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1 A bill to be entitled
2 An act relating to health care facilities; amending s.
3 83.42, F.S., relating to exclusions from part II of
4 ch. 83, F.S., the Florida Residential Landlord and
5 Tenant Act; clarifying that the procedures in s.
6 400.0255, F.S., for transfers and discharges are
7 exclusive to residents of a nursing home licensed
8 under part II of ch. 400, F.S.; amending s. 112.0455,
9 F.S., relating to the Drug-Free Workplace Act;
10 deleting a provision regarding retroactivity of the
11 act; deleting a provision that the act does not
12 abrogate the right of an employer under state law to
13 conduct drug test before a specified date; deleting a
14 provision that requires a laboratory to submit to the
15 Agency for Health Care Administration a monthly report
16 containing statistical information regarding the
17 testing of employees and job applicants; amending s.
18 381.21, F.S.; providing that a portion of the
19 additional fines assessed for traffic violations
20 within an enhanced penalty zone be remitted to the
21 Department of Revenue and deposited into the Brain and
22 Spinal Cord Injury Trust Fund of the Department of
23 Health to serve certain Medicaid recipients; repealing
24 s. 383.325, F.S., relating to confidentiality of
25 inspection reports of licensed birth center
26 facilities; creating s. 385.2031, F.S.; designating
27 the Florida Hospital/Sandford-Burnham Translational
28 Research Institute for Metabolism and Diabetes as a

29 resource for research in the prevention and treatment
30 of diabetes; amending s. 394.4787, F.S.; conforming a
31 cross-reference; amending s. 395.002, F.S.; revising
32 and deleting definitions applicable to the regulation
33 of hospitals and other licensed facilities; conforming
34 a cross-reference; amending s. 395.003, F.S.; deleting
35 an obsolete provision; conforming a cross-reference;
36 providing for certain specialty-licensed children's
37 hospitals to provide specified obstetrical services;
38 amending s. 395.0161, F.S.; deleting a requirement
39 that facilities licensed under part I of ch. 395,
40 F.S., pay licensing fees at the time of inspection;
41 amending s. 395.0193, F.S.; requiring a licensed
42 facility to report certain peer review information and
43 final disciplinary actions to the Division of Medical
44 Quality Assurance of the Department of Health rather
45 than the Division of Health Quality Assurance of the
46 Agency for Health Care Administration; amending s.
47 395.1023, F.S.; providing for the Department of
48 Children and Family Services rather than the
49 Department of Health to perform certain functions with
50 respect to child protection cases; requiring certain
51 hospitals to notify the Department of Children and
52 Family Services of compliance; amending s. 395.1041,
53 F.S., relating to hospital emergency services and
54 care; deleting obsolete provisions; repealing s.
55 395.1046, F.S., relating to complaint investigation
56 procedures; amending s. 395.1055, F.S.; requiring that

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57 licensed facility beds conform to standards specified
58 by the Agency for Health Care Administration, the
59 Florida Building Code, and the Florida Fire Prevention
60 Code; amending s. 395.3025, F.S.; authorizing the
61 disclosure of patient records to the Department of
62 Health rather than the Agency for Health Care
63 Administration in accordance with an issued subpoena;
64 requiring the department, rather than the agency, to
65 make available, upon written request by a practitioner
66 against whom probable cause has been found, any
67 patient records that form the basis of the
68 determination of probable cause; amending s. 395.3036,
69 F.S.; correcting a cross-reference; repealing s.
70 395.3037, F.S., relating to redundant definitions for
71 the Department of Health and the Agency for Health
72 Care Administration; amending s. 395.602, F.S.;
73 revising the definition of the term "rural hospital"
74 to delete an obsolete provision; amending s. 400.021,
75 F.S.; revising the definitions of the terms "geriatric
76 outpatient clinic" and "resident care plan"; amending
77 s. 400.0234, F.S., relating to medical records;
78 conforming provisions to changes made by the act;
79 amending s. 400.0255, F.S.; correcting an obsolete
80 cross-reference to administrative rules; amending s.
81 400.063, F.S.; deleting an obsolete provision
82 governing moneys received for the care of residents in
83 a nursing home facility; amending ss. 400.071 and
84 400.0712, F.S.; revising applicability of general

85 licensure requirements under part II of ch. 408, F.S.,
86 to applications for nursing home licensure; revising
87 provisions governing inactive licenses; amending s.
88 400.111, F.S.; providing for disclosure of the
89 controlling interest of a nursing home facility upon
90 request by the Agency for Health Care Administration;
91 amending s. 400.1183, F.S.; revising grievance record
92 maintenance and reporting requirements for nursing
93 homes; amending s. 400.141, F.S.; providing criteria
94 for the provision of respite services by nursing
95 homes; requiring a written plan of care; requiring a
96 contract for services; requiring that the release of a
97 resident to caregivers be designated in writing;
98 providing an exemption to the application of rules for
99 discharge planning; providing for residents' rights;
100 providing for the use of personal medications;
101 providing for terms of respite stay; providing for
102 communication of patient information; requiring a
103 physician's order for care and proof of a physical
104 examination; providing for services for respite
105 patients and duties of facilities with respect to such
106 patients; conforming a cross-reference; requiring
107 facilities to maintain clinical records that meet
108 specified standards; providing a fine for failing to
109 comply with an admissions moratorium; deleting a
110 requirement for facilities to submit certain
111 information related to management companies to the
112 agency; deleting a requirement for facilities to

113 | notify the agency of certain bankruptcy filings, to
114 | conform to changes made by the act; authorizing a
115 | facility to charge a fee to copy a resident's records;
116 | amending s. 400.142, F.S., relating to orders not to
117 | resuscitate; deleting provisions relating to agency
118 | adoption of rules; repealing s. 400.145, F.S.,
119 | relating to requirements for furnishing the records of
120 | residents in a licensed nursing home to certain
121 | specified parties; amending s. 400.147, F.S.; revising
122 | reporting requirements for licensed nursing home
123 | facilities relating to adverse incidents; amending s.
124 | 400.19, F.S.; revising inspection requirements for
125 | nursing homes; amending s. 400.23, F.S.; deleting an
126 | obsolete provision; correcting a reference; deleting a
127 | requirement that the rules for minimum standards of
128 | care for persons under 21 years of age include a
129 | certain methodology; directing the agency to adopt
130 | rules for minimum staffing standards in nursing homes
131 | that serve persons under 21 years of age; providing
132 | minimum staffing standards; amending s. 400.275, F.S.;
133 | revising agency duties with regard to training nursing
134 | home surveyor teams; revising requirements for team
135 | members; amending s. 400.462, F.S.; redefining the
136 | term "remuneration" for purposes of the Home Health
137 | Services Act; amending s. 400.484, F.S.; revising the
138 | classification of violations by a home health agency
139 | for which the agency imposes an administrative fine;
140 | amending s. 400.506, F.S.; authorizing an

141 administrator to manage up to five nurse registries
142 under certain circumstances; requiring an
143 administrator to designate, in writing, for each
144 licensed entity, a qualified alternate administrator
145 to serve during the administrator's absence; amending
146 s. 400.509, F.S.; providing that organizations that
147 provide companion services only to persons with
148 developmental disabilities, under contract with the
149 Agency for Persons with Disabilities, are exempt from
150 registration with the Agency for Health Care
151 Administration; reenacting ss. 400.464(5)(b) and
152 400.506(6)(a), F.S., relating to home health agencies
153 and licensure of nurse registries, respectively, to
154 incorporate the amendment made to s. 400.509, F.S., in
155 references thereto; amending s. 400.601, F.S.;

156 revising the definition of the term "hospice" to
157 include limited liability companies; amending s.
158 400.606, F.S.; revising the content requirements of
159 the plan accompanying an initial or change-of-
160 ownership application for licensure of a hospice;
161 revising requirements relating to certificates of need
162 for certain hospice facilities; amending s. 400.915,
163 F.S.; correcting an obsolete cross-reference to
164 administrative rules; amending s. 400.931, F.S.;

165 requiring each applicant for initial licensure, change
166 of ownership, or license renewal to operate a licensed
167 home medical equipment provider at a location outside
168 the state to submit documentation of accreditation, or

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169 an application for accreditation, from an accrediting
170 organization that is recognized by the Agency for
171 Health Care Administration; requiring an applicant
172 that has applied for accreditation to provide proof of
173 accreditation within a specified time; deleting a
174 requirement that an applicant for a home medical
175 equipment provider license submit a surety bond to the
176 agency; amending s. 400.967, F.S.; revising the
177 classification of violations by intermediate care
178 facilities for the developmentally disabled; providing
179 a penalty for certain violations; amending s.
180 400.9905, F.S.; revising the definitions of the terms
181 "clinic" and "portable equipment provider"; revising
182 requirements for an application for exemption from
183 health care clinic licensure requirements for certain
184 entities; providing for the agency to deny or revoke
185 the exemption under certain circumstances; including
186 health services provided to multiple locations within
187 the definition of the term "portable health service or
188 equipment provider"; amending s. 400.991, F.S.;
189 conforming terminology; revising application
190 requirements relating to documentation of financial
191 ability to operate a mobile clinic; amending s.
192 408.033, F.S.; providing that fees assessed on
193 selected health care facilities and organizations may
194 be collected prospectively at the time of licensure
195 renewal and prorated for the licensing period;
196 amending s. 408.034, F.S.; revising agency authority

197 relating to licensing of intermediate care facilities
 198 for the developmentally disabled; amending s. 408.036,
 199 F.S.; deleting an exemption from certain certificate-
 200 of-need review requirements for a hospice or a hospice
 201 inpatient facility; amending s. 408.037, F.S.;
 202 revising requirements for the financial information to
 203 be included in an application for a certificate of
 204 need; amending s. 408.043, F.S.; revising requirements
 205 for certain freestanding inpatient hospice care
 206 facilities to obtain a certificate of need; amending
 207 s. 408.061, F.S.; revising data reporting requirements
 208 for health care facilities; amending s. 408.07, F.S.;
 209 deleting a cross-reference; amending s. 408.10, F.S.;
 210 removing agency authority to investigate certain
 211 consumer complaints; amending s. 408.7056, F.S.;
 212 providing that, as of a specified date, the Subscriber
 213 Assistance Program applies only to plans that meet
 214 federal requirements for the preservation of the right
 215 to maintain existing health plan coverage; amending s.
 216 408.802, F.S.; removing applicability of part II of
 217 ch. 408, F.S., relating to general licensure
 218 requirements, to private review agents; amending s.
 219 408.804, F.S.; providing penalties for altering,
 220 defacing, or falsifying a license certificate issued
 221 by the agency or displaying such an altered, defaced,
 222 or falsified certificate; amending s. 408.806, F.S.;
 223 revising agency responsibilities for notification of
 224 licensees of impending expiration of a license;

225 requiring payment of a late fee for a license
 226 application to be considered complete under certain
 227 circumstances; amending s. 408.8065, F.S.; revising
 228 the requirements for becoming licensed as a home
 229 health agency, home medical equipment provider, or
 230 health care clinic; amending s. 408.809, F.S.;
 231 revising provisions to include a schedule for
 232 background rescreenings of certain employees; amending
 233 s. 408.810, F.S.; requiring that the controlling
 234 interest of a health care licensee notify the agency
 235 of certain court proceedings; providing a penalty;
 236 amending s. 408.813, F.S.; authorizing the agency to
 237 impose fines for unclassified violations of part II of
 238 ch. 408, F.S.; amending s. 409.91195, F.S.; revising
 239 the composition of the Medicaid Pharmaceutical and
 240 Therapeutics Committee; revising provisions relating
 241 to public testimony; providing for committee members
 242 to be notified in writing if the agency reverses their
 243 recommendation regarding preferred drugs; amending s.
 244 409.912, F.S.; revising provisions requiring the
 245 agency to post certain information relating to drugs
 246 subject to prior authorization on its Internet
 247 website; providing a definition of the term "step
 248 edit"; amending ss. 409.97 and 409.975, F.S.;
 249 conforming cross-references; providing that,
 250 notwithstanding s. 409.975, F.S., any hospital, as
 251 determined by the agency, may be considered an
 252 essential provider for purposes of implementing a

253 Medicaid managed care network; amending s. 429.11,
254 F.S.; revising licensure application requirements for
255 assisted living facilities to eliminate provisional
256 licenses; amending s. 429.294, F.S.; deleting a cross-
257 reference; amending s. 429.71, F.S.; revising the
258 classification of violations by adult family-care
259 homes; amending s. 429.195, F.S.; providing exceptions
260 to applicability of assisted living facility rebate
261 restrictions; amending s. 429.915, F.S.; revising
262 agency responsibilities regarding the issuance of
263 conditional licenses; amending ss. 430.80 and 430.81,
264 F.S.; conforming cross-references; repealing s.
265 440.102(9)(d), F.S., relating to a laboratory's
266 requirement to submit to the Agency for Health Care
267 Administration a monthly report containing statistical
268 information regarding the testing of employees and job
269 applicants; amending s. 483.035, F.S.; providing for a
270 clinical laboratory to be operated by certain nurses;
271 amending s. 483.051, F.S.; requiring the Agency for
272 Health Care Administration to provide for biennial
273 licensure of all nonwaived laboratories that meet
274 certain requirements; requiring the agency to
275 prescribe qualifications for such licensure; defining
276 nonwaived laboratories as laboratories that do not
277 have a certificate of waiver from the Centers for
278 Medicare and Medicaid Services; deleting requirements
279 for the registration of an alternate site testing
280 location when the clinical laboratory applies to renew

281 its license; amending s. 483.245, F.S.; prohibiting a
 282 clinical laboratory from placing a specimen collector
 283 or other personnel in any physician's office, unless
 284 the clinical lab and the physician's office are owned
 285 and operated by the same entity; providing for damages
 286 and injunctive relief; amending s. 483.294, F.S.;
 287 revising the frequency of agency inspections of
 288 multiphasic health testing centers; creating s.
 289 641.3120, F.S.; requiring the Office of Insurance
 290 Regulation to adopt rules to implement the National
 291 Association of Insurance Commissioners' Uniform Health
 292 Carrier External Review Model Act by a specified date;
 293 providing applicability; amending s. 627.602, F.S.;
 294 providing applicability of internal grievance
 295 procedures by a specified date; creating s. 627.6513,
 296 F.S.; providing applicability of internal grievance
 297 procedures by a specified date; amending s. 651.118,
 298 F.S.; conforming a cross-reference; amending s.
 299 817.505, F.S.; providing an exception to provisions
 300 prohibiting patient brokering; providing a directive
 301 to the Division of Statutory Revision; providing
 302 effective dates.

303
 304 Be It Enacted by the Legislature of the State of Florida:

305
 306 Section 1. Subsection (1) of section 83.42, Florida
 307 Statutes, is amended to read:

308 83.42 Exclusions from application of part.—This part does

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309 not apply to:

310 (1) Residency or detention in a facility, whether public
311 or private, when residence or detention is incidental to the
312 provision of medical, geriatric, educational, counseling,
313 religious, or similar services. For residents of a facility
314 licensed under part II of chapter 400, the provisions of s.
315 400.0255 are the exclusive procedures for all transfers and
316 discharges.

317 Section 2. Present paragraphs (f) through (k) of
318 subsection (10) of section 112.0455, Florida Statutes, are
319 redesignated as paragraphs (e) through (j), respectively, and
320 present paragraph (e) of subsection (10), subsection (12), and
321 paragraph (e) of subsection (14) of that section are amended to
322 read:

323 112.0455 Drug-Free Workplace Act.—

324 (10) EMPLOYER PROTECTION.—

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

330 (12) DRUG-TESTING STANDARDS; LABORATORIES.—

331 (a) The requirements of part II of chapter 408 apply to
332 the provision of services that require licensure pursuant to
333 this section and part II of chapter 408 and to entities licensed
334 by or applying for such licensure from the Agency for Health
335 Care Administration pursuant to this section. A license issued
336 by the agency is required in order to operate a laboratory.

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337 (b) A laboratory may analyze initial or confirmation drug
338 specimens only if:

339 1. The laboratory is licensed and approved by the Agency
340 for Health Care Administration using criteria established by the
341 United States Department of Health and Human Services as general
342 guidelines for modeling the state drug testing program and in
343 accordance with part II of chapter 408. Each applicant for
344 licensure and licensee must comply with all requirements of part
345 II of chapter 408.

346 2. The laboratory has written procedures to ensure chain
347 of custody.

348 3. The laboratory follows proper quality control
349 procedures, including, but not limited to:

350 a. The use of internal quality controls including the use
351 of samples of known concentrations which are used to check the
352 performance and calibration of testing equipment, and periodic
353 use of blind samples for overall accuracy.

354 b. An internal review and certification process for drug
355 test results, conducted by a person qualified to perform that
356 function in the testing laboratory.

357 c. Security measures implemented by the testing laboratory
358 to preclude adulteration of specimens and drug test results.

359 d. Other necessary and proper actions taken to ensure
360 reliable and accurate drug test results.

361 (c) A laboratory shall disclose to the employer a written
362 test result report within 7 working days after receipt of the
363 sample. All laboratory reports of a drug test result shall, at a
364 minimum, state:

365 1. The name and address of the laboratory which performed
 366 the test and the positive identification of the person tested.

367 2. Positive results on confirmation tests only, or
 368 negative results, as applicable.

369 3. A list of the drugs for which the drug analyses were
 370 conducted.

371 4. The type of tests conducted for both initial and
 372 confirmation tests and the minimum cutoff levels of the tests.

373 5. Any correlation between medication reported by the
 374 employee or job applicant pursuant to subparagraph (8)(b)2. and
 375 a positive confirmed drug test result.

376

377 A ~~No~~ report may not shall disclose the presence or absence of
 378 any drug other than a specific drug and its metabolites listed
 379 pursuant to this section.

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

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

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393 taken by the employee or job applicant.

394 (14) DISCIPLINE REMEDIES.—

395 (e) Upon resolving an appeal filed pursuant to paragraph
396 (c), and finding a violation of this section, the commission may
397 order the following relief:

398 1. Rescind the disciplinary action, expunge related
399 records from the personnel file of the employee or job applicant
400 and reinstate the employee.

401 2. Order compliance with paragraph (10) (f) ~~(10) (g)~~.

402 3. Award back pay and benefits.

403 4. Award the prevailing employee or job applicant the
404 necessary costs of the appeal, reasonable attorney's fees, and
405 expert witness fees.

406 Section 3. Subsection (15) of section 318.21, Florida
407 Statutes, is amended to read:

408 318.21 Disposition of civil penalties by county courts.—

409 All civil penalties received by a county court pursuant to the
410 provisions of this chapter shall be distributed and paid monthly
411 as follows:

412 (15) Of the additional fine assessed under s. 318.18(3) (e)
413 for a violation of s. 316.1893, 50 percent of the moneys
414 received from the fines shall be remitted to the Department of
415 Revenue and deposited into the Brain and Spinal Cord Injury
416 Trust Fund of Department of Health and appropriated to the
417 Department of Health Agency for Health Care Administration as
418 general revenue to ~~provide an enhanced Medicaid payment to~~
419 ~~nursing homes that~~ serve Medicaid recipients who have ~~with~~ brain
420 and spinal cord injuries that are medically complex and who are

421 technologically and respiratory dependent. The remaining 50
 422 percent of the moneys received from the enhanced fine imposed
 423 under s. 318.18(3) (e) shall be remitted to the Department of
 424 Revenue and deposited into the Department of Health Emergency
 425 Medical Services Trust Fund to provide financial support to
 426 certified trauma centers in the counties where enhanced penalty
 427 zones are established to ensure the availability and
 428 accessibility of trauma services. Funds deposited into the
 429 Emergency Medical Services Trust Fund under this subsection
 430 shall be allocated as follows:

431 (a) Fifty percent shall be allocated equally among all
 432 Level I, Level II, and pediatric trauma centers in recognition
 433 of readiness costs for maintaining trauma services.

434 (b) Fifty percent shall be allocated among Level I, Level
 435 II, and pediatric trauma centers based on each center's relative
 436 volume of trauma cases as reported in the Department of Health
 437 Trauma Registry.

438 Section 4. Section 383.325, Florida Statutes, is repealed.

439 Section 5. Section 385.2031, Florida Statutes, is created
 440 to read:

441 385.2031 Resource for research in the prevention and
 442 treatment of diabetes.—The Florida Hospital/Sanford-Burnham
 443 Translational Research Institute for Metabolism and Diabetes is
 444 designated as a resource in this state for research in the
 445 prevention and treatment of diabetes.

446 Section 6. Subsection (7) of section 394.4787, Florida
 447 Statutes, is amended to read:

448 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788,

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449 and 394.4789.—As used in this section and ss. 394.4786,
 450 394.4788, and 394.4789:

451 (7) "Specialty psychiatric hospital" means a hospital
 452 licensed by the agency pursuant to s. 395.002(26) ~~s. 395.002(28)~~
 453 and part II of chapter 408 as a specialty psychiatric hospital.

454 Section 7. Present subsections (15) through (33) of
 455 section 395.002, Florida Statutes, are redesignated as
 456 subsections (14) through (29), respectively, and present
 457 subsections (1), (14), (24), (28), (30), and (31) of that
 458 section are amended, to read:

459 395.002 Definitions.—As used in this chapter:

460 (1) "Accrediting organizations" means the Joint Commission
 461 on Accreditation of Healthcare Organizations, the American
 462 Osteopathic Association, the Commission on Accreditation of
 463 Rehabilitation Facilities, ~~and~~ the Accreditation Association for
 464 Ambulatory Health Care, Inc, and Det Norske Veritas.

465 ~~(14) "Initial denial determination" means a determination~~
 466 ~~by a private review agent that the health care services~~
 467 ~~furnished or proposed to be furnished to a patient are~~
 468 ~~inappropriate, not medically necessary, or not reasonable.~~

469 ~~(24) "Private review agent" means any person or entity~~
 470 ~~which performs utilization review services for third-party~~
 471 ~~payors on a contractual basis for outpatient or inpatient~~
 472 ~~services. However, the term shall not include full-time~~
 473 ~~employees, personnel, or staff of health insurers, health~~
 474 ~~maintenance organizations, or hospitals, or wholly owned~~
 475 ~~subsidiaries thereof or affiliates under common ownership, when~~
 476 ~~performing utilization review for their respective hospitals,~~

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477 ~~health maintenance organizations, or insureds of the same~~
 478 ~~insurance group. For this purpose, health insurers, health~~
 479 ~~maintenance organizations, and hospitals, or wholly owned~~
 480 ~~subsidiaries thereof or affiliates under common ownership,~~
 481 ~~include such entities engaged as administrators of self-~~
 482 ~~insurance as defined in s. 624.031.~~

483 ~~(26)~~(28) "Specialty hospital" means any facility which
 484 meets the provisions of subsection (12), and which regularly
 485 makes available either:

486 (a) The range of medical services offered by general
 487 hospitals, but restricted to a defined age or gender group of
 488 the population, or both;

489 (b) A restricted range of services appropriate to the
 490 diagnosis, care, and treatment of patients with specific
 491 categories of medical or psychiatric illnesses or disorders; or

492 (c) Intensive residential treatment programs for children
 493 and adolescents as defined in subsection (14) ~~(15)~~.

494 ~~(30) "Urgent care center" means a facility or clinic that~~
 495 ~~provides immediate but not emergent ambulatory medical care to~~
 496 ~~patients with or without an appointment. It does not include the~~
 497 ~~emergency department of a hospital.~~

498 ~~(31) "Utilization review" means a system for reviewing the~~
 499 ~~medical necessity or appropriateness in the allocation of health~~
 500 ~~care resources of hospital services given or proposed to be~~
 501 ~~given to a patient or group of patients.~~

502 Section 8. Paragraph (c) of subsection (1), paragraph (b)
 503 of subsection (2), and subsection (6) of section 395.003,
 504 Florida Statutes, are amended to read:

505 395.003 Licensure; denial, suspension, and revocation.—

506 (1)

507 ~~(c) Until July 1, 2006, additional emergency departments~~
 508 ~~located off the premises of licensed hospitals may not be~~
 509 ~~authorized by the agency.~~

510 (2)

511 (b) The agency shall, at the request of a licensee that is
 512 a teaching hospital as defined in s. 408.07(45), issue a single
 513 license to a licensee for facilities that have been previously
 514 licensed as separate premises, provided such separately licensed
 515 facilities, taken together, constitute the same premises as
 516 defined in s. 395.002(22) ~~s. 395.002(23)~~. Such license for the
 517 single premises shall include all of the beds, services, and
 518 programs that were previously included on the licenses for the
 519 separate premises. The granting of a single license under this
 520 paragraph shall not in any manner reduce the number of beds,
 521 services, or programs operated by the licensee.

522 (6) A specialty hospital may not provide any service or
 523 regularly serve any population group beyond those services or
 524 groups specified in its license. A specialty-licensed children's
 525 hospital that is authorized to provide pediatric cardiac
 526 catheterization and pediatric open-heart surgery services may
 527 provide cardiovascular service to adults who, as children, were
 528 previously served by the hospital for congenital heart disease,
 529 or to those patients who are referred for a specialized
 530 procedure only for congenital heart disease by an adult
 531 hospital, without obtaining additional licensure as a provider
 532 of adult cardiovascular services. The agency may request

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533 documentation as needed to support patient selection and
534 treatment. This subsection does not apply to a specialty-
535 licensed children's hospital that is already licensed to provide
536 adult cardiovascular services. A specialty-licensed children's
537 hospital with at least 50 total licensed neonatal intensive care
538 unit beds may provide obstetrical services, including labor and
539 delivery services, restricted to the diagnosis, care, and
540 treatment of pregnant women of any age who have at least one
541 maternal or fetal characteristic or condition which would
542 characterize the pregnancy or delivery as high risk or pregnant
543 women of any age who have received medical advice or a diagnosis
544 indicating that the fetus will require at least one perinatal
545 intervention.

546 Section 9. Subsection (3) of section 395.0161, Florida
547 Statutes, is amended to read:

548 395.0161 Licensure inspection.—

549 (3) In accordance with s. 408.805, an applicant or
550 licensee shall pay a fee for each license application submitted
551 under this part, part II of chapter 408, and applicable rules.
552 With the exception of state-operated licensed facilities, each
553 facility licensed under this part shall pay to the agency, ~~at~~
554 ~~the time of inspection,~~ the following fees:

555 (a) Inspection for licensure.—A fee shall be paid which is
556 not less than \$8 per hospital bed, nor more than \$12 per
557 hospital bed, except that the minimum fee shall be \$400 per
558 facility.

559 (b) Inspection for lifesafety only.—A fee shall be paid
560 which is not less than 75 cents per hospital bed, nor more than

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561 \$1.50 per hospital bed, except that the minimum fee shall be \$40
562 per facility.

563 Section 10. Subsections (2) and (4) of section 395.0193,
564 Florida Statutes, are amended to read:

565 395.0193 Licensed facilities; peer review; disciplinary
566 powers; agency or partnership with physicians.—

567 (2) Each licensed facility, as a condition of licensure,
568 shall provide for peer review of physicians who deliver health
569 care services at the facility. Each licensed facility shall
570 develop written, binding procedures by which such peer review
571 shall be conducted. Such procedures must ~~shall~~ include:

572 (a) Mechanism for choosing the membership of the body or
573 bodies that conduct peer review.

574 (b) Adoption of rules of order for the peer review
575 process.

576 (c) Fair review of the case with the physician involved.

577 (d) Mechanism to identify and avoid conflict of interest
578 on the part of the peer review panel members.

579 (e) Recording of agendas and minutes which do not contain
580 confidential material, for review by the Division of Medical
581 Quality Assurance of the department ~~Health Quality Assurance of~~
582 ~~the agency~~.

583 (f) Review, at least annually, of the peer review
584 procedures by the governing board of the licensed facility.

585 (g) Focus of the peer review process on review of
586 professional practices at the facility to reduce morbidity and
587 mortality and to improve patient care.

588 (4) Pursuant to ss. 458.337 and 459.016, any disciplinary

589 actions taken under subsection (3) shall be reported in writing
 590 to the Division of Medical Quality Assurance of the department
 591 ~~Health Quality Assurance of the agency~~ within 30 working days
 592 after its initial occurrence, regardless of the pendency of
 593 appeals to the governing board of the hospital. The notification
 594 shall identify the disciplined practitioner, the action taken,
 595 and the reason for such action. All final disciplinary actions
 596 taken under subsection (3), if different from those which were
 597 reported to the department agency within 30 days after the
 598 initial occurrence, shall be reported within 10 working days to
 599 the Division of Medical Quality Assurance of the department
 600 ~~Health Quality Assurance of the agency~~ in writing and shall
 601 specify the disciplinary action taken and the specific grounds
 602 therefor. The division shall review each report and determine
 603 whether it potentially involved conduct by the licensee that is
 604 subject to disciplinary action, in which case s. 456.073 shall
 605 apply. The reports are not subject to inspection under s.
 606 119.07(1) even if the division's investigation results in a
 607 finding of probable cause.

608 Section 11. Section 395.1023, Florida Statutes, is amended
 609 to read:

610 395.1023 Child abuse and neglect cases; duties.—Each
 611 licensed facility shall adopt a protocol that, at a minimum,
 612 requires the facility to:

613 (1) Incorporate a facility policy that every staff member
 614 has an affirmative duty to report, pursuant to chapter 39, any
 615 actual or suspected case of child abuse, abandonment, or
 616 neglect; and

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617 (2) In any case involving suspected child abuse,
618 abandonment, or neglect, designate, at the request of the
619 Department of Children and Family Services, a staff physician to
620 act as a liaison between the hospital and the Department of
621 Children and Family Services office which is investigating the
622 suspected abuse, abandonment, or neglect, and the child
623 protection team, as defined in s. 39.01, when the case is
624 referred to such a team.

625
626 Each general hospital and appropriate specialty hospital shall
627 comply with the provisions of this section and shall notify the
628 agency and the Department of Children and Family Services of its
629 compliance by sending a copy of its policy to the agency and the
630 Department of Children and Family Services as required by rule.
631 The failure by a general hospital or appropriate specialty
632 hospital to comply shall be punished by a fine not exceeding
633 \$1,000, to be fixed, imposed, and collected by the agency. Each
634 day in violation is considered a separate offense.

635 Section 12. Subsection (2) and paragraph (d) of subsection
636 (3) of section 395.1041, Florida Statutes, are amended to read:

637 395.1041 Access to emergency services and care.—

638 (2) INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The agency
639 shall establish and maintain an inventory of hospitals with
640 emergency services. The inventory shall list all services within
641 the service capability of the hospital, and such services shall
642 appear on the face of the hospital license. Each hospital having
643 emergency services shall notify the agency of its service
644 capability in the manner and form prescribed by the agency. The

645 agency shall use the inventory to assist emergency medical
 646 services providers and others in locating appropriate emergency
 647 medical care. The inventory shall also be made available to the
 648 general public. ~~On or before August 1, 1992, the agency shall~~
 649 ~~request that each hospital identify the services which are~~
 650 ~~within its service capability. On or before November 1, 1992,~~
 651 ~~the agency shall notify each hospital of the service capability~~
 652 ~~to be included in the inventory. The hospital has 15 days from~~
 653 ~~the date of receipt to respond to the notice. By December 1,~~
 654 ~~1992, the agency shall publish a final inventory.~~ Each hospital
 655 shall reaffirm its service capability when its license is
 656 renewed and shall notify the agency of the addition of a new
 657 service or the termination of a service prior to a change in its
 658 service capability.

659 (3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF
 660 FACILITY OR HEALTH CARE PERSONNEL.—

661 (d)1. Every hospital shall ensure the provision of
 662 services within the service capability of the hospital, at all
 663 times, either directly or indirectly through an arrangement with
 664 another hospital, through an arrangement with one or more
 665 physicians, or as otherwise made through prior arrangements. A
 666 hospital may enter into an agreement with another hospital for
 667 purposes of meeting its service capability requirement, and
 668 appropriate compensation or other reasonable conditions may be
 669 negotiated for these backup services.

670 2. If any arrangement requires the provision of emergency
 671 medical transportation, such arrangement must be made in
 672 consultation with the applicable provider and may not require

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673 the emergency medical service provider to provide transportation
 674 that is outside the routine service area of that provider or in
 675 a manner that impairs the ability of the emergency medical
 676 service provider to timely respond to prehospital emergency
 677 calls.

678 3. A hospital is ~~shall~~ not ~~be~~ required to ensure service
 679 capability at all times as required in subparagraph 1. if, prior
 680 to the receiving of any patient needing such service capability,
 681 such hospital has demonstrated to the agency that it lacks the
 682 ability to ensure such capability and it has exhausted all
 683 reasonable efforts to ensure such capability through backup
 684 arrangements. In reviewing a hospital's demonstration of lack of
 685 ability to ensure service capability, the agency shall consider
 686 factors relevant to the particular case, including the
 687 following:

- 688 a. Number and proximity of hospitals with the same service
 689 capability.
- 690 b. Number, type, credentials, and privileges of
 691 specialists.
- 692 c. Frequency of procedures.
- 693 d. Size of hospital.

694 4. The agency shall publish ~~proposed~~ rules implementing a
 695 reasonable exemption procedure ~~by November 1, 1992. Subparagraph~~
 696 ~~1. shall become effective upon the effective date of said rules~~
 697 ~~or January 31, 1993, whichever is earlier. For a period not to~~
 698 ~~exceed 1 year from the effective date of subparagraph 1., a~~
 699 ~~hospital requesting an exemption shall be deemed to be exempt~~
 700 ~~from offering the service until the agency initially acts to~~

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701 ~~deny or grant the original request.~~ The agency has 45 days after
 702 ~~from~~ the date of receipt of the request to approve or deny the
 703 request. ~~After the first year from the effective date of~~
 704 ~~subparagraph 1.7~~, If the agency fails to initially act within
 705 that ~~the~~ time period, the hospital is deemed to be exempt from
 706 offering the service until the agency initially acts to deny the
 707 request.

708 Section 13. Section 395.1046, Florida Statutes, is
 709 repealed.

710 Section 14. Paragraph (e) of subsection (1) of section
 711 395.1055, Florida Statutes, is amended to read:

712 395.1055 Rules and enforcement.—

713 (1) The agency shall adopt rules pursuant to ss.
 714 120.536(1) and 120.54 to implement the provisions of this part,
 715 which shall include reasonable and fair minimum standards for
 716 ensuring that:

717 (e) Licensed facility beds conform to minimum space,
 718 equipment, and furnishings standards as specified by the agency,
 719 the Florida Building Code, and the Florida Fire Prevention Code
 720 department.

721 Section 15. Paragraph (e) of subsection (4) of section
 722 395.3025, Florida Statutes, is amended to read:

723 395.3025 Patient and personnel records; copies;
 724 examination.—

725 (4) Patient records are confidential and must not be
 726 disclosed without the consent of the patient or his or her legal
 727 representative, but appropriate disclosure may be made without
 728 such consent to:

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729 (e) The department ~~agency~~ upon subpoena issued pursuant to
730 s. 456.071., ~~but~~ The records obtained thereby must be used
731 solely for the purpose of the agency, the department, and the
732 appropriate professional board in an ~~its~~ investigation,
733 prosecution, and appeal of disciplinary proceedings. If the
734 department ~~agency~~ requests copies of the records, the facility
735 shall charge a fee pursuant to this section ~~no more than its~~
736 ~~actual copying costs, including reasonable staff time~~. The
737 records must be sealed and must not be available to the public
738 pursuant to s. 119.07(1) or any other statute providing access
739 to records, nor may they be available to the public as part of
740 the record of investigation for and prosecution in disciplinary
741 proceedings made available to the public by the agency, the
742 department, or the appropriate regulatory board. However, the
743 department ~~agency~~ must make available, upon written request by a
744 practitioner against whom probable cause has been found, any
745 such records that form the basis of the determination of
746 probable cause.

747 Section 16. Subsection (2) of section 395.3036, Florida
748 Statutes, is amended to read:

749 395.3036 Confidentiality of records and meetings of
750 corporations that lease public hospitals or other public health
751 care facilities.—The records of a private corporation that
752 leases a public hospital or other public health care facility
753 are confidential and exempt from the provisions of s. 119.07(1)
754 and s. 24(a), Art. I of the State Constitution, and the meetings
755 of the governing board of a private corporation are exempt from
756 s. 286.011 and s. 24(b), Art. I of the State Constitution when

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757 the public lessor complies with the public finance
 758 accountability provisions of s. 155.40(5) with respect to the
 759 transfer of any public funds to the private lessee and when the
 760 private lessee meets at least three of the five following
 761 criteria:

762 (2) The public lessor and the private lessee do not
 763 commingle any of their funds in any account maintained by either
 764 of them, other than the payment of the rent and administrative
 765 fees or the transfer of funds pursuant to s. 155.40 ~~subsection~~
 766 ~~(2)~~.

767 Section 17. Section 395.3037, Florida Statutes, is
 768 repealed.

769 Section 18. Paragraph (e) of subsection (2) of section
 770 395.602, Florida Statutes, is amended to read:

771 395.602 Rural hospitals.—

772 (2) DEFINITIONS.—As used in this part:

773 (e) "Rural hospital" means an acute care hospital licensed
 774 under this chapter, having 100 or fewer licensed beds and an
 775 emergency room, which is:

776 1. The sole provider within a county with a population
 777 density of no greater than 100 persons per square mile;

778 2. An acute care hospital, in a county with a population
 779 density of no greater than 100 persons per square mile, which is
 780 at least 30 minutes of travel time, on normally traveled roads
 781 under normal traffic conditions, from any other acute care
 782 hospital within the same county;

783 3. A hospital supported by a tax district or subdistrict
 784 whose boundaries encompass a population of 100 persons or fewer

785 per square mile;

786 ~~4. A hospital in a constitutional charter county with a~~
 787 ~~population of over 1 million persons that has imposed a local~~
 788 ~~option health service tax pursuant to law and in an area that~~
 789 ~~was directly impacted by a catastrophic event on August 24,~~
 790 ~~1992, for which the Governor of Florida declared a state of~~
 791 ~~emergency pursuant to chapter 125, and has 120 beds or less that~~
 792 ~~serves an agricultural community with an emergency room~~
 793 ~~utilization of no less than 20,000 visits and a Medicaid~~
 794 ~~inpatient utilization rate greater than 15 percent;~~

795 4.5. A hospital with a service area that has a population
 796 of 100 persons or fewer per square mile. As used in this
 797 subparagraph, the term "service area" means the fewest number of
 798 zip codes that account for 75 percent of the hospital's
 799 discharges for the most recent 5-year period, based on
 800 information available from the hospital inpatient discharge
 801 database in the Florida Center for Health Information and Policy
 802 Analysis at the Agency for Health Care Administration; or

803 5.6. A hospital designated as a critical access hospital,
 804 as defined in s. 408.07(15).

805
 806 Population densities used in this paragraph must be based upon
 807 the most recently completed United States census. A hospital
 808 that received funds under s. 409.9116 for a quarter beginning no
 809 later than July 1, 2002, is deemed to have been and shall
 810 continue to be a rural hospital from that date through June 30,
 811 2015, if the hospital continues to have 100 or fewer licensed
 812 beds and an emergency room, ~~or meets the criteria of~~

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813 ~~subparagraph 4.~~ An acute care hospital that has not previously
 814 been designated as a rural hospital and that meets the criteria
 815 of this paragraph shall be granted such designation upon
 816 application, including supporting documentation to the Agency
 817 for Health Care Administration.

818 Section 19. Subsections (8) and (16) of section 400.021,
 819 Florida Statutes, are amended to read:

820 400.021 Definitions.—When used in this part, unless the
 821 context otherwise requires, the term:

822 (8) "Geriatric outpatient clinic" means a site for
 823 providing outpatient health care to persons 60 years of age or
 824 older, which is staffed by a registered nurse or a physician
 825 assistant, or by a licensed practical nurse who is under the
 826 direct supervision of a registered nurse, an advanced registered
 827 nurse practitioner, a physician assistant, or a physician.

828 (16) "Resident care plan" means a written plan developed,
 829 maintained, and reviewed not less than quarterly by a registered
 830 nurse, with participation from other facility staff and the
 831 resident or his or her designee or legal representative, which
 832 includes a comprehensive assessment of the needs of an
 833 individual resident; the type and frequency of services required
 834 to provide the necessary care for the resident to attain or
 835 maintain the highest practicable physical, mental, and
 836 psychosocial well-being; a listing of services provided within
 837 or outside the facility to meet those needs; and an explanation
 838 of service goals. ~~The resident care plan must be signed by the~~
 839 ~~director of nursing or another registered nurse employed by the~~
 840 ~~facility to whom institutional responsibilities have been~~

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841 ~~delegated and by the resident, the resident's designee, or the~~
 842 ~~resident's legal representative. The facility may not use an~~
 843 ~~agency or temporary registered nurse to satisfy the foregoing~~
 844 ~~requirement and must document the institutional responsibilities~~
 845 ~~that have been delegated to the registered nurse.~~

846 Section 20. Subsection (1) of section 400.0234, Florida
 847 Statutes, is amended to read:

848 400.0234 Availability of facility records for
 849 investigation of resident's rights violations and defenses;
 850 penalty.—

851 (1) Failure to provide complete copies of a resident's
 852 records, including, but not limited to, all medical records and
 853 the resident's chart, within the control or possession of the
 854 facility ~~in accordance with s. 400.145~~ shall constitute evidence
 855 of failure of that party to comply with good faith discovery
 856 requirements and shall waive the good faith certificate and
 857 presuit notice requirements under this part by the requesting
 858 party.

859 Section 21. Subsection (15) of section 400.0255, Florida
 860 Statutes, is amended to read:

861 400.0255 Resident transfer or discharge; requirements and
 862 procedures; hearings.—

863 (15) (a) The department's Office of Appeals Hearings shall
 864 conduct hearings under this section. The office shall notify the
 865 facility of a resident's request for a hearing.

866 (b) The department shall, by rule, establish procedures to
 867 be used for fair hearings requested by residents. These
 868 procedures shall be equivalent to the procedures used for fair

869 | hearings for other Medicaid cases appearing in s. 409.285 and
 870 | applicable rules, ~~chapter 10-2, part VI, Florida Administrative~~
 871 | ~~Code.~~ The burden of proof must be clear and convincing evidence.
 872 | A hearing decision must be rendered within 90 days after receipt
 873 | of the request for hearing.

874 | (c) If the hearing decision is favorable to the resident
 875 | who has been transferred or discharged, the resident must be
 876 | readmitted to the facility's first available bed.

877 | (d) The decision of the hearing officer is ~~shall be~~ final.
 878 | Any aggrieved party may appeal the decision to the district
 879 | court of appeal in the appellate district where the facility is
 880 | located. Review procedures shall be conducted in accordance with
 881 | the Florida Rules of Appellate Procedure.

882 | Section 22. Subsection (2) of section 400.063, Florida
 883 | Statutes, is amended to read:

884 | 400.063 Resident protection.—

885 | (2) The agency is authorized to establish for each
 886 | facility, subject to intervention by the agency, a separate bank
 887 | account for the deposit to the credit of the agency of any
 888 | moneys received from the Health Care Trust Fund or any other
 889 | moneys received for the maintenance and care of residents in the
 890 | facility, and the agency is authorized to disburse moneys from
 891 | such account to pay obligations incurred for the purposes of
 892 | this section. The agency is authorized to requisition moneys
 893 | from the Health Care Trust Fund in advance of an actual need for
 894 | cash on the basis of an estimate by the agency of moneys to be
 895 | spent under the authority of this section. Any bank account
 896 | established under this section need not be approved in advance

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897 | of its creation as required by s. 17.58, but shall be secured by
 898 | depository insurance equal to or greater than the balance of
 899 | such account or by the pledge of collateral security ~~in~~
 900 | ~~conformance with criteria established in s. 18.11.~~ The agency
 901 | shall notify the Chief Financial Officer of any such account so
 902 | established and shall make a quarterly accounting to the Chief
 903 | Financial Officer for all moneys deposited in such account.

904 | Section 23. Subsections (1) and (5) of section 400.071,
 905 | Florida Statutes, are amended to read:

906 | 400.071 Application for license.—

907 | (1) In addition to the requirements of part II of chapter
 908 | 408, the application for a license shall be under oath and must
 909 | contain the following:

910 | (a) The location of the facility for which a license is
 911 | sought and an indication, as in the original application, that
 912 | such location conforms to the local zoning ordinances.

913 | ~~(b) A signed affidavit disclosing any financial or~~
 914 | ~~ownership interest that a controlling interest as defined in~~
 915 | ~~part II of chapter 408 has held in the last 5 years in any~~
 916 | ~~entity licensed by this state or any other state to provide~~
 917 | ~~health or residential care which has closed voluntarily or~~
 918 | ~~involuntarily; has filed for bankruptcy; has had a receiver~~
 919 | ~~appointed; has had a license denied, suspended, or revoked; or~~
 920 | ~~has had an injunction issued against it which was initiated by a~~
 921 | ~~regulatory agency. The affidavit must disclose the reason any~~
 922 | ~~such entity was closed, whether voluntarily or involuntarily.~~

923 | ~~(c) The total number of beds and the total number of~~
 924 | ~~Medicare and Medicaid certified beds.~~

925 (b) ~~(d)~~ Information relating to the applicant and employees
 926 which the agency requires by rule. The applicant must
 927 demonstrate that sufficient numbers of qualified staff, by
 928 training or experience, will be employed to properly care for
 929 the type and number of residents who will reside in the
 930 facility.

931 ~~(c) Copies of any civil verdict or judgment involving the~~
 932 ~~applicant rendered within the 10 years preceding the~~
 933 ~~application, relating to medical negligence, violation of~~
 934 ~~residents' rights, or wrongful death. As a condition of~~
 935 ~~licensure, the licensee agrees to provide to the agency copies~~
 936 ~~of any new verdict or judgment involving the applicant, relating~~
 937 ~~to such matters, within 30 days after filing with the clerk of~~
 938 ~~the court. The information required in this paragraph shall be~~
 939 ~~maintained in the facility's licensure file and in an agency~~
 940 ~~database which is available as a public record.~~

941 (5) As a condition of licensure, each facility must
 942 establish and ~~submit with its application~~ a plan for quality
 943 assurance and for conducting risk management.

944 Section 24. Section 400.0712, Florida Statutes, is amended
 945 to read:

946 400.0712 Application for inactive license.—

947 ~~(1) As specified in this section, the agency may issue an~~
 948 ~~inactive license to a nursing home facility for all or a portion~~
 949 ~~of its beds. Any request by a licensee that a nursing home or~~
 950 ~~portion of a nursing home become inactive must be submitted to~~
 951 ~~the agency in the approved format. The facility may not initiate~~
 952 ~~any suspension of services, notify residents, or initiate~~

953 ~~inactivity before receiving approval from the agency; and a~~
 954 ~~licensee that violates this provision may not be issued an~~
 955 ~~inactive license.~~

956 (1)~~(2)~~ In addition to the powers granted under part II of
 957 chapter 408, the agency may issue an inactive license for a
 958 portion of the total beds to a nursing home that chooses to use
 959 an unoccupied contiguous portion of the facility for an
 960 alternative use to meet the needs of elderly persons through the
 961 use of less restrictive, less institutional services.

962 (a) An inactive license issued under this subsection may
 963 be granted for a period not to exceed the current licensure
 964 expiration date but may be renewed by the agency at the time of
 965 licensure renewal.

966 (b) A request to extend the inactive license must be
 967 submitted to the agency in the approved format and approved by
 968 the agency in writing.

969 (c) Nursing homes that receive an inactive license to
 970 provide alternative services shall not receive preference for
 971 participation in the Assisted Living for the Elderly Medicaid
 972 waiver.

973 (2)~~(3)~~ The agency shall adopt rules pursuant to ss.
 974 120.536(1) and 120.54 necessary to implement this section.

975 Section 25. Section 400.111, Florida Statutes, is amended
 976 to read:

977 400.111 Disclosure of controlling interest.—In addition to
 978 the requirements of part II of chapter 408, when requested by
 979 the agency, the licensee shall submit a signed affidavit
 980 disclosing any financial or ownership interest that a

981 controlling interest has held within the last 5 years in any
 982 entity licensed by the state or any other state to provide
 983 health or residential care which entity has closed voluntarily
 984 or involuntarily; has filed for bankruptcy; has had a receiver
 985 appointed; has had a license denied, suspended, or revoked; or
 986 has had an injunction issued against it which was initiated by a
 987 regulatory agency. The affidavit must disclose the reason such
 988 entity was closed, whether voluntarily or involuntarily.

989 Section 26. Subsection (2) of section 400.1183, Florida
 990 Statutes, is amended to read:

991 400.1183 Resident grievance procedures.—

992 (2) Each facility shall maintain records of all grievances
 993 and shall retain a log for agency inspection of ~~report to the~~
 994 ~~agency at the time of relicensure~~ the total number of grievances
 995 handled ~~during the prior licensure period~~, a categorization of
 996 the cases underlying the grievances, and the final disposition
 997 of the grievances.

998 Section 27. Subsection (1) of section 400.141, Florida
 999 Statutes, is amended, and subsection (3) is added to that
 1000 section to read:

1001 400.141 Administration and management of nursing home
 1002 facilities.—

1003 (1) Every licensed facility shall comply with all
 1004 applicable standards and rules of the agency and shall:

1005 (a) Be under the administrative direction and charge of a
 1006 licensed administrator.

1007 (b) Appoint a medical director licensed pursuant to
 1008 chapter 458 or chapter 459. The agency may establish by rule

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1009 | more specific criteria for the appointment of a medical
 1010 | director.

1011 | (c) Have available the regular, consultative, and
 1012 | emergency services of physicians licensed by the state.

1013 | (d) Provide for resident use of a community pharmacy as
 1014 | specified in s. 400.022(1)(q). Any other law to the contrary
 1015 | notwithstanding, a registered pharmacist licensed in Florida,
 1016 | that is under contract with a facility licensed under this
 1017 | chapter or chapter 429, shall repackage a nursing facility
 1018 | resident's bulk prescription medication that ~~which~~ has been
 1019 | packaged by another pharmacist licensed in any state in the
 1020 | United States into a unit dose system compatible with the system
 1021 | used by the nursing facility, if the pharmacist is requested to
 1022 | offer such service. In order to be eligible for the repackaging,
 1023 | a resident or the resident's spouse must receive prescription
 1024 | medication benefits provided through a former employer as part
 1025 | of his or her retirement benefits, a qualified pension plan as
 1026 | specified in s. 4972 of the Internal Revenue Code, a federal
 1027 | retirement program as specified under 5 C.F.R. s. 831, or a
 1028 | long-term care policy as defined in s. 627.9404(1). A pharmacist
 1029 | who correctly repackages and relabels the medication and the
 1030 | nursing facility that ~~which~~ correctly administers such
 1031 | repackaged medication under this paragraph may not be held
 1032 | liable in any civil or administrative action arising from the
 1033 | repackaging. In order to be eligible for the repackaging, a
 1034 | nursing facility resident for whom the medication is to be
 1035 | repackaged shall sign an informed consent form provided by the
 1036 | facility which includes an explanation of the repackaging

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1037 process and which notifies the resident of the immunities from
 1038 liability provided in this paragraph. A pharmacist who
 1039 repackages and relabels prescription medications, as authorized
 1040 under this paragraph, may charge a reasonable fee for costs
 1041 resulting from the implementation of this provision.

1042 (e) Provide for the access of the facility residents to
 1043 dental and other health-related services, recreational services,
 1044 rehabilitative services, and social work services appropriate to
 1045 their needs and conditions and not directly furnished by the
 1046 licensee. When a geriatric outpatient nurse clinic is conducted
 1047 in accordance with rules adopted by the agency, outpatients
 1048 attending such clinic shall not be counted as part of the
 1049 general resident population of the nursing home facility, nor
 1050 shall the nursing staff of the geriatric outpatient clinic be
 1051 counted as part of the nursing staff of the facility, until the
 1052 outpatient clinic load exceeds 15 a day.

1053 (f) Be allowed and encouraged by the agency to provide
 1054 other needed services under certain conditions. If the facility
 1055 has a standard licensure status, ~~and has had no class I or class~~
 1056 ~~II deficiencies during the past 2 years or has been awarded a~~
 1057 ~~Gold Seal under the program established in s. 400.235,~~ it may be
 1058 ~~encouraged by the agency to provide services, including, but not~~
 1059 limited to, respite and adult day services, which enable
 1060 individuals to move in and out of the facility. A facility is
 1061 not subject to any additional licensure requirements for
 1062 providing these services under the following conditions:-

1063 1. Respite care may be offered to persons in need of
 1064 short-term or temporary nursing home services. For each person

1065 admitted under the respite care program, the facility licensee
 1066 must:

1067 a. Have a written abbreviated plan of care that, at a
 1068 minimum, includes nutritional requirements, medication orders,
 1069 physician orders, nursing assessments, and dietary preferences.
 1070 The nursing or physician assessments may take the place of all
 1071 other assessments required for full-time residents.

1072 b. Have a contract that, at a minimum, specifies the
 1073 services to be provided to the respite resident, including
 1074 charges for services, activities, equipment, emergency medical
 1075 services, and the administration of medications. If multiple
 1076 respite admissions for a single person are anticipated, the
 1077 original contract is valid for 1 year after the date of
 1078 execution.

1079 c. Ensure that each resident is released to his or her
 1080 caregiver or an individual designated in writing by the
 1081 caregiver.

1082 2. A person admitted under the respite care program is:

1083 a. Exempt from requirements in rule related to discharge
 1084 planning.

1085 b. Covered by the residents' rights set forth in s.
 1086 400.022(1)(a)-(o) and (r)-(t). Property or funds of a resident
 1087 are not considered trust funds that are subject to the
 1088 requirements of s. 400.022(1)(h) until the resident has been in
 1089 the facility for more than 14 consecutive days.

1090 c. Allowed to use his or her personal medications for the
 1091 respite stay if permitted by facility policy. The facility must
 1092 obtain a physician's order for the medications. The caregiver

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1093 may provide information regarding the medications as part of the
1094 nursing assessment and that information must be in conformance
1095 with the physician's order. Medications shall be released with
1096 the resident upon discharge in accordance with a physician's
1097 current orders.

1098 3. A person receiving respite care is entitled to reside
1099 in the facility for a total of 60 days within a contract year or
1100 within a calendar year if the contract is for less than 12
1101 months. However, each single stay may not exceed 14 days. If a
1102 stay exceeds 14 consecutive days, the facility must comply with
1103 all requirements for assessment and care planning which apply to
1104 nursing home residents.

1105 4. A person receiving respite care must reside in a
1106 licensed nursing home bed.

1107 5. A prospective respite resident must provide medical
1108 information from a physician, a physician assistant, or a nurse
1109 practitioner and other information from the primary caregiver as
1110 may be required by the facility prior to or at the time of
1111 admission to receive respite care. The medical information must
1112 include a physician's order for respite care and proof of a
1113 physical examination by a licensed physician, physician
1114 assistant, or nurse practitioner. The physician's order and
1115 physical examination may be used to provide intermittent respite
1116 care for up to 12 months after the date the order is written.

1117 6. The facility must assume the duties of the primary
1118 caregiver. To ensure continuity of care and services, the
1119 resident is entitled to retain his or her personal physician and
1120 must have access to medically necessary services such as

1121 physical therapy, occupational therapy, or speech therapy, as
 1122 needed. The facility must arrange for transportation to these
 1123 services if necessary. ~~Respite care must be provided in~~
 1124 ~~accordance with this part and rules adopted by the agency.~~
 1125 ~~However, the agency shall, by rule, adopt modified requirements~~
 1126 ~~for resident assessment, resident care plans, resident~~
 1127 ~~contracts, physician orders, and other provisions, as~~
 1128 ~~appropriate, for short-term or temporary nursing home services.~~

1129 7. The agency shall allow for shared programming and staff
 1130 in a facility which meets minimum standards and offers services
 1131 pursuant to this paragraph, but, if the facility is cited for
 1132 deficiencies in patient care, may require additional staff and
 1133 programs appropriate to the needs of service recipients. A
 1134 person who receives respite care may not be counted as a
 1135 resident of the facility for purposes of the facility's licensed
 1136 capacity unless that person receives 24-hour respite care. A
 1137 person receiving either respite care for 24 hours or longer or
 1138 adult day services must be included when calculating minimum
 1139 staffing for the facility. Any costs and revenues generated by a
 1140 nursing home facility from nonresidential programs or services
 1141 shall be excluded from the calculations of Medicaid per diems
 1142 for nursing home institutional care reimbursement.

1143 (g) If the facility has a standard license ~~or is a Gold~~
 1144 ~~Seal facility~~, exceeds the minimum required hours of licensed
 1145 nursing and certified nursing assistant direct care per resident
 1146 per day, and is part of a continuing care facility licensed
 1147 under chapter 651 or a retirement community that offers other
 1148 services pursuant to part III of this chapter or part I or part

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1149 III of chapter 429 on a single campus, be allowed to share
1150 programming and staff. ~~At the time of inspection and in the~~
1151 ~~semiannual report required pursuant to paragraph (e),~~ A
1152 continuing care facility or retirement community that uses this
1153 option must demonstrate through staffing records that minimum
1154 staffing requirements for the facility were met. Licensed nurses
1155 and certified nursing assistants who work in the nursing home
1156 facility may be used to provide services elsewhere on campus if
1157 the facility exceeds the minimum number of direct care hours
1158 required per resident per day and the total number of residents
1159 receiving direct care services from a licensed nurse or a
1160 certified nursing assistant does not cause the facility to
1161 violate the staffing ratios required under s. 400.23(3)(a).
1162 Compliance with the minimum staffing ratios shall be based on
1163 total number of residents receiving direct care services,
1164 regardless of where they reside on campus. If the facility
1165 receives a conditional license, it may not share staff until the
1166 conditional license status ends. This paragraph does not
1167 restrict the agency's authority under federal or state law to
1168 require additional staff if a facility is cited for deficiencies
1169 in care which are caused by an insufficient number of certified
1170 nursing assistants or licensed nurses. The agency may adopt
1171 rules for the documentation necessary to determine compliance
1172 with this provision.

1173 (h) Maintain the facility premises and equipment and
1174 conduct its operations in a safe and sanitary manner.

1175 (i) If the licensee furnishes food service, provide a
1176 wholesome and nourishing diet sufficient to meet generally

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1177 | accepted standards of proper nutrition for its residents and
1178 | provide such therapeutic diets as may be prescribed by attending
1179 | physicians. In making rules to implement this paragraph, the
1180 | agency shall be guided by standards recommended by nationally
1181 | recognized professional groups and associations with knowledge
1182 | of dietetics.

1183 | (j) Keep full records of resident admissions and
1184 | discharges; medical and general health status, including medical
1185 | records, personal and social history, and identity and address
1186 | of next of kin or other persons who may have responsibility for
1187 | the affairs of the residents; and individual resident care plans
1188 | including, but not limited to, prescribed services, service
1189 | frequency and duration, and service goals. The records shall be
1190 | open to inspection by the agency. The facility must maintain
1191 | clinical records for each resident in accordance with accepted
1192 | professional standards and practices and which are complete,
1193 | accurately documented, readily accessible, and systematically
1194 | organized.

1195 | (k) Keep such fiscal records of its operations and
1196 | conditions as may be necessary to provide information pursuant
1197 | to this part.

1198 | (l) Furnish copies of personnel records for employees
1199 | affiliated with such facility, to any other facility licensed by
1200 | this state requesting this information pursuant to this part.
1201 | Such information contained in the records may include, but is
1202 | not limited to, disciplinary matters and any reason for
1203 | termination. Any facility releasing such records pursuant to
1204 | this part shall be considered to be acting in good faith and may

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1205 not be held liable for information contained in such records,
 1206 absent a showing that the facility maliciously falsified such
 1207 records.

1208 (m) Publicly display a poster provided by the agency
 1209 containing the names, addresses, and telephone numbers for the
 1210 state's abuse hotline, the State Long-Term Care Ombudsman, the
 1211 Agency for Health Care Administration consumer hotline, the
 1212 Advocacy Center for Persons with Disabilities, the Florida
 1213 Statewide Advocacy Council, and the Medicaid Fraud Control Unit,
 1214 with a clear description of the assistance to be expected from
 1215 each.

1216 ~~(n) Submit to the agency the information specified in s.~~
 1217 ~~400.071(1) (b) for a management company within 30 days after the~~
 1218 ~~effective date of the management agreement.~~

1219 ~~(o)1. Submit semiannually to the agency, or more~~
 1220 ~~frequently if requested by the agency, information regarding~~
 1221 ~~facility staff-to-resident ratios, staff turnover, and staff~~
 1222 ~~stability, including information regarding certified nursing~~
 1223 ~~assistants, licensed nurses, the director of nursing, and the~~
 1224 ~~facility administrator. For purposes of this reporting:~~

1225 ~~a. Staff-to-resident ratios must be reported in the~~
 1226 ~~categories specified in s. 400.23(3) (a) and applicable rules.~~
 1227 ~~The ratio must be reported as an average for the most recent~~
 1228 ~~calendar quarter.~~

1229 ~~b. Staff turnover must be reported for the most recent 12-~~
 1230 ~~month period ending on the last workday of the most recent~~
 1231 ~~calendar quarter prior to the date the information is submitted.~~
 1232 ~~The turnover rate must be computed quarterly, with the annual~~

1233 ~~rate being the cumulative sum of the quarterly rates. The~~
 1234 ~~turnover rate is the total number of terminations or separations~~
 1235 ~~experienced during the quarter, excluding any employee~~
 1236 ~~terminated during a probationary period of 3 months or less,~~
 1237 ~~divided by the total number of staff employed at the end of the~~
 1238 ~~period for which the rate is computed, and expressed as a~~
 1239 ~~percentage.~~

1240 ~~e. The formula for determining staff stability is the~~
 1241 ~~total number of employees that have been employed for more than~~
 1242 ~~12 months, divided by the total number of employees employed at~~
 1243 ~~the end of the most recent calendar quarter, and expressed as a~~
 1244 ~~percentage.~~

1245 (n)1.d. Comply with minimum-staffing requirements. A
 1246 nursing facility that fails ~~has failed~~ to comply with state
 1247 minimum-staffing requirements for 2 consecutive days may not
 1248 accept ~~is prohibited from accepting~~ new admissions until the
 1249 facility achieves ~~has achieved~~ the minimum-staffing requirements
 1250 for ~~a period of~~ 6 consecutive days. For the purposes of this
 1251 subparagraph ~~sub-subparagraph~~, any person who was a resident of
 1252 the facility and was absent from the facility for the purpose of
 1253 receiving medical care at a separate location or was on a leave
 1254 of absence is not considered a new admission. Failure to impose
 1255 such an admissions moratorium is subject to a \$1,000 fine
 1256 ~~constitutes a class II deficiency.~~

1257 2.e. A nursing facility that ~~which~~ does not have a
 1258 conditional license may be cited for failure to comply with the
 1259 standards in s. 400.23(3)(a)1.b. and c. only if it fails ~~has~~
 1260 ~~failed~~ to meet those standards on 2 consecutive days or if it

1261 fails ~~has failed~~ to meet at least 97 percent of those standards
 1262 on any one day.

1263 3.f. A facility that ~~which~~ has a conditional license must
 1264 be in compliance with the standards in s. 400.23(3)(a) at all
 1265 times.

1266 ~~2. This paragraph does not limit the agency's ability to~~
 1267 ~~impose a deficiency or take other actions if a facility does not~~
 1268 ~~have enough staff to meet the residents' needs.~~

1269 (o) ~~(p)~~ Notify a licensed physician when a resident
 1270 exhibits signs of dementia or cognitive impairment or has a
 1271 change of condition in order to rule out the presence of an
 1272 underlying physiological condition that may be contributing to
 1273 such dementia or impairment. The notification must occur within
 1274 30 days after the acknowledgment of such signs by facility
 1275 staff. If an underlying condition is determined to exist, the
 1276 facility shall arrange, with the appropriate health care
 1277 provider, the necessary care and services to treat the
 1278 condition.

1279 (p) ~~(q)~~ If the facility implements a dining and hospitality
 1280 attendant program, ensure that the program is developed and
 1281 implemented under the supervision of the facility director of
 1282 nursing. A licensed nurse, licensed speech or occupational
 1283 therapist, or a registered dietitian must conduct training of
 1284 dining and hospitality attendants. A person employed by a
 1285 facility as a dining and hospitality attendant must perform
 1286 tasks under the direct supervision of a licensed nurse.

1287 ~~(r) Report to the agency any filing for bankruptcy~~
 1288 ~~protection by the facility or its parent corporation,~~

1289 ~~divestiture or spin-off of its assets, or corporate~~
 1290 ~~reorganization within 30 days after the completion of such~~
 1291 ~~activity.~~

1292 (q)~~(s)~~ Maintain general and professional liability
 1293 insurance coverage that is in force at all times. In lieu of
 1294 general and professional liability insurance coverage, a state-
 1295 designated teaching nursing home and its affiliated assisted
 1296 living facilities created under s. 430.80 may demonstrate proof
 1297 of financial responsibility as provided in s. 430.80(3)(g).

1298 (r)~~(t)~~ Maintain in the medical record for each resident a
 1299 daily chart of certified nursing assistant services provided to
 1300 the resident. The certified nursing assistant who is caring for
 1301 the resident must complete this record by the end of his or her
 1302 shift. This record must indicate assistance with activities of
 1303 daily living, assistance with eating, and assistance with
 1304 drinking, and must record each offering of nutrition and
 1305 hydration for those residents whose plan of care or assessment
 1306 indicates a risk for malnutrition or dehydration.

1307 (s)~~(u)~~ Before November 30 of each year, subject to the
 1308 availability of an adequate supply of the necessary vaccine,
 1309 provide for immunizations against influenza viruses to all its
 1310 consenting residents in accordance with the recommendations of
 1311 the United States Centers for Disease Control and Prevention,
 1312 subject to exemptions for medical contraindications and
 1313 religious or personal beliefs. Subject to these exemptions, any
 1314 consenting person who becomes a resident of the facility after
 1315 November 30 but before March 31 of the following year must be
 1316 immunized within 5 working days after becoming a resident.

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1317 Immunization shall not be provided to any resident who provides
 1318 documentation that he or she has been immunized as required by
 1319 this paragraph. This paragraph does not prohibit a resident from
 1320 receiving the immunization from his or her personal physician if
 1321 he or she so chooses. A resident who chooses to receive the
 1322 immunization from his or her personal physician shall provide
 1323 proof of immunization to the facility. The agency may adopt and
 1324 enforce any rules necessary to comply with or implement this
 1325 paragraph.

1326 (t)~~(v)~~ Assess all residents for eligibility for
 1327 pneumococcal polysaccharide vaccination (PPV) and vaccinate
 1328 residents when indicated within 60 days after the effective date
 1329 of this act in accordance with the recommendations of the United
 1330 States Centers for Disease Control and Prevention, subject to
 1331 exemptions for medical contraindications and religious or
 1332 personal beliefs. Residents admitted after the effective date of
 1333 this act shall be assessed within 5 working days after ~~of~~
 1334 admission and, when indicated, vaccinated within 60 days in
 1335 accordance with the recommendations of the United States Centers
 1336 for Disease Control and Prevention, subject to exemptions for
 1337 medical contraindications and religious or personal beliefs.

1338 Immunization shall not be provided to any resident who provides
 1339 documentation that he or she has been immunized as required by
 1340 this paragraph. This paragraph does not prohibit a resident from
 1341 receiving the immunization from his or her personal physician if
 1342 he or she so chooses. A resident who chooses to receive the
 1343 immunization from his or her personal physician shall provide
 1344 proof of immunization to the facility. The agency may adopt and

1345 enforce any rules necessary to comply with or implement this
 1346 paragraph.

1347 ~~(u)(w)~~ Annually encourage and promote to its employees the
 1348 benefits associated with immunizations against influenza viruses
 1349 in accordance with the recommendations of the United States
 1350 Centers for Disease Control and Prevention. The agency may adopt
 1351 and enforce any rules necessary to comply with or implement this
 1352 paragraph.

1353
 1354 This subsection does not limit the agency's ability to impose a
 1355 penalty for a deficiency or take other actions if a facility
 1356 fails to maintain an adequate number of staff to meet the
 1357 residents' needs.

1358 (3) A facility may charge a reasonable fee for copying
 1359 resident records. The fee may not exceed \$1 per page for the
 1360 first 25 pages and 25 cents per page for each page in excess of
 1361 25 pages.

1362 Section 28. Subsection (3) of section 400.142, Florida
 1363 Statutes, is amended to read:

1364 400.142 Emergency medication kits; orders not to
 1365 resuscitate.—

1366 (3) Facility staff may withhold or withdraw
 1367 cardiopulmonary resuscitation if presented with an order not to
 1368 resuscitate executed pursuant to s. 401.45. ~~The agency shall~~
 1369 ~~adopt rules providing for the implementation of such orders.~~
 1370 Facility staff and facilities are shall not ~~be~~ subject to
 1371 criminal prosecution or civil liability, and are not ~~nor be~~
 1372 considered to have engaged in negligent or unprofessional

1373 | conduct, for withholding or withdrawing cardiopulmonary
 1374 | resuscitation pursuant to such an order and rules adopted by the
 1375 | agency. The absence of an order not to resuscitate executed
 1376 | pursuant to s. 401.45 does not preclude a physician from
 1377 | withholding or withdrawing cardiopulmonary resuscitation as
 1378 | otherwise permitted by law.

1379 | Section 29. Section 400.145, Florida Statutes, is
 1380 | repealed.

1381 | Section 30. Present subsections (9), (11), (12), (13),
 1382 | (14), and (15) of section 400.147, Florida Statutes, are
 1383 | redesignated as subsections (8), (9), (10), (11), (12), and
 1384 | (13), respectively, and present subsections (7), (8), and (10)
 1385 | of that section are amended to read:

1386 | 400.147 Internal risk management and quality assurance
 1387 | program.—

1388 | (7) The facility shall initiate an investigation ~~and shall~~
 1389 | ~~notify the agency~~ within 1 business day after the risk manager
 1390 | or his or her designee has received a report pursuant to
 1391 | paragraph (1)(d). Each facility shall complete the investigation
 1392 | and submit a report to the agency within 15 calendar days if the
 1393 | incident is determined to be an adverse incident as defined in
 1394 | subsection (5). ~~The notification must be made in writing and be~~
 1395 | ~~provided electronically, by facsimile device or overnight mail~~
 1396 | ~~delivery.~~ The agency shall develop a form for reporting this
 1397 | information, and the notification must include the name of the
 1398 | risk manager of the facility, information regarding the identity
 1399 | of the affected resident, the type of adverse incident, the
 1400 | initiation of an investigation by the facility, and whether the

1401 events causing or resulting in the adverse incident represent a
 1402 potential risk to any other resident. The notification is
 1403 confidential as provided by law and is not discoverable or
 1404 admissible in any civil or administrative action, except in
 1405 disciplinary proceedings by the agency or the appropriate
 1406 regulatory board. The agency may investigate, as it deems
 1407 appropriate, any such incident and prescribe measures that must
 1408 or may be taken in response to the incident. The agency shall
 1409 review each incident and determine whether it potentially
 1410 involved conduct by the health care professional who is subject
 1411 to disciplinary action, in which case the provisions of s.
 1412 456.073 shall apply.

1413 ~~(8)(a) Each facility shall complete the investigation and~~
 1414 ~~submit an adverse incident report to the agency for each adverse~~
 1415 ~~incident within 15 calendar days after its occurrence. If, after~~
 1416 ~~a complete investigation, the risk manager determines that the~~
 1417 ~~incident was not an adverse incident as defined in subsection~~
 1418 ~~(5), the facility shall include this information in the report.~~
 1419 ~~The agency shall develop a form for reporting this information.~~

1420 ~~(b) The information reported to the agency pursuant to~~
 1421 ~~paragraph (a) which relates to persons licensed under chapter~~
 1422 ~~458, chapter 459, chapter 461, or chapter 466 shall be reviewed~~
 1423 ~~by the agency. The agency shall determine whether any of the~~
 1424 ~~incidents potentially involved conduct by a health care~~
 1425 ~~professional who is subject to disciplinary action, in which~~
 1426 ~~case the provisions of s. 456.073 shall apply.~~

1427 ~~(c) The report submitted to the agency must also contain~~
 1428 ~~the name of the risk manager of the facility.~~

1429 ~~(d) The adverse incident report is confidential as~~
 1430 ~~provided by law and is not discoverable or admissible in any~~
 1431 ~~civil or administrative action, except in disciplinary~~
 1432 ~~proceedings by the agency or the appropriate regulatory board.~~

1433 ~~(10) By the 10th of each month, each facility subject to~~
 1434 ~~this section shall report any notice received pursuant to s.~~
 1435 ~~400.0233(2) and each initial complaint that was filed with the~~
 1436 ~~clerk of the court and served on the facility during the~~
 1437 ~~previous month by a resident or a resident's family member,~~
 1438 ~~guardian, conservator, or personal legal representative. The~~
 1439 ~~report must include the name of the resident, the resident's~~
 1440 ~~date of birth and social security number, the Medicaid~~
 1441 ~~identification number for Medicaid-eligible persons, the date or~~
 1442 ~~dates of the incident leading to the claim or dates of~~
 1443 ~~residency, if applicable, and the type of injury or violation of~~
 1444 ~~rights alleged to have occurred. Each facility shall also submit~~
 1445 ~~a copy of the notices received pursuant to s. 400.0233(2) and~~
 1446 ~~complaints filed with the clerk of the court. This report is~~
 1447 ~~confidential as provided by law and is not discoverable or~~
 1448 ~~admissible in any civil or administrative action, except in such~~
 1449 ~~actions brought by the agency to enforce the provisions of this~~
 1450 ~~part.~~

1451 Section 31. Subsection (3) of section 400.19, Florida
 1452 Statutes, is amended to read:

1453 400.19 Right of entry and inspection.—

1454 (3) The agency shall every 15 months conduct at least one
 1455 unannounced inspection to determine compliance by the licensee
 1456 with statutes, and with rules adopted ~~promulgated~~ under the

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1457 provisions of those statutes, governing minimum standards of
1458 construction, quality and adequacy of care, and rights of
1459 residents. The survey shall be conducted every 6 months for the
1460 next 2-year period if the facility has been cited for a class I
1461 deficiency, has been cited for two or more class II deficiencies
1462 arising from separate surveys or investigations within a 60-day
1463 period, or has had three or more substantiated complaints within
1464 a 6-month period, each resulting in at least one class I or
1465 class II deficiency. In addition to any other fees or fines in
1466 this part, the agency shall assess a fine for each facility that
1467 is subject to the 6-month survey cycle. The fine for the 2-year
1468 period shall be \$6,000, one-half to be paid at the completion of
1469 each survey. The agency may adjust this fine by the change in
1470 the Consumer Price Index, based on the 12 months immediately
1471 preceding the increase, to cover the cost of the additional
1472 surveys. The agency shall verify through subsequent inspection
1473 that any deficiency identified during inspection is corrected.
1474 However, the agency may verify the correction of a class III or
1475 class IV deficiency ~~unrelated to resident rights or resident~~
1476 ~~care~~ without reinspecting the facility if adequate written
1477 documentation has been received from the facility, which
1478 provides assurance that the deficiency has been corrected. The
1479 giving or causing to be given of advance notice of such
1480 unannounced inspections by an employee of the agency to any
1481 unauthorized person shall constitute cause for suspension of not
1482 less ~~fewer~~ than 5 working days according to the provisions of
1483 chapter 110.

1484 Section 32. Subsection (5) of section 400.23, Florida

1485 Statutes, is amended to read:

1486 400.23 Rules; evaluation and deficiencies; licensure
 1487 status.—

1488 (5) (a) The agency, in collaboration with the Division of
 1489 Children's Medical Services Network of the Department of Health,
 1490 ~~must, no later than December 31, 1993,~~ adopt rules for minimum
 1491 standards of care for persons under 21 years of age who reside
 1492 in nursing home facilities. ~~The rules must include a methodology~~
 1493 ~~for reviewing a nursing home facility under ss. 408.031-408.045~~
 1494 ~~which serves only persons under 21 years of age.~~ A facility may
 1495 be exempt from these standards for specific persons between 18
 1496 and 21 years of age, if the person's physician agrees that
 1497 minimum standards of care based on age are not necessary.

1498 (b) The agency, in collaboration with the Division of
 1499 Children's Medical Services Network, shall adopt rules for
 1500 minimum staffing requirements for nursing home facilities that
 1501 serve persons under 21 years of age, which shall apply in lieu
 1502 of the standards contained in subsection (3).

1503 1. For persons under 21 years of age who require skilled
 1504 care, the requirements shall include a minimum combined average
 1505 of licensed nurses, respiratory therapists, respiratory care
 1506 practitioners, and certified nursing assistants of 3.9 hours of
 1507 direct care per resident per day for each nursing home facility.

1508 2. For persons under 21 years of age who are fragile, the
 1509 requirements shall include a minimum combined average of
 1510 licensed nurses, respiratory therapists, respiratory care
 1511 practitioners, and certified nursing assistants of 5 hours of
 1512 direct care per resident per day for each nursing home facility.

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1513 Section 33. Subsection (1) of section 400.275, Florida
 1514 Statutes, is amended to read:

1515 400.275 Agency duties.—

1516 (1) ~~The agency shall ensure that each newly hired nursing~~
 1517 ~~home surveyor, as a part of basic training, is assigned full-~~
 1518 ~~time to a licensed nursing home for at least 2 days within a 7-~~
 1519 ~~day period to observe facility operations outside of the survey~~
 1520 ~~process before the surveyor begins survey responsibilities. Such~~
 1521 ~~observations may not be the sole basis of a deficiency citation~~
 1522 ~~against the facility.~~ The agency may not assign an individual to
 1523 be a member of a survey team for purposes of a survey,
 1524 evaluation, or consultation visit at a nursing home facility in
 1525 which the surveyor was an employee within the preceding 2 ~~5~~
 1526 years.

1527 Section 34. Subsection (27) of section 400.462, Florida
 1528 Statutes, is amended to read:

1529 400.462 Definitions.—As used in this part, the term:

1530 (27) "Remuneration" means any payment or other benefit
 1531 made directly or indirectly, overtly or covertly, in cash or in
 1532 kind. However, when the term is used in any provision of law
 1533 relating to a health care provider, such term does not mean an
 1534 item with an individual value of up to \$15, including, but not
 1535 limited to, plaques, certificates, trophies, or novelties that
 1536 are intended solely for presentation or are customarily given
 1537 away solely for promotional, recognition, or advertising
 1538 purposes.

1539 Section 35. For the purpose of incorporating the amendment
 1540 made by this act to section 400.509, Florida Statutes, in a

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1541 reference thereto, paragraph (b) of subsection (5) of section
 1542 400.464, Florida Statutes, is reenacted and amended to read:
 1543 400.464 Home health agencies to be licensed; expiration of
 1544 license; exemptions; unlawful acts; penalties.—

1545 (5) The following are exempt from the licensure
 1546 requirements of this part:

1547 (b) Home health services provided by a state agency,
 1548 either directly or through a contractor with:

- 1549 1. The Department of Elderly Affairs.
- 1550 2. The Department of Health, a community health center, or
 1551 a rural health network that furnishes home visits for the
 1552 purpose of providing environmental assessments, case management,
 1553 health education, personal care services, family planning, or
 1554 followup treatment, or for the purpose of monitoring and
 1555 tracking disease.

1556 3. Services provided to persons with developmental
 1557 disabilities, as defined in s. 393.063.

1558 4. Companion and sitter organizations that were registered
 1559 under s. 400.509(1) ~~on January 1, 1999,~~ and were authorized to
 1560 provide personal services under a developmental services
 1561 provider certificate ~~on January 1, 1999,~~ may continue to provide
 1562 such services to past, present, and future clients of the
 1563 organization who need such services, notwithstanding the
 1564 provisions of this act.

1565 5. The Department of Children and Family Services.

1566 Section 36. Section 400.484, Florida Statutes, is amended
 1567 to read:

1568 400.484 Right of inspection; violations ~~deficiencies~~;

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1569 fines.-

1570 (1) In addition to the requirements of s. 408.811, the
 1571 agency may make such inspections and investigations as are
 1572 necessary in order to determine the state of compliance with
 1573 this part, part II of chapter 408, and applicable rules.

1574 (2) The agency shall impose fines for various classes of
 1575 violations ~~deficiencies~~ in accordance with the following
 1576 schedule:

1577 (a) A class I violation is defined in s. 408.813
 1578 ~~deficiency is any act, omission, or practice that results in a~~
 1579 ~~patient's death, disablement, or permanent injury, or places a~~
 1580 ~~patient at imminent risk of death, disablement, or permanent~~
 1581 ~~injury.~~ Upon finding a class I violation ~~deficiency~~, the agency
 1582 shall impose an administrative fine in the amount of \$15,000 for
 1583 each occurrence and each day that the violation ~~deficiency~~
 1584 exists.

1585 (b) A class II violation is defined in s. 408.813
 1586 ~~deficiency is any act, omission, or practice that has a direct~~
 1587 ~~adverse effect on the health, safety, or security of a patient.~~
 1588 Upon finding a class II violation ~~deficiency~~, the agency shall
 1589 impose an administrative fine in the amount of \$5,000 for each
 1590 occurrence and each day that the violation ~~deficiency~~ exists.

1591 (c) A class III violation is defined in s. 408.813
 1592 ~~deficiency is any act, omission, or practice that has an~~
 1593 ~~indirect, adverse effect on the health, safety, or security of a~~
 1594 ~~patient.~~ Upon finding an uncorrected or repeated class III
 1595 violation ~~deficiency~~, the agency shall impose an administrative
 1596 fine not to exceed \$1,000 for each occurrence and each day that

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1597 the uncorrected or repeated violation ~~deficiency~~ exists.

1598 (d) A class IV violation is defined in s. 408.813
 1599 ~~deficiency is any act, omission, or practice related to required~~
 1600 ~~reports, forms, or documents which does not have the potential~~
 1601 ~~of negatively affecting patients.~~ These violations are of a type
 1602 that the agency determines do not threaten the health, safety,
 1603 or security of patients. Upon finding an uncorrected or repeated
 1604 class IV violation ~~deficiency~~, the agency shall impose an
 1605 administrative fine not to exceed \$500 for each occurrence and
 1606 each day that the uncorrected or repeated violation ~~deficiency~~
 1607 exists.

1608 (3) In addition to any other penalties imposed pursuant to
 1609 this section or part, the agency may assess costs related to an
 1610 investigation that results in a successful prosecution,
 1611 excluding costs associated with an attorney's time.

1612 Section 37. For the purpose of incorporating the amendment
 1613 made by this act to section 400.509, Florida Statutes, in a
 1614 reference thereto, paragraph (a) of subsection (6) of section
 1615 400.506, Florida Statutes, is reenacted, and subsection (16) of
 1616 that section is amended, to read:

1617 400.506 Licensure of nurse registries; requirements;
 1618 penalties.—

1619 (6) (a) A nurse registry may refer for contract in private
 1620 residences registered nurses and licensed practical nurses
 1621 registered and licensed under part I of chapter 464, certified
 1622 nursing assistants certified under part II of chapter 464, home
 1623 health aides who present documented proof of successful
 1624 completion of the training required by rule of the agency, and

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1625 companions or homemakers for the purposes of providing those
 1626 services authorized under s. 400.509(1). A licensed nurse
 1627 registry shall ensure that each certified nursing assistant
 1628 referred for contract by the nurse registry and each home health
 1629 aide referred for contract by the nurse registry is adequately
 1630 trained to perform the tasks of a home health aide in the home
 1631 setting. Each person referred by a nurse registry must provide
 1632 current documentation that he or she is free from communicable
 1633 diseases.

1634 (16) An administrator may manage only one nurse registry,
 1635 except that an administrator may manage up to five registries if
 1636 all five registries have identical controlling interests as
 1637 defined in s. 408.803 and are located within one agency
 1638 geographic service area or within an immediately contiguous
 1639 county. An administrator shall designate, in writing, for each
 1640 licensed entity, a qualified alternate administrator to serve
 1641 during the administrator's absence. In addition to any other
 1642 ~~penalties imposed pursuant to this section or part, the agency~~
 1643 ~~may assess costs related to an investigation that results in a~~
 1644 ~~successful prosecution, excluding costs associated with an~~
 1645 ~~attorney's time.~~

1646 Section 38. Subsection (1) of section 400.509, Florida
 1647 Statutes, is amended to read:

1648 400.509 Registration of particular service providers
 1649 exempt from licensure; certificate of registration; regulation
 1650 of registrants.—

1651 (1) Any organization that provides companion services or
 1652 homemaker services and does not provide a home health service to

1653 a person is exempt from licensure under this part. However, any
 1654 organization that provides companion services or homemaker
 1655 services must register with the agency. An organization under
 1656 contract with the Agency for Persons with Disabilities which
 1657 provides companion services only for persons with a
 1658 developmental disability, as defined in s. 393.063, is exempt
 1659 from registration.

1660 Section 39. Subsection (3) of section 400.601, Florida
 1661 Statutes, is amended to read:

1662 400.601 Definitions.—As used in this part, the term:

1663 (3) "Hospice" means a centrally administered corporation
 1664 or a limited liability company as defined in s. 608.4351
 1665 providing a continuum of palliative and supportive care for the
 1666 terminally ill patient and his or her family.

1667 Section 40. Paragraph (i) of subsection (1) and subsection
 1668 (4) of section 400.606, Florida Statutes, are amended to read:

1669 400.606 License; application; renewal; conditional license
 1670 or permit; certificate of need.—

1671 (1) In addition to the requirements of part II of chapter
 1672 408, the initial application and change of ownership application
 1673 must be accompanied by a plan for the delivery of home,
 1674 residential, and homelike inpatient hospice services to
 1675 terminally ill persons and their families. Such plan must
 1676 contain, but need not be limited to:

1677 ~~(i) The projected annual operating cost of the hospice.~~

1678
 1679 If the applicant is an existing licensed health care provider,
 1680 the application must be accompanied by a copy of the most recent

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1681 profit-loss statement and, if applicable, the most recent
 1682 licensure inspection report.

1683 (4) A freestanding hospice facility that is ~~primarily~~
 1684 engaged in providing inpatient and related services and that is
 1685 not otherwise licensed as a health care facility shall ~~be~~
 1686 ~~required to~~ obtain a certificate of need. However, a
 1687 freestanding hospice facility that has ~~with~~ six or fewer beds is
 1688 ~~shall not be~~ required to comply with institutional standards
 1689 such as, but not limited to, standards requiring sprinkler
 1690 systems, emergency electrical systems, or special lavatory
 1691 devices.

1692 Section 41. Section 400.915, Florida Statutes, is amended
 1693 to read:

1694 400.915 Construction and renovation; requirements.—The
 1695 requirements for the construction or renovation of a PPEC center
 1696 shall comply with:

1697 (1) The provisions of chapter 553, which pertain to
 1698 building construction standards, including plumbing, electrical
 1699 code, glass, manufactured buildings, accessibility for the
 1700 physically disabled;

1701 (2) The provisions of s. 633.022 and applicable rules
 1702 pertaining to physical minimum standards for nonresidential
 1703 child care physical facilities in rule 10M-12.003, Florida
 1704 Administrative Code, Child Care Standards; and

1705 (3) The standards or rules adopted pursuant to this part
 1706 and part II of chapter 408.

1707 Section 42. Section 400.931, Florida Statutes, is amended
 1708 to read:

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1709 400.931 Application for license; ~~fee; provisional license;~~
 1710 ~~temporary permit.~~—

1711 (1) In addition to the requirements of part II of chapter
 1712 408, the applicant must file with the application satisfactory
 1713 proof that the home medical equipment provider is in compliance
 1714 with this part and applicable rules, including:

1715 (a) A report, by category, of the equipment to be
 1716 provided, indicating those offered either directly by the
 1717 applicant or through contractual arrangements with existing
 1718 providers. Categories of equipment include:

- 1719 1. Respiratory modalities.
- 1720 2. Ambulation aids.
- 1721 3. Mobility aids.
- 1722 4. Sickroom setup.
- 1723 5. Disposables.

1724 (b) A report, by category, of the services to be provided,
 1725 indicating those offered either directly by the applicant or
 1726 through contractual arrangements with existing providers.
 1727 Categories of services include:

- 1728 1. Intake.
- 1729 2. Equipment selection.
- 1730 3. Delivery.
- 1731 4. Setup and installation.
- 1732 5. Patient training.
- 1733 6. Ongoing service and maintenance.
- 1734 7. Retrieval.

1735 (c) A listing of those with whom the applicant contracts,
 1736 both the providers the applicant uses to provide equipment or

1737 services to its consumers and the providers for whom the
 1738 applicant provides services or equipment.

1739 (2) An applicant for initial licensure, change of
 1740 ownership, or license renewal to operate a licensed home medical
 1741 equipment provider at a location outside the state must submit
 1742 documentation of accreditation or an application for
 1743 accreditation from an accrediting organization that is
 1744 recognized by the agency. An applicant that has applied for
 1745 accreditation must provide proof of accreditation that is not
 1746 conditional or provisional within 120 days after the date the
 1747 agency receives the application for licensure or the application
 1748 shall be withdrawn from further consideration. Such
 1749 accreditation must be maintained by the home medical equipment
 1750 provider in order to maintain licensure. ~~As an alternative to~~
 1751 ~~submitting proof of financial ability to operate as required in~~
 1752 ~~s. 408.810(8), the applicant may submit a \$50,000 surety bond to~~
 1753 ~~the agency.~~

1754 (3) As specified in part II of chapter 408, the home
 1755 medical equipment provider must also obtain and maintain
 1756 professional and commercial liability insurance. Proof of
 1757 liability insurance, as defined in s. 624.605, must be submitted
 1758 with the application. The agency shall set the required amounts
 1759 of liability insurance by rule, but the required amount must not
 1760 be less than \$250,000 per claim. In the case of contracted
 1761 services, it is required that the contractor have liability
 1762 insurance not less than \$250,000 per claim.

1763 (4) When a change of the general manager of a home medical
 1764 equipment provider occurs, the licensee must notify the agency

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1765 of the change within 45 days.

1766 (5) In accordance with s. 408.805, an applicant or a
 1767 licensee shall pay a fee for each license application submitted
 1768 under this part, part II of chapter 408, and applicable rules.
 1769 The amount of the fee shall be established by rule and may not
 1770 exceed \$300 per biennium. The agency shall set the fees in an
 1771 amount that is sufficient to cover its costs in carrying out its
 1772 responsibilities under this part. However, state, county, or
 1773 municipal governments applying for licenses under this part are
 1774 exempt from the payment of license fees.

1775 (6) An applicant for initial licensure, renewal, or change
 1776 of ownership shall also pay an inspection fee not to exceed
 1777 \$400, which shall be paid by all applicants except those not
 1778 subject to licensure inspection by the agency as described in s.
 1779 400.933.

1780 Section 43. Section 400.967, Florida Statutes, is amended
 1781 to read:

1782 400.967 Rules and classification of violations
 1783 ~~deficiencies~~.-

1784 (1) It is the intent of the Legislature that rules adopted
 1785 and enforced under this part and part II of chapter 408 include
 1786 criteria by which a reasonable and consistent quality of
 1787 resident care may be ensured, the results of such resident care
 1788 can be demonstrated, and safe and sanitary facilities can be
 1789 provided.

1790 (2) Pursuant to the intention of the Legislature, the
 1791 agency, in consultation with the Agency for Persons with
 1792 Disabilities and the Department of Elderly Affairs, shall adopt

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1793 and enforce rules to administer this part and part II of chapter
 1794 408, which shall include reasonable and fair criteria governing:

1795 (a) The location and construction of the facility;
 1796 including fire and life safety, plumbing, heating, cooling,
 1797 lighting, ventilation, and other housing conditions that ensure
 1798 the health, safety, and comfort of residents. The agency shall
 1799 establish standards for facilities and equipment to increase the
 1800 extent to which new facilities and a new wing or floor added to
 1801 an existing facility after July 1, 2000, are structurally
 1802 capable of serving as shelters only for residents, staff, and
 1803 families of residents and staff, and equipped to be self-
 1804 supporting during and immediately following disasters. The
 1805 agency shall update or revise the criteria as the need arises.
 1806 All facilities must comply with those lifesafety code
 1807 requirements and building code standards applicable at the time
 1808 of approval of their construction plans. The agency may require
 1809 alterations to a building if it determines that an existing
 1810 condition constitutes a distinct hazard to life, health, or
 1811 safety. The agency shall adopt fair and reasonable rules setting
 1812 forth conditions under which existing facilities undergoing
 1813 additions, alterations, conversions, renovations, or repairs are
 1814 required to comply with the most recent updated or revised
 1815 standards.

1816 (b) The number and qualifications of all personnel,
 1817 including management, medical nursing, and other personnel,
 1818 having responsibility for any part of the care given to
 1819 residents.

1820 (c) All sanitary conditions within the facility and its

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1821 surroundings, including water supply, sewage disposal, food
 1822 handling, and general hygiene, which will ensure the health and
 1823 comfort of residents.

1824 (d) The equipment essential to the health and welfare of
 1825 the residents.

1826 (e) A uniform accounting system.

1827 (f) The care, treatment, and maintenance of residents and
 1828 measurement of the quality and adequacy thereof.

1829 (g) The preparation and annual update of a comprehensive
 1830 emergency management plan. The agency shall adopt rules
 1831 establishing minimum criteria for the plan after consultation
 1832 with the Division of Emergency Management. At a minimum, the
 1833 rules must provide for plan components that address emergency
 1834 evacuation transportation; adequate sheltering arrangements;
 1835 postdisaster activities, including emergency power, food, and
 1836 water; postdisaster transportation; supplies; staffing;
 1837 emergency equipment; individual identification of residents and
 1838 transfer of records; and responding to family inquiries. The
 1839 comprehensive emergency management plan is subject to review and
 1840 approval by the local emergency management agency. During its
 1841 review, the local emergency management agency shall ensure that
 1842 the following agencies, at a minimum, are given the opportunity
 1843 to review the plan: the Department of Elderly Affairs, the
 1844 Agency for Persons with Disabilities, the Agency for Health Care
 1845 Administration, and the Division of Emergency Management. Also,
 1846 appropriate volunteer organizations must be given the
 1847 opportunity to review the plan. The local emergency management
 1848 agency shall complete its review within 60 days and either

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1849 | approve the plan or advise the facility of necessary revisions.

1850 | (h) The use of restraint and seclusion. Such rules must be
 1851 | consistent with recognized best practices; prohibit inherently
 1852 | dangerous restraint or seclusion procedures; establish
 1853 | limitations on the use and duration of restraint and seclusion;
 1854 | establish measures to ensure the safety of clients and staff
 1855 | during an incident of restraint or seclusion; establish
 1856 | procedures for staff to follow before, during, and after
 1857 | incidents of restraint or seclusion, including individualized
 1858 | plans for the use of restraints or seclusion in emergency
 1859 | situations; establish professional qualifications of and
 1860 | training for staff who may order or be engaged in the use of
 1861 | restraint or seclusion; establish requirements for facility data
 1862 | collection and reporting relating to the use of restraint and
 1863 | seclusion; and establish procedures relating to the
 1864 | documentation of the use of restraint or seclusion in the
 1865 | client's facility or program record.

1866 | (3) The agency shall adopt rules to provide that, when the
 1867 | criteria established under this part and part II of chapter 408
 1868 | are not met, such violations ~~deficiencies~~ shall be classified
 1869 | according to the nature of the violation ~~deficiency~~. The agency
 1870 | shall indicate the classification on the face of the notice of
 1871 | violation ~~deficiencies~~ as follows:

1872 | (a) A class I violation is defined in s. 408.813
 1873 | ~~deficiencies are those which the agency determines present an~~
 1874 | ~~imminent danger to the residents or guests of the facility or a~~
 1875 | ~~substantial probability that death or serious physical harm~~
 1876 | ~~would result therefrom. The condition or practice constituting a~~

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1877 ~~class I violation must be abated or eliminated immediately,~~
 1878 ~~unless a fixed period of time, as determined by the agency, is~~
 1879 ~~required for correction.~~ A class I violation deficiency is
 1880 subject to a civil penalty in an amount not less than \$5,000 and
 1881 not exceeding \$10,000 for each violation deficiency. A fine may
 1882 be levied notwithstanding the correction of the violation
 1883 deficiency.

1884 (b) A class II violation is defined in s. 408.813
 1885 ~~deficiencies are those which the agency determines have a direct~~
 1886 ~~or immediate relationship to the health, safety, or security of~~
 1887 ~~the facility residents, other than class I deficiencies.~~ A class
 1888 II violation deficiency is subject to a civil penalty in an
 1889 amount not less than \$1,000 and not exceeding \$5,000 for each
 1890 violation deficiency. A citation for a class II violation
 1891 deficiency shall specify the time within which the violation
 1892 deficiency must be corrected. If a class II violation deficiency
 1893 is corrected within the time specified, no civil penalty shall
 1894 be imposed, unless it is a repeated offense.

1895 (c) A class III violation is defined in s. 408.813
 1896 ~~deficiencies are those which the agency determines to have an~~
 1897 ~~indirect or potential relationship to the health, safety, or~~
 1898 ~~security of the facility residents, other than class I or class~~
 1899 ~~II deficiencies.~~ A class III violation deficiency is subject to
 1900 a civil penalty of not less than \$500 and not exceeding \$1,000
 1901 for each violation deficiency. A citation for a class III
 1902 violation deficiency shall specify the time within which the
 1903 violation deficiency must be corrected. If a class III violation
 1904 deficiency is corrected within the time specified, no civil

1905 penalty shall be imposed, unless it is a repeated offense.

1906 (d) A class IV violation is defined in s. 408.813. Upon
 1907 finding an uncorrected or repeated class IV violation, the
 1908 agency shall impose an administrative fine not to exceed \$500
 1909 for each occurrence and each day that the uncorrected or
 1910 repeated violation exists.

1911 (4) The agency shall approve or disapprove the plans and
 1912 specifications within 60 days after receipt of the final plans
 1913 and specifications. The agency may be granted one 15-day
 1914 extension for the review period, if the secretary of the agency
 1915 so approves. If the agency fails to act within the specified
 1916 time, it is deemed to have approved the plans and
 1917 specifications. When the agency disapproves plans and
 1918 specifications, it must set forth in writing the reasons for
 1919 disapproval. Conferences and consultations may be provided as
 1920 necessary.

1921 (5) The agency may charge an initial fee of \$2,000 for
 1922 review of plans and construction on all projects, no part of
 1923 which is refundable. The agency may also collect a fee, not to
 1924 exceed 1 percent of the estimated construction cost or the
 1925 actual cost of review, whichever is less, for the portion of the
 1926 review which encompasses initial review through the initial
 1927 revised construction document review. The agency may collect its
 1928 actual costs on all subsequent portions of the review and
 1929 construction inspections. Initial fee payment must accompany the
 1930 initial submission of plans and specifications. Any subsequent
 1931 payment that is due is payable upon receipt of the invoice from
 1932 the agency. Notwithstanding any other provision of law, all

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1933 money received by the agency under this section shall be deemed
 1934 to be trust funds, to be held and applied solely for the
 1935 operations required under this section.

1936 Section 44. Subsections (4) and (7) of section 400.9905,
 1937 Florida Statutes, are amended to read:

1938 400.9905 Definitions.—

1939 (4) "Clinic" means an entity at which health care services
 1940 are provided to individuals and which tenders charges for
 1941 reimbursement for such services, including a mobile clinic and a
 1942 portable health service or equipment provider. For purposes of
 1943 this part, the term does not include and the licensure
 1944 requirements of this part do not apply to:

1945 (a) Entities licensed or registered by the state under
 1946 chapter 395; or entities licensed or registered by the state and
 1947 providing only health care services within the scope of services
 1948 authorized under their respective licenses granted under ss.
 1949 383.30-383.335, chapter 390, chapter 394, chapter 397, this
 1950 chapter except part X, chapter 429, chapter 463, chapter 465,
 1951 chapter 466, chapter 478, part I of chapter 483, chapter 484, or
 1952 chapter 651; end-stage renal disease providers authorized under
 1953 42 C.F.R. part 405, subpart U; or providers certified under 42
 1954 C.F.R. part 485, subpart B or subpart H; or any entity that
 1955 provides neonatal or pediatric hospital-based health care
 1956 services or other health care services by licensed practitioners
 1957 solely within a hospital licensed under chapter 395.

1958 (b) Entities that own, directly or indirectly, entities
 1959 licensed or registered by the state pursuant to chapter 395; or
 1960 entities that own, directly or indirectly, entities licensed or

1961 registered by the state and providing only health care services
 1962 within the scope of services authorized pursuant to their
 1963 respective licenses granted under ss. 383.30-383.335, chapter
 1964 390, chapter 394, chapter 397, this chapter except part X,
 1965 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
 1966 part I of chapter 483, chapter 484, chapter 651; end-stage renal
 1967 disease providers authorized under 42 C.F.R. part 405, subpart
 1968 U; or providers certified under 42 C.F.R. part 485, subpart B or
 1969 subpart H; or any entity that provides neonatal or pediatric
 1970 hospital-based health care services by licensed practitioners
 1971 solely within a hospital licensed under chapter 395.

1972 (c) Entities that are owned, directly or indirectly, by an
 1973 entity licensed or registered by the state pursuant to chapter
 1974 395; or entities that are owned, directly or indirectly, by an
 1975 entity licensed or registered by the state and providing only
 1976 health care services within the scope of services authorized
 1977 pursuant to their respective licenses granted under ss. 383.30-
 1978 383.335, chapter 390, chapter 394, chapter 397, this chapter
 1979 except part X, chapter 429, chapter 463, chapter 465, chapter
 1980 466, chapter 478, part I of chapter 483, chapter 484, or chapter
 1981 651; end-stage renal disease providers authorized under 42
 1982 C.F.R. part 405, subpart U; or providers certified under 42
 1983 C.F.R. part 485, subpart B or subpart H; or any entity that
 1984 provides neonatal or pediatric hospital-based health care
 1985 services by licensed practitioners solely within a hospital
 1986 under chapter 395.

1987 (d) Entities that are under common ownership, directly or
 1988 indirectly, with an entity licensed or registered by the state

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1989 | pursuant to chapter 395; or entities that are under common
 1990 | ownership, directly or indirectly, with an entity licensed or
 1991 | registered by the state and providing only health care services
 1992 | within the scope of services authorized pursuant to their
 1993 | respective licenses granted under ss. 383.30-383.335, chapter
 1994 | 390, chapter 394, chapter 397, this chapter except part X,
 1995 | chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
 1996 | part I of chapter 483, chapter 484, or chapter 651; end-stage
 1997 | renal disease providers authorized under 42 C.F.R. part 405,
 1998 | subpart U; or providers certified under 42 C.F.R. part 485,
 1999 | subpart B or subpart H; or any entity that provides neonatal or
 2000 | pediatric hospital-based health care services by licensed
 2001 | practitioners solely within a hospital licensed under chapter
 2002 | 395.

2003 | (e) An entity that is exempt from federal taxation under
 2004 | 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
 2005 | under 26 U.S.C. s. 409 that has a board of trustees not less
 2006 | than two-thirds of which are Florida-licensed health care
 2007 | practitioners and provides only physical therapy services under
 2008 | physician orders, any community college or university clinic,
 2009 | and any entity owned or operated by the federal or state
 2010 | government, including agencies, subdivisions, or municipalities
 2011 | thereof.

2012 | (f) A sole proprietorship, group practice, partnership, or
 2013 | corporation that provides health care services by physicians
 2014 | covered by s. 627.419, that is directly supervised by one or
 2015 | more of such physicians, and that is wholly owned by one or more
 2016 | of those physicians or by a physician and the spouse, parent,

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2017 | child, or sibling of that physician.

2018 | (g) A sole proprietorship, group practice, partnership, or
 2019 | corporation that provides health care services by licensed
 2020 | health care practitioners under chapter 457, chapter 458,
 2021 | chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
 2022 | chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
 2023 | chapter 490, chapter 491, or part I, part III, part X, part
 2024 | XIII, or part XIV of chapter 468, or s. 464.012, which are
 2025 | wholly owned by one or more licensed health care practitioners,
 2026 | or the licensed health care practitioners set forth in this
 2027 | paragraph and the spouse, parent, child, or sibling of a
 2028 | licensed health care practitioner, so long as one of the owners
 2029 | who is a licensed health care practitioner is supervising the
 2030 | business activities and is legally responsible for the entity's
 2031 | compliance with all federal and state laws. However, a health
 2032 | care practitioner may not supervise services beyond the scope of
 2033 | the practitioner's license, except that, for the purposes of
 2034 | this part, a clinic owned by a licensee in s. 456.053(3)(b) that
 2035 | provides only services authorized pursuant to s. 456.053(3)(b)
 2036 | may be supervised by a licensee specified in s. 456.053(3)(b).

2037 | (h) Clinical facilities affiliated with an accredited
 2038 | medical school at which training is provided for medical
 2039 | students, residents, or fellows.

2040 | (i) Entities that provide only oncology or radiation
 2041 | therapy services by physicians licensed under chapter 458 or
 2042 | chapter 459 or entities that provide oncology or radiation
 2043 | therapy services by physicians licensed under chapter 458 or
 2044 | chapter 459 which are owned by a corporation whose shares are

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2045 publicly traded on a recognized stock exchange.

2046 (j) Clinical facilities affiliated with a college of
 2047 chiropractic accredited by the Council on Chiropractic Education
 2048 at which training is provided for chiropractic students.

2049 (k) Entities that provide licensed practitioners to staff
 2050 emergency departments or to deliver anesthesia services in
 2051 facilities licensed under chapter 395 and that derive at least
 2052 90 percent of their gross annual revenues from the provision of
 2053 such services. Entities claiming an exemption from licensure
 2054 under this paragraph must provide documentation demonstrating
 2055 compliance.

2056 (l) Orthotic, ~~or~~ prosthetic, pediatric cardiology,
 2057 perinatology, or anesthesia clinical facilities that are a
 2058 publicly traded corporation or that are wholly owned, directly
 2059 or indirectly, by a publicly traded corporation. As used in this
 2060 paragraph, a publicly traded corporation is a corporation that
 2061 issues securities traded on an exchange registered with the
 2062 United States Securities and Exchange Commission as a national
 2063 securities exchange.

2064 (m) Entities that are owned by a corporation that has \$250
 2065 million or more in total annual sales of health care services
 2066 provided by licensed health care practitioners when one or more
 2067 of the owners of the entity is a health care practitioner who is
 2068 licensed in this state, is responsible for supervising the
 2069 business activities of the entity, and is legally responsible
 2070 for the entity's compliance with state law for purposes of this
 2071 section.

2072 (n) Entities that are owned or controlled, directly or

2073 indirectly, by a publicly traded entity with \$100 million or
 2074 more, in the aggregate, in total annual revenues derived from
 2075 providing health care services by licensed health care
 2076 practitioners that are employed or contracted by an entity
 2077 described in this paragraph.

2078 (o) Entities that employ 50 or more licensed health care
 2079 practitioners licensed under chapter 458 or chapter 459 when the
 2080 billing for medical services is under a single tax
 2081 identification number. The application for exemption from
 2082 licensure requirements under this paragraph shall contain the
 2083 name, residence address, business address, and phone numbers of
 2084 the entity that owns the clinic; a complete list of the names
 2085 and contact information of all the officers and directors of the
 2086 corporation; the name, residence address, business address, and
 2087 medical practitioner license number of each health care
 2088 practitioner employed by the entity; the corporate tax
 2089 identification number of the entity seeking an exemption; a
 2090 listing of health care services to be provided by the entity at
 2091 the health care clinics owned or operated by the entity; and a
 2092 certified statement prepared by an independent certified public
 2093 accountant which states that the entity and the health care
 2094 clinics owned or operated by the entity have not received
 2095 payment for health care services under personal injury
 2096 protection insurance coverage for the preceding year. If the
 2097 agency determines that an entity that is exempt under this
 2098 paragraph has received payments for medical services under
 2099 personal injury protection insurance coverage, the agency may
 2100 deny or revoke the exemption from licensure under this

2101 paragraph.

2102 (7) "Portable health service or equipment provider" means
 2103 an entity that contracts with or employs persons to provide
 2104 portable health services or equipment to multiple locations
 2105 ~~performing treatment or diagnostic testing of individuals,~~ that
 2106 bills third-party payors for those services, and that otherwise
 2107 meets the definition of a clinic in subsection (4).

2108 Section 45. Paragraph (b) of subsection (1) and subsection
 2109 (4) of section 400.991, Florida Statutes, are amended to read:

2110 400.991 License requirements; background screenings;
 2111 prohibitions.—

2112 (1)

2113 (b) Each mobile clinic must obtain a separate health care
 2114 clinic license and must provide to the agency, at least
 2115 quarterly, its projected street location to enable the agency to
 2116 locate and inspect such clinic. A portable health service or
 2117 equipment provider must obtain a health care clinic license for
 2118 a single administrative office and is not required to submit
 2119 quarterly projected street locations.

2120 (4) In addition to the requirements of part II of chapter
 2121 408, the applicant must file with the application satisfactory
 2122 proof that the clinic is in compliance with this part and
 2123 applicable rules, including:

2124 (a) A listing of services to be provided either directly
 2125 by the applicant or through contractual arrangements with
 2126 existing providers;

2127 (b) The number and discipline of each professional staff
 2128 member to be employed; and

2129 (c) Proof of financial ability to operate as required
 2130 under ss. s. 408.810(8) and 408.8065. ~~As an alternative to~~
 2131 ~~submitting proof of financial ability to operate as required~~
 2132 ~~under s. 408.810(8), the applicant may file a surety bond of at~~
 2133 ~~least \$500,000 which guarantees that the clinic will act in full~~
 2134 ~~conformity with all legal requirements for operating a clinic,~~
 2135 ~~payable to the agency. The agency may adopt rules to specify~~
 2136 ~~related requirements for such surety bond.~~

2137 Section 46. Paragraph (a) of subsection (2) of section
 2138 408.033, Florida Statutes, is amended to read:

2139 408.033 Local and state health planning.—

2140 (2) FUNDING.—

2141 (a) The Legislature intends that the cost of local health
 2142 councils be borne by assessments on selected health care
 2143 facilities subject to facility licensure by the Agency for
 2144 Health Care Administration, including abortion clinics, assisted
 2145 living facilities, ambulatory surgical centers, birthing
 2146 centers, clinical laboratories except community nonprofit blood
 2147 banks and clinical laboratories operated by practitioners for
 2148 exclusive use regulated under s. 483.035, home health agencies,
 2149 hospices, hospitals, intermediate care facilities for the
 2150 developmentally disabled, nursing homes, health care clinics,
 2151 and multiphasic testing centers and by assessments on
 2152 organizations subject to certification by the agency pursuant to
 2153 chapter 641, part III, including health maintenance
 2154 organizations and prepaid health clinics. Fees assessed may be
 2155 collected prospectively at the time of licensure renewal and
 2156 prorated for the licensure period.

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2157 Section 47. Subsection (2) of section 408.034, Florida
 2158 Statutes, is amended to read:

2159 408.034 Duties and responsibilities of agency; rules.—

2160 (2) In the exercise of its authority to issue licenses to
 2161 health care facilities and health service providers, as provided
 2162 under chapters 393 and 395 and parts II, ~~and IV,~~ and VIII of
 2163 chapter 400, the agency may not issue a license to any health
 2164 care facility or health service provider that fails to receive a
 2165 certificate of need or an exemption for the licensed facility or
 2166 service.

2167 Section 48. Paragraph (d) of subsection (1) of section
 2168 408.036, Florida Statutes, is amended to read:

2169 408.036 Projects subject to review; exemptions.—

2170 (1) APPLICABILITY.—Unless exempt under subsection (3), all
 2171 health-care-related projects, as described in paragraphs (a)-
 2172 (g), are subject to review and must file an application for a
 2173 certificate of need with the agency. The agency is exclusively
 2174 responsible for determining whether a health-care-related
 2175 project is subject to review under ss. 408.031-408.045.

2176 (d) The establishment of a hospice or hospice inpatient
 2177 facility, ~~except as provided in s. 408.043.~~

2178 Section 49. Paragraph (c) of subsection (1) of section
 2179 408.037, Florida Statutes, is amended to read:

2180 408.037 Application content.—

2181 (1) Except as provided in subsection (2) for a general
 2182 hospital, an application for a certificate of need must contain:

2183 (c) An audited financial statement of the applicant or the
 2184 applicant's parent corporation if audited financial statements

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2185 of the applicant do not exist. In an application submitted by an
 2186 existing health care facility, health maintenance organization,
 2187 or hospice, financial condition documentation must include, but
 2188 need not be limited to, a balance sheet and a profit-and-loss
 2189 statement of the 2 previous fiscal years' operation.

2190 Section 50. Subsection (2) of section 408.043, Florida
 2191 Statutes, is amended to read:

2192 408.043 Special provisions.—

2193 (2) HOSPICES.—When an application is made for a
 2194 certificate of need to establish or to expand a hospice, the
 2195 need for such hospice shall be determined on the basis of the
 2196 need for and availability of hospice services in the community.
 2197 The formula on which the certificate of need is based shall
 2198 discourage regional monopolies and promote competition. The
 2199 inpatient hospice care component of a hospice which is a
 2200 freestanding facility, or a part of a facility, ~~which is~~
 2201 ~~primarily engaged in providing inpatient care and related~~
 2202 ~~services~~ and is not licensed as a health care facility shall
 2203 also be required to obtain a certificate of need. Provision of
 2204 hospice care by any current provider of health care is a
 2205 significant change in service and therefore requires a
 2206 certificate of need for such services.

2207 Section 51. Paragraph (a) of subsection (1) of section
 2208 408.061, Florida Statutes, is amended to read:

2209 408.061 Data collection; uniform systems of financial
 2210 reporting; information relating to physician charges;
 2211 confidential information; immunity.—

2212 (1) The agency shall require the submission by health care

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2213 facilities, health care providers, and health insurers of data
2214 necessary to carry out the agency's duties. Specifications for
2215 data to be collected under this section shall be developed by
2216 the agency with the assistance of technical advisory panels
2217 including representatives of affected entities, consumers,
2218 purchasers, and such other interested parties as may be
2219 determined by the agency.

2220 (a) Data submitted by health care facilities, including
2221 the facilities as defined in chapter 395, shall include, but are
2222 not limited to: case-mix data, patient admission and discharge
2223 data, hospital emergency department data which shall include the
2224 number of patients treated in the emergency department of a
2225 licensed hospital reported by patient acuity level, data on
2226 hospital-acquired infections as specified by rule, data on
2227 complications as specified by rule, data on readmissions as
2228 specified by rule, with patient and provider-specific
2229 identifiers included, actual charge data by diagnostic groups,
2230 financial data, accounting data, operating expenses, expenses
2231 incurred for rendering services to patients who cannot or do not
2232 pay, interest charges, depreciation expenses based on the
2233 expected useful life of the property and equipment involved, and
2234 demographic data. The agency shall adopt nationally recognized
2235 risk adjustment methodologies or software consistent with the
2236 standards of the Agency for Healthcare Research and Quality and
2237 as selected by the agency for all data submitted as required by
2238 this section. Data may be obtained from documents such as, but
2239 not limited to: leases, contracts, debt instruments, itemized
2240 patient bills, medical record abstracts, and related diagnostic

2241 information. Reported data elements shall be reported
 2242 electronically and ~~in accordance with rule 59E-7.012, Florida~~
 2243 ~~Administrative Code. Data submitted shall be~~ certified by the
 2244 chief executive officer or an appropriate and duly authorized
 2245 representative or employee of the licensed facility that the
 2246 information submitted is true and accurate.

2247 Section 52. Subsection (43) of section 408.07, Florida
 2248 Statutes, is amended to read:

2249 408.07 Definitions.—As used in this chapter, with the
 2250 exception of ss. 408.031-408.045, the term:

2251 (43) "Rural hospital" means an acute care hospital
 2252 licensed under chapter 395, having 100 or fewer licensed beds
 2253 and an emergency room, and which is:

2254 (a) The sole provider within a county with a population
 2255 density of no greater than 100 persons per square mile;

2256 (b) An acute care hospital, in a county with a population
 2257 density of no greater than 100 persons per square mile, which is
 2258 at least 30 minutes of travel time, on normally traveled roads
 2259 under normal traffic conditions, from another acute care
 2260 hospital within the same county;

2261 (c) A hospital supported by a tax district or subdistrict
 2262 whose boundaries encompass a population of 100 persons or fewer
 2263 per square mile;

2264 (d) A hospital with a service area that has a population
 2265 of 100 persons or fewer per square mile. As used in this
 2266 paragraph, the term "service area" means the fewest number of
 2267 zip codes that account for 75 percent of the hospital's
 2268 discharges for the most recent 5-year period, based on

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2269 information available from the hospital inpatient discharge
 2270 database in the Florida Center for Health Information and Policy
 2271 Analysis at the Agency for Health Care Administration; or
 2272 (e) A critical access hospital.

2273
 2274 Population densities used in this subsection must be based upon
 2275 the most recently completed United States census. A hospital
 2276 that received funds under s. 409.9116 for a quarter beginning no
 2277 later than July 1, 2002, is deemed to have been and shall
 2278 continue to be a rural hospital from that date through June 30,
 2279 2015, if the hospital continues to have 100 or fewer licensed
 2280 beds and an emergency room, ~~or meets the criteria of s.~~
 2281 ~~395.602(2)(c)4.~~ An acute care hospital that has not previously
 2282 been designated as a rural hospital and that meets the criteria
 2283 of this subsection shall be granted such designation upon
 2284 application, including supporting documentation, to the Agency
 2285 for Health Care Administration.

2286 Section 53. Section 408.10, Florida Statutes, is amended
 2287 to read:

2288 408.10 Consumer complaints.—The agency shall:
 2289 ~~(1)~~ publish and make available to the public a toll-free
 2290 telephone number for the purpose of handling consumer complaints
 2291 and shall serve as a liaison between consumer entities and other
 2292 private entities and governmental entities for the disposition
 2293 of problems identified by consumers of health care.

2294 ~~(2) Be empowered to investigate consumer complaints~~
 2295 ~~relating to problems with health care facilities' billing~~
 2296 ~~practices and issue reports to be made public in any cases where~~

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2297 ~~the agency determines the health care facility has engaged in~~
 2298 ~~billing practices which are unreasonable and unfair to the~~
 2299 ~~consumer.~~

2300 Section 54. Effective upon this act becoming a law,
 2301 section 408.7056, Florida Statutes, is amended to read:

2302 408.7056 Subscriber Assistance Program.—

2303 (1) As used in this section, the term:

2304 (a) "Agency" means the Agency for Health Care
 2305 Administration.

2306 (b) "Department" means the Department of Financial
 2307 Services.

2308 (c) "Grievance procedure" means an established set of
 2309 rules that specify a process for appeal of an organizational
 2310 decision.

2311 (d) "Health care provider" or "provider" means a state-
 2312 licensed or state-authorized facility, a facility principally
 2313 supported by a local government or by funds from a charitable
 2314 organization that holds a current exemption from federal income
 2315 tax under s. 501(c)(3) of the Internal Revenue Code, a licensed
 2316 practitioner, a county health department established under part
 2317 I of chapter 154, a prescribed pediatric extended care center
 2318 defined in s. 400.902, a federally supported primary care
 2319 program such as a migrant health center or a community health
 2320 center authorized under s. 329 or s. 330 of the United States
 2321 Public Health Services Act that delivers health care services to
 2322 individuals, or a community facility that receives funds from
 2323 the state under the Community Alcohol, Drug Abuse, and Mental
 2324 Health Services Act and provides mental health services to

2325 individuals.

2326 (e) "Managed care entity" means a health maintenance
 2327 organization or a prepaid health clinic certified under chapter
 2328 641, a prepaid health plan authorized under s. 409.912, or an
 2329 exclusive provider organization certified under s. 627.6472.

2330 (f) "Office" means the Office of Insurance Regulation of
 2331 the Financial Services Commission.

2332 (g) "Panel" means a subscriber assistance panel selected
 2333 as provided in subsection (11).

2334 (2) The agency shall adopt and implement a program to
 2335 provide assistance to subscribers, including those whose
 2336 grievances are not resolved by the managed care entity to the
 2337 satisfaction of the subscriber. The program shall consist of one
 2338 or more panels that meet as often as necessary to timely review,
 2339 consider, and hear grievances and recommend to the agency or the
 2340 office any actions that should be taken concerning individual
 2341 cases heard by the panel. The panel shall hear every grievance
 2342 filed by subscribers on behalf of subscribers, unless the
 2343 grievance:

2344 (a) Relates to a managed care entity's refusal to accept a
 2345 provider into its network of providers;

2346 (b) Is part of an internal grievance in a Medicare managed
 2347 care entity or a reconsideration appeal through the Medicare
 2348 appeals process which does not involve a quality of care issue;

2349 (c) Is related to a health plan not regulated by the state
 2350 such as an administrative services organization, third-party
 2351 administrator, or federal employee health benefit program;

2352 (d) Is related to appeals by in-plan suppliers and

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2353 providers, unless related to quality of care provided by the
 2354 plan;

2355 (e) Is part of a Medicaid fair hearing pursued under 42
 2356 C.F.R. ss. 431.220 et seq.;

2357 (f) Is the basis for an action pending in state or federal
 2358 court;

2359 (g) Is related to an appeal by nonparticipating providers,
 2360 unless related to the quality of care provided to a subscriber
 2361 by the managed care entity and the provider is involved in the
 2362 care provided to the subscriber;

2363 (h) Was filed before the subscriber completed the entire
 2364 internal grievance procedure of the managed care entity, the
 2365 managed care entity has complied with its timeframes for
 2366 completing the internal grievance procedure, and the
 2367 circumstances described in subsection (6) do not apply;

2368 (i) Has been resolved to the satisfaction of the
 2369 subscriber who filed the grievance, unless the managed care
 2370 entity's initial action is egregious or may be indicative of a
 2371 pattern of inappropriate behavior;

2372 (j) Is limited to seeking damages for pain and suffering,
 2373 lost wages, or other incidental expenses, including accrued
 2374 interest on unpaid balances, court costs, and transportation
 2375 costs associated with a grievance procedure;

2376 (k) Is limited to issues involving conduct of a health
 2377 care provider or facility, staff member, or employee of a
 2378 managed care entity which constitute grounds for disciplinary
 2379 action by the appropriate professional licensing board and is
 2380 not indicative of a pattern of inappropriate behavior, and the

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2381 agency, office, or department has reported these grievances to
2382 the appropriate professional licensing board or to the health
2383 facility regulation section of the agency for possible
2384 investigation; or

2385 (1) Is withdrawn by the subscriber. Failure of the
2386 subscriber to attend the hearing shall be considered a
2387 withdrawal of the grievance.

2388 (3) The agency shall review all grievances within 60 days
2389 after receipt and make a determination whether the grievance
2390 shall be heard. Once the agency notifies the panel, the
2391 subscriber, and the managed care entity that a grievance will be
2392 heard by the panel, the panel shall hear the grievance either in
2393 the network area or by teleconference no later than 120 days
2394 after the date the grievance was filed. The agency shall notify
2395 the parties, in writing, by facsimile transmission, or by phone,
2396 of the time and place of the hearing. The panel may take
2397 testimony under oath, request certified copies of documents, and
2398 take similar actions to collect information and documentation
2399 that will assist the panel in making findings of fact and a
2400 recommendation. The panel shall issue a written recommendation,
2401 supported by findings of fact, to the subscriber, to the managed
2402 care entity, and to the agency or the office no later than 15
2403 working days after hearing the grievance. If at the hearing the
2404 panel requests additional documentation or additional records,
2405 the time for issuing a recommendation is tolled until the
2406 information or documentation requested has been provided to the
2407 panel. The proceedings of the panel are not subject to chapter
2408 120.

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2409 (4) If, upon receiving a proper patient authorization
2410 along with a properly filed grievance, the agency requests
2411 records from a health care provider or managed care entity, the
2412 health care provider or managed care entity that has custody of
2413 the records has 10 days to provide the records to the agency.
2414 Records include medical records, communication logs associated
2415 with the grievance both to and from the subscriber, and
2416 contracts. Failure to provide requested records may result in
2417 the imposition of a fine of up to \$500. Each day that records
2418 are not produced is considered a separate violation.

2419 (5) Grievances that the agency determines pose an
2420 immediate and serious threat to a subscriber's health must be
2421 given priority over other grievances. The panel may meet at the
2422 call of the chair to hear the grievances as quickly as possible
2423 but no later than 45 days after the date the grievance is filed,
2424 unless the panel receives a waiver of the time requirement from
2425 the subscriber. The panel shall issue a written recommendation,
2426 supported by findings of fact, to the office or the agency
2427 within 10 days after hearing the expedited grievance.

2428 (6) When the agency determines that the life of a
2429 subscriber is in imminent and emergent jeopardy, the chair of
2430 the panel may convene an emergency hearing, within 24 hours
2431 after notification to the managed care entity and to the
2432 subscriber, to hear the grievance. The grievance must be heard
2433 notwithstanding that the subscriber has not completed the
2434 internal grievance procedure of the managed care entity. The
2435 panel shall, upon hearing the grievance, issue a written
2436 emergency recommendation, supported by findings of fact, to the

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2437 managed care entity, to the subscriber, and to the agency or the
 2438 office for the purpose of deferring the imminent and emergent
 2439 jeopardy to the subscriber's life. Within 24 hours after receipt
 2440 of the panel's emergency recommendation, the agency or office
 2441 may issue an emergency order to the managed care entity. An
 2442 emergency order remains in force until:

2443 (a) The grievance has been resolved by the managed care
 2444 entity;

2445 (b) Medical intervention is no longer necessary; or

2446 (c) The panel has conducted a full hearing under
 2447 subsection (3) and issued a recommendation to the agency or the
 2448 office, and the agency or office has issued a final order.

2449 (7) After hearing a grievance, the panel shall make a
 2450 recommendation to the agency or the office which may include
 2451 specific actions the managed care entity must take to comply
 2452 with state laws or rules regulating managed care entities.

2453 (8) A managed care entity, subscriber, or provider that is
 2454 affected by a panel recommendation may within 10 days after
 2455 receipt of the panel's recommendation, or 72 hours after receipt
 2456 of a recommendation in an expedited grievance, furnish to the
 2457 agency or office written evidence in opposition to the
 2458 recommendation or findings of fact of the panel.

2459 (9) No later than 30 days after the issuance of the
 2460 panel's recommendation and, for an expedited grievance, no later
 2461 than 10 days after the issuance of the panel's recommendation,
 2462 the agency or the office may adopt the panel's recommendation or
 2463 findings of fact in a proposed order or an emergency order, as
 2464 provided in chapter 120, which it shall issue to the managed

2465 care entity. The agency or office may issue a proposed order or
 2466 an emergency order, as provided in chapter 120, imposing fines
 2467 or sanctions, including those contained in ss. 641.25 and
 2468 641.52. The agency or the office may reject all or part of the
 2469 panel's recommendation. All fines collected under this
 2470 subsection must be deposited into the Health Care Trust Fund.

2471 (10) In determining any fine or sanction to be imposed,
 2472 the agency and the office may consider the following factors:

2473 (a) The severity of the noncompliance, including the
 2474 probability that death or serious harm to the health or safety
 2475 of the subscriber will result or has resulted, the severity of
 2476 the actual or potential harm, and the extent to which provisions
 2477 of chapter 641 were violated.

2478 (b) Actions taken by the managed care entity to resolve or
 2479 remedy any quality-of-care grievance.

2480 (c) Any previous incidents of noncompliance by the managed
 2481 care entity.

2482 (d) Any other relevant factors the agency or office
 2483 considers appropriate in a particular grievance.

2484 (11)(a) The panel shall consist of the Insurance Consumer
 2485 Advocate, or designee thereof, established by s. 627.0613; at
 2486 least two members employed by the agency and at least two
 2487 members employed by the department, chosen by their respective
 2488 agencies; a consumer appointed by the Governor; a physician
 2489 appointed by the Governor, as a standing member; and, if
 2490 necessary, physicians who have expertise relevant to the case to
 2491 be heard, on a rotating basis. The agency may contract with a
 2492 medical director, a primary care physician, or both, who shall

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2493 provide additional technical expertise to the panel but shall
2494 not be voting members of the panel. The medical director shall
2495 be selected from a health maintenance organization with a
2496 current certificate of authority to operate in Florida.

2497 (b) A majority of those panel members required under
2498 paragraph (a) shall constitute a quorum for any meeting or
2499 hearing of the panel. A grievance may not be heard or voted upon
2500 at any panel meeting or hearing unless a quorum is present,
2501 except that a minority of the panel may adjourn a meeting or
2502 hearing until a quorum is present. A panel convened for the
2503 purpose of hearing a subscriber's grievance in accordance with
2504 subsections (2) and (3) shall not consist of more than 11
2505 members.

2506 (12) Every managed care entity shall submit a quarterly
2507 report to the agency, the office, and the department listing the
2508 number and the nature of all subscribers' and providers'
2509 grievances which have not been resolved to the satisfaction of
2510 the subscriber or provider after the subscriber or provider
2511 follows the entire internal grievance procedure of the managed
2512 care entity. The agency shall notify all subscribers and
2513 providers included in the quarterly reports of their right to
2514 file an unresolved grievance with the panel.

2515 (13) A proposed order issued by the agency or office which
2516 only requires the managed care entity to take a specific action
2517 under subsection (7) is subject to a summary hearing in
2518 accordance with s. 120.574, unless all of the parties agree
2519 otherwise. If the managed care entity does not prevail at the
2520 hearing, the managed care entity must pay reasonable costs and

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2521 attorney's fees of the agency or the office incurred in that
 2522 proceeding.

2523 (14) (a) Any information that identifies a subscriber which
 2524 is held by the panel, agency, or department pursuant to this
 2525 section is confidential and exempt from the provisions of s.
 2526 119.07(1) and s. 24(a), Art. I of the State Constitution.
 2527 However, at the request of a subscriber or managed care entity
 2528 involved in a grievance procedure, the panel, agency, or
 2529 department shall release information identifying the subscriber
 2530 involved in the grievance procedure to the requesting subscriber
 2531 or managed care entity.

2532 (b) Meetings of the panel shall be open to the public
 2533 unless the provider or subscriber whose grievance will be heard
 2534 requests a closed meeting or the agency or the department
 2535 determines that information which discloses the subscriber's
 2536 medical treatment or history or information relating to internal
 2537 risk management programs as defined in s. 641.55(5)(c), (6), and
 2538 (8) may be revealed at the panel meeting, in which case that
 2539 portion of the meeting during which a subscriber's medical
 2540 treatment or history or internal risk management program
 2541 information is discussed shall be exempt from the provisions of
 2542 s. 286.011 and s. 24(b), Art. I of the State Constitution. All
 2543 closed meetings shall be recorded by a certified court reporter.

2544 (15) Effective May 1, 2012, this section applies only to
 2545 plans that meet the requirements of 45 C.F.R. s. 147.140.

2546 Section 55. Subsections (12) through (30) of section
 2547 408.802, Florida Statutes, are renumbered as subsections (11)
 2548 through (29), respectively, and present subsection (11) of that

2549 section is amended to read:

2550 408.802 Applicability.—The provisions of this part apply
 2551 to the provision of services that require licensure as defined
 2552 in this part and to the following entities licensed, registered,
 2553 or certified by the agency, as described in chapters 112, 383,
 2554 390, 394, 395, 400, 429, 440, 483, and 765:

2555 ~~(11) Private review agents, as provided under part I of~~
 2556 ~~chapter 395.~~

2557 Section 56. Subsection (3) is added to section 408.804,
 2558 Florida Statutes, to read:

2559 408.804 License required; display.—

2560 (3) Any person who knowingly alters, defaces, or falsifies
 2561 a license certificate issued by the agency, or causes or
 2562 procures any person to commit such an offense, commits a
 2563 misdemeanor of the second degree, punishable as provided in s.
 2564 775.082 or s. 775.083. Any licensee or provider who displays an
 2565 altered, defaced, or falsified license certificate is subject to
 2566 the penalties set forth in s. 408.815 and an administrative fine
 2567 of \$1,000 for each day of illegal display.

2568 Section 57. Paragraph (d) of subsection (2) of section
 2569 408.806, Florida Statutes, is amended, and paragraph (e) is
 2570 added to that subsection, to read:

2571 408.806 License application process.—

2572 (2)

2573 ~~(d) The agency shall notify the licensee by mail or~~
 2574 ~~electronically at least 90 days before the expiration of a~~
 2575 ~~license that a renewal license is necessary to continue~~
 2576 ~~operation.~~ The licensee's failure to timely file ~~submit~~ a

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2577 renewal application and license application fee with the agency
2578 shall result in a \$50 per day late fee charged to the licensee
2579 by the agency; however, the aggregate amount of the late fee may
2580 not exceed 50 percent of the licensure fee or \$500, whichever is
2581 less. The agency shall provide a courtesy notice to the licensee
2582 by United States mail, electronically, or by any other manner at
2583 its address of record or mailing address, if provided, at least
2584 90 days before the expiration of a license. This courtesy notice
2585 must inform the licensee of the expiration of the license. If
2586 the agency does not provide the courtesy notice or the licensee
2587 does not receive the courtesy notice, the licensee continues to
2588 be legally obligated to timely file the renewal application and
2589 license application fee with the agency and is not excused from
2590 the payment of a late fee. If an application is received after
2591 the required filing date and exhibits a hand-canceled postmark
2592 obtained from a United States post office dated on or before the
2593 required filing date, no fine will be levied.

2594 (e) The applicant must pay the late fee before a late
2595 application is considered complete and failure to pay the late
2596 fee is considered an omission from the application for licensure
2597 pursuant to paragraph (3) (b).

2598 Section 58. Paragraph (b) of subsection (1) of section
2599 408.8065, Florida Statutes, is amended to read:

2600 408.8065 Additional licensure requirements for home health
2601 agencies, home medical equipment providers, and health care
2602 clinics.—

2603 (1) An applicant for initial licensure, or initial
2604 licensure due to a change of ownership, as a home health agency,

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2605 home medical equipment provider, or health care clinic shall:

2606 (b) Submit projected ~~pro forma~~ financial statements,
 2607 including a balance sheet, income and expense statement, and a
 2608 statement of cash flows for the first 2 years of operation which
 2609 provide evidence that the applicant has sufficient assets,
 2610 credit, and projected revenues to cover liabilities and
 2611 expenses.

2612
 2613 All documents required under this subsection must be prepared in
 2614 accordance with generally accepted accounting principles and may
 2615 be in a compilation form. The financial statements must be
 2616 signed by a certified public accountant.

2617 Section 59. Section 408.809, Florida Statutes, is amended
 2618 to read:

2619 408.809 Background screening; prohibited offenses.—

2620 (1) Level 2 background screening pursuant to chapter 435
 2621 must be conducted through the agency on each of the following
 2622 persons, who are considered employees for the purposes of
 2623 conducting screening under chapter 435:

- 2624 (a) The licensee, if an individual.
- 2625 (b) The administrator or a similarly titled person who is
 2626 responsible for the day-to-day operation of the provider.
- 2627 (c) The financial officer or similarly titled individual
 2628 who is responsible for the financial operation of the licensee
 2629 or provider.

2630 (d) Any person who is a controlling interest if the agency
 2631 has reason to believe that such person has been convicted of any
 2632 offense prohibited by s. 435.04. For each controlling interest

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2633 | who has been convicted of any such offense, the licensee shall
2634 | submit to the agency a description and explanation of the
2635 | conviction at the time of license application.

2636 | (e) Any person, as required by authorizing statutes,
2637 | seeking employment with a licensee or provider who is expected
2638 | to, or whose responsibilities may require him or her to, provide
2639 | personal care or services directly to clients or have access to
2640 | client funds, personal property, or living areas; and any
2641 | person, as required by authorizing statutes, contracting with a
2642 | licensee or provider whose responsibilities require him or her
2643 | to provide personal care or personal services directly to
2644 | clients. Evidence of contractor screening may be retained by the
2645 | contractor's employer or the licensee.

2646 | (2) Every 5 years following his or her licensure,
2647 | employment, or entry into a contract in a capacity that under
2648 | subsection (1) would require level 2 background screening under
2649 | chapter 435, each such person must submit to level 2 background
2650 | rescreening as a condition of retaining such license or
2651 | continuing in such employment or contractual status. For any
2652 | such rescreening, the agency shall request the Department of Law
2653 | Enforcement to forward the person's fingerprints to the Federal
2654 | Bureau of Investigation for a national criminal history record
2655 | check. If the fingerprints of such a person are not retained by
2656 | the Department of Law Enforcement under s. 943.05(2)(g), the
2657 | person must file a complete set of fingerprints with the agency
2658 | and the agency shall forward the fingerprints to the Department
2659 | of Law Enforcement for state processing, and the Department of
2660 | Law Enforcement shall forward the fingerprints to the Federal

2661 Bureau of Investigation for a national criminal history record
 2662 check. The fingerprints may be retained by the Department of Law
 2663 Enforcement under s. 943.05(2)(g). The cost of the state and
 2664 national criminal history records checks required by level 2
 2665 screening may be borne by the licensee or the person
 2666 fingerprinted. Proof of compliance with level 2 screening
 2667 standards submitted within the previous 5 years to meet any
 2668 provider or professional licensure requirements of the agency,
 2669 the Department of Health, the Agency for Persons with
 2670 Disabilities, the Department of Children and Family Services, or
 2671 the Department of Financial Services for an applicant for a
 2672 certificate of authority or provisional certificate of authority
 2673 to operate a continuing care retirement community under chapter
 2674 651 satisfies the requirements of this section if the person
 2675 subject to screening has not been unemployed for more than 90
 2676 days and such proof is accompanied, under penalty of perjury, by
 2677 an affidavit of compliance with the provisions of chapter 435
 2678 and this section using forms provided by the agency.

2679 (3) All fingerprints must be provided in electronic
 2680 format. Screening results shall be reviewed by the agency with
 2681 respect to the offenses specified in s. 435.04 and this section,
 2682 and the qualifying or disqualifying status of the person named
 2683 in the request shall be maintained in a database. The qualifying
 2684 or disqualifying status of the person named in the request shall
 2685 be posted on a secure website for retrieval by the licensee or
 2686 designated agent on the licensee's behalf.

2687 (4) In addition to the offenses listed in s. 435.04, all
 2688 persons required to undergo background screening pursuant to

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2689 | this part or authorizing statutes must not have an arrest
 2690 | awaiting final disposition for, must not have been found guilty
 2691 | of, regardless of adjudication, or entered a plea of nolo
 2692 | contendere or guilty to, and must not have been adjudicated
 2693 | delinquent and the record not have been sealed or expunged for
 2694 | any of the following offenses or any similar offense of another
 2695 | jurisdiction:

2696 | (a) Any authorizing statutes, if the offense was a felony.

2697 | (b) This chapter, if the offense was a felony.

2698 | (c) Section 409.920, relating to Medicaid provider fraud.

2699 | (d) Section 409.9201, relating to Medicaid fraud.

2700 | (e) Section 741.28, relating to domestic violence.

2701 | (f) Section 817.034, relating to fraudulent acts through
 2702 | mail, wire, radio, electromagnetic, photoelectronic, or
 2703 | photooptical systems.

2704 | (g) Section 817.234, relating to false and fraudulent
 2705 | insurance claims.

2706 | (h) Section 817.505, relating to patient brokering.

2707 | (i) Section 817.568, relating to criminal use of personal
 2708 | identification information.

2709 | (j) Section 817.60, relating to obtaining a credit card
 2710 | through fraudulent means.

2711 | (k) Section 817.61, relating to fraudulent use of credit
 2712 | cards, if the offense was a felony.

2713 | (l) Section 831.01, relating to forgery.

2714 | (m) Section 831.02, relating to uttering forged
 2715 | instruments.

2716 | (n) Section 831.07, relating to forging bank bills,

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2717 checks, drafts, or promissory notes.

2718 (o) Section 831.09, relating to uttering forged bank
2719 bills, checks, drafts, or promissory notes.

2720 (p) Section 831.30, relating to fraud in obtaining
2721 medicinal drugs.

2722 (q) Section 831.31, relating to the sale, manufacture,
2723 delivery, or possession with the intent to sell, manufacture, or
2724 deliver any counterfeit controlled substance, if the offense was
2725 a felony.

2726 (5) A person who serves as a controlling interest of, is
2727 employed by, or contracts with a licensee on July 31, 2010, who
2728 has been screened and qualified according to standards specified
2729 in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,
2730 in accordance with the schedule provided in paragraphs (a)-(c).
2731 ~~The agency may adopt rules to establish a schedule to stagger~~
2732 ~~the implementation of the required rescreening over the 5-year~~
2733 ~~period, beginning July 31, 2010, through July 31, 2015.~~ If, upon
2734 rescreening, such person has a disqualifying offense that was
2735 not a disqualifying offense at the time of the last screening,
2736 but is a current disqualifying offense and was committed before
2737 the last screening, he or she may apply for an exemption from
2738 the appropriate licensing agency and, if agreed to by the
2739 employer, may continue to perform his or her duties until the
2740 licensing agency renders a decision on the application for
2741 exemption if the person is eligible to apply for an exemption
2742 and the exemption request is received by the agency within 30
2743 days after receipt of the rescreening results by the person. The
2744 rescreening schedule shall be as follows:

2745 (a) Individuals whose last screening was conducted before
 2746 December 31, 2003, must be rescreened by July 31, 2013.

2747 (b) Individuals whose last screening was conducted between
 2748 January 1, 2004, through December 31, 2007, must be rescreened
 2749 by July 31, 2014.

2750 (c) Individuals whose last screening was conducted between
 2751 January 1, 2008, through July 31, 2010, must be rescreened by
 2752 July 31, 2015.

2753 ~~(6)~~⁽⁵⁾ The costs associated with obtaining the required
 2754 screening must be borne by the licensee or the person subject to
 2755 screening. Licensees may reimburse persons for these costs. The
 2756 Department of Law Enforcement shall charge the agency for
 2757 screening pursuant to s. 943.053(3). The agency shall establish
 2758 a schedule of fees to cover the costs of screening.

2759 ~~(7)~~⁽⁶⁾(a) As provided in chapter 435, the agency may grant
 2760 an exemption from disqualification to a person who is subject to
 2761 this section and who:

- 2762 1. Does not have an active professional license or
- 2763 certification from the Department of Health; or
- 2764 2. Has an active professional license or certification
- 2765 from the Department of Health but is not providing a service
- 2766 within the scope of that license or certification.

2767 (b) As provided in chapter 435, the appropriate regulatory
 2768 board within the Department of Health, or the department itself
 2769 if there is no board, may grant an exemption from
 2770 disqualification to a person who is subject to this section and
 2771 who has received a professional license or certification from
 2772 the Department of Health or a regulatory board within that

2773 department and that person is providing a service within the
 2774 scope of his or her licensed or certified practice.

2775 (8)~~(7)~~ The agency and the Department of Health may adopt
 2776 rules pursuant to ss. 120.536(1) and 120.54 to implement this
 2777 section, chapter 435, and authorizing statutes requiring
 2778 background screening and to implement and adopt criteria
 2779 relating to retaining fingerprints pursuant to s. 943.05(2).

2780 (9)~~(8)~~ There is no unemployment compensation or other
 2781 monetary liability on the part of, and no cause of action for
 2782 damages arising against, an employer that, upon notice of a
 2783 disqualifying offense listed under chapter 435 or this section,
 2784 terminates the person against whom the report was issued,
 2785 whether or not that person has filed for an exemption with the
 2786 Department of Health or the agency.

2787 Section 60. Subsection (9) of section 408.810, Florida
 2788 Statutes, is amended to read:

2789 408.810 Minimum licensure requirements.—In addition to the
 2790 licensure requirements specified in this part, authorizing
 2791 statutes, and applicable rules, each applicant and licensee must
 2792 comply with the requirements of this section in order to obtain
 2793 and maintain a license.

2794 (9) A controlling interest may not withhold from the
 2795 agency any evidence of financial instability, including, but not
 2796 limited to, checks returned due to insufficient funds,
 2797 delinquent accounts, nonpayment of withholding taxes, unpaid
 2798 utility expenses, nonpayment for essential services, or adverse
 2799 court action concerning the financial viability of the provider
 2800 or any other provider licensed under this part that is under the

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2801 control of the controlling interest. A controlling interest
 2802 shall notify the agency within 10 days after a court action to
 2803 initiate bankruptcy, foreclosure, or eviction proceedings
 2804 concerning the provider in which the controlling interest is a
 2805 petitioner or defendant. Any person who violates this subsection
 2806 commits a misdemeanor of the second degree, punishable as
 2807 provided in s. 775.082 or s. 775.083. Each day of continuing
 2808 violation is a separate offense.

2809 Section 61. Subsection (3) is added to section 408.813,
 2810 Florida Statutes, to read:

2811 408.813 Administrative fines; violations.—As a penalty for
 2812 any violation of this part, authorizing statutes, or applicable
 2813 rules, the agency may impose an administrative fine.

2814 (3) The agency may impose an administrative fine for a
 2815 violation that is not designated as a class I, class II, class
 2816 III, or class IV violation. Unless otherwise specified by law,
 2817 the amount of the fine may not exceed \$500 for each violation.

2818 Unclassified violations include:

- 2819 (a) Violating any term or condition of a license.
- 2820 (b) Violating any provision of this part, authorizing
 2821 statutes, or applicable rules.
- 2822 (c) Exceeding licensed capacity.
- 2823 (d) Providing services beyond the scope of the license.
- 2824 (e) Violating a moratorium imposed pursuant to s. 408.814.

2825 Section 62. Subsections (1), (7), and (8) of section
 2826 409.91195, Florida Statutes, are amended to read:

2827 409.91195 Medicaid Pharmaceutical and Therapeutics
 2828 Committee.—There is created a Medicaid Pharmaceutical and

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2829 Therapeutics Committee within the agency for the purpose of
 2830 developing a Medicaid preferred drug list.

2831 (1) The committee shall be composed of 11 members
 2832 appointed by the Governor, consisting of one member licensed
 2833 under chapter 458 or chapter 459 nominated by the Florida
 2834 Medical Association; one member licensed under chapter 459
 2835 nominated by the Florida Osteopathic Medical Association; one
 2836 member licensed under chapter 458 or chapter 459 nominated by
 2837 the Florida chapter of the American Academy of Family
 2838 Physicians; one member licensed under chapter 458 or chapter 459
 2839 nominated by the Florida chapter of the American Academy of
 2840 Pediatrics; one member licensed under chapter 458 or chapter 459
 2841 nominated by the Florida Psychiatric Society; one member
 2842 licensed under chapter 465 nominated by the Florida Pharmacy
 2843 Association; one member licensed under chapter 465 nominated by
 2844 the Florida Society of Health System Pharmacists, Inc.; one
 2845 member licensed under chapter 465 nominated by the Florida
 2846 Retail Federation; one member licensed under chapter 465 who
 2847 works in a retail setting for an independent, nonchain pharmacy;
 2848 one member licensed under chapter 458 or chapter 459 nominated
 2849 by the Florida Academy of Physician Assistants; and one member
 2850 who represents a patient advocacy group and who shall be a
 2851 consumer representative. All members of the committee, except
 2852 the consumer representative, must be licensed to practice in the
 2853 state, must practice in the state, and must participate in the
 2854 Florida Medicaid fee-for-service pharmacy program. ~~Four members~~
 2855 ~~shall be physicians, licensed under chapter 458; one member~~
 2856 ~~licensed under chapter 459; five members shall be pharmacists~~

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2857 ~~licensed under chapter 465; and one member shall be a consumer~~
2858 ~~representative.~~ The members shall be appointed to serve for
2859 terms of 2 years after ~~from~~ the date of their appointment.
2860 Members may be appointed to no more than one term. ~~The agency~~
2861 ~~shall serve as staff for the committee and assist them with all~~
2862 ~~ministerial duties. The Governor shall ensure that at least some~~
2863 ~~of the members of the committee represent Medicaid participating~~
2864 ~~physicians and pharmacies serving all segments and diversity of~~
2865 ~~the Medicaid population, and have experience in either~~
2866 ~~developing or practicing under a preferred drug list. At least~~
2867 ~~one of the members shall represent the interests of~~
2868 ~~pharmaceutical manufacturers.~~

2869 (7) The committee shall ensure that interested parties,
2870 including pharmaceutical manufacturers agreeing to provide a
2871 supplemental rebate as outlined in this chapter, have an
2872 opportunity to present public testimony to the committee with
2873 information or evidence supporting inclusion of a product on the
2874 preferred drug list. Such public testimony shall occur prior to
2875 any recommendations made by the committee for inclusion or
2876 exclusion from the preferred drug list, allow for members of the
2877 committee to ask questions of the presenters of the public
2878 testimony, and allow 3 minutes of testimony per drug reviewed.
2879 The number of interested parties providing public testimony may
2880 not be limited by the agency. Upon timely notice, the agency
2881 shall ensure that any drug that has been approved or had any of
2882 its particular uses approved by the United States Food and Drug
2883 Administration under a priority review classification will be
2884 reviewed by the committee at the next regularly scheduled

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2885 meeting following 3 months of distribution of the drug to the
 2886 general public.

2887 (8) The committee shall develop its preferred drug list
 2888 recommendations by considering the clinical efficacy, safety,
 2889 and cost-effectiveness of a product. Whenever the agency does
 2890 not follow a recommendation by the committee, it must notify the
 2891 committee members in writing of its action at the next committee
 2892 meeting after the reversal of the committee's recommendation.

2893 Section 63. Subsection (37) of section 409.912, Florida
 2894 Statutes, is amended to read:

2895 409.912 Cost-effective purchasing of health care.—The
 2896 agency shall purchase goods and services for Medicaid recipients
 2897 in the most cost-effective manner consistent with the delivery
 2898 of quality medical care. To ensure that medical services are
 2899 effectively utilized, the agency may, in any case, require a
 2900 confirmation or second physician's opinion of the correct
 2901 diagnosis for purposes of authorizing future services under the
 2902 Medicaid program. This section does not restrict access to
 2903 emergency services or poststabilization care services as defined
 2904 in 42 C.F.R. part 438.114. Such confirmation or second opinion
 2905 shall be rendered in a manner approved by the agency. The agency
 2906 shall maximize the use of prepaid per capita and prepaid
 2907 aggregate fixed-sum basis services when appropriate and other
 2908 alternative service delivery and reimbursement methodologies,
 2909 including competitive bidding pursuant to s. 287.057, designed
 2910 to facilitate the cost-effective purchase of a case-managed
 2911 continuum of care. The agency shall also require providers to
 2912 minimize the exposure of recipients to the need for acute

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2913 inpatient, custodial, and other institutional care and the
2914 inappropriate or unnecessary use of high-cost services. The
2915 agency shall contract with a vendor to monitor and evaluate the
2916 clinical practice patterns of providers in order to identify
2917 trends that are outside the normal practice patterns of a
2918 provider's professional peers or the national guidelines of a
2919 provider's professional association. The vendor must be able to
2920 provide information and counseling to a provider whose practice
2921 patterns are outside the norms, in consultation with the agency,
2922 to improve patient care and reduce inappropriate utilization.
2923 The agency may mandate prior authorization, drug therapy
2924 management, or disease management participation for certain
2925 populations of Medicaid beneficiaries, certain drug classes, or
2926 particular drugs to prevent fraud, abuse, overuse, and possible
2927 dangerous drug interactions. The Pharmaceutical and Therapeutics
2928 Committee shall make recommendations to the agency on drugs for
2929 which prior authorization is required. The agency shall inform
2930 the Pharmaceutical and Therapeutics Committee of its decisions
2931 regarding drugs subject to prior authorization. The agency is
2932 authorized to limit the entities it contracts with or enrolls as
2933 Medicaid providers by developing a provider network through
2934 provider credentialing. The agency may competitively bid single-
2935 source-provider contracts if procurement of goods or services
2936 results in demonstrated cost savings to the state without
2937 limiting access to care. The agency may limit its network based
2938 on the assessment of beneficiary access to care, provider
2939 availability, provider quality standards, time and distance
2940 standards for access to care, the cultural competence of the

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2941 provider network, demographic characteristics of Medicaid
2942 beneficiaries, practice and provider-to-beneficiary standards,
2943 appointment wait times, beneficiary use of services, provider
2944 turnover, provider profiling, provider licensure history,
2945 previous program integrity investigations and findings, peer
2946 review, provider Medicaid policy and billing compliance records,
2947 clinical and medical record audits, and other factors. Providers
2948 are not entitled to enrollment in the Medicaid provider network.
2949 The agency shall determine instances in which allowing Medicaid
2950 beneficiaries to purchase durable medical equipment and other
2951 goods is less expensive to the Medicaid program than long-term
2952 rental of the equipment or goods. The agency may establish rules
2953 to facilitate purchases in lieu of long-term rentals in order to
2954 protect against fraud and abuse in the Medicaid program as
2955 defined in s. 409.913. The agency may seek federal waivers
2956 necessary to administer these policies.

2957 (37) (a) The agency shall implement a Medicaid prescribed-
2958 drug spending-control program that includes the following
2959 components:

2960 1. A Medicaid preferred drug list, which shall be a
2961 listing of cost-effective therapeutic options recommended by the
2962 Medicaid Pharmacy and Therapeutics Committee established
2963 pursuant to s. 409.91195 and adopted by the agency for each
2964 therapeutic class on the preferred drug list. At the discretion
2965 of the committee, and when feasible, the preferred drug list
2966 should include at least two products in a therapeutic class. The
2967 agency may post the preferred drug list and updates to the list
2968 on an Internet website without following the rulemaking

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2969 | procedures of chapter 120. Antiretroviral agents are excluded
 2970 | from the preferred drug list. The agency shall also limit the
 2971 | amount of a prescribed drug dispensed to no more than a 34-day
 2972 | supply unless the drug products' smallest marketed package is
 2973 | greater than a 34-day supply, or the drug is determined by the
 2974 | agency to be a maintenance drug in which case a 100-day maximum
 2975 | supply may be authorized. The agency may seek any federal
 2976 | waivers necessary to implement these cost-control programs and
 2977 | to continue participation in the federal Medicaid rebate
 2978 | program, or alternatively to negotiate state-only manufacturer
 2979 | rebates. The agency may adopt rules to administer this
 2980 | subparagraph. The agency shall continue to provide unlimited
 2981 | contraceptive drugs and items. The agency must establish
 2982 | procedures to ensure that:

2983 | a. There is a response to a request for prior consultation
 2984 | by telephone or other telecommunication device within 24 hours
 2985 | after receipt of a request for prior consultation; and

2986 | b. A 72-hour supply of the drug prescribed is provided in
 2987 | an emergency or when the agency does not provide a response
 2988 | within 24 hours as required by sub-subparagraph a.

2989 | 2. Reimbursement to pharmacies for Medicaid prescribed
 2990 | drugs shall be set at the lowest of: the average wholesale price
 2991 | (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
 2992 | plus 1.5 percent, the federal upper limit (FUL), the state
 2993 | maximum allowable cost (SMAC), or the usual and customary (UAC)
 2994 | charge billed by the provider.

2995 | 3. The agency shall develop and implement a process for
 2996 | managing the drug therapies of Medicaid recipients who are using

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2997 | significant numbers of prescribed drugs each month. The
2998 | management process may include, but is not limited to,
2999 | comprehensive, physician-directed medical-record reviews, claims
3000 | analyses, and case evaluations to determine the medical
3001 | necessity and appropriateness of a patient's treatment plan and
3002 | drug therapies. The agency may contract with a private
3003 | organization to provide drug-program-management services. The
3004 | Medicaid drug benefit management program shall include
3005 | initiatives to manage drug therapies for HIV/AIDS patients,
3006 | patients using 20 or more unique prescriptions in a 180-day
3007 | period, and the top 1,000 patients in annual spending. The
3008 | agency shall enroll any Medicaid recipient in the drug benefit
3009 | management program if he or she meets the specifications of this
3010 | provision and is not enrolled in a Medicaid health maintenance
3011 | organization.

3012 | 4. The agency may limit the size of its pharmacy network
3013 | based on need, competitive bidding, price negotiations,
3014 | credentialing, or similar criteria. The agency shall give
3015 | special consideration to rural areas in determining the size and
3016 | location of pharmacies included in the Medicaid pharmacy
3017 | network. A pharmacy credentialing process may include criteria
3018 | such as a pharmacy's full-service status, location, size,
3019 | patient educational programs, patient consultation, disease
3020 | management services, and other characteristics. The agency may
3021 | impose a moratorium on Medicaid pharmacy enrollment if it is
3022 | determined that it has a sufficient number of Medicaid-
3023 | participating providers. The agency must allow dispensing
3024 | practitioners to participate as a part of the Medicaid pharmacy

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3025 network regardless of the practitioner's proximity to any other
3026 entity that is dispensing prescription drugs under the Medicaid
3027 program. A dispensing practitioner must meet all credentialing
3028 requirements applicable to his or her practice, as determined by
3029 the agency.

3030 5. The agency shall develop and implement a program that
3031 requires Medicaid practitioners who prescribe drugs to use a
3032 counterfeit-proof prescription pad for Medicaid prescriptions.
3033 The agency shall require the use of standardized counterfeit-
3034 proof prescription pads by Medicaid-participating prescribers or
3035 prescribers who write prescriptions for Medicaid recipients. The
3036 agency may implement the program in targeted geographic areas or
3037 statewide.

3038 6. The agency may enter into arrangements that require
3039 manufacturers of generic drugs prescribed to Medicaid recipients
3040 to provide rebates of at least 15.1 percent of the average
3041 manufacturer price for the manufacturer's generic products.
3042 These arrangements shall require that if a generic-drug
3043 manufacturer pays federal rebates for Medicaid-reimbursed drugs
3044 at a level below 15.1 percent, the manufacturer must provide a
3045 supplemental rebate to the state in an amount necessary to
3046 achieve a 15.1-percent rebate level.

3047 7. The agency may establish a preferred drug list as
3048 described in this subsection, and, pursuant to the establishment
3049 of such preferred drug list, negotiate supplemental rebates from
3050 manufacturers that are in addition to those required by Title
3051 XIX of the Social Security Act and at no less than 14 percent of
3052 the average manufacturer price as defined in 42 U.S.C. s. 1936

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3053 on the last day of a quarter unless the federal or supplemental
3054 rebate, or both, equals or exceeds 29 percent. There is no upper
3055 limit on the supplemental rebates the agency may negotiate. The
3056 agency may determine that specific products, brand-name or
3057 generic, are competitive at lower rebate percentages. Agreement
3058 to pay the minimum supplemental rebate percentage guarantees a
3059 manufacturer that the Medicaid Pharmaceutical and Therapeutics
3060 Committee will consider a product for inclusion on the preferred
3061 drug list. However, a pharmaceutical manufacturer is not
3062 guaranteed placement on the preferred drug list by simply paying
3063 the minimum supplemental rebate. Agency decisions will be made
3064 on the clinical efficacy of a drug and recommendations of the
3065 Medicaid Pharmaceutical and Therapeutics Committee, as well as
3066 the price of competing products minus federal and state rebates.
3067 The agency may contract with an outside agency or contractor to
3068 conduct negotiations for supplemental rebates. For the purposes
3069 of this section, the term "supplemental rebates" means cash
3070 rebates. Value-added programs as a substitution for supplemental
3071 rebates are prohibited. The agency may seek any federal waivers
3072 to implement this initiative.

3073 8. The agency shall expand home delivery of pharmacy
3074 products. The agency may amend the state plan and issue a
3075 procurement, as necessary, in order to implement this program.
3076 The procurements must include agreements with a pharmacy or
3077 pharmacies located in the state to provide mail order delivery
3078 services at no cost to the recipients who elect to receive home
3079 delivery of pharmacy products. The procurement must focus on
3080 serving recipients with chronic diseases for which pharmacy

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3081 expenditures represent a significant portion of Medicaid
3082 pharmacy expenditures or which impact a significant portion of
3083 the Medicaid population. The agency may seek and implement any
3084 federal waivers necessary to implement this subparagraph.

3085 9. The agency shall limit to one dose per month any drug
3086 prescribed to treat erectile dysfunction.

3087 10.a. The agency may implement a Medicaid behavioral drug
3088 management system. The agency may contract with a vendor that
3089 has experience in operating behavioral drug management systems
3090 to implement this program. The agency may seek federal waivers
3091 to implement this program.

3092 b. The agency, in conjunction with the Department of
3093 Children and Family Services, may implement the Medicaid
3094 behavioral drug management system that is designed to improve
3095 the quality of care and behavioral health prescribing practices
3096 based on best practice guidelines, improve patient adherence to
3097 medication plans, reduce clinical risk, and lower prescribed
3098 drug costs and the rate of inappropriate spending on Medicaid
3099 behavioral drugs. The program may include the following
3100 elements:

3101 (I) Provide for the development and adoption of best
3102 practice guidelines for behavioral health-related drugs such as
3103 antipsychotics, antidepressants, and medications for treating
3104 bipolar disorders and other behavioral conditions; translate
3105 them into practice; review behavioral health prescribers and
3106 compare their prescribing patterns to a number of indicators
3107 that are based on national standards; and determine deviations
3108 from best practice guidelines.

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3109 (II) Implement processes for providing feedback to and
 3110 educating prescribers using best practice educational materials
 3111 and peer-to-peer consultation.

3112 (III) Assess Medicaid beneficiaries who are outliers in
 3113 their use of behavioral health drugs with regard to the numbers
 3114 and types of drugs taken, drug dosages, combination drug
 3115 therapies, and other indicators of improper use of behavioral
 3116 health drugs.

3117 (IV) Alert prescribers to patients who fail to refill
 3118 prescriptions in a timely fashion, are prescribed multiple same-
 3119 class behavioral health drugs, and may have other potential
 3120 medication problems.

3121 (V) Track spending trends for behavioral health drugs and
 3122 deviation from best practice guidelines.

3123 (VI) Use educational and technological approaches to
 3124 promote best practices, educate consumers, and train prescribers
 3125 in the use of practice guidelines.

3126 (VII) Disseminate electronic and published materials.

3127 (VIII) Hold statewide and regional conferences.

3128 (IX) Implement a disease management program with a model
 3129 quality-based medication component for severely mentally ill
 3130 individuals and emotionally disturbed children who are high
 3131 users of care.

3132 11. The agency shall implement a Medicaid prescription
 3133 drug management system.

3134 a. The agency may contract with a vendor that has
 3135 experience in operating prescription drug management systems in
 3136 order to implement this system. Any management system that is

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3137 | implemented in accordance with this subparagraph must rely on
3138 | cooperation between physicians and pharmacists to determine
3139 | appropriate practice patterns and clinical guidelines to improve
3140 | the prescribing, dispensing, and use of drugs in the Medicaid
3141 | program. The agency may seek federal waivers to implement this
3142 | program.

3143 | b. The drug management system must be designed to improve
3144 | the quality of care and prescribing practices based on best
3145 | practice guidelines, improve patient adherence to medication
3146 | plans, reduce clinical risk, and lower prescribed drug costs and
3147 | the rate of inappropriate spending on Medicaid prescription
3148 | drugs. The program must:

3149 | (I) Provide for the adoption of best practice guidelines
3150 | for the prescribing and use of drugs in the Medicaid program,
3151 | including translating best practice guidelines into practice;
3152 | reviewing prescriber patterns and comparing them to indicators
3153 | that are based on national standards and practice patterns of
3154 | clinical peers in their community, statewide, and nationally;
3155 | and determine deviations from best practice guidelines.

3156 | (II) Implement processes for providing feedback to and
3157 | educating prescribers using best practice educational materials
3158 | and peer-to-peer consultation.

3159 | (III) Assess Medicaid recipients who are outliers in their
3160 | use of a single or multiple prescription drugs with regard to
3161 | the numbers and types of drugs taken, drug dosages, combination
3162 | drug therapies, and other indicators of improper use of
3163 | prescription drugs.

3164 | (IV) Alert prescribers to recipients who fail to refill

3165 prescriptions in a timely fashion, are prescribed multiple drugs
 3166 that may be redundant or contraindicated, or may have other
 3167 potential medication problems.

3168 12. The agency may contract for drug rebate
 3169 administration, including, but not limited to, calculating
 3170 rebate amounts, invoicing manufacturers, negotiating disputes
 3171 with manufacturers, and maintaining a database of rebate
 3172 collections.

3173 13. The agency may specify the preferred daily dosing form
 3174 or strength for the purpose of promoting best practices with
 3175 regard to the prescribing of certain drugs as specified in the
 3176 General Appropriations Act and ensuring cost-effective
 3177 prescribing practices.

3178 14. The agency may require prior authorization for
 3179 Medicaid-covered prescribed drugs. The agency may prior-
 3180 authorize the use of a product:

- 3181 a. For an indication not approved in labeling;
- 3182 b. To comply with certain clinical guidelines; or
- 3183 c. If the product has the potential for overuse, misuse,
 3184 or abuse.

3185
 3186 The agency may require the prescribing professional to provide
 3187 information about the rationale and supporting medical evidence
 3188 for the use of a drug. The agency shall ~~may~~ post prior
 3189 authorization and step edit criteria and protocol and updates to
 3190 the list of drugs that are subject to prior authorization on the
 3191 agency's ~~an~~ Internet website within 21 days after the prior
 3192 authorization and step edit criteria and protocol and updates

3193 are approved by the agency. For purposes of this subparagraph,
 3194 the term "step edit" means an automatic electronic review of
 3195 certain medications subject to prior authorization ~~without~~
 3196 ~~amending its rule or engaging in additional rulemaking.~~

3197 15. The agency, in conjunction with the Pharmaceutical and
 3198 Therapeutics Committee, may require age-related prior
 3199 authorizations for certain prescribed drugs. The agency may
 3200 preauthorize the use of a drug for a recipient who may not meet
 3201 the age requirement or may exceed the length of therapy for use
 3202 of this product as recommended by the manufacturer and approved
 3203 by the Food and Drug Administration. Prior authorization may
 3204 require the prescribing professional to provide information
 3205 about the rationale and supporting medical evidence for the use
 3206 of a drug.

3207 16. The agency shall implement a step-therapy prior
 3208 authorization approval process for medications excluded from the
 3209 preferred drug list. Medications listed on the preferred drug
 3210 list must be used within the previous 12 months before the
 3211 alternative medications that are not listed. The step-therapy
 3212 prior authorization may require the prescriber to use the
 3213 medications of a similar drug class or for a similar medical
 3214 indication unless contraindicated in the Food and Drug
 3215 Administration labeling. The trial period between the specified
 3216 steps may vary according to the medical indication. The step-
 3217 therapy approval process shall be developed in accordance with
 3218 the committee as stated in s. 409.91195(7) and (8). A drug
 3219 product may be approved without meeting the step-therapy prior
 3220 authorization criteria if the prescribing physician provides the

3221 agency with additional written medical or clinical documentation
 3222 that the product is medically necessary because:

3223 a. There is not a drug on the preferred drug list to treat
 3224 the disease or medical condition which is an acceptable clinical
 3225 alternative;

3226 b. The alternatives have been ineffective in the treatment
 3227 of the beneficiary's disease; or

3228 c. Based on historic evidence and known characteristics of
 3229 the patient and the drug, the drug is likely to be ineffective,
 3230 or the number of doses have been ineffective.

3231
 3232 The agency shall work with the physician to determine the best
 3233 alternative for the patient. The agency may adopt rules waiving
 3234 the requirements for written clinical documentation for specific
 3235 drugs in limited clinical situations.

3236 17. The agency shall implement a return and reuse program
 3237 for drugs dispensed by pharmacies to institutional recipients,
 3238 which includes payment of a \$5 restocking fee for the
 3239 implementation and operation of the program. The return and
 3240 reuse program shall be implemented electronically and in a
 3241 manner that promotes efficiency. The program must permit a
 3242 pharmacy to exclude drugs from the program if it is not
 3243 practical or cost-effective for the drug to be included and must
 3244 provide for the return to inventory of drugs that cannot be
 3245 credited or returned in a cost-effective manner. The agency
 3246 shall determine if the program has reduced the amount of
 3247 Medicaid prescription drugs which are destroyed on an annual
 3248 basis and if there are additional ways to ensure more

3249 prescription drugs are not destroyed which could safely be
 3250 reused.

3251 (b) The agency shall implement this subsection to the
 3252 extent that funds are appropriated to administer the Medicaid
 3253 prescribed-drug spending-control program. The agency may
 3254 contract all or any part of this program to private
 3255 organizations.

3256 (c) The agency shall submit quarterly reports to the
 3257 Governor, the President of the Senate, and the Speaker of the
 3258 House of Representatives which must include, but need not be
 3259 limited to, the progress made in implementing this subsection
 3260 and its effect on Medicaid prescribed-drug expenditures.

3261 Section 64. Paragraph (a) of subsection (4) of section
 3262 409.97, Florida Statutes, is amended to read:

3263 409.97 State and local Medicaid partnerships.—

3264 (4) HOSPITAL RATE DISTRIBUTION.—

3265 (a) The agency is authorized to implement a tiered
 3266 hospital rate system to enhance Medicaid payments to all
 3267 hospitals when resources for the tiered rates are available from
 3268 general revenue and such contributions pursuant to subsection
 3269 (1) as are authorized under the General Appropriations Act.

3270 1. Tier 1 hospitals are statutory rural hospitals as
 3271 defined in s. 395.602, statutory teaching hospitals as defined
 3272 in s. 408.07(45), and specialty children's hospitals as defined
 3273 in s. 395.002(26) ~~s. 395.002(28)~~.

3274 2. Tier 2 hospitals are community hospitals not included
 3275 in Tier 1 that provided more than 9 percent of the hospital's
 3276 total inpatient days to Medicaid patients and charity patients,

3277 as defined in s. 409.911, and are located in the jurisdiction of
 3278 a local funding source pursuant to subsection (1).

3279 3. Tier 3 hospitals include all community hospitals.

3280 Section 65. Paragraph (b) of subsection (1) of section
 3281 409.975, Florida Statutes, is amended to read:

3282 409.975 Managed care plan accountability.—In addition to
 3283 the requirements of s. 409.967, plans and providers
 3284 participating in the managed medical assistance program shall
 3285 comply with the requirements of this section.

3286 (1) PROVIDER NETWORKS.—Managed care plans must develop and
 3287 maintain provider networks that meet the medical needs of their
 3288 enrollees in accordance with standards established pursuant to
 3289 s. 409.967(2)(b). Except as provided in this section, managed
 3290 care plans may limit the providers in their networks based on
 3291 credentials, quality indicators, and price.

3292 (b) Certain providers are statewide resources and
 3293 essential providers for all managed care plans in all regions.
 3294 All managed care plans must include these essential providers in
 3295 their networks. Statewide essential providers include:

3296 1. Faculty plans of Florida medical schools.

3297 2. Regional perinatal intensive care centers as defined in
 3298 s. 383.16(2).

3299 3. Hospitals licensed as specialty children's hospitals as
 3300 defined in s. 395.002(26) ~~s. 395.002(28)~~.

3301 4. Accredited and integrated systems serving medically
 3302 complex children that are comprised of separately licensed, but
 3303 commonly owned, health care providers delivering at least the
 3304 following services: medical group home, in-home and outpatient

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3305 nursing care and therapies, pharmacy services, durable medical
 3306 equipment, and Prescribed Pediatric Extended Care.

3307
 3308 Managed care plans that have not contracted with all statewide
 3309 essential providers in all regions as of the first date of
 3310 recipient enrollment must continue to negotiate in good faith.
 3311 Payments to physicians on the faculty of nonparticipating
 3312 Florida medical schools shall be made at the applicable Medicaid
 3313 rate. Payments for services rendered by regional perinatal
 3314 intensive care centers shall be made at the applicable Medicaid
 3315 rate as of the first day of the contract between the agency and
 3316 the plan. Payments to nonparticipating specialty children's
 3317 hospitals shall equal the highest rate established by contract
 3318 between that provider and any other Medicaid managed care plan.

3319 Section 66. (1) Notwithstanding s. 409.975, Florida
 3320 Statutes, and before the selection of managed care plans using
 3321 the invitations to negotiate pursuant to s. 409.966, Florida
 3322 Statutes, essential providers and hospitals determined by the
 3323 Agency for Health Care Administration to be necessary for a
 3324 managed care plan to demonstrate that it has an adequate
 3325 provider service network shall be deemed to be part of that
 3326 managed care plan's network in their application for enrollment
 3327 or expansion under the Medicaid program. Payment under this
 3328 section to essential providers by managed care plans shall be in
 3329 accordance with s. 409.975, Florida Statutes.

3330 (2) This section shall take effect upon this act becoming
 3331 a law.

3332 Section 67. Section 429.11, Florida Statutes, is amended

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3333 to read:

3334 429.11 Initial application for license; ~~provisional~~

3335 ~~license.~~

3336 (1) Each applicant for licensure must comply with all

3337 provisions of part II of chapter 408 and must:

3338 (a) Identify all other homes or facilities, including the

3339 addresses and the license or licenses under which they operate,

3340 if applicable, which are currently operated by the applicant or

3341 administrator and which provide housing, meals, and personal

3342 services to residents.

3343 (b) Provide the location of the facility for which a

3344 license is sought and documentation, signed by the appropriate

3345 local government official, which states that the applicant has

3346 met local zoning requirements.

3347 (c) Provide the name, address, date of birth, social

3348 security number, education, and experience of the administrator,

3349 if different from the applicant.

3350 (2) The applicant shall provide proof of liability

3351 insurance as defined in s. 624.605.

3352 (3) If the applicant is a community residential home, the

3353 applicant must provide proof that it has met the requirements

3354 specified in chapter 419.

3355 (4) The applicant must furnish proof that the facility has

3356 received a satisfactory firesafety inspection. The local

3357 authority having jurisdiction or the State Fire Marshal must

3358 conduct the inspection within 30 days after written request by

3359 the applicant.

3360 (5) The applicant must furnish documentation of a

3361 satisfactory sanitation inspection of the facility by the county
 3362 health department.

3363 ~~(6) In addition to the license categories available in s.~~
 3364 ~~408.808, a provisional license may be issued to an applicant~~
 3365 ~~making initial application for licensure or making application~~
 3366 ~~for a change of ownership. A provisional license shall be~~
 3367 ~~limited in duration to a specific period of time not to exceed 6~~
 3368 ~~months, as determined by the agency.~~

3369 (6)~~(7)~~ A county or municipality may not issue an
 3370 occupational license that is being obtained for the purpose of
 3371 operating a facility regulated under this part without first
 3372 ascertaining that the applicant has been licensed to operate
 3373 such facility at the specified location or locations by the
 3374 agency. The agency shall furnish to local agencies responsible
 3375 for issuing occupational licenses sufficient instruction for
 3376 making such determinations.

3377 Section 68. Subsection (1) of section 429.294, Florida
 3378 Statutes, is amended to read:

3379 429.294 Availability of facility records for investigation
 3380 of resident's rights violations and defenses; penalty.—

3381 (1) Failure to provide complete copies of a resident's
 3382 records, including, but not limited to, all medical records and
 3383 the resident's chart, within the control or possession of the
 3384 facility within 10 days, ~~in accordance with the provisions of s.~~
 3385 ~~400.145,~~ shall constitute evidence of failure of that party to
 3386 comply with good faith discovery requirements and shall waive
 3387 the good faith certificate and presuit notice requirements under
 3388 this part by the requesting party.

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3389 Section 69. Section 429.71, Florida Statutes, is amended
 3390 to read:

3391 429.71 Classification of violations ~~deficiencies~~;
 3392 administrative fines.—

3393 (1) In addition to the requirements of part II of chapter
 3394 408 and in addition to any other liability or penalty provided
 3395 by law, the agency may impose an administrative fine on a
 3396 provider according to the following classification:

3397 (a) Class I violations are defined in s. 408.813 ~~those~~
 3398 ~~conditions or practices related to the operation and maintenance~~
 3399 ~~of an adult family-care home or to the care of residents which~~
 3400 ~~the agency determines present an imminent danger to the~~
 3401 ~~residents or guests of the facility or a substantial probability~~
 3402 ~~that death or serious physical or emotional harm would result~~
 3403 ~~therefrom. The condition or practice that constitutes a class I~~
 3404 ~~violation must be abated or eliminated within 24 hours, unless a~~
 3405 ~~fixed period, as determined by the agency, is required for~~
 3406 ~~correction.~~ A class I violation ~~deficiency~~ is subject to an
 3407 administrative fine in an amount not less than \$500 and not
 3408 exceeding \$1,000 for each violation. ~~A fine may be levied~~
 3409 ~~notwithstanding the correction of the deficiency.~~

3410 (b) Class II violations are defined in s. 408.813 ~~those~~
 3411 ~~conditions or practices related to the operation and maintenance~~
 3412 ~~of an adult family-care home or to the care of residents which~~
 3413 ~~the agency determines directly threaten the physical or~~
 3414 ~~emotional health, safety, or security of the residents, other~~
 3415 ~~than class I violations.~~ A class II violation is subject to an
 3416 administrative fine in an amount not less than \$250 and not

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3417 | ~~exceeding \$500 for each violation. A citation for a class II~~
3418 | ~~violation must specify the time within which the violation is~~
3419 | ~~required to be corrected. If a class II violation is corrected~~
3420 | ~~within the time specified, no civil penalty shall be imposed,~~
3421 | ~~unless it is a repeated offense.~~

3422 | (c) Class III violations are defined in s. 408.813 ~~those~~
3423 | ~~conditions or practices related to the operation and maintenance~~
3424 | ~~of an adult family care home or to the care of residents which~~
3425 | ~~the agency determines indirectly or potentially threaten the~~
3426 | ~~physical or emotional health, safety, or security of residents,~~
3427 | ~~other than class I or class II violations. A class III violation~~
3428 | ~~is subject to an administrative fine in an amount not less than~~
3429 | ~~\$100 and not exceeding \$250 for each violation. A citation for a~~
3430 | ~~class III violation shall specify the time within which the~~
3431 | ~~violation is required to be corrected. If a class III violation~~
3432 | ~~is corrected within the time specified, no civil penalty shall~~
3433 | ~~be imposed, unless it is a repeated violation offense.~~

3434 | (d) Class IV violations are defined in s. 408.813 ~~those~~
3435 | ~~conditions or occurrences related to the operation and~~
3436 | ~~maintenance of an adult family care home, or related to the~~
3437 | ~~required reports, forms, or documents, which do not have the~~
3438 | ~~potential of negatively affecting the residents. A provider that~~
3439 | ~~does not correct A class IV violation within the time limit~~
3440 | ~~specified by the agency is subject to an administrative fine in~~
3441 | ~~an amount not less than \$50 and not exceeding \$100 for each~~
3442 | ~~violation. Any class IV violation that is corrected during the~~
3443 | ~~time the agency survey is conducted will be identified as an~~
3444 | ~~agency finding and not as a violation, unless it is a repeat~~

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3445 violation.

3446 (2) The agency may impose an administrative fine for
 3447 violations which do not qualify as class I, class II, class III,
 3448 or class IV violations. The amount of the fine shall not exceed
 3449 \$250 for each violation or \$2,000 in the aggregate. Unclassified
 3450 violations may include:

3451 (a) Violating any term or condition of a license.

3452 (b) Violating any provision of this part, part II of
 3453 chapter 408, or applicable rules.

3454 (c) Failure to follow the criteria and procedures provided
 3455 under part I of chapter 394 relating to the transportation,
 3456 voluntary admission, and involuntary examination of adult
 3457 family-care home residents.

3458 (d) Exceeding licensed capacity.

3459 (e) Providing services beyond the scope of the license.

3460 (f) Violating a moratorium.

3461 (3) Each day during which a violation occurs constitutes a
 3462 separate offense.

3463 (4) In determining whether a penalty is to be imposed, and
 3464 in fixing the amount of any penalty to be imposed, the agency
 3465 must consider:

3466 (a) The gravity of the violation.

3467 (b) Actions taken by the provider to correct a violation.

3468 (c) Any previous violation by the provider.

3469 (d) The financial benefit to the provider of committing or
 3470 continuing the violation.

3471 ~~(5) As an alternative to or in conjunction with an~~
 3472 ~~administrative action against a provider, the agency may request~~

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3473 ~~a plan of corrective action that demonstrates a good faith~~
 3474 ~~effort to remedy each violation by a specific date, subject to~~
 3475 ~~the approval of the agency.~~

3476 (5)~~(6)~~ The department shall set forth, by rule, notice
 3477 requirements and procedures for correction of deficiencies.

3478 Section 70. Section 429.195, Florida Statutes, is amended
 3479 to read:

3480 429.195 Rebates prohibited; penalties.—

3481 (1) It is unlawful for any assisted living facility
 3482 licensed under this part to contract or promise to pay or
 3483 receive any commission, bonus, kickback, or rebate or engage in
 3484 any split-fee arrangement in any form whatsoever with any
 3485 person, health care provider, or health care facility as
 3486 provided in s. 817.505 ~~physician, surgeon, organization, agency,~~
 3487 ~~or person, either directly or indirectly, for residents referred~~
 3488 ~~to an assisted living facility licensed under this part. A~~
 3489 ~~facility may employ or contract with persons to market the~~
 3490 ~~facility, provided the employee or contract provider clearly~~
 3491 ~~indicates that he or she represents the facility. A person or~~
 3492 ~~agency independent of the facility may provide placement or~~
 3493 ~~referral services for a fee to individuals seeking assistance in~~
 3494 ~~finding a suitable facility; however, any fee paid for placement~~
 3495 ~~or referral services must be paid by the individual looking for~~
 3496 ~~a facility, not by the facility.~~

3497 (2) This section does not apply to:

3498 (a) An individual employed by the assisted living facility
 3499 or with whom the facility contracts to market the facility, if
 3500 the individual clearly indicates that he or she works with or

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3501 for the facility.

3502 (b) Payments by an assisted living facility to a referral
 3503 service that provides information, consultation, or referrals to
 3504 consumers to assist them in finding appropriate care or housing
 3505 options for seniors or disabled adults if such referred
 3506 consumers are not Medicaid recipients.

3507 (c) A resident of an assisted living facility who refers a
 3508 friend, family member, or other individuals with whom the
 3509 resident has a personal relationship to the assisted living
 3510 facility, in which case the assisted living facility may provide
 3511 a monetary reward to the resident for making such referral.

3512 (3)(2) A violation of this section shall be considered
 3513 patient brokering and is punishable as provided in s. 817.505.

3514 Section 71. Section 429.915, Florida Statutes, is amended
 3515 to read:

3516 429.915 Conditional license.—In addition to the license
 3517 categories available in part II of chapter 408, the agency may
 3518 issue a conditional license to an applicant for license renewal
 3519 or change of ownership if the applicant fails to meet all
 3520 standards and requirements for licensure. A conditional license
 3521 issued under this subsection must be limited to a specific
 3522 period not exceeding 6 months, as determined by the agency, ~~and~~
 3523 ~~must be accompanied by an approved plan of correction.~~

3524 Section 72. Subsection (3) of section 430.80, Florida
 3525 Statutes, is amended to read:

3526 430.80 Implementation of a teaching nursing home pilot
 3527 project.—

3528 (3) To be designated as a teaching nursing home, a nursing

3529 home licensee must, at a minimum:

3530 (a) Provide a comprehensive program of integrated senior
 3531 services that include institutional services and community-based
 3532 services;

3533 (b) Participate in a nationally recognized accreditation
 3534 program and hold a valid accreditation, such as the
 3535 accreditation awarded by the Joint Commission on Accreditation
 3536 of Healthcare Organizations, or, at the time of initial
 3537 designation, possess a Gold Seal Award as conferred by the state
 3538 on its licensed nursing home;

3539 (c) Have been in business in this state for a minimum of
 3540 10 consecutive years;

3541 (d) Demonstrate an active program in multidisciplinary
 3542 education and research that relates to gerontology;

3543 (e) Have a formalized contractual relationship with at
 3544 least one accredited health profession education program located
 3545 in this state;

3546 (f) Have senior staff members who hold formal faculty
 3547 appointments at universities, which must include at least one
 3548 accredited health profession education program; and

3549 (g) Maintain insurance coverage pursuant to s.
 3550 400.141(1)(q) ~~s. 400.141(1)(s)~~ or proof of financial
 3551 responsibility in a minimum amount of \$750,000. Such proof of
 3552 financial responsibility may include:

- 3553 1. Maintaining an escrow account consisting of cash or
 3554 assets eligible for deposit in accordance with s. 625.52; or
- 3555 2. Obtaining and maintaining pursuant to chapter 675 an
 3556 unexpired, irrevocable, nontransferable and nonassignable letter

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3557 of credit issued by any bank or savings association organized
 3558 and existing under the laws of this state or any bank or savings
 3559 association organized under the laws of the United States that
 3560 has its principal place of business in this state or has a
 3561 branch office which is authorized to receive deposits in this
 3562 state. The letter of credit shall be used to satisfy the
 3563 obligation of the facility to the claimant upon presentment of a
 3564 final judgment indicating liability and awarding damages to be
 3565 paid by the facility or upon presentment of a settlement
 3566 agreement signed by all parties to the agreement when such final
 3567 judgment or settlement is a result of a liability claim against
 3568 the facility.

3569 Section 73. Paragraph (h) of subsection (2) of section
 3570 430.81, Florida Statutes, is amended to read:

3571 430.81 Implementation of a teaching agency for home and
 3572 community-based care.—

3573 (2) The Department of Elderly Affairs may designate a home
 3574 health agency as a teaching agency for home and community-based
 3575 care if the home health agency:

3576 (h) Maintains insurance coverage pursuant to s.
 3577 400.141(1)(g) ~~s. 400.141(1)(s)~~ or proof of financial
 3578 responsibility in a minimum amount of \$750,000. Such proof of
 3579 financial responsibility may include:

3580 1. Maintaining an escrow account consisting of cash or
 3581 assets eligible for deposit in accordance with s. 625.52; or

3582 2. Obtaining and maintaining, pursuant to chapter 675, an
 3583 unexpired, irrevocable, nontransferable, and nonassignable
 3584 letter of credit issued by any bank or savings association

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3585 authorized to do business in this state. This letter of credit
 3586 shall be used to satisfy the obligation of the agency to the
 3587 claimant upon presentation of a final judgment indicating
 3588 liability and awarding damages to be paid by the facility or
 3589 upon presentment of a settlement agreement signed by all parties
 3590 to the agreement when such final judgment or settlement is a
 3591 result of a liability claim against the agency.

3592 Section 74. Paragraph (d) of subsection (9) of section
 3593 440.102, Florida Statutes, is repealed.

3594 Section 75. Subsection (1) of section 483.035, Florida
 3595 Statutes, is amended to read:

3596 483.035 Clinical laboratories operated by practitioners
 3597 for exclusive use; licensure and regulation.—

3598 (1) A clinical laboratory operated by one or more
 3599 practitioners licensed under chapter 458, chapter 459, chapter
 3600 460, chapter 461, chapter 462, ~~or~~ chapter 466, or as an advanced
 3601 registered nurse practitioner licensed under part I in chapter
 3602 464, exclusively in connection with the diagnosis and treatment
 3603 of their own patients, must be licensed under this part and must
 3604 comply with the provisions of this part, except that the agency
 3605 shall adopt rules for staffing, for personnel, including
 3606 education and training of personnel, for proficiency testing,
 3607 and for construction standards relating to the licensure and
 3608 operation of the laboratory based upon and not exceeding the
 3609 same standards contained in the federal Clinical Laboratory
 3610 Improvement Amendments of 1988 and the federal regulations
 3611 adopted thereunder.

3612 Section 76. Subsections (1) and (9) of section 483.051,

3613 Florida Statutes, are amended to read:

3614 483.051 Powers and duties of the agency.—The agency shall
 3615 adopt rules to implement this part, which rules must include,
 3616 but are not limited to, the following:

3617 (1) LICENSING; QUALIFICATIONS.—The agency shall provide
 3618 for biennial licensure of all nonwaived clinical laboratories
 3619 meeting the requirements of this part and shall prescribe the
 3620 qualifications necessary for such licensure, including, but not
 3621 limited to, application for or proof of a federal Clinical
 3622 Laboratory Improvement Amendment (CLIA) certificate. For
 3623 purposes of this section, the term "nonwaived clinical
 3624 laboratories" means laboratories that perform any test that the
 3625 Centers for Medicare and Medicaid Services has determined does
 3626 not qualify for a certificate of waiver under the Clinical
 3627 Laboratory Improvement Amendments of 1988 and the federal rules
 3628 adopted thereunder.

3629 (9) ALTERNATE-SITE TESTING.—The agency, in consultation
 3630 with the Board of Clinical Laboratory Personnel, shall adopt, by
 3631 rule, the criteria for alternate-site testing to be performed
 3632 under the supervision of a clinical laboratory director. The
 3633 elements to be addressed in the rule include, but are not
 3634 limited to: a hospital internal needs assessment; a protocol of
 3635 implementation including tests to be performed and who will
 3636 perform the tests; criteria to be used in selecting the method
 3637 of testing to be used for alternate-site testing; minimum
 3638 training and education requirements for those who will perform
 3639 alternate-site testing, such as documented training, licensure,
 3640 certification, or other medical professional background not

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3641 limited to laboratory professionals; documented inservice
 3642 training as well as initial and ongoing competency validation;
 3643 an appropriate internal and external quality control protocol;
 3644 an internal mechanism for identifying and tracking alternate-
 3645 site testing by the central laboratory; and recordkeeping
 3646 requirements. ~~Alternate site testing locations must register~~
 3647 ~~when the clinical laboratory applies to renew its license.~~ For
 3648 purposes of this subsection, the term "alternate-site testing"
 3649 means any laboratory testing done under the administrative
 3650 control of a hospital, but performed out of the physical or
 3651 administrative confines of the central laboratory.

3652 Section 77. Subsection (1) of section 483.245, Florida
 3653 Statutes, is amended, and subsection (3) is added to that
 3654 section, to read:

3655 483.245 Rebates prohibited; penalties.—

3656 (1) It is unlawful for any person to pay or receive any
 3657 commission, bonus, kickback, or rebate or engage in any split-
 3658 fee arrangement in any form whatsoever with any dialysis
 3659 facility, physician, surgeon, organization, agency, or person,
 3660 either directly or indirectly, for patients referred to a
 3661 clinical laboratory licensed under this part. A clinical
 3662 laboratory licensed under this part is prohibited from placing,
 3663 directly or indirectly, through an independent staffing company
 3664 or lease arrangement, or otherwise, a specimen collector or
 3665 other personnel in any physician's office, unless the clinical
 3666 lab and the physician's office are owned and operated by the
 3667 same entity.

3668 (3) Any person aggrieved by a violation of this section

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3669 may bring a civil action for appropriate relief, including an
 3670 action for a declaratory judgment, injunctive relief, and actual
 3671 damages.

3672 Section 78. Section 483.294, Florida Statutes, is amended
 3673 to read:

3674 483.294 Inspection of centers.—In accordance with s.
 3675 408.811, the agency shall biennially, ~~at least once annually~~,
 3676 inspect the premises and operations of all centers subject to
 3677 licensure under this part.

3678 Section 79. Effective May 1, 2012, section 641.3120,
 3679 Florida Statutes, is created to read:

3680 641.3120 External review of adverse benefit
 3681 determinations.—The Office of Insurance Regulation shall adopt
 3682 rules to implement the National Association of Insurance
 3683 Commissioners' Uniform Health Carrier External Review Model Act
 3684 as amended in April 2010, which provides for independent,
 3685 external review of a health insurer's denial of coverage for
 3686 specific procedures or services.

3687 Section 80. Effective May 1, 2012, paragraph (h) is added
 3688 to subsection (1) of section 627.602, Florida Statutes, to read:

3689 627.602 Scope, format of policy.—

3690 (1) Each health insurance policy delivered or issued for
 3691 delivery to any person in this state must comply with all
 3692 applicable provisions of this code and all of the following
 3693 requirements:

3694 (h) Section 641.3120, relating to external review of
 3695 adverse benefit determinations, and the Employee Retirement
 3696 Income Security Act of 1974, as implemented by 29 C.F.R. s.

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3697 2560-503-1, relating to internal grievances, apply to all
 3698 policies issued under this part. This paragraph does not apply
 3699 to plans subject to the Subscriber Assistance Program
 3700 established under s. 408.7056.

3701 Section 81. Effective May 1, 2012, section 627.6513,
 3702 Florida Statutes, is created to read:

3703 627.6513 Internal grievance procedure applicability.-
 3704 Section 641.3120, relating to external review of adverse benefit
 3705 determinations, and the Employee Retirement Income Security Act
 3706 of 1974, as implemented by 29 C.F.R. s. 2560-503-1, relating to
 3707 internal grievances, apply to all policies issued under this
 3708 part. This paragraph does not apply to plans subject to the
 3709 Subscriber Assistance Program established under s. 408.7056.

3710 Section 82. Subsection (13) of section 651.118, Florida
 3711 Statutes, is amended to read:

3712 651.118 Agency for Health Care Administration;
 3713 certificates of need; sheltered beds; community beds.-

3714 (13) Residents, as defined in this chapter, are not
 3715 considered new admissions for the purpose of s. 400 141(1)(n)1.d
 3716 ~~s. 400.141(1)(o)1.d.~~

3717 Section 83. Paragraph (j) is added to subsection (3) of
 3718 section 817.505, Florida Statutes, to read:

3719 817.505 Patient brokering prohibited; exceptions;
 3720 penalties.-

3721 (3) This section shall not apply to:

3722 (j) Payments by an assisted living facility, as defined in
 3723 s. 429.02, or an agreement for or solicitation, offer, or
 3724 receipt of such payment by a referral service permitted under s.

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3725 | 429.195(2).

3726 | Section 84. In the interim between this act becoming law
3727 | and the 2013 Regular Session of the Legislature, the Division of
3728 | Statutory Revision shall provide the relevant substantive
3729 | committees of the Senate and the House of Representatives with
3730 | assistance, upon request, to enable such committees to prepare
3731 | draft legislation to correct the names of accrediting
3732 | organizations in the related Florida Statutes.

3733 | Section 85. Except as otherwise expressly provided in this
3734 | act, and except for this section and section 84, which shall
3735 | take effect upon this act becoming a law, this act shall take
3736 | effect July 1, 2012.