services, including prosthetic
3216 devices, and medically necessary ambulance, hospital, and
3217 nursing services. However, the medical benefits shall provide
3218 reimbursement only for such services and care that are lawfully
3219 provided, supervised, ordered, or prescribed by a physician
3220 licensed under chapter 458 or chapter 459, a dentist licensed

3221 under chapter 466, or a chiropractic physician licensed under
3222 chapter 460 or that are provided by any of the following persons
3223 or entities:
3224 1. A hospital or ambulatory surgical center licensed under
3225 chapter 395.
3226 2. A person or entity licensed under ss. 401.2101-401.45
3227 that provides emergency transportation and treatment.
3228 3. An entity wholly owned by one or more physicians
3229 licensed under chapter 458 or chapter 459, chiropractic
3230 physicians licensed under chapter 460, or dentists licensed
3231 under chapter 466 or by such practitioner or practitioners and
3232 the spouse, parent, child, or sibling of that practitioner or
3233 those practitioners.
3234 4. An entity wholly owned, directly or indirectly, by a
3235 hospital or hospitals.
3236 5. A health care clinic licensed under ss. 400.990-400.995
3237 that is:
3238 a. Accredited by the Joint Commission ~~on Accreditation of~~
3239 ~~Healthcare Organizations~~, the American Osteopathic Association,
3240 the Commission on Accreditation of Rehabilitation Facilities, or
3241 the Accreditation Association for Ambulatory Health Care, Inc.;
3242 or
3243 b. A health care clinic that:
3244 (I) Has a medical director licensed under chapter 458,
3245 chapter 459, or chapter 460;
3246 (II) Has been continuously licensed for more than 3 years
3247 or is a publicly traded corporation that issues securities
3248 traded on an exchange registered with the United States



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

3249 Securities and Exchange Commission as a national securities
3250 exchange; and
3251 (III) Provides at least four of the following medical
3252 specialties:
3253 (A) General medicine.
3254 (B) Radiography.
3255 (C) Orthopedic medicine.
3256 (D) Physical medicine.
3257 (E) Physical therapy.
3258 (F) Physical rehabilitation.
3259 (G) Prescribing or dispensing outpatient prescription
3260 medication.
3261 (H) Laboratory services.
3262
3263 The Financial Services Commission shall adopt by rule the form
3264 that must be used by an insurer and a health care provider
3265 specified in subparagraph 3., subparagraph 4., or subparagraph
3266 5. to document that the health care provider meets the criteria
3267 of this paragraph, which rule must include a requirement for a
3268 sworn statement or affidavit.
3269
3270 Only insurers writing motor vehicle liability insurance in this
3271 state may provide the required benefits of this section, and no
3272 such insurer shall require the purchase of any other motor
3273 vehicle coverage other than the purchase of property damage
3274 liability coverage as required by s. 627.7275 as a condition for
3275 providing such required benefits. Insurers may not require that
3276 property damage liability insurance in an amount greater than

3277 $10,000 be purchased in conjunction with personal injury
3278 protection. Such insurers shall make benefits and required
3279 property damage liability insurance coverage available through
3280 normal marketing channels. Any insurer writing motor vehicle
3281 liability insurance in this state who fails to comply with such
3282 availability requirement as a general business practice shall be
3283 deemed to have violated part IX of chapter 626, and such
3284 violation shall constitute an unfair method of competition or an
3285 unfair or deceptive act or practice involving the business of
3286 insurance; and any such insurer committing such violation shall
3287 be subject to the penalties afforded in such part, as well as
3288 those which may be afforded elsewhere in the insurance code.
3289 Section 89. Section 633.081, Florida Statutes, is amended
3290 to read:
3291 633.081 Inspection of buildings and equipment; orders;
3292 firesafety inspection training requirements; certification;
3293 disciplinary action.—The State Fire Marshal and her or his
3294 agents shall, at any reasonable hour, when the State Fire
3295 Marshal has reasonable cause to believe that a violation of this
3296 chapter or s. 509.215, or a rule promulgated thereunder, or a
3297 minimum firesafety code adopted by a local authority, may exist,
3298 inspect any and all buildings and structures which are subject
3299 to the requirements of this chapter or s. 509.215 and rules
3300 promulgated thereunder. The authority to inspect shall extend to
3301 all equipment, vehicles, and chemicals which are located within
3302 the premises of any such building or structure. The State Fire
3303 Marshal and her or his agents shall inspect nursing homes
3304 licensed under part II of chapter 400 only once every calendar

3305 year and upon receiving a complaint forming the basis of a
3306 reasonable cause to believe that a violation of this chapter or
3307 s. 509.215, or a rule promulgated thereunder, or a minimum
3308 firesafety code adopted by a local authority may exist and upon
3309 identifying such a violation in the course of conducting
3310 orientation or training activities within a nursing home.
3311 (1) Each county, municipality, and special district that
3312 has firesafety enforcement responsibilities shall employ or
3313 contract with a firesafety inspector. Except as provided in s.
3314 633.082(2), the firesafety inspector must conduct all firesafety
3315 inspections that are required by law. The governing body of a
3316 county, municipality, or special district that has firesafety
3317 enforcement responsibilities may provide a schedule of fees to
3318 pay only the costs of inspections conducted pursuant to this
3319 subsection and related administrative expenses. Two or more
3320 counties, municipalities, or special districts that have
3321 firesafety enforcement responsibilities may jointly employ or
3322 contract with a firesafety inspector.
3323 (2) Except as provided in s. 633.082(2), every firesafety
3324 inspection conducted pursuant to state or local firesafety
3325 requirements shall be by a person certified as having met the
3326 inspection training requirements set by the State Fire Marshal.
3327 Such person shall:
3328 (a) Be a high school graduate or the equivalent as
3329 determined by the department;
3330 (b) Not have been found guilty of, or having pleaded
3331 guilty or nolo contendere to, a felony or a crime punishable by
3332 imprisonment of 1 year or more under the law of the United

3333 States, or of any state thereof, which involves moral turpitude,
3334 without regard to whether a judgment of conviction has been
3335 entered by the court having jurisdiction of such cases;
3336 (c) Have her or his fingerprints on file with the
3337 department or with an agency designated by the department;
3338 (d) Have good moral character as determined by the
3339 department;
3340 (e) Be at least 18 years of age;
3341 (f) Have satisfactorily completed the firesafety inspector
3342 certification examination as prescribed by the department; and
3343 (g)1. Have satisfactorily completed, as determined by the
3344 department, a firesafety inspector training program of not less
3345 than 200 hours established by the department and administered by
3346 agencies and institutions approved by the department for the
3347 purpose of providing basic certification training for firesafety
3348 inspectors; or
3349 2. Have received in another state training which is
3350 determined by the department to be at least equivalent to that
3351 required by the department for approved firesafety inspector
3352 education and training programs in this state.
3353 (3) Each special state firesafety inspection which is
3354 required by law and is conducted by or on behalf of an agency of
3355 the state must be performed by an individual who has met the
3356 provision of subsection (2), except that the duration of the
3357 training program shall not exceed 120 hours of specific training
3358 for the type of property that such special state firesafety
3359 inspectors are assigned to inspect.
3360 (4) A firefighter certified pursuant to s. 633.35 may

3361 conduct firesafety inspections, under the supervision of a
3362 certified firesafety inspector, while on duty as a member of a
3363 fire department company conducting inservice firesafety
3364 inspections without being certified as a firesafety inspector,
3365 if such firefighter has satisfactorily completed an inservice
3366 fire department company inspector training program of at least
3367 24 hours' duration as provided by rule of the department.
3368 (5) Every firesafety inspector or special state firesafety
3369 inspector certificate is valid for a period of 3 years from the
3370 date of issuance. Renewal of certification shall be subject to
3371 the affected person's completing proper application for renewal
3372 and meeting all of the requirements for renewal as established
3373 under this chapter or by rule promulgated thereunder, which
3374 shall include completion of at least 40 hours during the
3375 preceding 3-year period of continuing education as required by
3376 the rule of the department or, in lieu thereof, successful
3377 passage of an examination as established by the department.
3378 (6) The State Fire Marshal may deny, refuse to renew,
3379 suspend, or revoke the certificate of a firesafety inspector or
3380 special state firesafety inspector if it finds that any of the
3381 following grounds exist:
3382 (a) Any cause for which issuance of a certificate could
3383 have been refused had it then existed and been known to the
3384 State Fire Marshal.
3385 (b) Violation of this chapter or any rule or order of the
3386 State Fire Marshal.
3387 (c) Falsification of records relating to the certificate.
3388 (d) Having been found guilty of or having pleaded guilty

3389 or nolo contendere to a felony, whether or not a judgment of
3390 conviction has been entered.
3391 (e) Failure to meet any of the renewal requirements.
3392 (f) Having been convicted of a crime in any jurisdiction
3393 which directly relates to the practice of fire code inspection,
3394 plan review, or administration.
3395 (g) Making or filing a report or record that the
3396 certificateholder knows to be false, or knowingly inducing
3397 another to file a false report or record, or knowingly failing
3398 to file a report or record required by state or local law, or
3399 knowingly impeding or obstructing such filing, or knowingly
3400 inducing another person to impede or obstruct such filing.
3401 (h) Failing to properly enforce applicable fire codes or
3402 permit requirements within this state which the
3403 certificateholder knows are applicable by committing willful
3404 misconduct, gross negligence, gross misconduct, repeated
3405 negligence, or negligence resulting in a significant danger to
3406 life or property.
3407 (i) Accepting labor, services, or materials at no charge
3408 or at a noncompetitive rate from any person who performs work
3409 that is under the enforcement authority of the certificateholder
3410 and who is not an immediate family member of the
3411 certificateholder. For the purpose of this paragraph, the term
3412 "immediate family member" means a spouse, child, parent,
3413 sibling, grandparent, aunt, uncle, or first cousin of the person
3414 or the person's spouse or any person who resides in the primary
3415 residence of the certificateholder.
3416 (7) The Division of State Fire Marshal and the Florida

3417 Building Code Administrators and Inspectors Board, established
3418 pursuant to s. 468.605, shall enter into a reciprocity agreement
3419 to facilitate joint recognition of continuing education
3420 recertification hours for certificateholders licensed under s.
3421 468.609 and firesafety inspectors certified under subsection
3422 (2).
3423 (8) The State Fire Marshal shall develop by rule an
3424 advanced training and certification program for firesafety
3425 inspectors having fire code management responsibilities. The
3426 program must be consistent with the appropriate provisions of
3427 NFPA 1037, or similar standards adopted by the division, and
3428 establish minimum training, education, and experience levels for
3429 firesafety inspectors having fire code management
3430 responsibilities.
3431 (9) The department shall provide by rule for the
3432 certification of firesafety inspectors.
3433 Section 90. Subsection (12) of section 641.495, Florida
3434 Statutes, is amended to read:
3435 641.495 Requirements for issuance and maintenance of
3436 certificate.—
3437 (12) The provisions of part I of chapter 395 do not apply
3438 to a health maintenance organization that, on or before January
3439 1, 1991, provides not more than 10 outpatient holding beds for
3440 short-term and hospice-type patients in an ambulatory care
3441 facility for its members, provided that such health maintenance
3442 organization maintains current accreditation by the Joint
3443 Commission ~~on Accreditation of Health Care Organizations~~, the

3444 Accreditation Association for Ambulatory Health Care, or the
3445 National Committee for Quality Assurance.
3446 Section 91. Subsection (13) of section 651.118, Florida
3447 Statutes, is amended to read:
3448 651.118 Agency for Health Care Administration;
3449 certificates of need; sheltered beds; community beds.—
3450 (13) Residents, as defined in this chapter, are not
3451 considered new admissions for the purpose of s.
3452 400.141(1)(n)~~(o)~~1.d.
3453 Section 92. Subsection (2) of section 766.1015, Florida
3454 Statutes, is amended to read:
3455 766.1015 Civil immunity for members of or consultants to
3456 certain boards, committees, or other entities.—
3457 (2) Such committee, board, group, commission, or other
3458 entity must be established in accordance with state law or in
3459 accordance with requirements of the Joint Commission ~~on~~
3460 ~~Accreditation of Healthcare Organizations~~, established and duly
3461 constituted by one or more public or licensed private hospitals
3462 or behavioral health agencies, or established by a governmental
3463 agency. To be protected by this section, the act, decision,
3464 omission, or utterance may not be made or done in bad faith or
3465 with malicious intent.
3466 Section 93. Subsection (4) of section 766.202, Florida
3467 Statutes, is amended to read:
3468 766.202 Definitions; ss. 766.201-766.212.—As used in ss.
3469 766.201-766.212, the term:
3470 (4) "Health care provider" means any hospital, ambulatory
3471 surgical center, or mobile surgical facility as defined and

3472 licensed under chapter 395; a birth center licensed under
3473 chapter 383; any person licensed under chapter 458, chapter 459,
3474 chapter 460, chapter 461, chapter 462, chapter 463, part I of
3475 chapter 464, chapter 466, chapter 467, part XIV of chapter 468,
3476 or chapter 486; a clinical lab licensed under chapter 483; a
3477 health maintenance organization certificated under part I of
3478 chapter 641; a blood bank; a plasma center; an industrial
3479 clinic; a renal dialysis facility; or a professional association
3480 partnership, corporation, joint venture, or other association
3481 for professional activity by health care providers.
3482 Section 94. This act shall take effect July 1, 2011.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ____ (Y/N)

ADOPTED AS AMENDED ____ (Y/N)

ADOPTED W/O OBJECTION ____ (Y/N)

FAILED TO ADOPT ____ (Y/N)

WITHDRAWN ____ (Y/N)

OTHER

---

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Quality Subcommittee
3 Representative(s) Hudson offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Subsection (1) of section 83.42, Florida
8 Statutes, is amended to read:
9 83.42 Exclusions from application of part.—This part does
10 not apply to:
11 (1) Residency or detention in a facility, whether public
12 or private, when residence or detention is incidental to the
13 provision of medical, geriatric, educational, counseling,
14 religious, or similar services. For residents of a facility
15 licensed under part II of chapter 400, the provisions of s.
16 400.0255 are the exclusive procedures for all transfers and
17 discharges.
18 Section 2. Paragraphs (f) through (k) of subsection (10)
19 of section 112.0455, Florida Statutes, are redesignated as

paragraphs (e) through (j), respectively, and present paragraph (e) of subsection (10) and paragraph (e) of subsection (14) of that section are amended to read:

112.0455 Drug-Free Workplace Act.—

(10) EMPLOYER PROTECTION.—

~~(e) Nothing in this section shall be construed to operate retroactively, and nothing in this section shall abrogate the right of an employer under state law to conduct drug tests prior to January 1, 1990. A drug test conducted by an employer prior to January 1, 1990, is not subject to this section.~~

(12) DRUG-TESTING STANDARDS; LABORATORIES.—

~~(d) The laboratory shall submit to the Agency for Health Care Administration a monthly report with statistical information regarding the testing of employees and job applicants. The reports shall include information on the methods of analyses conducted, the drugs tested for, the number of positive and negative results for both initial and confirmation tests, and any other information deemed appropriate by the Agency for Health Care Administration. No monthly report shall identify specific employees or job applicants.~~

(d) ~~(e)~~ Laboratories shall provide technical assistance to the employer, employee, or job applicant for the purpose of interpreting any positive confirmed test results which could have been caused by prescription or nonprescription medication taken by the employee or job applicant.

(14) DISCIPLINE REMEDIES.—

46 (e) Upon resolving an appeal filed pursuant to paragraph
47 (c), and finding a violation of this section, the commission may
48 order the following relief:
49 1. Rescind the disciplinary action, expunge related
50 records from the personnel file of the employee or job applicant
51 and reinstate the employee.
52 2. Order compliance with paragraph (10)(f)~~(g)~~.
53 3. Award back pay and benefits.
54 4. Award the prevailing employee or job applicant the
55 necessary costs of the appeal, reasonable attorney's fees, and
56 expert witness fees.
57 Section 3. Paragraph (n) of subsection (1) of section
58 154.11, Florida Statutes, is amended to read:
59 154.11 Powers of board of trustees.—
60 (1) The board of trustees of each public health trust
61 shall be deemed to exercise a public and essential governmental
62 function of both the state and the county and in furtherance
63 thereof it shall, subject to limitation by the governing body of
64 the county in which such board is located, have all of the
65 powers necessary or convenient to carry out the operation and
66 governance of designated health care facilities, including, but
67 without limiting the generality of, the foregoing:
68 (n) To appoint originally the staff of physicians to
69 practice in any designated facility owned or operated by the
70 board and to approve the bylaws and rules to be adopted by the
71 medical staff of any designated facility owned and operated by
72 the board, such governing regulations to be in accordance with
73 the standards of the Joint Commission ~~on the Accreditation of~~

74 ~~Hospitals~~ which provide, among other things, for the method of
75 appointing additional staff members and for the removal of staff
76 members.
77 Section 4. Subsection (15) of section 318.21, Florida
78 Statutes, is amended to read:
79 318.21 Disposition of civil penalties by county courts.—
80 All civil penalties received by a county court pursuant to the
81 provisions of this chapter shall be distributed and paid monthly
82 as follows:
83 (15) Of the additional fine assessed under s. 318.18(3)(e)
84 for a violation of s. 316.1893, 50 percent of the moneys
85 received from the fines shall be remitted to the Department of
86 Revenue and deposited into the Brain and Spinal Cord Injury
87 Trust Fund of Department of Health and shall be appropriated to
88 the Department of Health ~~Agency for Health Care Administration~~
89 as general revenue to ~~provide an enhanced Medicaid payment to~~
90 ~~nursing homes that~~ serve Medicaid recipients with brain and
91 spinal cord injuries that are medically complex and who are
92 technologically and respiratory dependent. The remaining 50
93 percent of the moneys received from the enhanced fine imposed
94 under s. 318.18(3)(e) shall be remitted to the Department of
95 Revenue and deposited into the Department of Health Emergency
96 Medical Services Trust Fund to provide financial support to
97 certified trauma centers in the counties where enhanced penalty
98 zones are established to ensure the availability and
99 accessibility of trauma services. Funds deposited into the
100 Emergency Medical Services Trust Fund under this subsection
101 shall be allocated as follows:

102 (a) Fifty percent shall be allocated equally among all
103 Level I, Level II, and pediatric trauma centers in recognition
104 of readiness costs for maintaining trauma services.
105 (b) Fifty percent shall be allocated among Level I, Level
106 II, and pediatric trauma centers based on each center's relative
107 volume of trauma cases as reported in the Department of Health
108 Trauma Registry.
109 Section 5. Section 383.325, Florida Statutes, is repealed.
110 Section 6. Subsection (7) of section 394.4787, Florida
111 Statutes, is amended to read:
112 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788,
113 and 394.4789.—As used in this section and ss. 394.4786,
114 394.4788, and 394.4789:
115 (7) "Specialty psychiatric hospital" means a hospital
116 licensed by the agency pursuant to s. 395.002(26) ~~(28)~~ and part
117 II of chapter 408 as a specialty psychiatric hospital.
118 Section 7. Subsection (2) of section 394.741, Florida
119 Statutes, is amended to read:
120 394.741 Accreditation requirements for providers of
121 behavioral health care services.—
122 (2) Notwithstanding any provision of law to the contrary,
123 accreditation shall be accepted by the agency and department in
124 lieu of the agency's and department's facility licensure onsite
125 review requirements and shall be accepted as a substitute for
126 the department's administrative and program monitoring
127 requirements, except as required by subsections (3) and (4),
128 for:

129 (a) Any organization from which the department purchases
130 behavioral health care services that is accredited by the Joint
131 Commission ~~on Accreditation of Healthcare Organizations~~ or the
132 Council on Accreditation ~~for Children and Family Services~~, or
133 has those services that are being purchased by the department
134 accredited by the Commission on Accreditation of Rehabilitation
135 Facilities ~~CARF—the Rehabilitation Accreditation Commission~~.
136 (b) Any mental health facility licensed by the agency or
137 any substance abuse component licensed by the department that is
138 accredited by the Joint Commission ~~on Accreditation of~~
139 ~~Healthcare Organizations~~, the Commission on Accreditation of
140 Rehabilitation Facilities ~~CARF—the Rehabilitation Accreditation~~
141 ~~Commission~~, or the Council on Accreditation ~~of Children and~~
142 ~~Family Services~~.
143 (c) Any network of providers from which the department or
144 the agency purchases behavioral health care services accredited
145 by the Joint Commission ~~on Accreditation of Healthcare~~
146 ~~Organizations~~, the Commission on Accreditation of Rehabilitation
147 Facilities ~~CARF—the Rehabilitation Accreditation Commission~~, the
148 Council on Accreditation ~~of Children and Family Services~~, or the
149 National Committee for Quality Assurance. A provider
150 organization, which is part of an accredited network, is
151 afforded the same rights under this part.
152 Section 8. Present subsections (15) through (32) of
153 section 395.002, Florida Statutes, are renumbered as subsections
154 (14) through (28), respectively, and present subsections (1),
155 (14), (24), (30), and (31) and paragraph (c) of present
156 subsection (28) of that section are amended to read:

Amendment No.

157 395.002 Definitions.—As used in this chapter:
158 (1) "Accrediting organizations" means nationally
159 recognized or approved accrediting organizations whose standards
160 incorporate comparable licensure requirements as determined by
161 the agency ~~the Joint Commission on Accreditation of Healthcare~~
162 ~~Organizations, the American Osteopathic Association, the~~
163 ~~Commission on Accreditation of Rehabilitation Facilities, and~~
164 ~~the Accreditation Association for Ambulatory Health Care, Inc~~.
165 ~~(14) "Initial denial determination" means a determination~~
166 ~~by a private review agent that the health care services~~
167 ~~furnished or proposed to be furnished to a patient are~~
168 ~~inappropriate, not medically necessary, or not reasonable.~~
169 ~~(24) "Private review agent" means any person or entity~~
170 ~~which performs utilization review services for third-party~~
171 ~~payors on a contractual basis for outpatient or inpatient~~
172 ~~services. However, the term shall not include full-time~~
173 ~~employees, personnel, or staff of health insurers, health~~
174 ~~maintenance organizations, or hospitals, or wholly owned~~
175 ~~subsidiaries thereof or affiliates under common ownership, when~~
176 ~~performing utilization review for their respective hospitals,~~
177 ~~health maintenance organizations, or insureds of the same~~
178 ~~insurance group. For this purpose, health insurers, health~~
179 ~~maintenance organizations, and hospitals, or wholly owned~~
180 ~~subsidiaries thereof or affiliates under common ownership,~~
181 ~~include such entities engaged as administrators of self-~~
182 ~~insurance as defined in s. 624.031.~~

183 (26) ~~(28)~~ "Specialty hospital" means any facility which
184 meets the provisions of subsection (12), and which regularly
185 makes available either:
186 (c) Intensive residential treatment programs for children
187 and adolescents as defined in subsection (14) ~~(15)~~.
188 ~~(30) "Utilization review" means a system for reviewing the~~
189 ~~medical necessity or appropriateness in the allocation of health~~
190 ~~care resources of hospital services given or proposed to be~~
191 ~~given to a patient or group of patients.~~
192 ~~(31) "Utilization review plan" means a description of the~~
193 ~~policies and procedures governing utilization review activities~~
194 ~~performed by a private review agent.~~
195 Section 9. Paragraph (c) of subsection (1) and paragraph
196 (b) of subsection (2) of section 395.003, Florida Statutes, are
197 amended to read:
198 395.003 Licensure; denial, suspension, and revocation.—
199 (1)
200 ~~(c) Until July 1, 2006, additional emergency departments~~
201 ~~located off the premises of licensed hospitals may not be~~
202 ~~authorized by the agency.~~
203 (2)
204 (b) The agency shall, at the request of a licensee that is
205 a teaching hospital as defined in s. 408.07(45), issue a single
206 license to a licensee for facilities that have been previously
207 licensed as separate premises, provided such separately licensed
208 facilities, taken together, constitute the same premises as
209 defined in s. 395.002(22) ~~(23)~~. Such license for the single
210 premises shall include all of the beds, services, and programs

211 that were previously included on the licenses for the separate
212 premises. The granting of a single license under this paragraph
213 shall not in any manner reduce the number of beds, services, or
214 programs operated by the licensee.
215 Section 10. Subsection (3) of section 395.0161, Florida
216 Statutes, is amended to read:
217 395.0161 Licensure inspection.—
218 (3) In accordance with s. 408.805, an applicant or
219 licensee shall pay a fee for each license application submitted
220 under this part, part II of chapter 408, and applicable rules.
221 With the exception of state-operated licensed facilities, each
222 facility licensed under this part shall pay to the agency~~, at~~
223 ~~the time of inspection,~~ the following fees:
224 (a) Inspection for licensure.—A fee shall be paid which is
225 not less than $8 per hospital bed, nor more than $12 per
226 hospital bed, except that the minimum fee shall be $400 per
227 facility.
228 (b) Inspection for lifesafety only.—A fee shall be paid
229 which is not less than 75 cents per hospital bed, nor more than
230 $1.50 per hospital bed, except that the minimum fee shall be $40
231 per facility.
232 Section 11. Paragraph (e) of subsection (2) and subsection
233 (4) of section 395.0193, Florida Statutes, are amended to read:
234 395.0193 Licensed facilities; peer review; disciplinary
235 powers; agency or partnership with physicians.—
236 (2) Each licensed facility, as a condition of licensure,
237 shall provide for peer review of physicians who deliver health
238 care services at the facility. Each licensed facility shall

239 develop written, binding procedures by which such peer review
240 shall be conducted. Such procedures shall include:
241 (e) Recording of agendas and minutes which do not contain
242 confidential material, for review by the Division of Medical
243 Quality Assurance of the department ~~Health Quality Assurance of~~
244 ~~the agency~~.
245 (4) Pursuant to ss. 458.337 and 459.016, any disciplinary
246 actions taken under subsection (3) shall be reported in writing
247 to the Division of Medical Quality Assurance of the department
248 ~~Health Quality Assurance of the agency~~ within 30 working days
249 after its initial occurrence, regardless of the pendency of
250 appeals to the governing board of the hospital. The notification
251 shall identify the disciplined practitioner, the action taken,
252 and the reason for such action. All final disciplinary actions
253 taken under subsection (3), if different from those which were
254 reported to the department ~~agency~~ within 30 days after the
255 initial occurrence, shall be reported within 10 working days to
256 the Division of Medical Quality Assurance of the department
257 ~~Health Quality Assurance of the agency~~ in writing and shall
258 specify the disciplinary action taken and the specific grounds
259 therefor. The division shall review each report and determine
260 whether it potentially involved conduct by the licensee that is
261 subject to disciplinary action, in which case s. 456.073 shall
262 apply. The reports are not subject to inspection under s.
263 119.07(1) even if the division's investigation results in a
264 finding of probable cause.
265 Section 12. Section 395.1023, Florida Statutes, is amended
266 to read:

267 395.1023 Child abuse and neglect cases; duties.—Each
268 licensed facility shall adopt a protocol that, at a minimum,
269 requires the facility to:
270 (1) Incorporate a facility policy that every staff member
271 has an affirmative duty to report, pursuant to chapter 39, any
272 actual or suspected case of child abuse, abandonment, or
273 neglect; and
274 (2) In any case involving suspected child abuse,
275 abandonment, or neglect, designate, at the request of the
276 Department of Children and Family Services, a staff physician to
277 act as a liaison between the hospital and the Department of
278 Children and Family Services office which is investigating the
279 suspected abuse, abandonment, or neglect, and the child
280 protection team, as defined in s. 39.01, when the case is
281 referred to such a team.
282
283 Each general hospital and appropriate specialty hospital shall
284 comply with the provisions of this section and shall notify the
285 agency and the Department of Children and Family Services of its
286 compliance by sending a copy of its policy to the agency and the
287 Department of Children and Family Services as required by rule.
288 The failure by a general hospital or appropriate specialty
289 hospital to comply shall be punished by a fine not exceeding
290 $1,000, to be fixed, imposed, and collected by the agency. Each
291 day in violation is considered a separate offense.
292 Section 13. Subsection (2) and paragraph (d) of subsection
293 (3) of section 395.1041, Florida Statutes, are amended to read:
294 395.1041 Access to emergency services and care.—

295 (2) INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The agency
296 shall establish and maintain an inventory of hospitals with
297 emergency services. The inventory shall list all services within
298 the service capability of the hospital, and such services shall
299 appear on the face of the hospital license. Each hospital having
300 emergency services shall notify the agency of its service
301 capability in the manner and form prescribed by the agency. The
302 agency shall use the inventory to assist emergency medical
303 services providers and others in locating appropriate emergency
304 medical care. The inventory shall also be made available to the
305 general public. ~~On or before August 1, 1992, the agency shall~~
306 ~~request that each hospital identify the services which are~~
307 ~~within its service capability. On or before November 1, 1992,~~
308 ~~the agency shall notify each hospital of the service capability~~
309 ~~to be included in the inventory. The hospital has 15 days from~~
310 ~~the date of receipt to respond to the notice. By December 1,~~
311 ~~1992, the agency shall publish a final inventory.~~ Each hospital
312 shall reaffirm its service capability when its license is
313 renewed and shall notify the agency of the addition of a new
314 service or the termination of a service prior to a change in its
315 service capability.
316 (3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF
317 FACILITY OR HEALTH CARE PERSONNEL.—
318 (d)1. Every hospital shall ensure the provision of
319 services within the service capability of the hospital, at all
320 times, either directly or indirectly through an arrangement with
321 another hospital, through an arrangement with one or more
322 physicians, or as otherwise made through prior arrangements. A

323 hospital may enter into an agreement with another hospital for
324 purposes of meeting its service capability requirement, and
325 appropriate compensation or other reasonable conditions may be
326 negotiated for these backup services.
327 2. If any arrangement requires the provision of emergency
328 medical transportation, such arrangement must be made in
329 consultation with the applicable provider and may not require
330 the emergency medical service provider to provide transportation
331 that is outside the routine service area of that provider or in
332 a manner that impairs the ability of the emergency medical
333 service provider to timely respond to prehospital emergency
334 calls.
335 3. A hospital shall not be required to ensure service
336 capability at all times as required in subparagraph 1. if, prior
337 to the receiving of any patient needing such service capability,
338 such hospital has demonstrated to the agency that it lacks the
339 ability to ensure such capability and it has exhausted all
340 reasonable efforts to ensure such capability through backup
341 arrangements. In reviewing a hospital's demonstration of lack of
342 ability to ensure service capability, the agency shall consider
343 factors relevant to the particular case, including the
344 following:
345 a. Number and proximity of hospitals with the same service
346 capability.
347 b. Number, type, credentials, and privileges of
348 specialists.
349 c. Frequency of procedures.
350 d. Size of hospital.

351 4. The agency shall publish ~~proposed~~ rules implementing a
352 reasonable exemption procedure ~~by November 1, 1992~~. ~~Subparagraph~~
353 ~~1. shall become effective upon the effective date of said rules~~
354 ~~or January 31, 1993, whichever is earlier. For a period not to~~
355 ~~exceed 1 year from the effective date of subparagraph 1., a~~
356 ~~hospital requesting an exemption shall be deemed to be exempt~~
357 ~~from offering the service until the agency initially acts to~~
358 ~~deny or grant the original request.~~ The agency has 45 days after
359 ~~from~~ the date of receipt of the request to approve or deny the
360 request. ~~After the first year from the effective date of~~
361 ~~subparagraph 1.,~~ If the agency fails to initially act within
362 that ~~the~~ time period, the hospital is deemed to be exempt from
363 offering the service until the agency initially acts to deny the
364 request.
365 Section 14. Section 395.1046, Florida Statutes, is
366 repealed.
367 Section 15. Paragraph (e) of subsection (1) of section
368 395.1055, Florida Statutes, is amended to read:
369 395.1055 Rules and enforcement.—
370 (1) The agency shall adopt rules pursuant to ss.
371 120.536(1) and 120.54 to implement the provisions of this part,
372 which shall include reasonable and fair minimum standards for
373 ensuring that:
374 (e) Licensed facility beds conform to minimum space,
375 equipment, and furnishings standards as specified by the agency,
376 the Florida Building Code, and the Florida Fire Prevention Code
377 ~~department~~.

378 Section 16. Subsection (1) of section 395.10972, Florida
379 Statutes, is amended to read:
380 395.10972 Health Care Risk Manager Advisory Council.—The
381 Secretary of Health Care Administration may appoint a seven-
382 member advisory council to advise the agency on matters
383 pertaining to health care risk managers. The members of the
384 council shall serve at the pleasure of the secretary. The
385 council shall designate a chair. The council shall meet at the
386 call of the secretary or at those times as may be required by
387 rule of the agency. The members of the advisory council shall
388 receive no compensation for their services, but shall be
389 reimbursed for travel expenses as provided in s. 112.061. The
390 council shall consist of individuals representing the following
391 areas:
392 (1) Two shall be active health care risk managers,
393 including one risk manager who is recommended by and a member of
394 the Florida Society for ~~of~~ Healthcare Risk Management and
395 Patient Safety.
396 Section 17. Subsection (3) of section 395.2050, Florida
397 Statutes, is amended to read:
398 395.2050 Routine inquiry for organ and tissue donation;
399 certification for procurement activities; death records review.—
400 (3) Each organ procurement organization designated by the
401 federal Centers for Medicare and Medicaid Services ~~Health Care~~
402 ~~Financing Administration~~ and licensed by the state shall conduct
403 an annual death records review in the organ procurement
404 organization's affiliated donor hospitals. The organ procurement
405 organization shall enlist the services of every Florida licensed

406 tissue bank and eye bank affiliated with or providing service to
407 the donor hospital and operating in the same service area to
408 participate in the death records review.
409 Section 18. Subsection (2) of section 395.3036, Florida
410 Statutes, is amended to read:
411 395.3036 Confidentiality of records and meetings of
412 corporations that lease public hospitals or other public health
413 care facilities.—The records of a private corporation that
414 leases a public hospital or other public health care facility
415 are confidential and exempt from the provisions of s. 119.07(1)
416 and s. 24(a), Art. I of the State Constitution, and the meetings
417 of the governing board of a private corporation are exempt from
418 s. 286.011 and s. 24(b), Art. I of the State Constitution when
419 the public lessor complies with the public finance
420 accountability provisions of s. 155.40(5) with respect to the
421 transfer of any public funds to the private lessee and when the
422 private lessee meets at least three of the five following
423 criteria:
424 (2) The public lessor and the private lessee do not
425 commingle any of their funds in any account maintained by either
426 of them, other than the payment of the rent and administrative
427 fees or the transfer of funds pursuant to s. 155.40 ~~subsection~~
428 ~~(2)~~.
429 Section 19. Section 395.3037, Florida Statutes, is
430 repealed.
431 Section 20. Subsections (1), (4), and (5) of section
432 395.3038, Florida Statutes, are amended to read:

Amendment No.

433 395.3038 State-listed primary stroke centers and
434 comprehensive stroke centers; notification of hospitals.—
435 (1) The agency shall make available on its website and to
436 the department a list of the name and address of each hospital
437 that meets the criteria for a primary stroke center and the name
438 and address of each hospital that meets the criteria for a
439 comprehensive stroke center. The list of primary and
440 comprehensive stroke centers shall include only those hospitals
441 that attest in an affidavit submitted to the agency that the
442 hospital meets the named criteria, or those hospitals that
443 attest in an affidavit submitted to the agency that the hospital
444 is certified as a primary or a comprehensive stroke center by
445 the Joint Commission ~~on Accreditation of Healthcare~~
446 ~~Organizations~~.
447 (4) The agency shall adopt by rule criteria for a primary
448 stroke center which are substantially similar to the
449 certification standards for primary stroke centers of the Joint
450 Commission ~~on Accreditation of Healthcare Organizations~~.
451 (5) The agency shall adopt by rule criteria for a
452 comprehensive stroke center. However, if the Joint Commission ~~on~~
453 ~~Accreditation of Healthcare Organizations~~ establishes criteria
454 for a comprehensive stroke center, the agency shall establish
455 criteria for a comprehensive stroke center which are
456 substantially similar to those criteria established by the Joint
457 Commission ~~on Accreditation of Healthcare Organizations~~.
458 Section 21. Paragraph (e) of subsection (2) of section
459 395.602, Florida Statutes, is amended to read:
460 395.602 Rural hospitals.—

461 (2) DEFINITIONS.—As used in this part:
462 (e) "Rural hospital" means an acute care hospital licensed
463 under this chapter, having 100 or fewer licensed beds and an
464 emergency room, which is:
465 1. The sole provider within a county with a population
466 density of no greater than 100 persons per square mile;
467 2. An acute care hospital, in a county with a population
468 density of no greater than 100 persons per square mile, which is
469 at least 30 minutes of travel time, on normally traveled roads
470 under normal traffic conditions, from any other acute care
471 hospital within the same county;
472 3. A hospital supported by a tax district or subdistrict
473 whose boundaries encompass a population of 100 persons or fewer
474 per square mile;
475 ~~4. A hospital in a constitutional charter county with a~~
476 ~~population of over 1 million persons that has imposed a local~~
477 ~~option health service tax pursuant to law and in an area that~~
478 ~~was directly impacted by a catastrophic event on August 24,~~
479 ~~1992, for which the Governor of Florida declared a state of~~
480 ~~emergency pursuant to chapter 125, and has 120 beds or less that~~
481 ~~serves an agricultural community with an emergency room~~
482 ~~utilization of no less than 20,000 visits and a Medicaid~~
483 ~~inpatient utilization rate greater than 15 percent;~~
484 4.~~5.~~ A hospital with a service area that has a population
485 of 100 persons or fewer per square mile. As used in this
486 subparagraph, the term "service area" means the fewest number of
487 zip codes that account for 75 percent of the hospital's
488 discharges for the most recent 5-year period, based on

Amendment No.

489 information available from the hospital inpatient discharge
490 database in the Florida Center for Health Information and Policy
491 Analysis at the Agency for Health Care Administration; or
492 5. ~~6.~~ A hospital designated as a critical access hospital,
493 as defined in s. 408.07(15).
494 Population densities used in this paragraph must be based upon
495 the most recently completed United States census. A hospital
496 that received funds under s. 409.9116 for a quarter beginning no
497 later than July 1, 2002, is deemed to have been and shall
498 continue to be a rural hospital from that date through June 30,
499 2015, if the hospital continues to have 100 or fewer licensed
500 beds and an emergency room~~, or meets the criteria of~~
501 ~~subparagraph 4~~. An acute care hospital that has not previously
502 been designated as a rural hospital and that meets the criteria
503 of this paragraph shall be granted such designation upon
504 application, including supporting documentation to the Agency
505 for Health Care Administration.
506 Section 22. Subsection (8) of section 400.021, Florida
507 Statutes, is amended to read:
508 400.021 Definitions.—When used in this part, unless the
509 context otherwise requires, the term:
510 (8) "Geriatric outpatient clinic" means a site for
511 providing outpatient health care to persons 60 years of age or
512 older, which is staffed by a registered nurse or a physician
513 assistant, or a licensed practical nurse under the direct
514 supervision of a registered nurse, advanced registered nurse
515 practitioner, or physician.

516 (16) "Resident care plan" means a written plan developed,
517 maintained, and reviewed not less than quarterly by a registered
518 nurse, with participation from other facility staff and the
519 resident or his or her designee or legal representative, which
520 includes a comprehensive assessment of the needs of an
521 individual resident; the type and frequency of services required
522 to provide the necessary care for the resident to attain or
523 maintain the highest practicable physical, mental, and
524 psychosocial well-being; a listing of services provided within
525 or outside the facility to meet those needs; and an explanation
526 of service goals. ~~The resident care plan must be signed by the~~
527 ~~director of nursing or another registered nurse employed by the~~
528 ~~facility to whom institutional responsibilities have been~~
529 ~~delegated and by the resident, the resident's designee, or the~~
530 ~~resident's legal representative. The facility may not use an~~
531 ~~agency or temporary registered nurse to satisfy the foregoing~~
532 ~~requirement and must document the institutional responsibilities~~
533 ~~that have been delegated to the registered nurse.~~
534 Section 23. Paragraph (g) of subsection (2) of section
535 400.0239, Florida Statutes, is amended to read:
536 400.0239 Quality of Long-Term Care Facility Improvement
537 Trust Fund.—
538 (2) Expenditures from the trust fund shall be allowable
539 for direct support of the following:
540 (g) Other initiatives authorized by the Centers for
541 Medicare and Medicaid Services for the use of federal civil
542 monetary penalties~~, including projects recommended through the~~

543 ~~Medicaid "Up-or-Out" Quality of Care Contract Management Program~~
544 ~~pursuant to s. 400.148~~.
545 Section 24. Subsection (15) of section 400.0255, Florida
546 Statutes, is amended to read
547 400.0255 Resident transfer or discharge; requirements and
548 procedures; hearings.—
549 (15)(a) The department's Office of Appeals Hearings shall
550 conduct hearings under this section. The office shall notify the
551 facility of a resident's request for a hearing.
552 (b) The department shall, by rule, establish procedures to
553 be used for fair hearings requested by residents. These
554 procedures shall be equivalent to the procedures used for fair
555 hearings for other Medicaid cases appearing in s. 409.285 and
556 applicable rules~~, chapter 10-2, part VI, Florida Administrative~~
557 ~~Code~~. The burden of proof must be clear and convincing evidence.
558 A hearing decision must be rendered within 90 days after receipt
559 of the request for hearing.
560 (c) If the hearing decision is favorable to the resident
561 who has been transferred or discharged, the resident must be
562 readmitted to the facility's first available bed.
563 (d) The decision of the hearing officer shall be final.
564 Any aggrieved party may appeal the decision to the district
565 court of appeal in the appellate district where the facility is
566 located. Review procedures shall be conducted in accordance with
567 the Florida Rules of Appellate Procedure.
568 Section 25. Subsection (2) of section 400.063, Florida
569 Statutes, is amended to read:
570 400.063 Resident protection.—

571 (2) The agency is authorized to establish for each
572 facility, subject to intervention by the agency, a separate bank
573 account for the deposit to the credit of the agency of any
574 moneys received from the Health Care Trust Fund or any other
575 moneys received for the maintenance and care of residents in the
576 facility, and the agency is authorized to disburse moneys from
577 such account to pay obligations incurred for the purposes of
578 this section. The agency is authorized to requisition moneys
579 from the Health Care Trust Fund in advance of an actual need for
580 cash on the basis of an estimate by the agency of moneys to be
581 spent under the authority of this section. Any bank account
582 established under this section need not be approved in advance
583 of its creation as required by s. 17.58, but shall be secured by
584 depository insurance equal to or greater than the balance of
585 such account or by the pledge of collateral security ~~in~~
586 ~~conformance with criteria established in s. 18.11~~. The agency
587 shall notify the Chief Financial Officer of any such account so
588 established and shall make a quarterly accounting to the Chief
589 Financial Officer for all moneys deposited in such account.
590 Section 26. Subsections (1) and (5) of section 400.071,
591 Florida Statutes, are amended to read:
592 400.071 Application for license.—
593 (1) In addition to the requirements of part II of chapter
594 408, the application for a license shall be under oath and must
595 contain the following:
596 (a) The location of the facility for which a license is
597 sought and an indication, as in the original application, that
598 such location conforms to the local zoning ordinances.

599 ~~(b) A signed affidavit disclosing any financial or~~
600 ~~ownership interest that a controlling interest as defined in~~
601 ~~part II of chapter 408 has held in the last 5 years in any~~
602 ~~entity licensed by this state or any other state to provide~~
603 ~~health or residential care which has closed voluntarily or~~
604 ~~involuntarily; has filed for bankruptcy; has had a receiver~~
605 ~~appointed; has had a license denied, suspended, or revoked; or~~
606 ~~has had an injunction issued against it which was initiated by a~~
607 ~~regulatory agency. The affidavit must disclose the reason any~~
608 ~~such entity was closed, whether voluntarily or involuntarily.~~
609 ~~(c) The total number of beds and the total number of~~
610 ~~Medicare and Medicaid certified beds.~~
611 (b) ~~(d)~~ Information relating to the applicant and employees
612 which the agency requires by rule. The applicant must
613 demonstrate that sufficient numbers of qualified staff, by
614 training or experience, will be employed to properly care for
615 the type and number of residents who will reside in the
616 facility.
617 ~~(e) Copies of any civil verdict or judgment involving the~~
618 ~~applicant rendered within the 10 years preceding the~~
619 ~~application, relating to medical negligence, violation of~~
620 ~~residents' rights, or wrongful death. As a condition of~~
621 ~~licensure, the licensee agrees to provide to the agency copies~~
622 ~~of any new verdict or judgment involving the applicant, relating~~
623 ~~to such matters, within 30 days after filing with the clerk of~~
624 ~~the court. The information required in this paragraph shall be~~
625 ~~maintained in the facility's licensure file and in an agency~~
626 ~~database which is available as a public record.~~

627 (5) As a condition of licensure, each facility must
628 establish ~~and submit with its application~~ a plan for quality
629 assurance and for conducting risk management.
630 Section 27. Section 400.0712, Florida Statutes, is amended
631 to read:
632 400.0712 Application for inactive license.—
633 ~~(1) As specified in this section, the agency may issue an~~
634 ~~inactive license to a nursing home facility for all or a portion~~
635 ~~of its beds. Any request by a licensee that a nursing home or~~
636 ~~portion of a nursing home become inactive must be submitted to~~
637 ~~the agency in the approved format. The facility may not initiate~~
638 ~~any suspension of services, notify residents, or initiate~~
639 ~~inactivity before receiving approval from the agency; and a~~
640 ~~licensee that violates this provision may not be issued an~~
641 ~~inactive license.~~
642 (1) ~~(2)~~ In addition to the powers granted under part II of
643 chapter 408, the agency may issue an inactive license for a
644 portion of the total beds to a nursing home that chooses to use
645 an unoccupied contiguous portion of the facility for an
646 alternative use to meet the needs of elderly persons through the
647 use of less restrictive, less institutional services.
648 (a) An inactive license issued under this subsection may
649 be granted for a period not to exceed the current licensure
650 expiration date but may be renewed by the agency at the time of
651 licensure renewal.
652 (b) A request to extend the inactive license must be
653 submitted to the agency in the approved format and approved by
654 the agency in writing.

655 (c) Nursing homes that receive an inactive license to
656 provide alternative services shall not receive preference for
657 participation in the Assisted Living for the Elderly Medicaid
658 waiver.
659 (2) ~~(3)~~ The agency shall adopt rules pursuant to ss.
660 120.536(1) and 120.54 necessary to implement this section.
661 Section 28. Section 400.111, Florida Statutes, is amended
662 to read:
663 400.111 Disclosure of controlling interest.—In addition to
664 the requirements of part II of chapter 408, when requested by
665 the agency, the licensee shall submit a signed affidavit
666 disclosing any financial or ownership interest that a
667 controlling interest has held within the last 5 years in any
668 entity licensed by the state or any other state to provide
669 health or residential care which entity has closed voluntarily
670 or involuntarily; has filed for bankruptcy; has had a receiver
671 appointed; has had a license denied, suspended, or revoked; or
672 has had an injunction issued against it which was initiated by a
673 regulatory agency. The affidavit must disclose the reason such
674 entity was closed, whether voluntarily or involuntarily.
675 Section 29. Subsection (2) of section 400.1183, Florida
676 Statutes, is amended to read:
677 400.1183 Resident grievance procedures.—
678 (2) Each facility shall maintain records of all grievances
679 and shall retain a log for agency inspection of ~~report to the~~
680 ~~agency at the time of relicensure~~ the total number of grievances
681 handled ~~during the prior licensure period~~, a categorization of

682 the cases underlying the grievances, and the final disposition
683 of the grievances.
684 Section 30. Paragraphs (o) through (w) of subsection (1)
685 of section 400.141, Florida Statutes, are redesignated as
686 paragraphs (n) through (u), respectively, and present paragraphs
687 (f), (g), (j), (n), (o), and (r) of that subsection are amended,
688 and subsection (3) is created.
689 400.141 Administration and management of nursing home
690 facilities.—
691 (1) Every licensed facility shall comply with all
692 applicable standards and rules of the agency and shall:
693 (f) Be allowed and encouraged by the agency to provide
694 other needed services under certain conditions. If the facility
695 has a standard licensure status~~, and has had no class I or class~~
696 ~~II deficiencies during the past 2 years or has been awarded a~~
697 ~~Gold Seal under the program established in s. 400.235,~~ it may be
698 ~~encouraged by the agency~~ to provide services, including, but not
699 limited to, respite and adult day services, which enable
700 individuals to move in and out of the facility. A facility is
701 not subject to any additional licensure requirements for
702 providing these services, under the following conditions:~~.~~
703 1. Respite care may be offered to persons in need of
704 short-term or temporary nursing home services. For each person
705 admitted under the respite care program, the facility licensee
706 must:
707 a. Have a written abbreviated plan of care that, at a
708 minimum, includes nutritional requirements, medication orders,
709 physician orders, nursing assessments, and dietary preferences.

710 The nursing or physician assessments may take the place of all
711 other assessments required for full-time residents.
712 b. Have a contract that, at a minimum, specifies the
713 services to be provided to the respite resident, including
714 charges for services, activities, equipment, emergency medical
715 services, and the administration of medications. If multiple
716 respite admissions for a single person are anticipated, the
717 original contract is valid for 1 year after the date of
718 execution.
719 c. Ensure that each resident is released to his or her
720 caregiver or an individual designated in writing by the
721 caregiver.
722 2. A person admitted under the respite care program is:
723 a. Exempt from requirements in rule related to discharge
724 planning.
725 b. Covered by the residents' rights set forth in s.
726 400.022(1)(a)-(o) and (r)-(t). Funds or property of the resident
727 shall not be considered trust funds subject to the requirements
728 of s. 400.022(1)(h) until the resident has been in the facility
729 for more than 14 consecutive days.
730 c. Allowed to use his or her personal medications for the
731 respite stay if permitted by facility policy. The facility must
732 obtain a physician's order for the medications. The caregiver
733 may provide information regarding the medications as part of the
734 nursing assessment and that information must agree with the
735 physician's order. Medications shall be released with the
736 resident upon discharge in accordance with current physician's
737 orders.

738 3. A person receiving respite care is entitled to reside
739 in the facility for a total of 60 days within a contract year or
740 within a calendar year if the contract is for less than 12
741 months. However, each single stay may not exceed 14 days. If a
742 stay exceeds 14 consecutive days, the facility must comply with
743 all assessment and care planning requirements applicable to
744 nursing home residents.
745 4. A person receiving respite care must reside in a
746 licensed nursing home bed.
747 5. A prospective respite resident must provide medical
748 information from a physician, a physician assistant, or a nurse
749 practitioner and other information from the primary caregiver as
750 may be required by the facility prior to or at the time of
751 admission to receive respite care. The medical information must
752 include a physician's order for respite care and proof of a
753 physical examination by a licensed physician, physician
754 assistant, or nurse practitioner. The physician's order and
755 physical examination may be used to provide intermittent respite
756 care for up to 12 months after the date the order is written.
757 6. The facility must assume the duties of the primary
758 caregiver. To ensure continuity of care and services, the
759 resident is entitled to retain his or her personal physician and
760 must have access to medically necessary services such as
761 physical therapy, occupational therapy, or speech therapy, as
762 needed. The facility must arrange for transportation to these
763 services if necessary. ~~Respite care must be provided in~~
764 ~~accordance with this part and rules adopted by the agency.~~
765 ~~However, the agency shall, by rule, adopt modified requirements~~

766 ~~for resident assessment, resident care plans, resident~~
767 ~~contracts, physician orders, and other provisions, as~~
768 ~~appropriate, for short-term or temporary nursing home services.~~
769 7. The agency shall allow for shared programming and staff
770 in a facility which meets minimum standards and offers services
771 pursuant to this paragraph, but, if the facility is cited for
772 deficiencies in patient care, may require additional staff and
773 programs appropriate to the needs of service recipients. A
774 person who receives respite care may not be counted as a
775 resident of the facility for purposes of the facility's licensed
776 capacity unless that person receives 24-hour respite care. A
777 person receiving either respite care for 24 hours or longer or
778 adult day services must be included when calculating minimum
779 staffing for the facility. Any costs and revenues generated by a
780 nursing home facility from nonresidential programs or services
781 shall be excluded from the calculations of Medicaid per diems
782 for nursing home institutional care reimbursement.
783 (g) If the facility has a standard license ~~or is a Gold~~
784 ~~Seal facility~~, exceeds the minimum required hours of licensed
785 nursing and certified nursing assistant direct care per resident
786 per day, and is part of a continuing care facility licensed
787 under chapter 651 or a retirement community that offers other
788 services pursuant to part III of this chapter or part I or part
789 III of chapter 429 on a single campus, be allowed to share
790 programming and staff. At the time of inspection ~~and in the~~
791 ~~semiannual report required pursuant to paragraph (o),~~ a
792 continuing care facility or retirement community that uses this
793 option must demonstrate through staffing records that minimum

794 staffing requirements for the facility were met. Licensed nurses
795 and certified nursing assistants who work in the nursing home
796 facility may be used to provide services elsewhere on campus if
797 the facility exceeds the minimum number of direct care hours
798 required per resident per day and the total number of residents
799 receiving direct care services from a licensed nurse or a
800 certified nursing assistant does not cause the facility to
801 violate the staffing ratios required under s. 400.23(3)(a).
802 Compliance with the minimum staffing ratios shall be based on
803 total number of residents receiving direct care services,
804 regardless of where they reside on campus. If the facility
805 receives a conditional license, it may not share staff until the
806 conditional license status ends. This paragraph does not
807 restrict the agency's authority under federal or state law to
808 require additional staff if a facility is cited for deficiencies
809 in care which are caused by an insufficient number of certified
810 nursing assistants or licensed nurses. The agency may adopt
811 rules for the documentation necessary to determine compliance
812 with this provision.
813 (j) Keep full records of resident admissions and
814 discharges; medical and general health status, including medical
815 records, personal and social history, and identity and address
816 of next of kin or other persons who may have responsibility for
817 the affairs of the residents; and individual resident care plans
818 including, but not limited to, prescribed services, service
819 frequency and duration, and service goals. The records shall be
820 open to inspection by the agency. The facility must maintain
821 clinical records on each resident in accordance with accepted

822 professional standards and practices that are complete,
823 accurately documented, readily accessible, and systematically
824 organized.
825 ~~(n) Submit to the agency the information specified in s.~~
826 ~~400.071(1)(b) for a management company within 30 days after the~~
827 ~~effective date of the management agreement.~~
828 (n) ~~(o)~~1. ~~Submit semiannually to the agency, or more~~
829 ~~frequently if requested by the agency, information regarding~~
830 ~~facility staff-to-resident ratios, staff turnover, and staff~~
831 ~~stability, including information regarding certified nursing~~
832 ~~assistants, licensed nurses, the director of nursing, and the~~
833 ~~facility administrator. For purposes of this reporting:~~
834 ~~a. Staff-to-resident ratios must be reported in the~~
835 ~~categories specified in s. 400.23(3)(a) and applicable rules.~~
836 ~~The ratio must be reported as an average for the most recent~~
837 ~~calendar quarter.~~
838 ~~b. Staff turnover must be reported for the most recent 12-~~
839 ~~month period ending on the last workday of the most recent~~
840 ~~calendar quarter prior to the date the information is submitted.~~
841 ~~The turnover rate must be computed quarterly, with the annual~~
842 ~~rate being the cumulative sum of the quarterly rates. The~~
843 ~~turnover rate is the total number of terminations or separations~~
844 ~~experienced during the quarter, excluding any employee~~
845 ~~terminated during a probationary period of 3 months or less,~~
846 ~~divided by the total number of staff employed at the end of the~~
847 ~~period for which the rate is computed, and expressed as a~~
848 ~~percentage.~~

849 ~~c. The formula for determining staff stability is the~~
850 ~~total number of employees that have been employed for more than~~
851 ~~12 months, divided by the total number of employees employed at~~
852 ~~the end of the most recent calendar quarter, and expressed as a~~
853 ~~percentage.~~
854 ~~d.~~ A nursing facility that has failed to comply with state
855 minimum-staffing requirements for 2 consecutive days is
856 prohibited from accepting new admissions until the facility has
857 achieved the minimum-staffing requirements for a period of 6
858 consecutive days. For the purposes of this sub-subparagraph, any
859 person who was a resident of the facility and was absent from
860 the facility for the purpose of receiving medical care at a
861 separate location or was on a leave of absence is not considered
862 a new admission. Failure to impose such an admissions moratorium
863 is subject to a $1,000 fine ~~constitutes a class II deficiency~~.
864 2.~~e.~~ A nursing facility which does not have a conditional
865 license may be cited for failure to comply with the standards in
866 s. 400.23(3)(a)1.b. and c. only if it has failed to meet those
867 standards on 2 consecutive days or if it has failed to meet at
868 least 97 percent of those standards on any one day.
869 3.~~f.~~ A facility which has a conditional license must be in
870 compliance with the standards in s. 400.23(3)(a) at all times.
871 (r)~~2.~~ This subsection ~~paragraph~~ does not limit the
872 agency's ability to impose a deficiency or take other actions if
873 a facility does not have enough staff to meet the residents'
874 needs.
875 ~~(r) Report to the agency any filing for bankruptcy~~
876 ~~protection by the facility or its parent corporation,~~

877 ~~divestiture or spin-off of its assets, or corporate~~
878 ~~reorganization within 30 days after the completion of such~~
879 ~~activity.~~
880 (3) A facility may charge a reasonable fee for the copying
881 of resident records. Such fee shall not exceed $1 per page for
882 the first 25 pages and 25 cents per page for each page in excess
883 of 25 pages.
884 Section 31. Subsection (3) of section 400.142, Florida
885 Statutes, is amended to read:
886 400.142 Emergency medication kits; orders not to
887 resuscitate.—
888 (3) Facility staff may withhold or withdraw
889 cardiopulmonary resuscitation if presented with an order not to
890 resuscitate executed pursuant to s. 401.45. ~~The agency shall~~
891 ~~adopt rules providing for the implementation of such orders.~~
892 Facility staff and facilities shall not be subject to criminal
893 prosecution or civil liability, nor be considered to have
894 engaged in negligent or unprofessional conduct, for withholding
895 or withdrawing cardiopulmonary resuscitation pursuant to such an
896 order and rules adopted by the agency. The absence of an order
897 not to resuscitate executed pursuant to s. 401.45 does not
898 preclude a physician from withholding or withdrawing
899 cardiopulmonary resuscitation as otherwise permitted by law.
900 Section 32. Section 400.145, Florida Statutes, is
901 repealed.
902 Section 33. Subsections (11) through (15) of section
903 400.147, Florida Statutes, are renumbered as subsections (10)

904 through (14), respectively, and present subsections (7), (8),
905 and (10) are amended to read:
906 400.147 Internal risk management and quality assurance
907 program.—
908 (7) The facility shall initiate an investigation and shall
909 notify the agency within 1 business day after the risk manager
910 or his or her designee has received a report pursuant to
911 paragraph (1)(d). Each facility shall complete the investigation
912 and submit a report to the agency within 15 calendar days if the
913 incident is determined to be an adverse incident as defined in
914 (5). ~~The notification must be made in writing and be provided~~
915 ~~electronically, by facsimile device or overnight mail delivery.~~
916 The agency shall develop a form for reporting this information
917 and the notification must include the name of the risk manager
918 of the facility, information regarding the identity of the
919 affected resident, the type of adverse incident, the initiation
920 of an investigation by the facility, and whether the events
921 causing or resulting in the adverse incident represent a
922 potential risk to any other resident. The notification is
923 confidential as provided by law and is not discoverable or
924 admissible in any civil or administrative action, except in
925 disciplinary proceedings by the agency or the appropriate
926 regulatory board. The agency may investigate, as it deems
927 appropriate, any such incident and prescribe measures that must
928 or may be taken in response to the incident. The agency shall
929 review each report ~~incident~~ and determine whether it potentially
930 involved conduct by the health care professional who is subject

931 to disciplinary action, in which case the provisions of s.
932 456.073 shall apply.
933 ~~(8)(a) Each facility shall complete the investigation and~~
934 ~~submit an adverse incident report to the agency for each adverse~~
935 ~~incident within 15 calendar days after its occurrence. If, after~~
936 ~~a complete investigation, the risk manager determines that the~~
937 ~~incident was not an adverse incident as defined in subsection~~
938 ~~(5), the facility shall include this information in the report.~~
939 ~~The agency shall develop a form for reporting this information.~~
940 ~~(b) The information reported to the agency pursuant to~~
941 ~~paragraph (a) which relates to persons licensed under chapter~~
942 ~~458, chapter 459, chapter 461, or chapter 466 shall be reviewed~~
943 ~~by the agency. The agency shall determine whether any of the~~
944 ~~incidents potentially involved conduct by a health care~~
945 ~~professional who is subject to disciplinary action, in which~~
946 ~~case the provisions of s. 456.073 shall apply.~~
947 ~~(c) The report submitted to the agency must also contain~~
948 ~~the name of the risk manager of the facility.~~
949 ~~(d) The adverse incident report is confidential as~~
950 ~~provided by law and is not discoverable or admissible in any~~
951 ~~civil or administrative action, except in disciplinary~~
952 ~~proceedings by the agency or the appropriate regulatory board.~~
953 (8)~~(9)~~ Abuse, neglect, or exploitation must be reported to
954 the agency as required by 42 C.F.R. s. 483.13(c) and to the
955 department as required by chapters 39 and 415.
956 ~~(10) By the 10th of each month, each facility subject to~~
957 ~~this section shall report any notice received pursuant to s.~~
958 ~~400.0233(2) and each initial complaint that was filed with the~~

959 ~~clerk of the court and served on the facility during the~~
960 ~~previous month by a resident or a resident's family member,~~
961 ~~guardian, conservator, or personal legal representative. The~~
962 ~~report must include the name of the resident, the resident's~~
963 ~~date of birth and social security number, the Medicaid~~
964 ~~identification number for Medicaid-eligible persons, the date or~~
965 ~~dates of the incident leading to the claim or dates of~~
966 ~~residency, if applicable, and the type of injury or violation of~~
967 ~~rights alleged to have occurred. Each facility shall also submit~~
968 ~~a copy of the notices received pursuant to s. 400.0233(2) and~~
969 ~~complaints filed with the clerk of the court. This report is~~
970 ~~confidential as provided by law and is not discoverable or~~
971 ~~admissible in any civil or administrative action, except in such~~
972 ~~actions brought by the agency to enforce the provisions of this~~
973 ~~part.~~
974 Section 34. Section 400.148, Florida Statutes, is
975 repealed.
976 Section 35. Paragraph (e) of subsection (2) of section
977 400.179, Florida Statutes, is amended to read:
978 400.179 Liability for Medicaid underpayments and
979 overpayments.—
980 (2) Because any transfer of a nursing facility may expose
981 the fact that Medicaid may have underpaid or overpaid the
982 transferor, and because in most instances, any such underpayment
983 or overpayment can only be determined following a formal field
984 audit, the liabilities for any such underpayments or
985 overpayments shall be as follows:

986 ~~(e) For the 2009-2010 fiscal year only, the provisions of~~
987 ~~paragraph (d) shall not apply. This paragraph expires July 1,~~
988 ~~2010.~~
989 Section 36. Subsection (3) of section 400.19, Florida
990 Statutes, is amended to read:
991 400.19 Right of entry and inspection.—
992 (3) The agency shall every 15 months conduct at least one
993 unannounced inspection to determine compliance by the licensee
994 with statutes, and with rules promulgated under the provisions
995 of those statutes, governing minimum standards of construction,
996 quality and adequacy of care, and rights of residents. The
997 survey shall be conducted every 6 months for the next 2-year
998 period if the facility has been cited for a class I deficiency,
999 has been cited for two or more class II deficiencies arising
1000 from separate surveys or investigations within a 60-day period,
1001 or has had three or more substantiated complaints within a 6-
1002 month period, each resulting in at least one class I or class II
1003 deficiency. In addition to any other fees or fines in this part,
1004 the agency shall assess a fine for each facility that is subject
1005 to the 6-month survey cycle. The fine for the 2-year period
1006 shall be $6,000, one-half to be paid at the completion of each
1007 survey. The agency may adjust this fine by the change in the
1008 Consumer Price Index, based on the 12 months immediately
1009 preceding the increase, to cover the cost of the additional
1010 surveys. The agency shall verify through subsequent inspection
1011 that any deficiency identified during inspection is corrected.
1012 However, the agency may verify the correction of a class III or
1013 class IV deficiency ~~unrelated to resident rights or resident~~

1014 care without reinspecting the facility if adequate written
1015 documentation has been received from the facility, which
1016 provides assurance that the deficiency has been corrected. The
1017 giving or causing to be given of advance notice of such
1018 unannounced inspections by an employee of the agency to any
1019 unauthorized person shall constitute cause for suspension of not
1020 fewer than 5 working days according to the provisions of chapter
1021 110.
1022 Section 37. Subsection (5) of section 400.23, Florida
1023 Statutes, is amended to read:
1024 400.23 Rules; evaluation and deficiencies; licensure
1025 status.—
1026 (5)(a) The agency, in collaboration with the Division of
1027 Children's Medical Services Network of the Department of Health,
1028 must, no later than December 31, 1993, adopt rules for minimum
1029 standards of care for persons under 21 years of age who reside
1030 in nursing home facilities. The rules must include a methodology
1031 for reviewing a nursing home facility under ss. 408.031-408.045
1032 which serves only persons under 21 years of age. A facility may
1033 be exempt from these standards for specific persons between 18
1034 and 21 years of age, if the person's physician agrees that
1035 minimum standards of care based on age are not necessary.
1036 (b) The agency, in collaboration with the Division of
1037 Children's Medical Services Network, shall adopt rules for
1038 minimum staffing requirements for nursing home facilities that
1039 serve persons under 21 years of age, which shall apply in lieu
1040 of the standards contained in subsection (3).

1041 1. For persons under 21 years of age who require skilled
1042 care, the requirements shall include a minimum combined average
1043 of licensed nurses, respiratory therapists, respiratory care
1044 practitioners, and certified nursing assistants of 3.9 hours of
1045 direct care per resident per day for each nursing home facility.
1046 2. For persons under 21 years of age who are fragile, the
1047 requirements shall include a minimum combined average of
1048 licensed nurses, respiratory therapists, respiratory care
1049 practitioners, and certified nursing assistants of 5 hours of
1050 direct care per resident per day for each nursing home facility.
1051 Section 38. Subsection (1) of section 400.275, Florida
1052 Statutes, is amended to read:
1053 400.275 Agency duties.—
1054 (1) ~~The agency shall ensure that each newly hired nursing~~
1055 ~~home surveyor, as a part of basic training, is assigned full-~~
1056 ~~time to a licensed nursing home for at least 2 days within a 7-~~
1057 ~~day period to observe facility operations outside of the survey~~
1058 ~~process before the surveyor begins survey responsibilities. Such~~
1059 ~~observations may not be the sole basis of a deficiency citation~~
1060 ~~against the facility.~~ The agency may not assign an individual to
1061 be a member of a survey team for purposes of a survey,
1062 evaluation, or consultation visit at a nursing home facility in
1063 which the surveyor was an employee within the preceding 2 ~~5~~
1064 years.
1065 Section 39. Subsection (2) of section 400.484, Florida
1066 Statutes, is amended to read:
1067 400.484 Right of inspection; violations ~~deficiencies~~;
1068 fines.—

Amendment No.

1069 (2) The agency shall impose fines for various classes of
1070 violations ~~deficiencies~~ in accordance with the following
1071 schedule:
1072 (a) Class I violations are defined in s. 408.813. ~~A class~~
1073 ~~I deficiency is any act, omission, or practice that results in a~~
1074 ~~patient's death, disablement, or permanent injury, or places a~~
1075 ~~patient at imminent risk of death, disablement, or permanent~~
1076 ~~injury.~~ Upon finding a class I violation ~~deficiency~~, the agency
1077 shall impose an administrative fine in the amount of $15,000 for
1078 each occurrence and each day that the violation ~~deficiency~~
1079 exists.
1080 (b) Class II violations are defined in s. 408.813. ~~A class~~
1081 ~~II deficiency is any act, omission, or practice that has a~~
1082 ~~direct adverse effect on the health, safety, or security of a~~
1083 ~~patient.~~ Upon finding a class II violation ~~deficiency~~, the
1084 agency shall impose an administrative fine in the amount of
1085 $5,000 for each occurrence and each day that the violation
1086 ~~deficiency~~ exists.
1087 (c) Class III violations are defined in s. 408.813. ~~A~~
1088 ~~class III deficiency is any act, omission, or practice that has~~
1089 ~~an indirect, adverse effect on the health, safety, or security~~
1090 ~~of a patient.~~ Upon finding an uncorrected or repeated class III
1091 violation ~~deficiency~~, the agency shall impose an administrative
1092 fine not to exceed $1,000 for each occurrence and each day that
1093 the uncorrected or repeated violation ~~deficiency~~ exists.
1094 (d) Class IV violations are defined in s. 408.813. ~~A class~~
1095 ~~IV deficiency is any act, omission, or practice related to~~
1096 ~~required reports, forms, or documents which does not have the~~

1097 ~~potential of negatively affecting patients. These violations are~~
1098 ~~of a type that the agency determines do not threaten the health,~~
1099 ~~safety, or security of patients.~~ Upon finding an uncorrected or
1100 repeated class IV <u>violation</u> ~~deficiency~~, the agency shall impose
1101 an administrative fine not to exceed $500 for each occurrence
1102 and each day that the uncorrected or repeated <u>violation</u>
1103 ~~deficiency~~ exists.
1104 Section 40. Paragraph (a) of subsection (15) of section
1105 400.506, Florida Statutes, is amended to read:
1106 400.506 Licensure of nurse registries; requirements;
1107 penalties.—
1108 (15)(a) The agency may deny, suspend, or revoke the
1109 license of a nurse registry and shall impose a fine of $5,000
1110 against a nurse registry that:
1111 1. Provides services to residents in an assisted living
1112 facility for which the nurse registry does not receive fair
1113 market value remuneration.
1114 2. Provides staffing to an assisted living facility for
1115 which the nurse registry does not receive fair market value
1116 remuneration.
1117 3. Fails to provide the agency, upon request, with copies
1118 of all contracts with assisted living facilities which were
1119 executed within the last 5 years.
1120 4. Gives remuneration to a case manager, discharge
1121 planner, facility-based staff member, or third-party vendor who
1122 is involved in the discharge planning process of a facility
1123 licensed under chapter 395 or this chapter and from whom the
1124 nurse registry receives referrals. A nurse registry is exempt

1125 from this subparagraph if it does not bill the Florida Medicaid
1126 program or the Medicare program or share a controlling interest
1127 with any entity licensed, registered, or certified under part II
1128 of chapter 408 that bills the Florida Medicaid program or the
1129 Medicare program.
1130 5. Gives remuneration to a physician, a member of the
1131 physician's office staff, or an immediate family member of the
1132 physician, and the nurse registry received a patient referral in
1133 the last 12 months from that physician or the physician's office
1134 staff. A nurse registry is exempt from this subparagraph if it
1135 does not bill the ~~Florida Medicaid program or the~~ Medicare
1136 program or share a controlling interest with any entity
1137 licensed, registered, or certified under part II of chapter 408
1138 that bills the ~~Florida Medicaid program or the~~ Medicare program.
1139 (18) An administrator may manage only one nurse registry,
1140 except that an administrator may manage up to five registries if
1141 all five registries have identical controlling interests as
1142 defined in s. 408.803 and are located within one agency
1143 geographic service area or within an immediately contiguous
1144 county. An administrator shall designate, in writing, for each
1145 licensed entity, a qualified alternate administrator to serve
1146 during the administrator's absence.
1147 Section 41. Subsection (1) of section 400.509, Florida
1148 Statutes, is amended to read:
1149 400.509 Registration of particular service providers
1150 exempt from licensure; certificate of registration; regulation
1151 of registrants.—

1152 (1) Any organization that provides companion services or
1153 homemaker services and does not provide a home health service to
1154 a person is exempt from licensure under this part. However, any
1155 organization that provides companion services or homemaker
1156 services must register with the agency. Organizations that
1157 provide companion services only for persons with developmental
1158 disabilities, as defined in s. 393.063, under contract with the
1159 Agency for Persons with Disabilities, are exempt from
1160 registration.
1161 Section 42. Paragraph (i) of subsection (1) and subsection
1162 (4) of section 400.606, Florida Statutes, are amended to read:
1163 400.606 License; application; renewal; conditional license
1164 or permit; certificate of need.—
1165 (1) In addition to the requirements of part II of chapter
1166 408, the initial application and change of ownership application
1167 must be accompanied by a plan for the delivery of home,
1168 residential, and homelike inpatient hospice services to
1169 terminally ill persons and their families. Such plan must
1170 contain, but need not be limited to:
1171 ~~(i) The projected annual operating cost of the hospice.~~
1172 If the applicant is an existing licensed health care provider,
1173 the application must be accompanied by a copy of the most recent
1174 profit-loss statement and, if applicable, the most recent
1175 licensure inspection report.
1176 (4) A freestanding hospice facility that is ~~primarily~~
1177 engaged in providing inpatient and related services and that is
1178 not otherwise licensed as a health care facility shall be
1179 required to obtain a certificate of need. However, a

1180 freestanding hospice facility with six or fewer beds shall not
1181 be required to comply with institutional standards such as, but
1182 not limited to, standards requiring sprinkler systems, emergency
1183 electrical systems, or special lavatory devices.
1184 Section 43. Subsection (2) of section 400.607, Florida
1185 Statutes, is amended to read:
1186 400.607 Denial, suspension, revocation of license;
1187 emergency actions; imposition of administrative fine; grounds.—
1188 (2) A violation of this part, part II of chapter 408, or
1189 applicable rules ~~Any of the following actions~~ by a licensed
1190 hospice or any of its employees shall be grounds for
1191 administrative action by the agency against a hospice.~~:~~
1192 ~~(a) A violation of the provisions of this part, part II of~~
1193 ~~chapter 408, or applicable rules.~~
1194 ~~(b) An intentional or negligent act materially affecting~~
1195 ~~the health or safety of a patient.~~
1196 Section 44. Section 400.915, Florida Statutes, is amended
1197 to read:
1198 400.915 Construction and renovation; requirements.—The
1199 requirements for the construction or renovation of a PPEC center
1200 shall comply with:
1201 (1) The provisions of chapter 553, which pertain to
1202 building construction standards, including plumbing, electrical
1203 code, glass, manufactured buildings, accessibility for the
1204 physically disabled;
1205 (2) The provisions of s. 633.022 and applicable rules
1206 pertaining to physical ~~minimum~~ standards for nonresidential

Amendment No.

1207 child care ~~physical~~ facilities ~~in rule 10M-12.003, Florida~~
1208 ~~Administrative Code, Child Care Standards~~; and
1209 (3) The standards or rules adopted pursuant to this part
1210 and part II of chapter 408.
1211 Section 45. Subsection (1) of section 400.925, Florida
1212 Statutes, is amended to read:
1213 400.925 Definitions.—As used in this part, the term:
1214 (1) "Accrediting organizations" means the Joint Commission
1215 ~~on Accreditation of Healthcare Organizations~~ or other national
1216 accreditation agencies whose standards for accreditation are
1217 comparable to those required by this part for licensure.
1218 Section 46. Subsections (3) through (6) of section
1219 400.931, Florida Statutes, are renumbered as subsections (2)
1220 through (5), respectively, and present subsection (2) of that
1221 section is amended to read:
1222 400.931 Application for license; fee~~; provisional license;~~
1223 ~~temporary permit~~.—
1224 (2) <u>An applicant for initial licensure, change of</u>
1225 <u>ownership, or renewal to operate a licensed home medical</u>
1226 <u>equipment provider at a location outside the state of Florida</u>
1227 <u>must submit documentation of accreditation, or an application</u>
1228 <u>for accreditation, from an accrediting organization that is</u>
1229 <u>recognized by the agency. An applicant that has applied for</u>
1230 <u>accreditation must provide proof of accreditation that is not</u>
1231 <u>conditional or provisional within 120 days after the date of the</u>
1232 <u>agency's receipt of the application for licensure or the</u>
1233 <u>application shall be withdrawn from further consideration. Such</u>
1234 <u>accreditation must be maintained by the home medical equipment</u>

1235 provider to maintain licensure. ~~As an alternative to submitting~~
1236 ~~proof of financial ability to operate as required in s.~~
1237 ~~408.810(8), the applicant may submit a $50,000 surety bond to~~
1238 ~~the agency.~~
1239 Section 47. Subsection (2) of section 400.932, Florida
1240 Statutes, is amended to read:
1241 400.932 Administrative penalties.—
1242 (2) A violation of this part, part II of chapter 408, or
1243 applicable rules ~~Any of the following actions~~ by an employee of
1244 a home medical equipment provider shall be ~~are~~ grounds for
1245 administrative action or penalties by the agency.~~:~~
1246 ~~(a) Violation of this part, part II of chapter 408, or~~
1247 ~~applicable rules.~~
1248 ~~(b) An intentional, reckless, or negligent act that~~
1249 ~~materially affects the health or safety of a patient.~~
1250 Section 48. Subsection (3) of section 400.967, Florida
1251 Statutes, is amended to read:
1252 400.967 Rules and classification of violations
1253 ~~deficiencies~~.—
1254 (3) The agency shall adopt rules to provide that, when the
1255 criteria established under this part and part II of chapter 408
1256 are not met, such violations ~~deficiencies~~ shall be classified
1257 according to the nature of the violation ~~deficiency~~. The agency
1258 shall indicate the classification on the face of the notice of
1259 deficiencies as follows:
1260 (a) Class I violations ~~deficiencies~~ are defined in s.
1261 408.813 ~~those which the agency determines present an imminent~~
1262 ~~danger to the residents or guests of the facility or a~~

1263 ~~substantial probability that death or serious physical harm~~
1264 ~~would result therefrom~~. ~~The condition or practice constituting a~~
1265 ~~class I violation must be abated or eliminated immediately,~~
1266 ~~unless a fixed period of time, as determined by the agency, is~~
1267 ~~required for correction.~~ A class I violation ~~deficiency~~ is
1268 subject to a civil penalty in an amount not less than $5,000 and
1269 not exceeding $10,000 for each violation ~~deficiency~~. A fine may
1270 be levied notwithstanding the correction of the violation
1271 ~~deficiency~~.
1272 (b) Class II violations ~~deficiencies~~ are defined in s.
1273 408.813 ~~those which the agency determines have a direct or~~
1274 ~~immediate relationship to the health, safety, or security of the~~
1275 ~~facility residents, other than class I deficiencies~~. A class II
1276 violation ~~deficiency~~ is subject to a civil penalty in an amount
1277 not less than $1,000 and not exceeding $5,000 for each violation
1278 ~~deficiency~~. A citation for a class II violation ~~deficiency~~ shall
1279 specify the time within which the violation ~~deficiency~~ must be
1280 corrected. If a class II violation ~~deficiency~~ is corrected
1281 within the time specified, no civil penalty shall be imposed,
1282 unless it is a repeated offense.
1283 (c) Class III violations ~~deficiencies~~ are defined in s.
1284 408.813 ~~those which the agency determines to have an indirect or~~
1285 ~~potential relationship to the health, safety, or security of the~~
1286 ~~facility residents, other than class I or class II deficiencies~~.
1287 A class III violation ~~deficiency~~ is subject to a civil penalty
1288 of not less than $500 and not exceeding $1,000 for each
1289 deficiency. A citation for a class III violation ~~deficiency~~
1290 shall specify the time within which the violation ~~deficiency~~

1291 must be corrected. If a class III violation ~~deficiency~~ is
1292 corrected within the time specified, no civil penalty shall be
1293 imposed, unless it is a repeated offense.
1294 (d) Class IV violations are defined in s. 408.813. Upon
1295 finding an uncorrected or repeated class IV violation, the
1296 agency shall impose an administrative fine not to exceed $500
1297 for each occurrence and each day that the uncorrected or
1298 repeated violation exists.
1299 Section 49. Subsections (4) and (7) of section 400.9905,
1300 Florida Statutes, are amended to read:
1301 400.9905 Definitions.—
1302 (4) "Clinic" means an entity at which health care services
1303 are provided to individuals and which tenders charges for
1304 reimbursement for such services, including a mobile clinic and a
1305 portable health service or equipment provider. For purposes of
1306 this part, the term does not include and the licensure
1307 requirements of this part do not apply to:
1308 (a) Entities licensed or registered by the state under
1309 chapter 395; or entities licensed or registered by the state and
1310 providing only health care services within the scope of services
1311 authorized under their respective licenses granted under ss.
1312 383.30-383.335, chapter 390, chapter 394, chapter 397, this
1313 chapter except part X, chapter 429, chapter 463, chapter 465,
1314 chapter 466, chapter 478, part I of chapter 483, chapter 484, or
1315 chapter 651; end-stage renal disease providers authorized under
1316 42 C.F.R. part 405, subpart U; or providers certified under 42
1317 C.F.R. part 485, subpart B or subpart H; or any entity that
1318 provides neonatal or pediatric hospital-based health care

1319 services or other health care services by licensed practitioners
1320 solely within a hospital licensed under chapter 395.
1321 (b) Entities that own, directly or indirectly, entities
1322 licensed or registered by the state pursuant to chapter 395; or
1323 entities that own, directly or indirectly, entities licensed or
1324 registered by the state and providing only health care services
1325 within the scope of services authorized pursuant to their
1326 respective licenses granted under ss. 383.30-383.335, chapter
1327 390, chapter 394, chapter 397, this chapter except part X,
1328 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
1329 part I of chapter 483, chapter 484, chapter 651; end-stage renal
1330 disease providers authorized under 42 C.F.R. part 405, subpart
1331 U; or providers certified under 42 C.F.R. part 485, subpart B or
1332 subpart H; or any entity that provides neonatal or pediatric
1333 hospital-based health care services by licensed practitioners
1334 solely within a hospital licensed under chapter 395.
1335 (c) Entities that are owned, directly or indirectly, by an
1336 entity licensed or registered by the state pursuant to chapter
1337 395; or entities that are owned, directly or indirectly, by an
1338 entity licensed or registered by the state and providing only
1339 health care services within the scope of services authorized
1340 pursuant to their respective licenses granted under ss. 383.30-
1341 383.335, chapter 390, chapter 394, chapter 397, this chapter
1342 except part X, chapter 429, chapter 463, chapter 465, chapter
1343 466, chapter 478, part I of chapter 483, chapter 484, or chapter
1344 651; end-stage renal disease providers authorized under 42
1345 C.F.R. part 405, subpart U; or providers certified under 42
1346 C.F.R. part 485, subpart B or subpart H; or any entity that

1347 provides neonatal or pediatric hospital-based health care
1348 services by licensed practitioners solely within a hospital
1349 under chapter 395.
1350 (d) Entities that are under common ownership, directly or
1351 indirectly, with an entity licensed or registered by the state
1352 pursuant to chapter 395; or entities that are under common
1353 ownership, directly or indirectly, with an entity licensed or
1354 registered by the state and providing only health care services
1355 within the scope of services authorized pursuant to their
1356 respective licenses granted under ss. 383.30-383.335, chapter
1357 390, chapter 394, chapter 397, this chapter except part X,
1358 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
1359 part I of chapter 483, chapter 484, or chapter 651; end-stage
1360 renal disease providers authorized under 42 C.F.R. part 405,
1361 subpart U; or providers certified under 42 C.F.R. part 485,
1362 subpart B or subpart H; or any entity that provides neonatal or
1363 pediatric hospital-based health care services by licensed
1364 practitioners solely within a hospital licensed under chapter
1365 395.
1366 (e) An entity that is exempt from federal taxation under
1367 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
1368 under 26 U.S.C. s. 409 that has a board of trustees not less
1369 than two-thirds of which are Florida-licensed health care
1370 practitioners and provides only physical therapy services under
1371 physician orders, any community college or university clinic,
1372 and any entity owned or operated by the federal or state
1373 government, including agencies, subdivisions, or municipalities
1374 thereof.

1375 (f) A sole proprietorship, group practice, partnership, or
1376 corporation that provides health care services by physicians
1377 covered by s. 627.419, that is directly supervised by one or
1378 more of such physicians, and that is wholly owned by one or more
1379 of those physicians or by a physician and the spouse, parent,
1380 child, or sibling of that physician.
1381 (g) A sole proprietorship, group practice, partnership, or
1382 corporation that provides health care services by licensed
1383 health care practitioners under chapter 457, chapter 458,
1384 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
1385 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
1386 chapter 490, chapter 491, or part I, part III, part X, part
1387 XIII, or part XIV of chapter 468, or s. 464.012, which are
1388 wholly owned by one or more licensed health care practitioners,
1389 or the licensed health care practitioners set forth in this
1390 paragraph and the spouse, parent, child, or sibling of a
1391 licensed health care practitioner, so long as one of the owners
1392 who is a licensed health care practitioner is supervising the
1393 business activities and is legally responsible for the entity's
1394 compliance with all federal and state laws. However, a health
1395 care practitioner may not supervise services beyond the scope of
1396 the practitioner's license, except that, for the purposes of
1397 this part, a clinic owned by a licensee in s. 456.053(3)(b) that
1398 provides only services authorized pursuant to s. 456.053(3)(b)
1399 may be supervised by a licensee specified in s. 456.053(3)(b).
1400 (h) Clinical facilities affiliated with an accredited
1401 medical school at which training is provided for medical
1402 students, residents, or fellows.

1403 (i) Entities that provide only oncology or radiation
1404 therapy services by physicians licensed under chapter 458 or
1405 chapter 459 or entities that provide oncology or radiation
1406 therapy services by physicians licensed under chapter 458 or
1407 chapter 459 which are owned by a corporation whose shares are
1408 publicly traded on a recognized stock exchange.
1409 (j) Clinical facilities affiliated with a college of
1410 chiropractic accredited by the Council on Chiropractic Education
1411 at which training is provided for chiropractic students.
1412 (k) Entities that provide licensed practitioners to staff
1413 emergency departments or to deliver anesthesia services in
1414 facilities licensed under chapter 395 and that derive at least
1415 90 percent of their gross annual revenues from the provision of
1416 such services. Entities claiming an exemption from licensure
1417 under this paragraph must provide documentation demonstrating
1418 compliance.
1419 (l) Orthotic, ~~or~~ prosthetic, pediatric cardiology, or
1420 perinatology clinical facilities that are a publicly traded
1421 corporation or that are wholly owned, directly or indirectly, by
1422 a publicly traded corporation. As used in this paragraph, a
1423 publicly traded corporation is a corporation that issues
1424 securities traded on an exchange registered with the United
1425 States Securities and Exchange Commission as a national
1426 securities exchange.
1427 (m) Entities that are owned by a corporation that has $250
1428 million or more in total annual sales of health care services
1429 provided by licensed health care practitioners if one or more of
1430 the owners of the entity is a health care practitioner who is

1431 licensed in this state, is responsible for supervising the
1432 business activities of the entity, and is legally responsible
1433 for the entity's compliance with state law for purposes of this
1434 section.
1435 (n) Entities that are owned or controlled, directly or
1436 indirectly, by a publicly traded entity with $100 million or
1437 more, in the aggregate, in total annual revenues derived from
1438 providing health care services by licensed health care
1439 practitioners that are employed or contracted by an entity
1440 described in this paragraph.
1441 (7) "Portable health service or equipment provider" means
1442 an entity that contracts with or employs persons to provide
1443 portable health services or equipment to multiple locations
1444 ~~performing treatment or diagnostic testing of individuals~~, that
1445 bills third-party payors for those services, and that otherwise
1446 meets the definition of a clinic in subsection (4).
1447 Section 50. Paragraph (b) of subsection (1) and paragraph
1448 (c) of subsection (4) of section 400.991, Florida Statutes, are
1449 amended to read:
1450 400.991 License requirements; background screenings;
1451 prohibitions.—
1452 (1)
1453 (b) Each mobile clinic must obtain a separate health care
1454 clinic license and must provide to the agency, at least
1455 quarterly, its projected street location to enable the agency to
1456 locate and inspect such clinic. A portable health service or
1457 equipment provider must obtain a health care clinic license for

Amendment No.

1458 a single administrative office and is not required to submit
1459 quarterly projected street locations.
1460 (4) In addition to the requirements of part II of chapter
1461 408, the applicant must file with the application satisfactory
1462 proof that the clinic is in compliance with this part and
1463 applicable rules, including:
1464 (c) Proof of financial ability to operate as required
1465 under ss. ~~s.~~ 408.810(8) and 408.8065. ~~As an alternative to~~
1466 ~~submitting proof of financial ability to operate as required~~
1467 ~~under s. 408.810(8), the applicant may file a surety bond of at~~
1468 ~~least $500,000 which guarantees that the clinic will act in full~~
1469 ~~conformity with all legal requirements for operating a clinic,~~
1470 ~~payable to the agency. The agency may adopt rules to specify~~
1471 ~~related requirements for such surety bond.~~
1472 Section 51. Paragraph (g) of subsection (1) and paragraph
1473 (a) of subsection (7) of section 400.9935, Florida Statutes, are
1474 amended to read:
1475 400.9935 Clinic responsibilities.—
1476 (1) Each clinic shall appoint a medical director or clinic
1477 director who shall agree in writing to accept legal
1478 responsibility for the following activities on behalf of the
1479 clinic. The medical director or the clinic director shall:
1480 (g) Conduct systematic reviews of clinic billings to
1481 ensure that the billings are not fraudulent or unlawful. Upon
1482 discovery of an unlawful charge, the medical director or clinic
1483 director shall take immediate corrective action. If the clinic
1484 performs only the technical component of magnetic resonance
1485 imaging, static radiographs, computed tomography, or positron

1486 emission tomography, and provides the professional
1487 interpretation of such services, in a fixed facility that is
1488 accredited by the Joint Commission ~~on Accreditation of~~
1489 ~~Healthcare Organizations~~ or the Accreditation Association for
1490 Ambulatory Health Care, and the American College of Radiology;
1491 and if, in the preceding quarter, the percentage of scans
1492 performed by that clinic which was billed to all personal injury
1493 protection insurance carriers was less than 15 percent, the
1494 chief financial officer of the clinic may, in a written
1495 acknowledgment provided to the agency, assume the responsibility
1496 for the conduct of the systematic reviews of clinic billings to
1497 ensure that the billings are not fraudulent or unlawful.
1498 (7)(a) Each clinic engaged in magnetic resonance imaging
1499 services must be accredited by the Joint Commission ~~on~~
1500 ~~Accreditation of Healthcare Organizations~~, the American College
1501 of Radiology, or the Accreditation Association for Ambulatory
1502 Health Care, within 1 year after licensure. A clinic that is
1503 accredited by the American College of Radiology or is within the
1504 original 1-year period after licensure and replaces its core
1505 magnetic resonance imaging equipment shall be given 1 year after
1506 the date on which the equipment is replaced to attain
1507 accreditation. However, a clinic may request a single, 6-month
1508 extension if it provides evidence to the agency establishing
1509 that, for good cause shown, such clinic cannot be accredited
1510 within 1 year after licensure, and that such accreditation will
1511 be completed within the 6-month extension. After obtaining
1512 accreditation as required by this subsection, each such clinic
1513 must maintain accreditation as a condition of renewal of its

1514 license. A clinic that files a change of ownership application
1515 must comply with the original accreditation timeframe
1516 requirements of the transferor. The agency shall deny a change
1517 of ownership application if the clinic is not in compliance with
1518 the accreditation requirements. When a clinic adds, replaces, or
1519 modifies magnetic resonance imaging equipment and the
1520 accreditation agency requires new accreditation, the clinic must
1521 be accredited within 1 year after the date of the addition,
1522 replacement, or modification but may request a single, 6-month
1523 extension if the clinic provides evidence of good cause to the
1524 agency.
1525 Section 52. Paragraph (a) of subsection (2) of section
1526 408.033, Florida Statutes, is amended to read:
1527 408.033 Local and state health planning.—
1528 (2) FUNDING.—
1529 (a) The Legislature intends that the cost of local health
1530 councils be borne by assessments on selected health care
1531 facilities subject to facility licensure by the Agency for
1532 Health Care Administration, including abortion clinics, assisted
1533 living facilities, ambulatory surgical centers, birthing
1534 centers, clinical laboratories except community nonprofit blood
1535 banks and clinical laboratories operated by practitioners for
1536 exclusive use regulated under s. 483.035, home health agencies,
1537 hospices, hospitals, intermediate care facilities for the
1538 developmentally disabled, nursing homes, health care clinics,
1539 and multiphasic testing centers and by assessments on
1540 organizations subject to certification by the agency pursuant to
1541 chapter 641, part III, including health maintenance

1542 organizations and prepaid health clinics. <u>Fees assessed may be</u>
1543 <u>collected prospectively at the time of licensure renewal and</u>
1544 <u>prorated for the licensure period.</u>
1545 Section 53. Subsection (2) of section 408.034, Florida
1546 Statutes, is amended to read:
1547 408.034 Duties and responsibilities of agency; rules.—
1548 (2) In the exercise of its authority to issue licenses to
1549 health care facilities and health service providers, as provided
1550 under chapters 393 and 395 and parts II<u>,</u> ~~and~~ IV<u>, and VIII</u> of
1551 chapter 400, the agency may not issue a license to any health
1552 care facility or health service provider that fails to receive a
1553 certificate of need or an exemption for the licensed facility or
1554 service.
1555 Section 54. Paragraph (d) of subsection (1), and paragraph
1556 (m) of subsection (3) of section 408.036, Florida Statutes, are
1557 amended to read:
1558 408.036 Projects subject to review; exemptions.—
1559 (1) APPLICABILITY.—Unless exempt under subsection (3), all
1560 health-care-related projects, as described in paragraphs (a)-
1561 (g), are subject to review and must file an application for a
1562 certificate of need with the agency. The agency is exclusively
1563 responsible for determining whether a health-care-related
1564 project is subject to review under ss. 408.031-408.045.
1565 (d) The establishment of a hospice or hospice inpatient
1566 facility~~, except as provided in s. 408.043~~.
1567 (3) EXEMPTIONS.—Upon request, the following projects are
1568 subject to exemption from the provisions of subsection (1):

1569 (m)1. For the provision of adult open-heart services in a
1570 hospital located within the boundaries of a health service
1571 planning district, as defined in s. 408.032(5), which has
1572 experienced an annual net out-migration of at least 600 open-
1573 heart-surgery cases for 3 consecutive years according to the
1574 most recent data reported to the agency, and the district's
1575 population per licensed and operational open-heart programs
1576 exceeds the state average of population per licensed and
1577 operational open-heart programs by at least 25 percent. All
1578 hospitals within a health service planning district which meet
1579 the criteria reference in sub-subparagraphs 2.a.-h. shall be
1580 eligible for this exemption on July 1, 2004, and shall receive
1581 the exemption upon filing for it and subject to the following:
1582 a. A hospital that has received a notice of intent to
1583 grant a certificate of need or a final order of the agency
1584 granting a certificate of need for the establishment of an open-
1585 heart-surgery program is entitled to receive a letter of
1586 exemption for the establishment of an adult open-heart-surgery
1587 program upon filing a request for exemption and complying with
1588 the criteria enumerated in sub-subparagraphs 2.a.-h., and is
1589 entitled to immediately commence operation of the program.
1590 b. An otherwise eligible hospital that has not received a
1591 notice of intent to grant a certificate of need or a final order
1592 of the agency granting a certificate of need for the
1593 establishment of an open-heart-surgery program is entitled to
1594 immediately receive a letter of exemption for the establishment
1595 of an adult open-heart-surgery program upon filing a request for
1596 exemption and complying with the criteria enumerated in sub-

1597 subparagraphs 2.a.-h., but is not entitled to commence operation
1598 of its program until December 31, 2006.
1599 2. A hospital shall be exempt from the certificate-of-need
1600 review for the establishment of an open-heart-surgery program
1601 when the application for exemption submitted under this
1602 paragraph complies with the following criteria:
1603 a. The applicant must certify that it will meet and
1604 continuously maintain the minimum licensure requirements adopted
1605 by the agency governing adult open-heart programs, including the
1606 most current guidelines of the American College of Cardiology
1607 and American Heart Association Guidelines for Adult Open Heart
1608 Programs.
1609 b. The applicant must certify that it will maintain
1610 sufficient appropriate equipment and health personnel to ensure
1611 quality and safety.
1612 c. The applicant must certify that it will maintain
1613 appropriate times of operation and protocols to ensure
1614 availability and appropriate referrals in the event of
1615 emergencies.
1616 d. The applicant can demonstrate that it has discharged at
1617 least 300 inpatients with a principal diagnosis of ischemic
1618 heart disease for the most recent 12-month period as reported to
1619 the agency.
1620 e. The applicant is a general acute care hospital that is
1621 in operation for 3 years or more.
1622 f. The applicant is performing more than 300 diagnostic
1623 cardiac catheterization procedures per year, combined inpatient
1624 and outpatient.

1625 g. The applicant's payor mix at a minimum reflects the
1626 community average for Medicaid, charity care, and self-pay
1627 patients or the applicant must certify that it will provide a
1628 minimum of 5 percent of Medicaid, charity care, and self-pay to
1629 open-heart-surgery patients.
1630 h. If the applicant fails to meet the established criteria
1631 for open-heart programs or fails to reach 300 surgeries per year
1632 by the end of its third year of operation, it must show cause
1633 why its exemption should not be revoked.
1634 ~~3. By December 31, 2004, and annually thereafter, the~~
1635 ~~agency shall submit a report to the Legislature providing~~
1636 ~~information concerning the number of requests for exemption it~~
1637 ~~has received under this paragraph during the calendar year and~~
1638 ~~the number of exemptions it has granted or denied during the~~
1639 ~~calendar year.~~
1640 Section 55. Paragraph (c) of subsection (1) of section
1641 408.037, Florida Statutes, is amended to read:
1642 408.037 Application content.—
1643 (1) Except as provided in subsection (2) for a general
1644 hospital, an application for a certificate of need must contain:
1645 (c) An audited financial statement of the applicant or
1646 applicant's parent corporation if audited financial statements
1647 of the applicant do not exist. In an application submitted by an
1648 existing health care facility, health maintenance organization,
1649 or hospice, financial condition documentation must include, but
1650 need not be limited to, a balance sheet and a profit-and-loss
1651 statement of the 2 previous fiscal years' operation.

1652 Section 56. Subsection (2) of section 408.043, Florida
1653 Statutes, is amended to read:
1654 408.043 Special provisions.—
1655 (2) HOSPICES.—When an application is made for a
1656 certificate of need to establish or to expand a hospice, the
1657 need for such hospice shall be determined on the basis of the
1658 need for and availability of hospice services in the community.
1659 The formula on which the certificate of need is based shall
1660 discourage regional monopolies and promote competition. The
1661 inpatient hospice care component of a hospice which is a
1662 freestanding facility, or a part of a facility, ~~which is~~
1663 ~~primarily engaged in providing inpatient care and related~~
1664 ~~services~~ and is not licensed as a health care facility shall
1665 also be required to obtain a certificate of need. Provision of
1666 hospice care by any current provider of health care is a
1667 significant change in service and therefore requires a
1668 certificate of need for such services.
1669 Section 57. Paragraph (k) of subsection (3) of section
1670 408.05, Florida Statutes, is amended to read:
1671 408.05 Florida Center for Health Information and Policy
1672 Analysis.—
1673 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to
1674 produce comparable and uniform health information and statistics
1675 for the development of policy recommendations, the agency shall
1676 perform the following functions:
1677 (k) Develop, in conjunction with the State Consumer Health
1678 Information and Policy Advisory Council, and implement a long-
1679 range plan for making available health care quality measures and

1680 financial data that will allow consumers to compare health care
1681 services. The health care quality measures and financial data
1682 the agency must make available shall include, but is not limited
1683 to, pharmaceuticals, physicians, health care facilities, and
1684 health plans and managed care entities. The agency shall update
1685 the plan and report on the status of its implementation
1686 annually. The agency shall also make the plan and status report
1687 available to the public on its Internet website. As part of the
1688 plan, the agency shall identify the process and timeframes for
1689 implementation, any barriers to implementation, and
1690 recommendations of changes in the law that may be enacted by the
1691 Legislature to eliminate the barriers. As preliminary elements
1692 of the plan, the agency shall:
1693 1. Make available patient-safety indicators, inpatient
1694 quality indicators, and performance outcome and patient charge
1695 data collected from health care facilities pursuant to s.
1696 408.061(1)(a) and (2). The terms "patient-safety indicators" and
1697 "inpatient quality indicators" shall be as defined by the
1698 Centers for Medicare and Medicaid Services, the National Quality
1699 Forum, the Joint Commission ~~on Accreditation of Healthcare~~
1700 ~~Organizations~~, the Agency for Healthcare Research and Quality,
1701 the Centers for Disease Control and Prevention, or a similar
1702 national entity that establishes standards to measure the
1703 performance of health care providers, or by other states. The
1704 agency shall determine which conditions, procedures, health care
1705 quality measures, and patient charge data to disclose based upon
1706 input from the council. When determining which conditions and
1707 procedures are to be disclosed, the council and the agency shall

1708 consider variation in costs, variation in outcomes, and
1709 magnitude of variations and other relevant information. When
1710 determining which health care quality measures to disclose, the
1711 agency:
1712 a. Shall consider such factors as volume of cases; average
1713 patient charges; average length of stay; complication rates;
1714 mortality rates; and infection rates, among others, which shall
1715 be adjusted for case mix and severity, if applicable.
1716 b. May consider such additional measures that are adopted
1717 by the Centers for Medicare and Medicaid Studies, National
1718 Quality Forum, the Joint Commission ~~on Accreditation of~~
1719 ~~Healthcare Organizations~~, the Agency for Healthcare Research and
1720 Quality, Centers for Disease Control and Prevention, or a
1721 similar national entity that establishes standards to measure
1722 the performance of health care providers, or by other states.
1723
1724 When determining which patient charge data to disclose, the
1725 agency shall include such measures as the average of
1726 undiscounted charges on frequently performed procedures and
1727 preventive diagnostic procedures, the range of procedure charges
1728 from highest to lowest, average net revenue per adjusted patient
1729 day, average cost per adjusted patient day, and average cost per
1730 admission, among others.
1731 2. Make available performance measures, benefit design,
1732 and premium cost data from health plans licensed pursuant to
1733 chapter 627 or chapter 641. The agency shall determine which
1734 health care quality measures and member and subscriber cost data
1735 to disclose, based upon input from the council. When determining

1736 which data to disclose, the agency shall consider information
1737 that may be required by either individual or group purchasers to
1738 assess the value of the product, which may include membership
1739 satisfaction, quality of care, current enrollment or membership,
1740 coverage areas, accreditation status, premium costs, plan costs,
1741 premium increases, range of benefits, copayments and
1742 deductibles, accuracy and speed of claims payment, credentials
1743 of physicians, number of providers, names of network providers,
1744 and hospitals in the network. Health plans shall make available
1745 to the agency any such data or information that is not currently
1746 reported to the agency or the office.
1747 3. Determine the method and format for public disclosure
1748 of data reported pursuant to this paragraph. The agency shall
1749 make its determination based upon input from the State Consumer
1750 Health Information and Policy Advisory Council. At a minimum,
1751 the data shall be made available on the agency's Internet
1752 website in a manner that allows consumers to conduct an
1753 interactive search that allows them to view and compare the
1754 information for specific providers. The website must include
1755 such additional information as is determined necessary to ensure
1756 that the website enhances informed decisionmaking among
1757 consumers and health care purchasers, which shall include, at a
1758 minimum, appropriate guidance on how to use the data and an
1759 explanation of why the data may vary from provider to provider.
1760 4. Publish on its website undiscounted charges for no
1761 fewer than 150 of the most commonly performed adult and
1762 pediatric procedures, including outpatient, inpatient,
1763 diagnostic, and preventative procedures.

1764 Section 58. Paragraph (a) of subsection (1) of section
1765 408.061, Florida Statutes, is amended to read:
1766 408.061 Data collection; uniform systems of financial
1767 reporting; information relating to physician charges;
1768 confidential information; immunity.—
1769 (1) The agency shall require the submission by health care
1770 facilities, health care providers, and health insurers of data
1771 necessary to carry out the agency's duties. Specifications for
1772 data to be collected under this section shall be developed by
1773 the agency with the assistance of technical advisory panels
1774 including representatives of affected entities, consumers,
1775 purchasers, and such other interested parties as may be
1776 determined by the agency.
1777 (a) Data submitted by health care facilities, including
1778 the facilities as defined in chapter 395, shall include, but are
1779 not limited to: case-mix data, patient admission and discharge
1780 data, hospital emergency department data which shall include the
1781 number of patients treated in the emergency department of a
1782 licensed hospital reported by patient acuity level, data on
1783 hospital-acquired infections as specified by rule, data on
1784 complications as specified by rule, data on readmissions as
1785 specified by rule, with patient and provider-specific
1786 identifiers included, actual charge data by diagnostic groups,
1787 financial data, accounting data, operating expenses, expenses
1788 incurred for rendering services to patients who cannot or do not
1789 pay, interest charges, depreciation expenses based on the
1790 expected useful life of the property and equipment involved, and
1791 demographic data. The agency shall adopt nationally recognized

1792 risk adjustment methodologies or software consistent with the
1793 standards of the Agency for Healthcare Research and Quality and
1794 as selected by the agency for all data submitted as required by
1795 this section. Data may be obtained from documents such as, but
1796 not limited to: leases, contracts, debt instruments, itemized
1797 patient bills, medical record abstracts, and related diagnostic
1798 information. Reported data elements shall be reported
1799 electronically and ~~in accordance with rule 59E-7.012, Florida~~
1800 ~~Administrative Code. Data submitted shall be~~ certified by the
1801 chief executive officer or an appropriate and duly authorized
1802 representative or employee of the licensed facility that the
1803 information submitted is true and accurate.
1804 Section 59. Subsection (43) of section 408.07, Florida
1805 Statutes, is amended to read:
1806 408.07 Definitions.—As used in this chapter, with the
1807 exception of ss. 408.031-408.045, the term:
1808 (43) "Rural hospital" means an acute care hospital
1809 licensed under chapter 395, having 100 or fewer licensed beds
1810 and an emergency room, and which is:
1811 (a) The sole provider within a county with a population
1812 density of no greater than 100 persons per square mile;
1813 (b) An acute care hospital, in a county with a population
1814 density of no greater than 100 persons per square mile, which is
1815 at least 30 minutes of travel time, on normally traveled roads
1816 under normal traffic conditions, from another acute care
1817 hospital within the same county;

1818 (c) A hospital supported by a tax district or subdistrict
1819 whose boundaries encompass a population of 100 persons or fewer
1820 per square mile;
1821 (d) A hospital with a service area that has a population
1822 of 100 persons or fewer per square mile. As used in this
1823 paragraph, the term "service area" means the fewest number of
1824 zip codes that account for 75 percent of the hospital's
1825 discharges for the most recent 5-year period, based on
1826 information available from the hospital inpatient discharge
1827 database in the Florida Center for Health Information and Policy
1828 Analysis at the Agency for Health Care Administration; or
1829 (e) A critical access hospital.
1830
1831 Population densities used in this subsection must be based upon
1832 the most recently completed United States census. A hospital
1833 that received funds under s. 409.9116 for a quarter beginning no
1834 later than July 1, 2002, is deemed to have been and shall
1835 continue to be a rural hospital from that date through June 30,
1836 2015, if the hospital continues to have 100 or fewer licensed
1837 beds and an emergency room~~, or meets the criteria of s.~~
1838 ~~395.602(2)(e)4~~. An acute care hospital that has not previously
1839 been designated as a rural hospital and that meets the criteria
1840 of this subsection shall be granted such designation upon
1841 application, including supporting documentation, to the Agency
1842 for Health Care Administration.
1843 Section 60. Section 408.10, Florida Statutes, is amended
1844 to read:
1845 408.10 Consumer complaints.—The agency shall~~:~~

1846 ~~(1)~~ publish and make available to the public a toll-free
1847 telephone number for the purpose of handling consumer complaints
1848 and shall serve as a liaison between consumer entities and other
1849 private entities and governmental entities for the disposition
1850 of problems identified by consumers of health care.
1851 ~~(2) Be empowered to investigate consumer complaints~~
1852 ~~relating to problems with health care facilities' billing~~
1853 ~~practices and issue reports to be made public in any cases where~~
1854 ~~the agency determines the health care facility has engaged in~~
1855 ~~billing practices which are unreasonable and unfair to the~~
1856 ~~consumer.~~
1857 Section 61. Subsections (12) through (30) of section
1858 408.802, Florida Statutes, are renumbered as subsections (11)
1859 through (29), respectively, and present subsection (11) of that
1860 section is amended to read:
1861 408.802 Applicability.—The provisions of this part apply
1862 to the provision of services that require licensure as defined
1863 in this part and to the following entities licensed, registered,
1864 or certified by the agency, as described in chapters 112, 383,
1865 390, 394, 395, 400, 429, 440, 483, and 765:
1866 ~~(11) Private review agents, as provided under part I of~~
1867 ~~chapter 395.~~
1868 Section 62. Subsection (3) is added to section 408.804,
1869 Florida Statutes, to read:
1870 408.804 License required; display.—
1871 (3) Any person who knowingly alters, defaces, or falsifies
1872 a license certificate issued by the agency, or causes or
1873 procures any person to commit such an offense, commits a

1874 misdemeanor of the second degree, punishable as provided in s.
1875 775.082 or s 775.083. Any licensee or provider who displays an
1876 altered, defaced, or falsified license certificate is subject to
1877 the penalties set forth in s. 408.815 and an administrative fine
1878 of $1,000 for each day of illegal display.

1879 Section 63. Paragraph (d) of subsection (2) of section
1880 408.806, Florida Statutes, is amended, present subsections (3)
1881 through (8) are renumbered as subsections (4) through (9),
1882 respectively, and a new subsection (3) is added to that section,
1883 to read:

1884 408.806 License application process.—

1885 (2)

1886 (d) ~~The agency shall notify the licensee by mail or~~
1887 ~~electronically at least 90 days before the expiration of a~~
1888 ~~license that a renewal license is necessary to continue~~
1889 ~~operation.~~ The licensee's failure to timely file ~~submit~~ a
1890 renewal application and license application fee with the agency
1891 shall result in a $50 per day late fee charged to the licensee
1892 by the agency; however, the aggregate amount of the late fee may
1893 not exceed 50 percent of the licensure fee or $500, whichever is
1894 less. The agency shall provide a courtesy notice to the licensee
1895 by United States mail, electronically, or by any other manner at
1896 its address of record or mailing address, if provided, at least
1897 90 days prior to the expiration of a license informing the
1898 licensee of the expiration of the license. If the licensee does
1899 not receive the courtesy notice or the licensee does not receive
1900 the courtesy notice, the licensee continues to be legally
1901 obligated to timely file the renewal application and license

1902 application fee with the agency and is not excused from the
1903 payment of a late fee. If an application is received after the
1904 required filing date and exhibits a hand-canceled postmark
1905 obtained from a United States post office dated on or before the
1906 required filing date, no fine will be levied.
1907 (e) Payment of the late fee is required to consider any
1908 late application complete, and failure to pay the late fee is
1909 considered an omission from the application.
1910 Section 64. Paragraph (b) of subsection (1) of section
1911 408.8065, Florida Statutes, is amended to read:
1912 408.8065 Additional licensure requirements for home health
1913 agencies, home medical equipment providers, and health care
1914 clinics.—
1915 (1) An applicant for initial licensure, or initial
1916 licensure due to a change of ownership, as a home health agency,
1917 home medical equipment provider, or health care clinic shall:
1918 (b) Submit projected ~~pro forma~~ financial statements,
1919 including a balance sheet, income and expense statement, and a
1920 statement of cash flows for the first 2 years of operation which
1921 provide evidence that the applicant has sufficient assets,
1922 credit, and projected revenues to cover liabilities and
1923 expenses.
1924
1925 All documents required under this subsection must be prepared in
1926 accordance with generally accepted accounting principles and may
1927 be in a compilation form. The financial statements must be
1928 signed by a certified public accountant.

1929 Section 65. Subsection (4) is amended and subsections (5)
1930 through (8) of section 408.809, Florida Statutes are renumbered
1931 as subsections (6) through (9), respectively.
1932 408.809 Background screening; prohibited offenses.—
1933 (4) In addition to the offenses listed in s. 435.04, all
1934 persons required to undergo background screening pursuant to
1935 this part or authorizing statutes must not have an arrest
1936 awaiting final disposition for, must not have been found guilty
1937 of, regardless of adjudication, or entered a plea of nolo
1938 contendere or guilty to, and must not have been adjudicated
1939 delinquent and the record not have been sealed or expunged for
1940 any of the following offenses or any similar offense of another
1941 jurisdiction:
1942 (a) Any authorizing statutes, if the offense was a felony.
1943 (b) This chapter, if the offense was a felony.
1944 (c) Section 409.920, relating to Medicaid provider fraud.
1945 (d) Section 409.9201, relating to Medicaid fraud.
1946 (e) Section 741.28, relating to domestic violence.
1947 (f) Section 817.034, relating to fraudulent acts through
1948 mail, wire, radio, electromagnetic, photoelectronic, or
1949 photooptical systems.
1950 (g) Section 817.234, relating to false and fraudulent
1951 insurance claims.
1952 (h) Section 817.505, relating to patient brokering.
1953 (i) Section 817.568, relating to criminal use of personal
1954 identification information.
1955 (j) Section 817.60, relating to obtaining a credit card
1956 through fraudulent means.

Amendment No.

1957 (k) Section 817.61, relating to fraudulent use of credit
1958 cards, if the offense was a felony.
1959 (l) Section 831.01, relating to forgery.
1960 (m) Section 831.02, relating to uttering forged
1961 instruments.
1962 (n) Section 831.07, relating to forging bank bills,
1963 checks, drafts, or promissory notes.
1964 (o) Section 831.09, relating to uttering forged bank
1965 bills, checks, drafts, or promissory notes.
1966 (p) Section 831.30, relating to fraud in obtaining
1967 medicinal drugs.
1968 (q) Section 831.31, relating to the sale, manufacture,
1969 delivery, or possession with the intent to sell, manufacture, or
1970 deliver any counterfeit controlled substance, if the offense was
1971 a felony.
1972
1973 (5) A person who serves as a controlling interest of, is
1974 employed by, or contracts with a licensee on July 31, 2010, who
1975 has been screened and qualified according to standards specified
1976 in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015 in
1977 accordance with the schedule below. ~~The agency may adopt rules~~
1978 ~~to establish a schedule to stagger the implementation of the~~
1979 ~~required rescreening over the 5-year period, beginning July 31,~~
1980 ~~2010, through July 31, 2015.~~ If, upon rescreening, such person
1981 has a disqualifying offense that was not a disqualifying offense
1982 at the time of the last screening, but is a current
1983 disqualifying offense and was committed before the last
1984 screening, he or she may apply for an exemption from the

1985 appropriate licensing agency and, if agreed to by the employer,
1986 may continue to perform his or her duties until the licensing
1987 agency renders a decision on the application for exemption if
1988 the person is eligible to apply for an exemption and the
1989 exemption request is received by the agency within 30 days after
1990 receipt of the rescreening results by the person. The
1991 rescreening schedule shall be:
1992 (a) Individuals in which the last screening was conducted prior
1993 to December 31, 2003 must be rescreened by July 31, 2013;
1994 (b) Individuals in which the last screening conducted was
1995 between January 1, 2004 through December 31, 2007 must be
1996 rescreened by July 31, 2014;
1997 (c) Individuals in which the last screening conducted was
1998 between January 1, 2008 through July 31, 2010 must be rescreened
1999 by July 31, 2015.
2000 (6)~~(5)~~ The costs associated with obtaining the required
2001 screening must be borne by the licensee or the person subject to
2002 screening. Licensees may reimburse persons for these costs. The
2003 Department of Law Enforcement shall charge the agency for
2004 screening pursuant to s. 943.053(3). The agency shall establish
2005 a schedule of fees to cover the costs of screening.
2006 (7)~~(6)~~(a) As provided in chapter 435, the agency may grant
2007 an exemption from disqualification to a person who is subject to
2008 this section and who:
2009 1. Does not have an active professional license or
2010 certification from the Department of Health; or

2011 2. Has an active professional license or certification
2012 from the Department of Health but is not providing a service
2013 within the scope of that license or certification.
2014 (b) As provided in chapter 435, the appropriate regulatory
2015 board within the Department of Health, or the department itself
2016 if there is no board, may grant an exemption from
2017 disqualification to a person who is subject to this section and
2018 who has received a professional license or certification from
2019 the Department of Health or a regulatory board within that
2020 department and that person is providing a service within the
2021 scope of his or her licensed or certified practice.
2022 (8) ~~(7)~~ The agency and the Department of Health may adopt
2023 rules pursuant to ss. 120.536(1) and 120.54 to implement this
2024 section, chapter 435, and authorizing statutes requiring
2025 background screening and to implement and adopt criteria
2026 relating to retaining fingerprints pursuant to s. 943.05(2).
2027 (9) ~~(8)~~ There is no unemployment compensation or other
2028 monetary liability on the part of, and no cause of action for
2029 damages arising against, an employer that, upon notice of a
2030 disqualifying offense listed under chapter 435 or this section,
2031 terminates the person against whom the report was issued,
2032 whether or not that person has filed for an exemption with the
2033 Department of Health or the agency.
2034 Section 66. Subsections (6) and (9) of section 408.810,
2035 Florida Statutes, are amended to read:
2036 408.810 Minimum licensure requirements.—In addition to the
2037 licensure requirements specified in this part, authorizing
2038 statutes, and applicable rules, each applicant and licensee must

2039 comply with the requirements of this section in order to obtain
2040 and maintain a license.
2041 (9) A controlling interest may not withhold from the
2042 agency any evidence of financial instability, including, but not
2043 limited to, checks returned due to insufficient funds,
2044 delinquent accounts, nonpayment of withholding taxes, unpaid
2045 utility expenses, nonpayment for essential services, or adverse
2046 court action concerning the financial viability of the provider
2047 or any other provider licensed under this part that is under the
2048 control of the controlling interest. A controlling interest
2049 shall notify the agency within 10 days after a court action to
2050 initiate bankruptcy, foreclosure, or eviction proceedings
2051 concerning the provider, in which the controlling interest is a
2052 petitioner or defendant. Any person who violates this subsection
2053 commits a misdemeanor of the second degree, punishable as
2054 provided in s. 775.082 or s. 775.083. Each day of continuing
2055 violation is a separate offense.
2056 Section 67. Subsection (3) is added to section 408.813,
2057 Florida Statutes, to read:
2058 408.813 Administrative fines; violations.—As a penalty for
2059 any violation of this part, authorizing statutes, or applicable
2060 rules, the agency may impose an administrative fine.
2061 (3) The agency may impose an administrative fine for a
2062 violation that is not designated as a class I, class II, class
2063 III, or class IV violation. Unless otherwise specified by law,
2064 the amount of the fine shall not exceed $500 for each violation.
2065 Unclassified violations may include:
2066 (a) Violating any term or condition of a license.

2067 (b) Violating any provision of this part, authorizing
2068 statutes, or applicable rules.
2069 (c) Exceeding licensed capacity.
2070 (d) Providing services beyond the scope of the license.
2071 (e) Violating a moratorium imposed pursuant to s. 408.814.
2072 Section 68. Subsection (2) of section 408.815, Florida
2073 Statutes, is amended, and subsection (5) is added to that
2074 section, to read:
2075 408.815 License or application denial; revocation.—
2076 (2) If a licensee lawfully continues to operate while a
2077 denial or revocation is pending in litigation, the licensee must
2078 continue to meet all other requirements of this part,
2079 authorizing statutes, and applicable rules and must file
2080 subsequent renewal applications for licensure and pay all
2081 licensure fees. The provisions of ss. 120.60(1) and 408.806(4)
2082 ~~(3)~~(c) shall not apply to renewal applications filed during the
2083 time period in which the litigation of the denial or revocation
2084 is pending until that litigation is final.
2085 (5) In order to ensure the health, safety, and welfare of
2086 clients when a license has been denied, revoked, or is set to
2087 terminate, the agency may extend the license expiration date for
2088 a period of up to 30 days for the sole purpose of allowing the
2089 safe and orderly discharge of clients. The agency may impose
2090 conditions on the extension, including, but not limited to,
2091 prohibiting or limiting admissions, expedited discharge
2092 planning, required status reports, and mandatory monitoring by
2093 the agency or third parties. When imposing these conditions, the
2094 agency shall take into consideration the nature and number of

2095 clients, the availability and location of acceptable alternative
2096 placements, and the ability of the licensee to continue
2097 providing care to the clients. The agency may terminate the
2098 extension or modify the conditions at any time. This authority
2099 is in addition to any other authority granted to the agency
2100 under chapter 120, this part, and authorizing statutes but
2101 creates no right or entitlement to an extension of a license
2102 expiration date.
2103 Section 69. Subsection (1) of section 409.91196, Florida
2104 Statutes, is amended to read:
2105 409.91196 Supplemental rebate agreements; public records
2106 and public meetings exemption.—
2107 (1) The rebate amount, percent of rebate, manufacturer's
2108 pricing, and supplemental rebate, and other trade secrets as
2109 defined in s. 688.002 that the agency has identified for use in
2110 negotiations, held by the Agency for Health Care Administration
2111 under s. 409.912(39)(a)8.~~7.~~ are confidential and exempt from s.
2112 119.07(1) and s. 24(a), Art. I of the State Constitution.
2113 Section 70. Paragraph (a) of subsection (39) of section
2114 409.912, Florida Statutes, is amended to read:
2115 409.912 Cost-effective purchasing of health care.—The
2116 agency shall purchase goods and services for Medicaid recipients
2117 in the most cost-effective manner consistent with the delivery
2118 of quality medical care. To ensure that medical services are
2119 effectively utilized, the agency may, in any case, require a
2120 confirmation or second physician's opinion of the correct
2121 diagnosis for purposes of authorizing future services under the
2122 Medicaid program. This section does not restrict access to

2123 emergency services or poststabilization care services as defined
2124 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2125 shall be rendered in a manner approved by the agency. The agency
2126 shall maximize the use of prepaid per capita and prepaid
2127 aggregate fixed-sum basis services when appropriate and other
2128 alternative service delivery and reimbursement methodologies,
2129 including competitive bidding pursuant to s. 287.057, designed
2130 to facilitate the cost-effective purchase of a case-managed
2131 continuum of care. The agency shall also require providers to
2132 minimize the exposure of recipients to the need for acute
2133 inpatient, custodial, and other institutional care and the
2134 inappropriate or unnecessary use of high-cost services. The
2135 agency shall contract with a vendor to monitor and evaluate the
2136 clinical practice patterns of providers in order to identify
2137 trends that are outside the normal practice patterns of a
2138 provider's professional peers or the national guidelines of a
2139 provider's professional association. The vendor must be able to
2140 provide information and counseling to a provider whose practice
2141 patterns are outside the norms, in consultation with the agency,
2142 to improve patient care and reduce inappropriate utilization.
2143 The agency may mandate prior authorization, drug therapy
2144 management, or disease management participation for certain
2145 populations of Medicaid beneficiaries, certain drug classes, or
2146 particular drugs to prevent fraud, abuse, overuse, and possible
2147 dangerous drug interactions. The Pharmaceutical and Therapeutics
2148 Committee shall make recommendations to the agency on drugs for
2149 which prior authorization is required. The agency shall inform
2150 the Pharmaceutical and Therapeutics Committee of its decisions

2151 regarding drugs subject to prior authorization. The agency is
2152 authorized to limit the entities it contracts with or enrolls as
2153 Medicaid providers by developing a provider network through
2154 provider credentialing. The agency may competitively bid single-
2155 source-provider contracts if procurement of goods or services
2156 results in demonstrated cost savings to the state without
2157 limiting access to care. The agency may limit its network based
2158 on the assessment of beneficiary access to care, provider
2159 availability, provider quality standards, time and distance
2160 standards for access to care, the cultural competence of the
2161 provider network, demographic characteristics of Medicaid
2162 beneficiaries, practice and provider-to-beneficiary standards,
2163 appointment wait times, beneficiary use of services, provider
2164 turnover, provider profiling, provider licensure history,
2165 previous program integrity investigations and findings, peer
2166 review, provider Medicaid policy and billing compliance records,
2167 clinical and medical record audits, and other factors. Providers
2168 shall not be entitled to enrollment in the Medicaid provider
2169 network. The agency shall determine instances in which allowing
2170 Medicaid beneficiaries to purchase durable medical equipment and
2171 other goods is less expensive to the Medicaid program than long-
2172 term rental of the equipment or goods. The agency may establish
2173 rules to facilitate purchases in lieu of long-term rentals in
2174 order to protect against fraud and abuse in the Medicaid program
2175 as defined in s. 409.913. The agency may seek federal waivers
2176 necessary to administer these policies.

2177 (39)(a) The agency shall implement a Medicaid prescribed-
2178 drug spending-control program that includes the following
2179 components:
2180 1. A Medicaid preferred drug list, which shall be a
2181 listing of cost-effective therapeutic options recommended by the
2182 Medicaid Pharmacy and Therapeutics Committee established
2183 pursuant to s. 409.91195 and adopted by the agency for each
2184 therapeutic class on the preferred drug list. At the discretion
2185 of the committee, and when feasible, the preferred drug list
2186 should include at least two products in a therapeutic class. The
2187 agency may post the preferred drug list and updates to the
2188 preferred drug list on an Internet website without following the
2189 rulemaking procedures of chapter 120. Antiretroviral agents are
2190 excluded from the preferred drug list. The agency shall also
2191 limit the amount of a prescribed drug dispensed to no more than
2192 a 34-day supply unless the drug products' smallest marketed
2193 package is greater than a 34-day supply, or the drug is
2194 determined by the agency to be a maintenance drug in which case
2195 a 100-day maximum supply may be authorized. The agency is
2196 authorized to seek any federal waivers necessary to implement
2197 these cost-control programs and to continue participation in the
2198 federal Medicaid rebate program, or alternatively to negotiate
2199 state-only manufacturer rebates. The agency may adopt rules to
2200 implement this subparagraph. The agency shall continue to
2201 provide unlimited contraceptive drugs and items. The agency must
2202 establish procedures to ensure that:

2203 a. There is a response to a request for prior consultation
2204 by telephone or other telecommunication device within 24 hours
2205 after receipt of a request for prior consultation; and
2206 b. A 72-hour supply of the drug prescribed is provided in
2207 an emergency or when the agency does not provide a response
2208 within 24 hours as required by sub-subparagraph a.
2209 2. Reimbursement to pharmacies for Medicaid prescribed
2210 drugs shall be set at the lesser of: the average wholesale price
2211 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
2212 plus 4.75 percent, the federal upper limit (FUL), the state
2213 maximum allowable cost (SMAC), or the usual and customary (UAC)
2214 charge billed by the provider.
2215 3. For a prescribed drug billed as a 340B prescribed
2216 medication, the claim must meet the requirements of the Deficit
2217 Reduction Act of 2005 and the federal 340B program, contain a
2218 national drug code, and be billed at the actual acquisition cost
2219 or payment shall be denied.
2220 4.~~3.~~ The agency shall develop and implement a process for
2221 managing the drug therapies of Medicaid recipients who are using
2222 significant numbers of prescribed drugs each month. The
2223 management process may include, but is not limited to,
2224 comprehensive, physician-directed medical-record reviews, claims
2225 analyses, and case evaluations to determine the medical
2226 necessity and appropriateness of a patient's treatment plan and
2227 drug therapies. The agency may contract with a private
2228 organization to provide drug-program-management services. The
2229 Medicaid drug benefit management program shall include
2230 initiatives to manage drug therapies for HIV/AIDS patients,

2231 patients using 20 or more unique prescriptions in a 180-day
2232 period, and the top 1,000 patients in annual spending. The
2233 agency shall enroll any Medicaid recipient in the drug benefit
2234 management program if he or she meets the specifications of this
2235 provision and is not enrolled in a Medicaid health maintenance
2236 organization.

2237 5.~~4.~~ The agency may limit the size of its pharmacy network
2238 based on need, competitive bidding, price negotiations,
2239 credentialing, or similar criteria. The agency shall give
2240 special consideration to rural areas in determining the size and
2241 location of pharmacies included in the Medicaid pharmacy
2242 network. A pharmacy credentialing process may include criteria
2243 such as a pharmacy's full-service status, location, size,
2244 patient educational programs, patient consultation, disease
2245 management services, and other characteristics. The agency may
2246 impose a moratorium on Medicaid pharmacy enrollment when it is
2247 determined that it has a sufficient number of Medicaid-
2248 participating providers. The agency must allow dispensing
2249 practitioners to participate as a part of the Medicaid pharmacy
2250 network regardless of the practitioner's proximity to any other
2251 entity that is dispensing prescription drugs under the Medicaid
2252 program. A dispensing practitioner must meet all credentialing
2253 requirements applicable to his or her practice, as determined by
2254 the agency.

2255 6.~~5.~~ The agency shall develop and implement a program that
2256 requires Medicaid practitioners who prescribe drugs to use a
2257 counterfeit-proof prescription pad for Medicaid prescriptions.
2258 The agency shall require the use of standardized counterfeit-

2259 proof prescription pads by Medicaid-participating prescribers or
2260 prescribers who write prescriptions for Medicaid recipients. The
2261 agency may implement the program in targeted geographic areas or
2262 statewide.

2263 7.~~6.~~ The agency may enter into arrangements that require
2264 manufacturers of generic drugs prescribed to Medicaid recipients
2265 to provide rebates of at least 15.1 percent of the average
2266 manufacturer price for the manufacturer's generic products.
2267 These arrangements shall require that if a generic-drug
2268 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2269 at a level below 15.1 percent, the manufacturer must provide a
2270 supplemental rebate to the state in an amount necessary to
2271 achieve a 15.1-percent rebate level.

2272 8.~~7.~~ The agency may establish a preferred drug list as
2273 described in this subsection, and, pursuant to the establishment
2274 of such preferred drug list, it is authorized to negotiate
2275 supplemental rebates from manufacturers that are in addition to
2276 those required by Title XIX of the Social Security Act and at no
2277 less than 14 percent of the average manufacturer price as
2278 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
2279 the federal or supplemental rebate, or both, equals or exceeds
2280 29 percent. There is no upper limit on the supplemental rebates
2281 the agency may negotiate. The agency may determine that specific
2282 products, brand-name or generic, are competitive at lower rebate
2283 percentages. Agreement to pay the minimum supplemental rebate
2284 percentage will guarantee a manufacturer that the Medicaid
2285 Pharmaceutical and Therapeutics Committee will consider a
2286 product for inclusion on the preferred drug list. However, a

2287 pharmaceutical manufacturer is not guaranteed placement on the
2288 preferred drug list by simply paying the minimum supplemental
2289 rebate. Agency decisions will be made on the clinical efficacy
2290 of a drug and recommendations of the Medicaid Pharmaceutical and
2291 Therapeutics Committee, as well as the price of competing
2292 products minus federal and state rebates. The agency is
2293 authorized to contract with an outside agency or contractor to
2294 conduct negotiations for supplemental rebates. For the purposes
2295 of this section, the term "supplemental rebates" means cash
2296 rebates. Effective July 1, 2004, value-added programs as a
2297 substitution for supplemental rebates are prohibited. The agency
2298 is authorized to seek any federal waivers to implement this
2299 initiative.

2300 9.~~8.~~ The Agency for Health Care Administration shall
2301 expand home delivery of pharmacy products. To assist Medicaid
2302 patients in securing their prescriptions and reduce program
2303 costs, the agency shall expand its current mail-order-pharmacy
2304 diabetes-supply program to include all generic and brand-name
2305 drugs used by Medicaid patients with diabetes. Medicaid
2306 recipients in the current program may obtain nondiabetes drugs
2307 on a voluntary basis. This initiative is limited to the
2308 geographic area covered by the current contract. The agency may
2309 seek and implement any federal waivers necessary to implement
2310 this subparagraph.

2311 10.~~9.~~ The agency shall limit to one dose per month any
2312 drug prescribed to treat erectile dysfunction.

2313 11.~~10.~~a. The agency may implement a Medicaid behavioral
2314 drug management system. The agency may contract with a vendor

2315 that has experience in operating behavioral drug management
2316 systems to implement this program. The agency is authorized to
2317 seek federal waivers to implement this program.
2318 b. The agency, in conjunction with the Department of
2319 Children and Family Services, may implement the Medicaid
2320 behavioral drug management system that is designed to improve
2321 the quality of care and behavioral health prescribing practices
2322 based on best practice guidelines, improve patient adherence to
2323 medication plans, reduce clinical risk, and lower prescribed
2324 drug costs and the rate of inappropriate spending on Medicaid
2325 behavioral drugs. The program may include the following
2326 elements:
2327 (I) Provide for the development and adoption of best
2328 practice guidelines for behavioral health-related drugs such as
2329 antipsychotics, antidepressants, and medications for treating
2330 bipolar disorders and other behavioral conditions; translate
2331 them into practice; review behavioral health prescribers and
2332 compare their prescribing patterns to a number of indicators
2333 that are based on national standards; and determine deviations
2334 from best practice guidelines.
2335 (II) Implement processes for providing feedback to and
2336 educating prescribers using best practice educational materials
2337 and peer-to-peer consultation.
2338 (III) Assess Medicaid beneficiaries who are outliers in
2339 their use of behavioral health drugs with regard to the numbers
2340 and types of drugs taken, drug dosages, combination drug
2341 therapies, and other indicators of improper use of behavioral
2342 health drugs.

Amendment No.

2343 (IV) Alert prescribers to patients who fail to refill
2344 prescriptions in a timely fashion, are prescribed multiple same-
2345 class behavioral health drugs, and may have other potential
2346 medication problems.
2347 (V) Track spending trends for behavioral health drugs and
2348 deviation from best practice guidelines.
2349 (VI) Use educational and technological approaches to
2350 promote best practices, educate consumers, and train prescribers
2351 in the use of practice guidelines.
2352 (VII) Disseminate electronic and published materials.
2353 (VIII) Hold statewide and regional conferences.
2354 (IX) Implement a disease management program with a model
2355 quality-based medication component for severely mentally ill
2356 individuals and emotionally disturbed children who are high
2357 users of care.
2358 12.~~11.~~a. The agency shall implement a Medicaid
2359 prescription drug management system. The agency may contract
2360 with a vendor that has experience in operating prescription drug
2361 management systems in order to implement this system. Any
2362 management system that is implemented in accordance with this
2363 subparagraph must rely on cooperation between physicians and
2364 pharmacists to determine appropriate practice patterns and
2365 clinical guidelines to improve the prescribing, dispensing, and
2366 use of drugs in the Medicaid program. The agency may seek
2367 federal waivers to implement this program.
2368 b. The drug management system must be designed to improve
2369 the quality of care and prescribing practices based on best
2370 practice guidelines, improve patient adherence to medication

2371 plans, reduce clinical risk, and lower prescribed drug costs and
2372 the rate of inappropriate spending on Medicaid prescription
2373 drugs. The program must:
2374 (I) Provide for the development and adoption of best
2375 practice guidelines for the prescribing and use of drugs in the
2376 Medicaid program, including translating best practice guidelines
2377 into practice; reviewing prescriber patterns and comparing them
2378 to indicators that are based on national standards and practice
2379 patterns of clinical peers in their community, statewide, and
2380 nationally; and determine deviations from best practice
2381 guidelines.
2382 (II) Implement processes for providing feedback to and
2383 educating prescribers using best practice educational materials
2384 and peer-to-peer consultation.
2385 (III) Assess Medicaid recipients who are outliers in their
2386 use of a single or multiple prescription drugs with regard to
2387 the numbers and types of drugs taken, drug dosages, combination
2388 drug therapies, and other indicators of improper use of
2389 prescription drugs.
2390 (IV) Alert prescribers to patients who fail to refill
2391 prescriptions in a timely fashion, are prescribed multiple drugs
2392 that may be redundant or contraindicated, or may have other
2393 potential medication problems.
2394 (V) Track spending trends for prescription drugs and
2395 deviation from best practice guidelines.
2396 (VI) Use educational and technological approaches to
2397 promote best practices, educate consumers, and train prescribers
2398 in the use of practice guidelines.

2399 (VII) Disseminate electronic and published materials.
2400 (VIII) Hold statewide and regional conferences.
2401 (IX) Implement disease management programs in cooperation
2402 with physicians and pharmacists, along with a model quality-
2403 based medication component for individuals having chronic
2404 medical conditions.
2405 13.~~12.~~ The agency is authorized to contract for drug
2406 rebate administration, including, but not limited to,
2407 calculating rebate amounts, invoicing manufacturers, negotiating
2408 disputes with manufacturers, and maintaining a database of
2409 rebate collections.
2410 14.~~13.~~ The agency may specify the preferred daily dosing
2411 form or strength for the purpose of promoting best practices
2412 with regard to the prescribing of certain drugs as specified in
2413 the General Appropriations Act and ensuring cost-effective
2414 prescribing practices.
2415 15.~~14.~~ The agency may require prior authorization for
2416 Medicaid-covered prescribed drugs. The agency may, but is not
2417 required to, prior-authorize the use of a product:
2418 a. For an indication not approved in labeling;
2419 b. To comply with certain clinical guidelines; or
2420 c. If the product has the potential for overuse, misuse,
2421 or abuse.
2422
2423 The agency may require the prescribing professional to provide
2424 information about the rationale and supporting medical evidence
2425 for the use of a drug. The agency ~~may~~ shall accept electronic
2426 prior authorization requests from prescribers or pharmacists for

2427 any drug requiring prior authorization and post prior
2428 authorization criteria and protocol and updates to the list of
2429 drugs that are subject to prior authorization on an Internet
2430 website without amending its rule or engaging in additional
2431 rulemaking.
2432 16.~~15.~~ The agency, in conjunction with the Pharmaceutical
2433 and Therapeutics Committee, may require age-related prior
2434 authorizations for certain prescribed drugs. The agency may
2435 preauthorize the use of a drug for a recipient who may not meet
2436 the age requirement or may exceed the length of therapy for use
2437 of this product as recommended by the manufacturer and approved
2438 by the Food and Drug Administration. Prior authorization may
2439 require the prescribing professional to provide information
2440 about the rationale and supporting medical evidence for the use
2441 of a drug.
2442 17.~~16.~~ The agency shall implement a step-therapy prior
2443 authorization approval process for medications excluded from the
2444 preferred drug list. Medications listed on the preferred drug
2445 list must be used within the previous 12 months prior to the
2446 alternative medications that are not listed. The step-therapy
2447 prior authorization may require the prescriber to use the
2448 medications of a similar drug class or for a similar medical
2449 indication unless contraindicated in the Food and Drug
2450 Administration labeling. The trial period between the specified
2451 steps may vary according to the medical indication. The step-
2452 therapy approval process shall be developed in accordance with
2453 the committee as stated in s. 409.91195(7) and (8). A drug
2454 product may be approved without meeting the step-therapy prior

2455 authorization criteria if the prescribing physician provides the
2456 agency with additional written medical or clinical documentation
2457 that the product is medically necessary because:
2458 a. There is not a drug on the preferred drug list to treat
2459 the disease or medical condition which is an acceptable clinical
2460 alternative;
2461 b. The alternatives have been ineffective in the treatment
2462 of the beneficiary's disease; or
2463 c. Based on historic evidence and known characteristics of
2464 the patient and the drug, the drug is likely to be ineffective,
2465 or the number of doses have been ineffective.
2466
2467 The agency shall work with the physician to determine the best
2468 alternative for the patient. The agency may adopt rules waiving
2469 the requirements for written clinical documentation for specific
2470 drugs in limited clinical situations.
2471 18.~~17.~~ The agency shall implement a return and reuse
2472 program for drugs dispensed by pharmacies to institutional
2473 recipients, which includes payment of a $5 restocking fee for
2474 the implementation and operation of the program. The return and
2475 reuse program shall be implemented electronically and in a
2476 manner that promotes efficiency. The program must permit a
2477 pharmacy to exclude drugs from the program if it is not
2478 practical or cost-effective for the drug to be included and must
2479 provide for the return to inventory of drugs that cannot be
2480 credited or returned in a cost-effective manner. The agency
2481 shall determine if the program has reduced the amount of
2482 Medicaid prescription drugs which are destroyed on an annual

Amendment No.

2483 basis and if there are additional ways to ensure more
2484 prescription drugs are not destroyed which could safely be
2485 reused. The agency's conclusion and recommendations shall be
2486 reported to the Legislature by December 1, 2005.
2487 Section 71. Subsections (3) and (4) of section 429.07,
2488 Florida Statutes, are amended, and subsections (6) and (7) are
2489 added to that section, to read:
2490 429.07 License required; fee; inspections.—
2491 (3) In addition to the requirements of s. 408.806, each
2492 license granted by the agency must state the type of care for
2493 which the license is granted. Licenses shall be issued for one
2494 or more of the following categories of care: standard, extended
2495 congregate care, ~~limited nursing services,~~ or limited mental
2496 health.
2497 (a) A standard license shall be issued to a facility
2498 ~~facilities~~ providing one or more of the personal services
2499 identified in s. 429.02. Such licensee ~~facilities~~ may also
2500 employ or contract with a person ~~licensed under part I of~~
2501 ~~chapter 464~~ to ~~administer medications and~~ perform other tasks as
2502 specified in s. 429.255.
2503 (b) An extended congregate care license shall be issued to
2504 a licensee ~~facilities~~ providing, directly or through contract,
2505 services beyond those authorized in paragraph (a), including
2506 services performed by persons licensed under part I of chapter
2507 464 and supportive services, as defined by rule, to persons who
2508 would otherwise be disqualified from continued residence in a
2509 facility licensed under this part.

2510 1. In order for extended congregate care services to be
2511 provided, the agency must first determine that all requirements
2512 established in law and rule are met and must specifically
2513 designate, on the ~~facility's~~ license, that such services may be
2514 provided and whether the designation applies to all or part of
2515 the facility. Such designation may be made at the time of
2516 initial licensure or relicensure, or upon request in writing by
2517 a licensee under this part and part II of chapter 408. The
2518 notification of approval or the denial of the request shall be
2519 made in accordance with part II of chapter 408. An existing
2520 licensee ~~facilities~~ qualifying to provide extended congregate
2521 care services must have maintained a standard license and ~~may~~
2522 not ~~have~~ been subject to administrative sanctions during the
2523 previous 2 years, or since initial licensure if ~~the facility has~~
2524 ~~been~~ licensed for less than 2 years, for any of the following
2525 reasons:
2526 a. A class I or class II violation;
2527 b. Three or more repeat or recurring class III violations
2528 of identical or similar resident care standards from which a
2529 pattern of noncompliance is found by the agency;
2530 c. Three or more class III violations that were not
2531 corrected in accordance with the corrective action plan approved
2532 by the agency;
2533 d. Violation of resident care standards which results in
2534 requiring the facility to employ the services of a consultant
2535 pharmacist or consultant dietitian;
2536 e. Denial, suspension, or revocation of a license for
2537 another facility licensed under this part in which the applicant

2538 for an extended congregate care license has at least 25 percent
2539 ownership interest; or
2540 f. Imposition of a moratorium pursuant to this part or
2541 part II of chapter 408 or initiation of injunctive proceedings.
2542 2. A facility that is licensed to provide extended
2543 congregate care services shall maintain a written progress
2544 report for ~~on~~ each person who receives services which describes
2545 the type, amount, duration, scope, and outcome of services that
2546 are rendered and the general status of the resident's health. ~~A~~
2547 ~~registered nurse, or appropriate designee, representing the~~
2548 ~~agency shall visit the facility at least quarterly to monitor~~
2549 ~~residents who are receiving extended congregate care services~~
2550 ~~and to determine if the facility is in compliance with this~~
2551 ~~part, part II of chapter 408, and relevant rules. One of the~~
2552 ~~visits may be in conjunction with the regular survey. The~~
2553 ~~monitoring visits may be provided through contractual~~
2554 ~~arrangements with appropriate community agencies. A registered~~
2555 ~~nurse shall serve as part of the team that inspects the~~
2556 ~~facility. The agency may waive one of the required yearly~~
2557 ~~monitoring visits for a facility that has been licensed for at~~
2558 ~~least 24 months to provide extended congregate care services,~~
2559 ~~if, during the inspection, the registered nurse determines that~~
2560 ~~extended congregate care services are being provided~~
2561 ~~appropriately, and if the facility has no class I or class II~~
2562 ~~violations and no uncorrected class III violations. The agency~~
2563 ~~must first consult with the long-term care ombudsman council for~~
2564 ~~the area in which the facility is located to determine if any~~
2565 ~~complaints have been made and substantiated about the quality of~~

2566 ~~services or care. The agency may not waive one of the required~~
2567 ~~yearly monitoring visits if complaints have been made and~~
2568 ~~substantiated.~~
2569 3. A facility that is licensed to provide extended
2570 congregate care services must:
2571 a. Demonstrate the capability to meet unanticipated
2572 resident service needs.
2573 b. Offer a physical environment that promotes a homelike
2574 setting, provides for resident privacy, promotes resident
2575 independence, and allows sufficient congregate space as defined
2576 by rule.
2577 c. Have sufficient staff available, taking into account
2578 the physical plant and firesafety features of the building, to
2579 assist with the evacuation of residents in an emergency.
2580 d. Adopt and follow policies and procedures that maximize
2581 resident independence, dignity, choice, and decisionmaking to
2582 permit residents to age in place, so that moves due to changes
2583 in functional status are minimized or avoided.
2584 e. Allow residents or, if applicable, a resident's
2585 representative, designee, surrogate, guardian, or attorney in
2586 fact to make a variety of personal choices, participate in
2587 developing service plans, and share responsibility in
2588 decisionmaking.
2589 f. Implement the concept of managed risk.
2590 g. Provide, directly or through contract, the services of
2591 a person licensed under part I of chapter 464.

2592 h. In addition to the training mandated in s. 429.52,
2593 provide specialized training as defined by rule for facility
2594 staff.
2595 4. A facility that is licensed to provide extended
2596 congregate care services is exempt from the criteria for
2597 continued residency set forth in rules adopted under s. 429.41.
2598 A licensed facility must adopt its own requirements within
2599 guidelines for continued residency set forth by rule. However,
2600 the facility may not serve residents who require 24-hour nursing
2601 supervision. A licensed facility that provides extended
2602 congregate care services must also provide each resident with a
2603 written copy of facility policies governing admission and
2604 retention.
2605 5. The primary purpose of extended congregate care
2606 services is to allow residents, as they become more impaired,
2607 the option of remaining in a familiar setting from which they
2608 would otherwise be disqualified for continued residency. A
2609 facility licensed to provide extended congregate care services
2610 may also admit an individual who exceeds the admission criteria
2611 for a facility with a standard license, if the individual is
2612 determined appropriate for admission to the extended congregate
2613 care facility.
2614 6. Before the admission of an individual to a facility
2615 licensed to provide extended congregate care services, the
2616 individual must undergo a medical examination as provided in s.
2617 429.26(4) and the facility must develop a preliminary service
2618 plan for the individual.

2619 7. When a licensee ~~facility~~ can no longer provide or
2620 arrange for services in accordance with the resident's service
2621 plan and needs and the licensee's ~~facility's~~ policy, the
2622 licensee ~~facility~~ shall make arrangements for relocating the
2623 person in accordance with s. 429.28(1)(k).
2624 8. Failure to provide extended congregate care services
2625 may result in denial of extended congregate care license
2626 renewal.
2627 ~~(c) A limited nursing services license shall be issued to~~
2628 ~~a facility that provides services beyond those authorized in~~
2629 ~~paragraph (a) and as specified in this paragraph.~~
2630 ~~1. In order for limited nursing services to be provided in~~
2631 ~~a facility licensed under this part, the agency must first~~
2632 ~~determine that all requirements established in law and rule are~~
2633 ~~met and must specifically designate, on the facility's license,~~
2634 ~~that such services may be provided. Such designation may be made~~
2635 ~~at the time of initial licensure or relicensure, or upon request~~
2636 ~~in writing by a licensee under this part and part II of chapter~~
2637 ~~408. Notification of approval or denial of such request shall be~~
2638 ~~made in accordance with part II of chapter 408. Existing~~
2639 ~~facilities qualifying to provide limited nursing services shall~~
2640 ~~have maintained a standard license and may not have been subject~~
2641 ~~to administrative sanctions that affect the health, safety, and~~
2642 ~~welfare of residents for the previous 2 years or since initial~~
2643 ~~licensure if the facility has been licensed for less than 2~~
2644 ~~years.~~
2645 ~~2. Facilities that are licensed to provide limited nursing~~
2646 ~~services shall maintain a written progress report on each person~~

2647 ~~who receives such nursing services, which report describes the~~
2648 ~~type, amount, duration, scope, and outcome of services that are~~
2649 ~~rendered and the general status of the resident's health. A~~
2650 ~~registered nurse representing the agency shall visit such~~
2651 ~~facilities at least twice a year to monitor residents who are~~
2652 ~~receiving limited nursing services and to determine if the~~
2653 ~~facility is in compliance with applicable provisions of this~~
2654 ~~part, part II of chapter 408, and related rules. The monitoring~~
2655 ~~visits may be provided through contractual arrangements with~~
2656 ~~appropriate community agencies. A registered nurse shall also~~
2657 ~~serve as part of the team that inspects such facility.~~
2658 ~~3. A person who receives limited nursing services under~~
2659 ~~this part must meet the admission criteria established by the~~
2660 ~~agency for assisted living facilities. When a resident no longer~~
2661 ~~meets the admission criteria for a facility licensed under this~~
2662 ~~part, arrangements for relocating the person shall be made in~~
2663 ~~accordance with s. 429.28(1)(k), unless the facility is licensed~~
2664 ~~to provide extended congregate care services.~~
2665 (4) In accordance with s. 408.805, an applicant or
2666 licensee shall pay a fee for each license application submitted
2667 under this part, part II of chapter 408, and applicable rules.
2668 The amount of the fee shall be established by rule.
2669 (a) The biennial license fee required of a facility is
2670 $300 per license, with an additional fee of $71 ~~$50~~ per resident
2671 based on the total licensed resident capacity of the facility,
2672 except that no additional fee will be assessed for beds
2673 designated for recipients of optional state supplementation

2674 payments provided for in s. 409.212. The total fee may not
2675 exceed $10,000.
2676 (b) In addition to the total fee assessed under paragraph
2677 (a), the agency shall require facilities that are licensed to
2678 provide extended congregate care services under this part to pay
2679 an additional fee per licensed facility. The amount of the
2680 biennial fee shall be $400 per license, with an additional fee
2681 of $10 per resident based on the total licensed resident
2682 capacity of the facility.
2683 ~~(c) In addition to the total fee assessed under paragraph~~
2684 ~~(a), the agency shall require facilities that are licensed to~~
2685 ~~provide limited nursing services under this part to pay an~~
2686 ~~additional fee per licensed facility. The amount of the biennial~~
2687 ~~fee shall be $250 per license, with an additional fee of $10 per~~
2688 ~~resident based on the total licensed resident capacity of the~~
2689 ~~facility.~~
2690 (6) In order to determine whether the facility is
2691 adequately protecting residents' rights as provided in s.
2692 429.28, the agency's standard licensure survey shall include
2693 private informal conversations with a sample of residents and
2694 consultation with the ombudsman council in the planning and
2695 service area in which the facility is located to discuss
2696 residents' experiences within the facility.
2697 (7) An assisted living facility that has been cited within
2698 the previous 24-month period for a class I or class II
2699 violation, regardless of the status of any enforcement or
2700 disciplinary action, is subject to periodic unannounced
2701 monitoring to determine if the facility is in compliance with

2702 this part, part II of chapter 408, and applicable rules.
2703 Monitoring may occur through a desk review or an onsite
2704 assessment. If the class I or class II violation relates to
2705 providing or failing to provide nursing care, a registered nurse
2706 must participate in monitoring activities during the 12-month
2707 period following the violation.

2708 Section 72. Subsection (7) of section 429.11, Florida
2709 Statutes, is renumbered as subsection (6), and present
2710 subsection (6) of that section is amended to read:

2711 429.11 Initial application for license~~; provisional~~
2712 ~~license~~.—

2713 ~~(6) In addition to the license categories available in s.~~
2714 ~~408.808, a provisional license may be issued to an applicant~~
2715 ~~making initial application for licensure or making application~~
2716 ~~for a change of ownership. A provisional license shall be~~
2717 ~~limited in duration to a specific period of time not to exceed 6~~
2718 ~~months, as determined by the agency.~~

2719 Section 73. Section 429.12, Florida Statutes, is amended
2720 to read:

2721 429.12 Sale or transfer of ownership of a facility.—It is
2722 the intent of the Legislature to protect the rights of the
2723 residents of an assisted living facility when the facility is
2724 sold or the ownership thereof is transferred. Therefore, in
2725 addition to the requirements of part II of chapter 408, whenever
2726 a facility is sold or the ownership thereof is transferred,
2727 including leasing,~~:~~

2728 ~~(1)~~ the transferee shall notify the residents, in writing,
2729 of the change of ownership within 7 days after receipt of the
2730 new license.
2731 ~~(2) The transferor of a facility the license of which is~~
2732 ~~denied pending an administrative hearing shall, as a part of the~~
2733 ~~written change-of-ownership contract, advise the transferee that~~
2734 ~~a plan of correction must be submitted by the transferee and~~
2735 ~~approved by the agency at least 7 days before the change of~~
2736 ~~ownership and that failure to correct the condition which~~
2737 ~~resulted in the moratorium pursuant to part II of chapter 408 or~~
2738 ~~denial of licensure is grounds for denial of the transferee's~~
2739 ~~license.~~
2740 Section 74. Subsection (5) of section 429.14, Florida
2741 Statutes, is amended to read:
2742 429.14 Administrative penalties.—
2743 (5) An action taken by the agency to suspend, deny, or
2744 revoke a facility's license under this part or part II of
2745 chapter 408, in which the agency claims that the facility owner
2746 or an employee of the facility has threatened the health,
2747 safety, or welfare of a resident of the facility shall be heard
2748 by the Division of Administrative Hearings of the Department of
2749 Management Services within 120 days after receipt of the
2750 facility's request for a hearing, unless that time limitation is
2751 waived by both parties. The administrative law judge must render
2752 a decision within 30 days after receipt of a proposed
2753 recommended order.
2754 Section 75. Subsections (1), (4), and (5) of section
2755 429.17, Florida Statutes, are amended to read:

2756 429.17 Expiration of license; renewal; conditional
2757 license.—
2758 (1) ~~Limited nursing,~~ Extended congregate care~~,~~ and limited
2759 mental health licenses shall expire at the same time as the
2760 facility's standard license, regardless of when issued.
2761 (4) In addition to the license categories available in s.
2762 408.808, a conditional license may be issued to an applicant for
2763 license renewal if the applicant fails to meet all standards and
2764 requirements for licensure. A conditional license issued under
2765 this subsection shall be limited in duration to a specific
2766 period of time not to exceed 6 months, as determined by the
2767 agency~~, and shall be accompanied by an agency-approved plan of~~
2768 ~~correction~~.
2769 (5) When an extended congregate care ~~or limited nursing~~
2770 ~~license~~ is requested during a facility's biennial license
2771 period, the fee shall be prorated in order to permit the
2772 additional license to expire at the end of the biennial license
2773 period. The fee shall be calculated as of the date the
2774 additional license application is received by the agency.
2775 Section 76. Subsections (6) through (10) of section
2776 429.23, Florida Statutes, are renumbered as subsections (5)
2777 through (9), respectively, and present subsection (5) of that
2778 section is amended to read:
2779 429.23 Internal risk management and quality assurance
2780 program; adverse incidents and reporting requirements.—
2781 ~~(5) Each facility shall report monthly to the agency any~~
2782 ~~liability claim filed against it. The report must include the~~
2783 ~~name of the resident, the dates of the incident leading to the~~

2784 ~~claim, if applicable, and the type of injury or violation of~~
2785 ~~rights alleged to have occurred. This report is not discoverable~~
2786 ~~in any civil or administrative action, except in such actions~~
2787 ~~brought by the agency to enforce the provisions of this part.~~
2788 Section 77. Paragraph (a) of subsection (1) and subsection
2789 (2) of section 429.255, Florida Statutes, are amended to read:
2790 429.255 Use of personnel; emergency care.—
2791 (1)(a) Persons under contract to the facility or~~,~~ facility
2792 staff~~, or volunteers,~~ who are licensed according to part I of
2793 chapter 464, or those persons exempt under s. 464.022(1), and
2794 others as defined by rule, may administer medications to
2795 residents, take residents' vital signs, manage individual weekly
2796 pill organizers for residents who self-administer medication,
2797 give prepackaged enemas ordered by a physician, observe
2798 residents, document observations on the appropriate resident's
2799 record, report observations to the resident's physician, and
2800 contract or allow residents or a resident's representative,
2801 designee, surrogate, guardian, or attorney in fact to contract
2802 with a third party, provided residents meet the criteria for
2803 appropriate placement as defined in s. 429.26. Persons under
2804 contract to the facility or facility staff who are licensed
2805 according to part I of chapter 464 may provide limited nursing
2806 services. Nursing assistants certified pursuant to part II of
2807 chapter 464 may take residents' vital signs as directed by a
2808 licensed nurse or physician. The facility is responsible for
2809 maintaining documentation of services provided under this
2810 paragraph and as required by rule and ensuring that staff are

2811 adequately trained to monitor residents receiving these
2812 services.
2813 (2) In facilities licensed to provide extended congregate
2814 care, persons under contract to the facility or~~,~~ facility staff~~,~~
2815 ~~or volunteers,~~ who are licensed according to part I of chapter
2816 464, or those persons exempt under s. 464.022(1), or those
2817 persons certified as nursing assistants pursuant to part II of
2818 chapter 464, may also perform all duties within the scope of
2819 their license or certification, as approved by the facility
2820 administrator and pursuant to this part.
2821 Section 78. Subsections (4), (5), (6), and (7) of section
2822 429.28, Florida Statutes, are renumbered as subsections (3),
2823 (4), (5), and (6), respectively, and present subsections (3) and
2824 (6) of that section are amended to read:
2825 429.28 Resident bill of rights.—
2826 ~~(3)(a) The agency shall conduct a survey to determine~~
2827 ~~general compliance with facility standards and compliance with~~
2828 ~~residents' rights as a prerequisite to initial licensure or~~
2829 ~~licensure renewal.~~
2830 ~~(b) In order to determine whether the facility is~~
2831 ~~adequately protecting residents' rights, the biennial survey~~
2832 ~~shall include private informal conversations with a sample of~~
2833 ~~residents and consultation with the ombudsman council in the~~
2834 ~~planning and service area in which the facility is located to~~
2835 ~~discuss residents' experiences within the facility.~~
2836 ~~(c) During any calendar year in which no survey is~~
2837 ~~conducted, the agency shall conduct at least one monitoring~~
2838 ~~visit of each facility cited in the previous year for a class I~~

2839 ~~or class II violation, or more than three uncorrected class III~~
2840 ~~violations.~~
2841 ~~(d) The agency may conduct periodic followup inspections~~
2842 ~~as necessary to monitor the compliance of facilities with a~~
2843 ~~history of any class I, class II, or class III violations that~~
2844 ~~threaten the health, safety, or security of residents.~~
2845 ~~(e) The agency may conduct complaint investigations as~~
2846 ~~warranted to investigate any allegations of noncompliance with~~
2847 ~~requirements required under this part or rules adopted under~~
2848 ~~this part.~~
2849 (5)~~(6)~~ Any facility which terminates the residency of an
2850 individual who participated in activities specified in
2851 subsection (4) ~~(5)~~ shall show good cause in a court of competent
2852 jurisdiction.
2853 Section 79. Paragraphs (i) and (j) of subsection (1) and
2854 subsection (3) of section 429.41, Florida Statutes, are amended
2855 and subsequent subsection (4) and (5) are renumbered.
2856 429.41 Rules establishing standards.—
2857 (1) It is the intent of the Legislature that rules
2858 published and enforced pursuant to this section shall include
2859 criteria by which a reasonable and consistent quality of
2860 resident care and quality of life may be ensured and the results
2861 of such resident care may be demonstrated. Such rules shall also
2862 ensure a safe and sanitary environment that is residential and
2863 noninstitutional in design or nature. It is further intended
2864 that reasonable efforts be made to accommodate the needs and
2865 preferences of residents to enhance the quality of life in a
2866 facility. The agency, in consultation with the department, may

2867 adopt rules to administer the requirements of part II of chapter
2868 408. In order to provide safe and sanitary facilities and the
2869 highest quality of resident care accommodating the needs and
2870 preferences of residents, the department, in consultation with
2871 the agency, the Department of Children and Family Services, and
2872 the Department of Health, shall adopt rules, policies, and
2873 procedures to administer this part, which must include
2874 reasonable and fair minimum standards in relation to:
2875 (i) Facilities holding an ~~a limited nursing,~~ extended
2876 congregate care~~,~~ or limited mental health license.
2877 (j) The establishment of specific criteria to define
2878 appropriateness of resident admission and continued residency in
2879 a facility holding a standard, ~~limited nursing,~~ extended
2880 congregate care, and limited mental health license.
2881 ~~(3) The department shall submit a copy of proposed rules~~
2882 ~~to the Speaker of the House of Representatives, the President of~~
2883 ~~the Senate, and appropriate committees of substance for review~~
2884 ~~and comment prior to the promulgation thereof. Rules promulgated~~
2885 ~~by the department shall encourage the development of homelike~~
2886 ~~facilities which promote the dignity, individuality, personal~~
2887 ~~strengths, and decisionmaking ability of residents.~~
2888 Section 80. Subsections (1) and (2) of section 429.53,
2889 Florida Statutes, are amended to read:
2890 429.53 Consultation by the agency.—
2891 (1) The ~~area offices of licensure and certification of the~~
2892 agency shall provide consultation to the following upon request:
2893 (a) A licensee of a facility.

2894 (b) A person interested in obtaining a license to operate
2895 a facility under this part.
2896 (2) As used in this section, "consultation" includes:
2897 (a) An explanation of the requirements of this part and
2898 rules adopted pursuant thereto;
2899 (b) An explanation of the license application and renewal
2900 procedures; and
2901 ~~(c) The provision of a checklist of general local and~~
2902 ~~state approvals required prior to constructing or developing a~~
2903 ~~facility and a listing of the types of agencies responsible for~~
2904 ~~such approvals;~~
2905 ~~(d) An explanation of benefits and financial assistance~~
2906 ~~available to a recipient of supplemental security income~~
2907 ~~residing in a facility;~~
2908 (c)~~(e)~~ Any other information which the agency deems
2909 necessary to promote compliance with the requirements of this
2910 part~~; and~~
2911 ~~(f) A preconstruction review of a facility to ensure~~
2912 ~~compliance with agency rules and this part~~.
2913 Section 81. Subsections (1) and (5) are amended and
2914 subsequent subsections of section 429.71, Florida Statutes, are
2915 renumbered:
2916 429.71 Classification of violations ~~deficiencies~~;
2917 administrative fines.—
2918 (1) In addition to the requirements of part II of chapter
2919 408 and in addition to any other liability or penalty provided
2920 by law, the agency may impose an administrative fine on a
2921 provider according to the following classification:

2922 (a) Class I violations are defined in s. 408.813 ~~those~~
2923 ~~conditions or practices related to the operation and maintenance~~
2924 ~~of an adult family-care home or to the care of residents which~~
2925 ~~the agency determines present an imminent danger to the~~
2926 ~~residents or guests of the facility or a substantial probability~~
2927 ~~that death or serious physical or emotional harm would result~~
2928 ~~therefrom. The condition or practice that constitutes a class I~~
2929 ~~violation must be abated or eliminated within 24 hours, unless a~~
2930 ~~fixed period, as determined by the agency, is required for~~
2931 ~~correction~~. A class I violation ~~deficiency~~ is subject to an
2932 administrative fine in an amount not less than $500 and not
2933 exceeding $1,000 for each violation. ~~A fine may be levied~~
2934 ~~notwithstanding the correction of the deficiency.~~
2935 (b) Class II violations are defined in s. 408.813 ~~those~~
2936 ~~conditions or practices related to the operation and maintenance~~
2937 ~~of an adult family-care home or to the care of residents which~~
2938 ~~the agency determines directly threaten the physical or~~
2939 ~~emotional health, safety, or security of the residents, other~~
2940 ~~than class I violations~~. A class II violation is subject to an
2941 administrative fine in an amount not less than $250 and not
2942 exceeding $500 for each violation. ~~A citation for a class II~~
2943 ~~violation must specify the time within which the violation is~~
2944 ~~required to be corrected. If a class II violation is corrected~~
2945 ~~within the time specified, no civil penalty shall be imposed,~~
2946 ~~unless it is a repeated offense.~~
2947 (c) Class III violations are defined in s. 408.813 ~~those~~
2948 ~~conditions or practices related to the operation and maintenance~~
2949 ~~of an adult family-care home or to the care of residents which~~

2950 ~~the agency determines indirectly or potentially threaten the~~
2951 ~~physical or emotional health, safety, or security of residents,~~
2952 ~~other than class I or class II violations~~. A class III violation
2953 is subject to an administrative fine in an amount not less than
2954 $100 and not exceeding $250 for each violation. ~~A citation for a~~
2955 ~~class III violation shall specify the time within which the~~
2956 ~~violation is required to be corrected.~~ If a class III violation
2957 is corrected within the time specified, no civil penalty shall
2958 be imposed, unless it is a repeated violation ~~offense~~.
2959 (d) Class IV violations are defined in s. 408.813 ~~those~~
2960 ~~conditions or occurrences related to the operation and~~
2961 ~~maintenance of an adult family-care home, or related to the~~
2962 ~~required reports, forms, or documents, which do not have the~~
2963 ~~potential of negatively affecting the residents~~. ~~A provider that~~
2964 ~~does not correct~~ A class IV violation ~~within the time limit~~
2965 ~~specified by the agency~~ is subject to an administrative fine in
2966 an amount not less than $50 and not exceeding $100 for each
2967 violation. Any class IV violation that is corrected during the
2968 time the agency survey is conducted will be identified as an
2969 agency finding and not as a violation, unless it is a repeat
2970 violation.
2971 ~~(5) As an alternative to or in conjunction with an~~
2972 ~~administrative action against a provider, the agency may request~~
2973 ~~a plan of corrective action that demonstrates a good faith~~
2974 ~~effort to remedy each violation by a specific date, subject to~~
2975 ~~the approval of the agency.~~
2976 Section 82. Section 429.915, Florida Statutes, is amended
2977 to read:

2978 429.915 Conditional license.—In addition to the license
2979 categories available in part II of chapter 408, the agency may
2980 issue a conditional license to an applicant for license renewal
2981 or change of ownership if the applicant fails to meet all
2982 standards and requirements for licensure. A conditional license
2983 issued under this subsection must be limited to a specific
2984 period not exceeding 6 months, as determined by the agency~~, and~~
2985 ~~must be accompanied by an approved plan of correction~~.

2986 Section 83. Paragraphs (b) and (g) of subsection (3) of
2987 section 430.80, Florida Statutes, are amended to read:

2988 430.80 Implementation of a teaching nursing home pilot
2989 project.—

2990 (3) To be designated as a teaching nursing home, a nursing
2991 home licensee must, at a minimum:

2992 (b) Participate in a nationally recognized accreditation
2993 program and hold a valid accreditation, such as the
2994 accreditation awarded by the Joint Commission ~~on Accreditation~~
2995 ~~of Healthcare Organizations~~, or, at the time of initial
2996 designation, possess a Gold Seal Award as conferred by the state
2997 on its licensed nursing home;

2998 (g) Maintain insurance coverage pursuant to s.
2999 400.141(1)(q) ~~(s)~~ or proof of financial responsibility in a
3000 minimum amount of $750,000. Such proof of financial
3001 responsibility may include:

3002 1. Maintaining an escrow account consisting of cash or
3003 assets eligible for deposit in accordance with s. 625.52; or

3004 2. Obtaining and maintaining pursuant to chapter 675 an
3005 unexpired, irrevocable, nontransferable and nonassignable letter

3006 of credit issued by any bank or savings association organized
3007 and existing under the laws of this state or any bank or savings
3008 association organized under the laws of the United States that
3009 has its principal place of business in this state or has a
3010 branch office which is authorized to receive deposits in this
3011 state. The letter of credit shall be used to satisfy the
3012 obligation of the facility to the claimant upon presentment of a
3013 final judgment indicating liability and awarding damages to be
3014 paid by the facility or upon presentment of a settlement
3015 agreement signed by all parties to the agreement when such final
3016 judgment or settlement is a result of a liability claim against
3017 the facility.
3018 Section 84. Paragraph (d) of subsection (9) of section
3019 440.102, Florida Statutes, is amended to read:
3020 440.102 Drug-free workplace program requirements.—The
3021 following provisions apply to a drug-free workplace program
3022 implemented pursuant to law or to rules adopted by the Agency
3023 for Health Care Administration:
3024 (9) DRUG-TESTING STANDARDS FOR LABORATORIES.—
3025 ~~(d) The laboratory shall submit to the Agency for Health~~
3026 ~~Care Administration a monthly report with statistical~~
3027 ~~information regarding the testing of employees and job~~
3028 ~~applicants. The report must include information on the methods~~
3029 ~~of analysis conducted, the drugs tested for, the number of~~
3030 ~~positive and negative results for both initial tests and~~
3031 ~~confirmation tests, and any other information deemed appropriate~~
3032 ~~by the Agency for Health Care Administration. A monthly report~~
3033 ~~must not identify specific employees or job applicants.~~

3034 Section 85. Paragraph (a) of subsection (2) of section
3035 440.13, Florida Statutes, is amended to read:
3036 440.13 Medical services and supplies; penalty for
3037 violations; limitations.—
3038 (2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—
3039 (a) Subject to the limitations specified elsewhere in this
3040 chapter, the employer shall furnish to the employee such
3041 medically necessary remedial treatment, care, and attendance for
3042 such period as the nature of the injury or the process of
3043 recovery may require, which is in accordance with established
3044 practice parameters and protocols of treatment as provided for
3045 in this chapter, including medicines, medical supplies, durable
3046 medical equipment, orthoses, prostheses, and other medically
3047 necessary apparatus. Remedial treatment, care, and attendance,
3048 including work-hardening programs or pain-management programs
3049 accredited by the Commission on Accreditation of Rehabilitation
3050 Facilities or the Joint Commission ~~on the Accreditation of~~
3051 ~~Health Organizations~~ or pain-management programs affiliated with
3052 medical schools, shall be considered as covered treatment only
3053 when such care is given based on a referral by a physician as
3054 defined in this chapter. Medically necessary treatment, care,
3055 and attendance does not include chiropractic services in excess
3056 of 24 treatments or rendered 12 weeks beyond the date of the
3057 initial chiropractic treatment, whichever comes first, unless
3058 the carrier authorizes additional treatment or the employee is
3059 catastrophically injured.
3060

3061 Failure of the carrier to timely comply with this subsection
3062 shall be a violation of this chapter and the carrier shall be
3063 subject to penalties as provided for in s. 440.525.
3064 Section 86. Subsection (1) of section 483.035, Florida
3065 Statutes, is amended to read:
3066 483.035 Clinical laboratories operated by practitioners
3067 for exclusive use; licensure and regulation.—
3068 (1) A clinical laboratory operated by one or more
3069 practitioners licensed under chapter 458, chapter 459, chapter
3070 460, chapter 461, chapter 462, <u>chapter 464 part I,</u> or chapter
3071 466, exclusively in connection with the diagnosis and treatment
3072 of their own patients, must be licensed under this part and must
3073 comply with the provisions of this part, except that the agency
3074 shall adopt rules for staffing, for personnel, including
3075 education and training of personnel, for proficiency testing,
3076 and for construction standards relating to the licensure and
3077 operation of the laboratory based upon and not exceeding the
3078 same standards contained in the federal Clinical Laboratory
3079 Improvement Amendments of 1988 and the federal regulations
3080 adopted thereunder.
3081 Section 87. Subsections (1) and (9) of section 483.051,
3082 Florida Statutes, are amended to read:
3083 483.051 Powers and duties of the agency.—The agency shall
3084 adopt rules to implement this part, which rules must include,
3085 but are not limited to, the following:
3086 (1) LICENSING; QUALIFICATIONS.—The agency shall provide
3087 for biennial licensure of all clinical laboratories meeting the
3088 requirements of this part and shall prescribe the qualifications

3089 necessary for such licensure including but not limited to
3090 application for or proof of a federal Clinical Laboratory
3091 Improvement Amendment (CLIA) certificate.
3092 Non-waived laboratories are those that perform any test that the
3093 Centers for Medicare and Medicaid Services has determined does
3094 not qualify for a certificate of waiver under the Clinical
3095 Laboratory Improvement Amendments of 1988 and the federal rules
3096 adopted thereunder.
3097 (9) ALTERNATE-SITE TESTING.—The agency, in consultation
3098 with the Board of Clinical Laboratory Personnel, shall adopt, by
3099 rule, the criteria for alternate-site testing to be performed
3100 under the supervision of a clinical laboratory director. The
3101 elements to be addressed in the rule include, but are not
3102 limited to: a hospital internal needs assessment; a protocol of
3103 implementation including tests to be performed and who will
3104 perform the tests; criteria to be used in selecting the method
3105 of testing to be used for alternate-site testing; minimum
3106 training and education requirements for those who will perform
3107 alternate-site testing, such as documented training, licensure,
3108 certification, or other medical professional background not
3109 limited to laboratory professionals; documented inservice
3110 training as well as initial and ongoing competency validation;
3111 an appropriate internal and external quality control protocol;
3112 an internal mechanism for identifying and tracking alternate-
3113 site testing by the central laboratory; and recordkeeping
3114 requirements. ~~Alternate-site testing locations must register~~
3115 ~~when the clinical laboratory applies to renew its license.~~ For
3116 purposes of this subsection, the term "alternate-site testing"

3117 means any laboratory testing done under the administrative
3118 control of a hospital, but performed out of the physical or
3119 administrative confines of the central laboratory.
3120 Section 88. Section 483.294, Florida Statutes, is amended
3121 to read:
3122 483.294 Inspection of centers.—In accordance with s.
3123 408.811, the agency shall biennially, ~~at least once annually,~~
3124 inspect the premises and operations of all centers subject to
3125 licensure under this part.
3126 Section 89. Subsection (4) is added to section 626.9541,
3127 Florida Statutes, to read:
3128 626.9541 Unfair methods of competition and unfair or
3129 deceptive acts or practices defined; alternative rates of
3130 payment; wellness programs.—
3131 (4) WELLNESS PROGRAMS.—An insurer issuing a group or
3132 individual health benefit plan may offer a voluntary wellness or
3133 health-improvement program that allows for rewards or
3134 incentives, including, but not limited to, merchandise, gift
3135 cards, debit cards, premium discounts or rebates, contributions
3136 towards a member's health savings account, modifications to
3137 copayment, deductible, or coinsurance amounts, or any
3138 combination of these incentives, to encourage or reward
3139 participation in the program. The health plan member may be
3140 required to provide verification, such as a statement from his
3141 or her physician, that a medical condition makes it unreasonably
3142 difficult or medically inadvisable for the individual to
3143 participate in the wellness program. Any reward or incentive
3144 established under this subsection is not an insurance benefit

3145 and does not violate this section. This subsection does not
3146 prohibit an insurer from offering incentives or rewards to
3147 members for adherence to wellness or health improvement programs
3148 if otherwise allowed by state or federal law. Notwithstanding
3149 any provision of this subsection, no insurer, nor its agent, may
3150 use any incentive authorized by this subsection for the purpose
3151 of redirecting patients from one health care insurance plan to
3152 another.

3153 Section 90. Subsection (1) of section 627.645, Florida
3154 Statutes, is amended to read:

3155 627.645 Denial of health insurance claims restricted.—

3156 (1) No claim for payment under a health insurance policy
3157 or self-insured program of health benefits for treatment, care,
3158 or services in a licensed hospital which is accredited by the
3159 Joint Commission ~~on the Accreditation of Hospitals~~, the American
3160 Osteopathic Association, or the Commission on the Accreditation
3161 of Rehabilitative Facilities shall be denied because such
3162 hospital lacks major surgical facilities and is primarily of a
3163 rehabilitative nature, if such rehabilitation is specifically
3164 for treatment of physical disability.

3165 Section 91. Paragraph (c) of subsection (2) of section
3166 627.668, Florida Statutes, is amended to read:

3167 627.668 Optional coverage for mental and nervous disorders
3168 required; exception.—

3169 (2) Under group policies or contracts, inpatient hospital
3170 benefits, partial hospitalization benefits, and outpatient
3171 benefits consisting of durational limits, dollar amounts,

3172 deductibles, and coinsurance factors shall not be less favorable
3173 than for physical illness generally, except that:
3174 (c) Partial hospitalization benefits shall be provided
3175 under the direction of a licensed physician. For purposes of
3176 this part, the term "partial hospitalization services" is
3177 defined as those services offered by a program accredited by the
3178 Joint Commission ~~on Accreditation of Hospitals (JCAH)~~ or in
3179 compliance with equivalent standards. Alcohol rehabilitation
3180 programs accredited by the Joint Commission ~~on Accreditation of~~
3181 ~~Hospitals~~ or approved by the state and licensed drug abuse
3182 rehabilitation programs shall also be qualified providers under
3183 this section. In any benefit year, if partial hospitalization
3184 services or a combination of inpatient and partial
3185 hospitalization are utilized, the total benefits paid for all
3186 such services shall not exceed the cost of 30 days of inpatient
3187 hospitalization for psychiatric services, including physician
3188 fees, which prevail in the community in which the partial
3189 hospitalization services are rendered. If partial
3190 hospitalization services benefits are provided beyond the limits
3191 set forth in this paragraph, the durational limits, dollar
3192 amounts, and coinsurance factors thereof need not be the same as
3193 those applicable to physical illness generally.
3194 Section 92. Subsection (3) of section 627.669, Florida
3195 Statutes, is amended to read:
3196 627.669 Optional coverage required for substance abuse
3197 impaired persons; exception.—
3198 (3) The benefits provided under this section shall be
3199 applicable only if treatment is provided by, or under the

3200 supervision of, or is prescribed by, a licensed physician or
3201 licensed psychologist and if services are provided in a program
3202 accredited by the Joint Commission ~~on Accreditation of Hospitals~~
3203 or approved by the state.
3204 Section 93. Paragraph (a) of subsection (1) of section
3205 627.736, Florida Statutes, is amended to read:
3206 627.736 Required personal injury protection benefits;
3207 exclusions; priority; claims.—
3208 (1) REQUIRED BENEFITS.—Every insurance policy complying
3209 with the security requirements of s. 627.733 shall provide
3210 personal injury protection to the named insured, relatives
3211 residing in the same household, persons operating the insured
3212 motor vehicle, passengers in such motor vehicle, and other
3213 persons struck by such motor vehicle and suffering bodily injury
3214 while not an occupant of a self-propelled vehicle, subject to
3215 the provisions of subsection (2) and paragraph (4)(e), to a
3216 limit of $10,000 for loss sustained by any such person as a
3217 result of bodily injury, sickness, disease, or death arising out
3218 of the ownership, maintenance, or use of a motor vehicle as
3219 follows:
3220 (a) *Medical benefits.*—Eighty percent of all reasonable
3221 expenses for medically necessary medical, surgical, X-ray,
3222 dental, and rehabilitative services, including prosthetic
3223 devices, and medically necessary ambulance, hospital, and
3224 nursing services. However, the medical benefits shall provide
3225 reimbursement only for such services and care that are lawfully
3226 provided, supervised, ordered, or prescribed by a physician
3227 licensed under chapter 458 or chapter 459, a dentist licensed

3228 under chapter 466, or a chiropractic physician licensed under
3229 chapter 460 or that are provided by any of the following persons
3230 or entities:
3231 1. A hospital or ambulatory surgical center licensed under
3232 chapter 395.
3233 2. A person or entity licensed under ss. 401.2101-401.45
3234 that provides emergency transportation and treatment.
3235 3. An entity wholly owned by one or more physicians
3236 licensed under chapter 458 or chapter 459, chiropractic
3237 physicians licensed under chapter 460, or dentists licensed
3238 under chapter 466 or by such practitioner or practitioners and
3239 the spouse, parent, child, or sibling of that practitioner or
3240 those practitioners.
3241 4. An entity wholly owned, directly or indirectly, by a
3242 hospital or hospitals.
3243 5. A health care clinic licensed under ss. 400.990-400.995
3244 that is:
3245 a. Accredited by the Joint Commission ~~on Accreditation of~~
3246 ~~Healthcare Organizations~~, the American Osteopathic Association,
3247 the Commission on Accreditation of Rehabilitation Facilities, or
3248 the Accreditation Association for Ambulatory Health Care, Inc.;
3249 or
3250 b. A health care clinic that:
3251 (I) Has a medical director licensed under chapter 458,
3252 chapter 459, or chapter 460;
3253 (II) Has been continuously licensed for more than 3 years
3254 or is a publicly traded corporation that issues securities
3255 traded on an exchange registered with the United States

3256 Securities and Exchange Commission as a national securities
3257 exchange; and
3258 (III) Provides at least four of the following medical
3259 specialties:
3260 (A) General medicine.
3261 (B) Radiography.
3262 (C) Orthopedic medicine.
3263 (D) Physical medicine.
3264 (E) Physical therapy.
3265 (F) Physical rehabilitation.
3266 (G) Prescribing or dispensing outpatient prescription
3267 medication.
3268 (H) Laboratory services.
3269
3270 The Financial Services Commission shall adopt by rule the form
3271 that must be used by an insurer and a health care provider
3272 specified in subparagraph 3., subparagraph 4., or subparagraph
3273 5. to document that the health care provider meets the criteria
3274 of this paragraph, which rule must include a requirement for a
3275 sworn statement or affidavit.
3276
3277 Only insurers writing motor vehicle liability insurance in this
3278 state may provide the required benefits of this section, and no
3279 such insurer shall require the purchase of any other motor
3280 vehicle coverage other than the purchase of property damage
3281 liability coverage as required by s. 627.7275 as a condition for
3282 providing such required benefits. Insurers may not require that
3283 property damage liability insurance in an amount greater than

3284 $10,000 be purchased in conjunction with personal injury
3285 protection. Such insurers shall make benefits and required
3286 property damage liability insurance coverage available through
3287 normal marketing channels. Any insurer writing motor vehicle
3288 liability insurance in this state who fails to comply with such
3289 availability requirement as a general business practice shall be
3290 deemed to have violated part IX of chapter 626, and such
3291 violation shall constitute an unfair method of competition or an
3292 unfair or deceptive act or practice involving the business of
3293 insurance; and any such insurer committing such violation shall
3294 be subject to the penalties afforded in such part, as well as
3295 those which may be afforded elsewhere in the insurance code.
3296 Section 94. Section 633.081, Florida Statutes, is amended
3297 to read:
3298 633.081 Inspection of buildings and equipment; orders;
3299 firesafety inspection training requirements; certification;
3300 disciplinary action.—The State Fire Marshal and her or his
3301 agents shall, at any reasonable hour, when the State Fire
3302 Marshal has reasonable cause to believe that a violation of this
3303 chapter or s. 509.215, or a rule promulgated thereunder, or a
3304 minimum firesafety code adopted by a local authority, may exist,
3305 inspect any and all buildings and structures which are subject
3306 to the requirements of this chapter or s. 509.215 and rules
3307 promulgated thereunder. The authority to inspect shall extend to
3308 all equipment, vehicles, and chemicals which are located within
3309 the premises of any such building or structure. The State Fire
3310 Marshal and her or his agents shall inspect nursing homes
3311 licensed under part II of chapter 400 only once every calendar

3312 year and upon receiving a complaint forming the basis of a
3313 reasonable cause to believe that a violation of this chapter or
3314 s. 509.215, or a rule promulgated thereunder, or a minimum
3315 firesafety code adopted by a local authority may exist and upon
3316 identifying such a violation in the course of conducting
3317 orientation or training activities within a nursing home.
3318 (1) Each county, municipality, and special district that
3319 has firesafety enforcement responsibilities shall employ or
3320 contract with a firesafety inspector. Except as provided in s.
3321 633.082(2), the firesafety inspector must conduct all firesafety
3322 inspections that are required by law. The governing body of a
3323 county, municipality, or special district that has firesafety
3324 enforcement responsibilities may provide a schedule of fees to
3325 pay only the costs of inspections conducted pursuant to this
3326 subsection and related administrative expenses. Two or more
3327 counties, municipalities, or special districts that have
3328 firesafety enforcement responsibilities may jointly employ or
3329 contract with a firesafety inspector.
3330 (2) Except as provided in s. 633.082(2), every firesafety
3331 inspection conducted pursuant to state or local firesafety
3332 requirements shall be by a person certified as having met the
3333 inspection training requirements set by the State Fire Marshal.
3334 Such person shall:
3335 (a) Be a high school graduate or the equivalent as
3336 determined by the department;
3337 (b) Not have been found guilty of, or having pleaded
3338 guilty or nolo contendere to, a felony or a crime punishable by
3339 imprisonment of 1 year or more under the law of the United

Amendment No.

3340 States, or of any state thereof, which involves moral turpitude,
3341 without regard to whether a judgment of conviction has been
3342 entered by the court having jurisdiction of such cases;
3343 (c) Have her or his fingerprints on file with the
3344 department or with an agency designated by the department;
3345 (d) Have good moral character as determined by the
3346 department;
3347 (e) Be at least 18 years of age;
3348 (f) Have satisfactorily completed the firesafety inspector
3349 certification examination as prescribed by the department; and
3350 (g)1. Have satisfactorily completed, as determined by the
3351 department, a firesafety inspector training program of not less
3352 than 200 hours established by the department and administered by
3353 agencies and institutions approved by the department for the
3354 purpose of providing basic certification training for firesafety
3355 inspectors; or
3356 2. Have received in another state training which is
3357 determined by the department to be at least equivalent to that
3358 required by the department for approved firesafety inspector
3359 education and training programs in this state.
3360 (3) Each special state firesafety inspection which is
3361 required by law and is conducted by or on behalf of an agency of
3362 the state must be performed by an individual who has met the
3363 provision of subsection (2), except that the duration of the
3364 training program shall not exceed 120 hours of specific training
3365 for the type of property that such special state firesafety
3366 inspectors are assigned to inspect.

3367 (4) A firefighter certified pursuant to s. 633.35 may
3368 conduct firesafety inspections, under the supervision of a
3369 certified firesafety inspector, while on duty as a member of a
3370 fire department company conducting inservice firesafety
3371 inspections without being certified as a firesafety inspector,
3372 if such firefighter has satisfactorily completed an inservice
3373 fire department company inspector training program of at least
3374 24 hours' duration as provided by rule of the department.
3375 (5) Every firesafety inspector or special state firesafety
3376 inspector certificate is valid for a period of 3 years from the
3377 date of issuance. Renewal of certification shall be subject to
3378 the affected person's completing proper application for renewal
3379 and meeting all of the requirements for renewal as established
3380 under this chapter or by rule promulgated thereunder, which
3381 shall include completion of at least 40 hours during the
3382 preceding 3-year period of continuing education as required by
3383 the rule of the department or, in lieu thereof, successful
3384 passage of an examination as established by the department.
3385 (6) The State Fire Marshal may deny, refuse to renew,
3386 suspend, or revoke the certificate of a firesafety inspector or
3387 special state firesafety inspector if it finds that any of the
3388 following grounds exist:
3389 (a) Any cause for which issuance of a certificate could
3390 have been refused had it then existed and been known to the
3391 State Fire Marshal.
3392 (b) Violation of this chapter or any rule or order of the
3393 State Fire Marshal.
3394 (c) Falsification of records relating to the certificate.

3395 (d) Having been found guilty of or having pleaded guilty
3396 or nolo contendere to a felony, whether or not a judgment of
3397 conviction has been entered.
3398 (e) Failure to meet any of the renewal requirements.
3399 (f) Having been convicted of a crime in any jurisdiction
3400 which directly relates to the practice of fire code inspection,
3401 plan review, or administration.
3402 (g) Making or filing a report or record that the
3403 certificateholder knows to be false, or knowingly inducing
3404 another to file a false report or record, or knowingly failing
3405 to file a report or record required by state or local law, or
3406 knowingly impeding or obstructing such filing, or knowingly
3407 inducing another person to impede or obstruct such filing.
3408 (h) Failing to properly enforce applicable fire codes or
3409 permit requirements within this state which the
3410 certificateholder knows are applicable by committing willful
3411 misconduct, gross negligence, gross misconduct, repeated
3412 negligence, or negligence resulting in a significant danger to
3413 life or property.
3414 (i) Accepting labor, services, or materials at no charge
3415 or at a noncompetitive rate from any person who performs work
3416 that is under the enforcement authority of the certificateholder
3417 and who is not an immediate family member of the
3418 certificateholder. For the purpose of this paragraph, the term
3419 "immediate family member" means a spouse, child, parent,
3420 sibling, grandparent, aunt, uncle, or first cousin of the person
3421 or the person's spouse or any person who resides in the primary
3422 residence of the certificateholder.

3423 (7) The Division of State Fire Marshal and the Florida
3424 Building Code Administrators and Inspectors Board, established
3425 pursuant to s. 468.605, shall enter into a reciprocity agreement
3426 to facilitate joint recognition of continuing education
3427 recertification hours for certificateholders licensed under s.
3428 468.609 and firesafety inspectors certified under subsection
3429 (2).

3430 (8) The State Fire Marshal shall develop by rule an
3431 advanced training and certification program for firesafety
3432 inspectors having fire code management responsibilities. The
3433 program must be consistent with the appropriate provisions of
3434 NFPA 1037, or similar standards adopted by the division, and
3435 establish minimum training, education, and experience levels for
3436 firesafety inspectors having fire code management
3437 responsibilities.

3438 (9) The department shall provide by rule for the
3439 certification of firesafety inspectors.

3440 Section 95. Subsection (12) of section 641.495, Florida
3441 Statutes, is amended to read:

3442 641.495 Requirements for issuance and maintenance of
3443 certificate.—

3444 (12) The provisions of part I of chapter 395 do not apply
3445 to a health maintenance organization that, on or before January
3446 1, 1991, provides not more than 10 outpatient holding beds for
3447 short-term and hospice-type patients in an ambulatory care
3448 facility for its members, provided that such health maintenance
3449 organization maintains current accreditation by the Joint
3450 Commission ~~on Accreditation of Health Care Organizations~~, the

Amendment No.

3451 Accreditation Association for Ambulatory Health Care, or the
3452 National Committee for Quality Assurance.
3453 Section 96. Subsection (13) of section 651.118, Florida
3454 Statutes, is amended to read:
3455 651.118 Agency for Health Care Administration;
3456 certificates of need; sheltered beds; community beds.—
3457 (13) Residents, as defined in this chapter, are not
3458 considered new admissions for the purpose of s.
3459 400.141(1)<u>(n)</u>~~(o)~~1.~~d.~~
3460 Section 97. Subsection (2) of section 766.1015, Florida
3461 Statutes, is amended to read:
3462 766.1015 Civil immunity for members of or consultants to
3463 certain boards, committees, or other entities.—
3464 (2) Such committee, board, group, commission, or other
3465 entity must be established in accordance with state law or in
3466 accordance with requirements of the Joint Commission ~~on~~
3467 ~~Accreditation of Healthcare Organizations~~, established and duly
3468 constituted by one or more public or licensed private hospitals
3469 or behavioral health agencies, or established by a governmental
3470 agency. To be protected by this section, the act, decision,
3471 omission, or utterance may not be made or done in bad faith or
3472 with malicious intent.
3473 Section 98. Subsection (4) of section 766.202, Florida
3474 Statutes, is amended to read:
3475 766.202 Definitions; ss. 766.201-766.212.—As used in ss.
3476 766.201-766.212, the term:
3477 (4) "Health care provider" means any hospital, ambulatory
3478 surgical center, or mobile surgical facility as defined and

3479 licensed under chapter 395; a birth center licensed under
3480 chapter 383; any person licensed under chapter 458, chapter 459,
3481 chapter 460, chapter 461, chapter 462, chapter 463, part I of
3482 chapter 464, chapter 466, chapter 467, part XIV of chapter 468,
3483 or chapter 486; a clinical lab licensed under chapter 483; a
3484 health maintenance organization certificated under part I of
3485 chapter 641; a blood bank; a plasma center; an industrial
3486 clinic; a renal dialysis facility; or a professional association
3487 partnership, corporation, joint venture, or other association
3488 for professional activity by health care providers.
3489 Section 99. This act shall take effect July 1, 2011.
3490
3491
3492 -----------------------------------------------------
3493 **T I T L E A M E N D M E N T**
3494 Remove the entire title and insert:
3495 A bill to be entitled
3496 An act relating to health care; amending s. 83.42, F.S.,
3497 establishing s. 400.0255 as exclusive procedures for
3498 resident transfer and discharge; amending s. 112.0455,
3499 F.S., relating to the Drug-Free Workplace Act; deleting
3500 obsolete provisions; amending s. 318.21, F.S.; revising
3501 distribution of funds from civil penalties imposed for
3502 traffic infractions by county courts; repealing s.
3503 383.325, F.S., relating to confidentiality of inspection
3504 reports of licensed birth center facilities; amending s.
3505 395.002, F.S.; revising and deleting definitions
3506 applicable to regulation of hospitals and other licensed

3507 facilities; conforming a cross-reference; amending s.
3508 395.003, F.S.; deleting an obsolete provision; conforming
3509 a cross-reference; amending s. 395.0161, F.S.; relating to
3510 licensure inspection; amending s. 395.0193, F.S.;
3511 requiring a licensed facility to report certain peer
3512 review information and final disciplinary actions to the
3513 Division of Medical Quality Assurance of the Department of
3514 Health rather than the Division of Health Quality
3515 Assurance of the Agency for Health Care Administration;
3516 amending s. 395.1023, F.S.; providing for the Department
3517 of Children and Family Services rather than the Department
3518 of Health to perform certain functions with respect to
3519 child protection cases; requiring certain hospitals to
3520 notify the Department of Children and Family Services of
3521 compliance; amending s. 395.1041, F.S., relating to
3522 hospital emergency services and care; deleting obsolete
3523 provisions; repealing s. 395.1046, F.S., relating to
3524 complaint investigation procedures; amending s. 395.1055,
3525 F.S.; requiring licensed facility beds to conform to
3526 standards specified by the Agency for Health Care
3527 Administration, the Florida Building Code, and the Florida
3528 Fire Prevention Code; amending s. 395.10972, F.S.;
3529 revising a reference to the Florida Society of Healthcare
3530 Risk Management to conform to the current designation;
3531 amending s. 395.2050, F.S.; revising a reference to the
3532 federal Health Care Financing Administration to conform to
3533 the current designation; amending s. 395.3036, F.S.;
3534 correcting a reference; repealing s. 395.3037, F.S.,

3535 relating to redundant definitions; amending ss. 154.11,
3536 394.741, 395.3038, 400.925, 400.9935, 408.05, 440.13,
3537 627.645, 627.668, 627.669, 627.736, 641.495, and 766.1015,
3538 F.S.; revising references to the Joint Commission on
3539 Accreditation of Healthcare Organizations, the Commission
3540 on Accreditation of Rehabilitation Facilities, and the
3541 Council on Accreditation to conform to their current
3542 designations; amending s. 395.602, F.S.; revising the
3543 definition of the term "rural hospital" to delete an
3544 obsolete provision; amending s. 400.021, F.S.; revising
3545 the definition of the term "geriatric outpatient clinic";
3546 amending s. 400.0255, F.S.; correcting an obsolete cross-
3547 reference to administrative rules; amending s. 400.063,
3548 F.S.; deleting an obsolete provision; amending ss. 400.071
3549 and 400.0712, F.S.; revising applicability of general
3550 licensure requirements under part II of ch. 408, F.S., to
3551 applications for nursing home licensure; revising
3552 provisions governing inactive licenses; amending s.
3553 400.111, F.S.; providing for disclosure of controlling
3554 interest of a nursing home facility upon request by the
3555 Agency for Health Care Administration; amending s.
3556 400.1183, F.S.; revising grievance record maintenance and
3557 reporting requirements for nursing homes; amending s.
3558 400.141, F.S.; providing criteria for the provision of
3559 respite services by nursing homes; requiring a written
3560 plan of care; requiring a contract for services; requiring
3561 resident release to caregivers to be designated in
3562 writing; providing an exemption to the application of

3563 discharge planning rules; providing for residents' rights;
3564 providing for use of personal medications; providing terms
3565 of respite stay; providing for communication of patient
3566 information; requiring a physician's order for care and
3567 proof of a physical examination; providing for services
3568 for respite patients and duties of facilities with respect
3569 to such patients; conforming a cross-reference; requiring
3570 facilities to maintain clinical records that meet
3571 specified standards; providing a fine relating to an
3572 admissions moratorium; deleting requirement for facilities
3573 to submit certain information related to management
3574 companies to the agency; deleting a requirement for
3575 facilities to notify the agency of certain bankruptcy
3576 filings to conform to changes made by the act; amending s.
3577 400.142, F.S.; deleting language relating to agency
3578 adoption of rules; repealing s. 400.145, F.S., relating to
3579 records of care and treatment of residents; amending
3580 400.147, F.S.; revising reporting requirements for
3581 licensed nursing home facilities relating to adverse
3582 incidents; repealing s. 400.148, F.S., relating to the
3583 Medicaid "Up-or-Out" Quality of Care Contract Management
3584 Program; amending s. 400.179, F.S.; deleting an obsolete
3585 provision; amending s. 400.19, F.S.; revising inspection
3586 requirements; amending s. 400.23, F.S.; deleting an
3587 obsolete provision; correcting a reference; directing the
3588 agency to adopt rules for minimum staffing standards in
3589 nursing homes that serve persons under 21 years of age;
3590 providing minimum staffing standards; amending s. 400.275,

3591 F.S.; revising agency duties with regard to training
3592 nursing home surveyor teams; revising requirements for
3593 team members; amending s. 400.484, F.S.; revising the
3594 schedule of home health agency inspection violations;
3595 amending s. 400.506, F.S.; deleting language relating to
3596 exemptions from penalties imposed on nurse registries if a
3597 nurse registry does not bill the Florida Medicaid Program;
3598 providing criteria for an administrator to manage a nurse
3599 registry; amending s. 400.509; revising the service
3600 providers exempt from licensure registration to include
3601 organizations that provide companion services only for
3602 persons with developmental disabilities; amending s.
3603 400.606, F.S.; revising the content requirements of the
3604 plan accompanying an initial or change-of-ownership
3605 application for licensure of a hospice; revising
3606 requirements relating to certificates of need for certain
3607 hospice facilities; amending s. 400.607, F.S.; revising
3608 grounds for agency action against a hospice; amending s.
3609 400.915, F.S.; correcting an obsolete cross-reference to
3610 administrative rules; amending s. 400.931, F.S.; deleting
3611 a requirement that an applicant for a home medical
3612 equipment provider license submit a surety bond to the
3613 agency; requiring applicants to subit documentation of
3614 accreditation; amending s. 400.932, F.S.; revising grounds
3615 for the imposition of administrative penalties for certain
3616 violations by an employee of a home medical equipment
3617 provider; amending s. 400.967, F.S.; revising the schedule
3618 of inspection violations for intermediate care facilities

Amendment No.

3619 for the developmentally disabled; providing a penalty for
3620 certain violations; amending s. 400.9905, F.S.; revising
3621 the definitions of the terms "clinic" and "portable
3622 equipment provider"; providing that part X of ch, 400,
3623 F.S., the Health Care Clinic Act, does not apply to
3624 certain clinical facilities, an entity owned by a
3625 corporation with a specified amount of annual sales of
3626 health care services under certain circumstances, or an
3627 entity owned or controlled by a publicly traded entity
3628 with a specified amount of annual revenues; amending s.
3629 400.991, F.S.; conforming terminology; revising
3630 application requirements relating to documentation of
3631 financial ability to operate a mobile clinic; amending s.
3632 408.033, relating to funding of local and state health
3633 planning; amending s. 408.034, F.S.; revising agency
3634 authority relating to licensing of intermediate care
3635 facilities for the developmentally disabled; amending s.
3636 408.036, F.S.; deleting an exemption from certain
3637 certificate-of-need review requirements for a hospice or a
3638 hospice inpatient facility; amending s. 408.037, F.S.;
3639 revising certificate-of-need requirements for general
3640 hospital applicants to evaluate the applicant's parent
3641 corporation if audited financial statements of the
3642 applicant do not exist; amending s. 408.043, F.S.;
3643 revising requirements for certain freestanding inpatient
3644 hospice care facilities to obtain a certificate of need;
3645 amending s. 408.061, F.S.; revising health care facility
3646 data reporting requirements; amending s. 408.10, F.S.;

3647 removing agency authority to investigate certain consumer
3648 complaints; amending s. 408.802, F.S.; removing
3649 applicability of part II of ch. 408, F.S., relating to
3650 general licensure requirements, to private review agents;
3651 amending s. 408.804, F.S.; providing penalties for
3652 altering, defacing, or falsifying a license certificate
3653 issued by the agency or displaying such an altered,
3654 defaced, or falsified certificate; amending s. 408.806,
3655 F.S.; revising agency responsibilities for notification of
3656 licensees of impending expiration of a license; requiring
3657 payment of a late fee for a license application to be
3658 considered complete under certain circumstances; amending
3659 s. 408.8065, F.S., relating to additional licensure
3660 requirements for home health agencies, home medical
3661 equipment providers, and health care clinics; amending s.
3662 408.809, F.S.; deleting authorization for the Agency for
3663 Health Care Administration to develop rules to establish a
3664 schedule to stagger the implementation of the required
3665 rescreening; providing the schedule in statute; amending
3666 s. 408.810, F.S.; revising provisions relating to
3667 information required for licensure; requiring proof of
3668 submission of notice to a mortgagor or landlord regarding
3669 provision of services requiring licensure; requiring
3670 disclosure of information by a controlling interest of
3671 certain court actions relating to financial instability
3672 within a specified time period; amending s. 408.813, F.S.;
3673 authorizing the agency to impose fines for unclassified
3674 violations of part II of ch. 408, F.S.; amending s.

3675 408.815, F.S.; authorizing the agency to extend a license
3676 expiration date under certain circumstances; conforming a
3677 cross-reference; amending s. 409.91196, F.S.; conforming a
3678 cross-reference; amending s. 409.912, F.S.; revising
3679 procedures for implementation of a Medicaid prescribed-
3680 drug spending-control program; amending s. 429.07, F.S.;
3681 deleting the requirement for an assisted living facility
3682 to obtain an additional license in order to provide
3683 limited nursing services; deleting the requirement for the
3684 agency to conduct quarterly monitoring visits of
3685 facilities that hold a license to provide extended
3686 congregate care services; deleting the requirement for the
3687 department to report annually on the status of and
3688 recommendations related to extended congregate care;
3689 deleting the requirement for the agency to conduct
3690 monitoring visits at least twice a year to facilities
3691 providing limited nursing services; increasing the per
3692 resident licensure fees required for the standard license;
3693 eliminating the license fee for the limited nursing
3694 services license; transferring from another provision of
3695 law the requirement that the standard survey of an
3696 assisted living facility include specific actions to
3697 determine whether the facility is adequately protecting
3698 residents' rights; providing that under specified
3699 conditions an assisted living facility that has a class I
3700 or class II violation is subject to periodic unannounced
3701 monitoring; requiring a registered nurse to participate in
3702 certain monitoring visits; amending s. 429.11, F.S.;

3703 revising licensure application requirements for assisted
3704 living facilities to eliminate provisional licenses;
3705 amending s. 429.12, F.S.; deleting a requirement that a
3706 transferor of an assisted living facility advise the
3707 transferee to submit a plan for correction of certain
3708 deficiencies to the Agency for Health Care Administration
3709 before ownership of the facility is transferred; amending
3710 s. 429.14, F.S.; clarifying provisions relating to a
3711 facility's request for a hearing under certain
3712 circumstances; amending s. 429.17, F.S.; deleting
3713 provisions relating to the limited nursing services
3714 license; revising agency responsibilities regarding the
3715 issuance of conditional licenses; amending s. 429.23,
3716 F.S.; deleting reporting requirements for assisted living
3717 facilities relating to liability claims; amending s.
3718 429.255, F.S.; eliminating provisions authorizing the use
3719 of volunteers to provide certain health-care-related
3720 services in assisted living facilities; authorizing
3721 assisted living facilities to provide limited nursing
3722 services; requiring an assisted living facility to be
3723 responsible for certain recordkeeping and staff to be
3724 trained to monitor residents receiving certain health-
3725 care-related services; amending s. 429.28, F.S.; deleting
3726 a requirement for a biennial survey of an assisted living
3727 facility, to conform to changes made by the act;
3728 conforming a cross-reference; amending s. 429.41, F.S.,
3729 relating to rulemaking; conforming provisions to changes
3730 made by the act; deleting the requirement for the

Amendment No.

3731 Department of Elder Affairs to submit a copy of proposed
3732 rules to the Speaker of the House of Representatives, the
3733 President of the Senate, and appropriate committees of
3734 substance for review and comment prior to promulgation;
3735 amending s. 429.53, F.S.; revising provisions relating to
3736 consultation by the agency; revising a definition;
3737 amending s. 429.71, F.S.; revising schedule of inspection
3738 violations for adult family-care homes; amending s.
3739 429.915, F.S.; revising agency responsibilities regarding
3740 the issuance of conditional licenses; amending s. 440.102,
3741 F.S.; deleting the requirement for laboratories to submit
3742 a monthly report to the Agency for Health Care
3743 Administration with statistical information regarding the
3744 testing of employees and job applicants; amending s.
3745 440.13, F.S., relating to medical services and supplies;
3746 amending s. 483.035, F.S.; requiring clinical laboratories
3747 operated by one or more practitioners licensed under
3748 chapter 464 part I to be licensed under this part;
3749 amending s. 483.051, F.S., establishing qualifications
3750 necessary for clinical laboratory licensure; amending s.
3751 483.294, F.S.; revising frequency of agency inspections of
3752 multiphasic health testing centers; amending s. 626.9541,
3753 F.S.; authorizing an insurer offering a group or
3754 individual health benefit plan to offer a wellness
3755 program; authorizing rewards or incentives; providing for
3756 verification of a member's inability to participate for
3757 medical reasons; providing that such rewards or incentives
3758 are not insurance benefits; amending s. 633.081, F.S.;

3759 limiting State Fire Marshal inspections of nursing homes
3760 to once a year; providing for additional inspections based
3761 on complaints and violations identified in the course of
3762 orientation or training activities; amending s. 766.202,
3763 F.S.; adding persons licensed under part XIV of ch. 468,
3764 F.S., to the definition of "health care provider";
3765 amending ss. 394.4787, 400.0239, 408.07, 430.80, and
3766 651.118, F.S.; conforming terminology and references to
3767 changes made by the act; revising a reference; providing
3768 an effective date.
3769

HB 367

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 367 Health Care Provider Contracts
**SPONSOR(S):** Hooper and others
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 546

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health & Human Services Quality Subcommittee | | Poche MW | Calamas |
| 2) Insurance & Banking Subcommittee | | | |
| 3) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS


House Bill 367 amends ss. 627.6474, 636.035 and 641.315, F.S., to prohibit certain health insurance provider contracts from containing provisions requiring dentists to provide services at a fee set by the health insurer, prepaid limited health service organization or health maintenance organization unless the services are covered under the applicable subscriber agreement. The bill defines "covered services" and specifies what services are not considered "covered services".

The bill does not appear to have a fiscal impact.

The bill provides an effective date of July 1, 2011.

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Current Situation**

Regulation of Health Insurers and Health Maintenance Organizations (HMOs)

The Office of Insurance Regulation (OIR) regulates health insurance policies and rates under Part VI of Chapter 627, F.S. OIR also regulates HMO contracts and rates under Part I of Chapter 641, F.S. The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under Part III of Chapter 641, F.S.

Health Care Practitioners

Health care practitioners, as defined in s. 456.001(4), F.S., include, but are not limited to, physicians, osteopathic physicians, chiropractors, podiatrists, nurses, pharmacists, dentists, midwives, optometrists, speech pathologists, occupational therapists, orthotic providers, massage therapists, clinical laboratory personnel, and psychologists.

Health Insurer Provider Arrangements

Health insurer provider contracts are regulated by the OIR. Current Florida law does not prohibit provider contracts between health insurers and dentists from containing provisions that require the dentist to provide services to the subscribers to a health insurance plan or policy at a fee set by the health insurer, regardless of whether or not the services are covered under the health insurance plan or policy.

Section 627.6474, F.S., provides that a health insurer cannot require a contracted health care practitioner to accept the terms of other health care practitioner contracts with the insurer, or any other insurer or HMO under common management and control with the insurer, including Medicare and Medicaid practitioner contracts, preferred provider[1], exclusive provider organizations[2], or provider contracts[3], except for a practitioner in a group practice[4] who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this provision is considered void.[5]

Prepaid Limited Health Service Organization (PLHSO) Provider Arrangements

PLHSOs are authorized in s. 636.003, F.S. This section defines "limited health service" to include the following:

- ambulance services;
- dental care services;
- vision care services;
- mental health services;
- substance abuse services;
- chiropractic services;

[1] S. 627.6471, F.S.
[2] S. 627.6472, F.S.
[3] S. 641.315, F.S.
[4] A group practice is a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association such that services are provided through the joint use of shared office space, facilities, equipment, and personnel; services are billed in the name of the group and amounts received are treated as receipts of the group; and overhead expenses and income is distributed by methods determined by the group. See s. 456.053(h), F.S.
[5] S. 627.6474, F.S.

- podiatric care services; and
- pharmaceutical services.

AHCA currently has two types of PLHSOs- a prepaid dental health plan (PDHP), as authorized in s. 409.912(43), F.S., and a prepaid mental health plan (PMHP), as authorized in s. 409.912(4)(b), F.S. These prepaid limited health service organizations are administered under contract with AHCA and reimbursed on a capitated basis.

As of March 2011, approximately 253,739 beneficiaries are enrolled in the PDHP program and 648,730 beneficiaries are enrolled in the PMHP program.[6]

Provider arrangements for PLHSOs are authorized in s. 636.035, F.S. Current law does not prohibit provider contracts between PLHSOs and dentists from containing provisions that require dentists to provide non-covered services to the PLHSO subscribers at a fee set by the PLHSO.

<u>HMO Provider Contracts</u>

Section 641.315, F.S., specifies requirements for the HMO provider contracts with "health care practitioners" as defined in s. 456.001(4), F.S. Section 641.315, F.S., does not currently prohibit provider contracts between health maintenance organizations and dentists from containing provisions that require the practitioner to provide services to the HMO subscribers at a fee set by the HMO unless the services are covered services under the applicable subscriber agreement.

**Effect of Proposed Changes**

The bill amends s. 627.6474, F.S., to add PLHSO provider arrangement contracts, authorized under s. 636.035, F.S., to the list of insurers which may not require a health care practitioner to accept the terms of other health care practitioner contracts with an insurer, prepaid limited health service organization, or HMO. The bill also amends s. 627.6474(2), F.S., to prohibit contracts between health insurers and dentists from containing provisions that require dentists to provide services to the health insurer subscribers at a fee set by the insurer, unless the services are covered services under the applicable subscriber agreement.

The bill amends s. 636.035, F.S., to prohibit provider contracts between a PLHSO and a dentist from containing any provision that requires dentists to provide services at a fee set by the PLHSO unless the services are covered services under the applicable subscriber agreement.

Also, the bill amends s. 641.315, F.S., to prohibit provider contracts between a HMO and a dentist from containing provisions that require the dentist to provide services to the HMO subscribers at a fee set by the HMO unless the services are covered services under the applicable subscriber agreement.

The bill defines "covered services" as those services that are reimbursable under an applicable contract, subject to contractual limitations on benefits. The bill specifically exempts from the definition of "covered services" any dental services provided by a dentist to a covered individual who has met or exceeded the periodic maximum amount of benefits allowed by the individual's health insurance plan or policy. Also, services that are not listed in an individual's health insurance plan or policy as a benefit to which the individual is entitled under the plan or policy are not considered covered services.

The bill applies to all contracts entered into or renewed on or after July 1, 2011.

B. SECTION DIRECTORY:

---

[6] Email correspondence from AHCA staff dated March 11, 2011, providing total enrolled beneficiaries in the PDHP and PMHP programs for March 2011, on file with Health and Human Services Quality Subcommittee.

**Section 1:** Amends s. 627.6474, F.S., relating to provider contracts and health care practitioners
**Section 2:** Amends s. 636.035, F.S., relating to provider arrangements and prepaid limited health service organizations
**Section 3:** Amends s. 641.315, F.S., relating to provider contracts and health maintenance organizations
**Section 4:** Provides an effective date of July 1, 2011

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may allow dentists to charge higher fees to patients for services that are not considered "covered services" under a contract with a PLHSO, HMO, or health insurance company. There may be an increase in the cost of dental insurance coverage to pay for services that are not "covered services" and for which insurers may not contract with dentists.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to health care provider contracts;
3 amending s. 627.6474, F.S.; prohibiting insurers from
4 requiring contracted health care practitioners to accept
5 the terms of other contracts between prepaid limited
6 health service organizations and providers of limited
7 health care services; prohibiting contracts between health
8 insurers and dentists from containing certain fee
9 requirements set by the insurer under certain
10 circumstances; providing a definition; providing
11 application; amending s. 636.035, F.S.; prohibiting
12 contracts between prepaid limited health service
13 organizations and dentists from containing certain fee
14 requirements set by the organization under certain
15 circumstances; providing a definition; providing
16 application; amending s. 641.315, F.S.; prohibiting
17 contracts between health maintenance organizations and
18 dentists from containing certain fee requirements set by
19 the organization under certain circumstances; providing a
20 definition; providing application; providing an effective
21 date.
22
23 Be It Enacted by the Legislature of the State of Florida:
24
25 Section 1. Section 627.6474, Florida Statutes, is amended
26 to read:
27 627.6474 Provider contracts.—
28 (1) A health insurer may ~~shall~~ not require a contracted



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 health care practitioner as defined in s. 456.001(4) to accept
30 the terms of other health care practitioner contracts with the
31 insurer or any other insurer, or health maintenance
32 organization, under common management and control with the
33 insurer, including Medicare and Medicaid practitioner contracts
34 and those authorized by s. s. 636.035, 627.6471, s. 627.6472, or
35 s. 641.315, except for a practitioner in a group practice as
36 defined in s. 456.053 who must accept the terms of a contract
37 negotiated for the practitioner by the group, as a condition of
38 continuation or renewal of the contract. Any contract provision
39 that violates this section is void. A violation of this section
40 is not subject to the criminal penalty specified in s. 624.15.
41 (2) A contract between a health insurer and a dentist
42 licensed under chapter 466 for the provision of services to
43 patients may not contain any provision that requires the dentist
44 to provide services to the insured under such contract at a fee
45 set by the health insurer unless such services are covered
46 services under the applicable contract. As used in this
47 subsection, the term "covered services" means services
48 reimbursable under the applicable contract, subject to
49 contractual limitations on benefits, such as deductibles,
50 coinsurance, and copayments, as may apply. However, the term
51 "covered services" does not include any dental services provided
52 by a dentist to a covered person who has met or exceeded the
53 annual or other periodic payment maximum established by the
54 contract or services that are not listed as a benefit that the
55 covered person is entitled to receive under the contract. This
56 subsection applies to all contracts entered into or renewed on

57 or after July 1, 2011.
58 Section 2. Subsection (13) is added to section 636.035,
59 Florida Statutes, to read:
60 636.035 Provider arrangements.—
61 (13) A contract between a prepaid limited health service
62 organization and a dentist licensed under chapter 466 for the
63 provision of services to subscribers of the prepaid limited
64 health service organization may not contain any provision that
65 requires the dentist to provide services to subscribers of the
66 prepaid limited health service organization at a fee set by the
67 prepaid limited health service organization unless such services
68 are covered services under the applicable contract. As used in
69 this subsection, the term "covered services" means services
70 reimbursable under the applicable contract, subject to
71 contractual limitations on benefits, such as deductibles,
72 coinsurance, and copayments, as may apply. However, the term
73 "covered services" does not include any dental services provided
74 by a dentist to a covered person who has met or exceeded the
75 annual or other periodic payment maximum established by the
76 contract or services that are not listed as a benefit that the
77 covered person is entitled to receive under the contract. This
78 subsection applies to all contracts entered into or renewed on
79 or after July 1, 2011.
80 Section 3. Subsection (11) is added to section 641.315,
81 Florida Statutes, to read:
82 641.315 Provider contracts.—
83 (11) A contract between a health maintenance organization
84 and a dentist licensed under chapter 466 for the provision of

85 services to subscribers of the health maintenance organization
86 may not contain any provision that requires the dentist to
87 provide services to subscribers of the health maintenance
88 organization at a fee set by the health maintenance organization
89 unless such services are covered services under the applicable
90 contract. As used in this subsection, the term "covered
91 services" means services reimbursable under the applicable
92 contract, subject to contractual limitations on benefits, such
93 as deductibles, coinsurance, and copayments, as may apply.
94 However, the term "covered services" does not include any dental
95 services provided by a dentist to a covered person who has met
96 or exceeded the annual or other periodic payment maximum
97 established by the contract or services that are not listed as a
98 benefit that the covered person is entitled to receive under the
99 contract. This subsection applies to all contracts entered into
100 or renewed on or after July 1, 2011.
101 Section 4. This act shall take effect July 1, 2011.

HB 467

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 467 Entities Contracting with the Medicaid Program
**SPONSOR(S):** Albritton and others
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 472

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health & Human Services Quality Subcommittee | | Poche | Calamas |
| 2) Finance & Tax Committee | | | |
| 3) Health Care Appropriations Subcommittee | | | |
| 4) Health & Human Services Committee | | | |

## SUMMARY ANALYSIS


House Bill 467 exempts a prepaid limited health service organization licensed under Chapter 636, F.S., from payment of a tax on premiums, contributions, and assessments received under a contract with Medicaid to solely provide services to Medicaid recipients.

The bill provides for remedial retroactive application of the exemption to December 31, 1998. The bill expressly states that the retroactive application does not create a right to a refund for any tax, penalty or interest on premiums, contributions, and assessments paid to the Department of Revenue prior to the effective date.

The bill has a negative fiscal impact to the state.

The bill provides an effective date of July 1, 2011.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

### A. EFFECT OF PROPOSED CHANGES:

**Current Situation**

Chapter 636, F.S., regulates the operation and administration of prepaid limited health service organizations[12] (PLHSO) and discount medical plan organizations in the state of Florida. PLHSOs solely providing services to Medicaid recipients under a contract with Medicaid are exempt from several provisions of Chapter 636, F.S., including those related to rates and charges[3]; changes in rates and benefits, material modifications, and the addition of limited health services[4]; restrictions upon expulsion or refusal to issue or renew a contract[5]; notice of cancellation of contract[6]; and extension of benefits.[7]

Since 1993, Florida law has imposed a tax on the insurance premiums, contributions, and assessments received by a PLHSO.[8] The premium tax is to be paid annually and is calculated at a rate of 1.75 percent of the gross amount of premiums, contributions, and assessments collected on health insurance policies issued by PLHSOs.[9]

There are five PLHSOs which provide mental health services to Medicaid recipients through a contract with AHCA that are subject to this tax[10]. One organization, Lakeview Center, Inc. (Lakeview), filed a legal challenge in 2007 to the imposition of the tax by the Department of Revenue.[11] According to the court's order, Lakeview had been paying the premium tax under s. 624.509, F.S., since 2003. Subsequently, Lakeview determined that the tax was paid in error and sought a refund from DOR. The request for refund was denied and Lakeview timely filed a Complaint with the Circuit Court for the Second Circuit in Tallahassee. The court found that Lakeview contracted with the Agency for Health Care Administration (AHCA) to provide mental health and other services to Medicaid recipients. Lakeview was paid a fixed sum by AHCA to provide the stated services. Lakeview argued that the fixed sum paid by AHCA under the contract did not constitute a premium to trigger the imposition of the premium tax under s. 624.509, F.S. The court disagreed, finding that a rule established by the Office of Insurance Regulation (OIR), which regulated Lakeview as an insurer in the state of Florida, defined "premium"[12] and concluded that the fixed rate paid to Lakeview by AHCA met the definition and was taxable.

---

[1] Part I, Ch. 636, F.S.

[2] S. 636.003(7), F.S., defines a "prepaid limited health service organization" as "any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers; s. 636.003(5), F.S., defines a "limited health service" as ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services.

[3] S. 636.017, F.S.

[4] S. 636.018, F.S.

[5] S. 636.022, F.S.

[6] S. 636.028, F.S.

[7] S. 636.034, F.S.

[8] S. 636.066(1), F.S.

[9] S. 624.509(1)(a), F.S.

[10] Agency for Health Care Administration, 2011 Bill Analysis and Economic Impact Statement for SB 472/HB 467; the five vendors are: Lakeview Center, Inc. (d/b/a Access Behavioral Health), Magellan Behavioral Health of Florida, Inc., North Florida Behavioral Health Partners, Inc., Florida Health Partners, Inc., and The Community Based Care Partnership, LLC.

[11] *See* Lakeview Center, Inc. v. State of Florida, Dept. of Revenue, No. 2007-CA-1255 (Fla. 2nd Cir. Co. Jan 23, 2008), *per curiam affirmed*, Lakeview Center, Inc. v. State of Florida, Dept. of Revenue, 8 So.3d 1136 (Fla. 1st DCA 2009)(unpublished disposition).

[12] Rule 69O-203.013(6), F.A.C. (2007), defined "premium" as "[t]he contracted sum paid by or on behalf of a subscriber or group of subscribers on a prepaid per capita or a prepaid aggregate basis for limited health services rendered by or through the PLHSO."

Currently, some PLHSOs are paying the premium tax and some are not. Additional information regarding the identity of those PLHSOs and the amount being paid or owed is not available due to confidentiality provisions.[13]

**Effect of Proposed Changes**

The bill exempts any entity providing services solely to Medicaid recipients through a contract with Medicaid from payment of the premium tax required by s. 624.509, F.S. The bill also provides for retroactive application of the exemption from tax to December 31, 1998. The bill provides that the retroactive application is remedial in nature and does not create the right to a refund of any tax, penalty or interest to those companies that have paid the tax or a penalty or interest prior to July 1, 2011.

Exempting PLHSOs from the premium tax will impact the way in which AHCA determines the capitation rate for the organizations that provide mental health services to Medicaid recipients. The rates will be adjusted for the 2011-12 year, effective September 1, 2011, and would result in a reduction to the rates paid to the plans by Medicaid.

Passage of the bill will result in the forgiveness of $11.2 million of past due taxes and interest, as determined by the Revenue Estimating Impact Conference.[14] Further, it is estimated that, for the next four fiscal years looking forward, there is a negative impact to the amount of taxes collected for General Revenue of $1.6 million to $1.7 million. The companies who have paid the tax to date will not receive a refund.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 636.0145, F.S., relating to certain entities contracting with Medicaid.
**Section 2:** Creates an unnumbered section of general law which provides for retroactive application of the amended statute to December 31, 1998, clarifies that retroactive application of the amended statute is remedial in nature and does not create a right to a refund or authorize any governmental entity to issue a refund of any tax, penalty or interest remitted to the Department of Revenue before July 1, 2011.
**Section 3:** Provides an effective date of July 1, 2011.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

[13] S. 231.015(9), F.S., The Taxpayer Bill of Rights, and s. 213.053(2)(a), F.S., through sub-subsection (1)(q).
[14] Report of the Revenue Estimating Conference, Insurance Premium Tax, Certain Prepaid Health Plans, February 25, 2011.

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A PLHSO which provides mental health services only to Medicaid recipients through a contract with Medicaid, through AHCA, will be exempt from paying the premium tax on the funds received through the contract to provide the services. If the tax is no longer imposed on the PLHSO, the amount of the tax (1.75 percent of the fixed rate paid for services) will be removed from the rate paid by Medicaid.

D. FISCAL COMMENTS:

On February 25, 2011, the Revenue Estimating Conference adopted a consensus estimate of the tax impact of exempting PLHSOs from payment of the premium tax in s. 624.509, F.S. Assuming an effective tax rate of .75%, the bill will have a negative impact of $11.2 million for FY 11-12. This figure contains the past due tax and interest that has not been remitted to date by the PLHSOs subject to the statute. The bill will have the following negative impact for each of the next four fiscal years:

| | FY2011-12 Cash | FY 2011-12 Annualized | FY 2012-13 Cash | FY 2013-14 Cash | FY 2014-15 Cash |
|---|---|---|---|---|---|
| General Revenue | ($11.2m) | ($1.6m) | ($1.6m) | ($1.6m) | ($1.7m) |
| State Trust | 0 | 0 | 0 | 0 | 0 |
| Total State Impact | ($11.2m) | ($1.6m) | ($1.6m) | ($1.6m) | ($1.7m) |
| Total Local Impact | 0 | 0 | 0 | 0 | 0 |
| Total Impact | ($11.2m) | ($1.6m) | ($1.6m) | ($1.6m) | ($1.7m) |

According to AHCA, the capitation rates for prepaid mental health plans for September 1, 2010 to August 31, 2011 were increased by 1.75 percent to account for the premium tax. This is a recurring add-on. As a result, while the state would be collecting $1.6 million in tax revenue, assuming the tax was collected, the state is spending $1.6 million in General Revenue to increase the capitation rates each year. If the bill passes, AHCA will readjust the capitation rates effective September 1, 2011 to account for the elimination of tax liability. The removal of the tax will result in a reduction to the rates paid to the PLHSOs by Medicaid. Medicaid will not seek to recoup two months (July 2011 and August 2011) of the 1.75 percent rate added to current capitation rates from companies that have been paying the tax. Instead, an adjustment will be made to the capitation rate for 2011-12 to account for the "overpayment". However, AHCA will recoup the portion of the capitation payment relating to the premium tax that has already been disbursed to companies that have not paid the premium tax for 2010-2011.[15]

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

15

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of sales tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to entities contracting with the Medicaid
3 Program; amending s. 636.0145, F.S.; exempting certain
4 entities providing services solely to Medicaid recipients
5 under a Medicaid contract from being subject to the
6 premium tax imposed on premiums, contributions, and
7 assessments received by prepaid limited health service
8 organizations; providing for retroactive operation;
9 specifying that the act is remedial in nature and not a
10 basis for certain refunds of tax, penalty, or interest;
11 providing an effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Section 636.0145, Florida Statutes, is amended
16 to read:
17 636.0145 Certain entities contracting with Medicaid.—
18 Notwithstanding the requirements of s. 409.912(4)(b), an entity
19 that is providing comprehensive inpatient and outpatient mental
20 health care services to certain Medicaid recipients in
21 Hillsborough, Highlands, Hardee, Manatee, and Polk Counties
22 through a capitated, prepaid arrangement pursuant to the federal
23 waiver provided for in s. 409.905(5) must become licensed under
24 chapter 636 by December 31, 1998. Any entity licensed under this
25 chapter which provides services solely to Medicaid recipients
26 under a contract with Medicaid is ~~shall be~~ exempt from ss.
27 636.017, 636.018, 636.022, 636.028, ~~and~~ 636.034, and 636.066(1).

28 Section 2. This act shall operate retroactively to
29 December 31, 1998; however, the retroactive operation of this
30 act is remedial in nature, does not create a right to a refund,
31 and does not authorize a refund by any governmental entity of
32 any tax, penalty, or interest remitted to the Department of
33 Revenue before July 1, 2011.
34 Section 3. This act shall take effect July 1, 2011.

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCB HSQS 11-01 Repeals Obsolete Language relating to the Department of Health
**SPONSOR(S):** Health & Human Services Quality Subcommittee
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| Orig. Comm.: Health & Human Services Quality Subcommittee | | Batchelor | Calamas |

### SUMMARY ANALYSIS


PCB HSQS 11-01 repeals the following sections of law:

- Section 381.00325 F.S., relating to the Hepatitis A Awareness program; and
- Section 381.06015, F.S., relating to the Public Cord Blood Tissue Bank

The bill does not appear to have a fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2011.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The bill repeals two current sections of law related to the Department of Health (DOH).

Hepatitis A Awareness Program

The bill repeals s. 381.00325, F.S., requiring DOH to develop a Hepatitis A Awareness Program. The purpose of the program is to provide education and information to the public regarding the availability of the Hepatitis A vaccine.

DOH, per s. 381.0011(7), F.S., is to provide information to the public regarding the prevention, control, and cure of diseases and illnesses. Under this authority, the Division of Disease Control, within DOH, currently has a Hepatitis Awareness Program web page that provides necessary information regarding vaccines and educational tools for Hepatitis A, B and C.

Public Cord Blood Tissue Bank

The bill repeals s. 381.06015, F.S., enacted in 2000, which establishes a statewide consortium known as the Public Cord Blood Tissue Bank (consortium). The consortium was intended to be a nonprofit legal entity to collect and screen for infectious and genetic disease, perform tissue typing, cryopreserve and store umbilical cord blood as a resource to the public. Pursuant to s.381.06015 (1), F.S., The University of Florida, University of South Florida, University of Miami and the Mayo Clinic Jacksonville were to make up the consortium. The consortium was never created.

B. SECTION DIRECTORY:

**Section 1**: Repeals s. 381.00325, F.S., related to the Hepatitis A Awareness Program.

**Section 2**: Repeals s. 381.06015, F.S., related to the Public Cord Blood Tissue Bank.

**Section 3**: Provides an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

BILL ORIGINAL YEAR

1 A bill to be entitled
2 An act relating to repealing s. 381.00325, F.S., relating
3 to Hepatitis A awareness program; repealing s. 381.06015,
4 F.S., relating to Public Cord Blood Tissue Bank; providing
5 an effective date.
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. <u>Section 381.00325, Florida Statutes, is</u>
10 <u>repealed.</u>
11 Section 2. <u>Section 381.06015, Florida Statutes, is</u>
12 <u>repealed.</u>
13 Section 3. This act shall take effect July 1, 2011.


CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

V