By Senator Garcia

40-00630D-12 20121884__

1 A bill to be entitled
2 An act relating to health regulation by the Agency for
3 Health Care Administration; amending s. 83.42, F.S.,
4 relating to exclusions from part II of ch. 83, F.S.,
5 the Florida Residential Landlord and Tenant Act;
6 clarifying that the procedures in s. 400.0255, F.S.,
7 for transfers and discharges are exclusive to
8 residents of a nursing home licensed under part II of
9 ch. 400, F.S.; amending s. 112.0455, F.S., relating to
10 the Drug-Free Workplace Act; deleting a provision
11 regarding retroactivity of the act; deleting a
12 provision specifying that the act does not abrogate
13 the right of an employer under state law to conduct
14 drug tests before a certain date; deleting a provision
15 that requires a laboratory to submit to the Agency for
16 Health Care Administration a monthly report containing
17 statistical information regarding the testing of
18 employees and job applicants; amending s. 318.21,
19 F.S.; providing that a portion of the additional fines
20 assessed for traffic violations within an enhanced
21 penalty zone be remitted to the Department of Revenue
22 and deposited into the Brain and Spinal Cord Injury
23 Trust Fund of the Department of Health to serve
24 certain Medicaid recipients; repealing s. 383.325,
25 F.S., relating to confidentiality of inspection
26 reports of licensed birth center facilities; creating
27 s. 385.2031, F.S.; designating the Florida
28 Hospital/Sandford-Burnham Translational Research
29 Institute for Metabolism and Diabetes as a resource

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30 for research in the prevention and treatment of
31 diabetes; amending s. 395.002, F.S.; redefining the
32 term “accrediting organizations” as it applies to the
33 regulation of hospitals and other licensed facilities;
34 conforming a cross-reference; amending s. 395.003,
35 F.S.; deleting an obsolete provision; authorizing a
36 specialty-licensed children’s hospital that has at
37 least a specified number of licensed neonatal
38 intensive care unit beds to provide obstetrical
39 services that are restricted to the diagnosis, care,
40 and treatment of certain pregnant women; amending s.
41 395.0161, F.S.; deleting a requirement that facilities
42 licensed under part I of ch. 395, F.S., pay licensing
43 fees at the time of inspection; amending s. 395.0193,
44 F.S.; requiring a licensed facility to report certain
45 peer review information and final disciplinary actions
46 to the Division of Medical Quality Assurance of the
47 Department of Health rather than the Division of
48 Health Quality Assurance of the Agency for Health Care
49 Administration; amending s. 395.1023, F.S.; providing
50 for the Department of Children and Family Services
51 rather than the Department of Health to perform
52 certain functions with respect to child protection
53 cases; requiring certain hospitals to notify the
54 Department of Children and Family Services of
55 compliance; amending s. 395.1041, F.S., relating to
56 hospital emergency services and care; deleting
57 obsolete provisions; repealing s. 395.1046, F.S.,
58 relating to complaint investigation procedures;

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59 amending s. 395.1055, F.S.; requiring that licensed
60 facility beds conform to standards specified by the
61 Agency for Health Care Administration, the Florida
62 Building Code, and the Florida Fire Prevention Code;
63 amending s. 395.3025, F.S.; authorizing the disclosure
64 of patient records to the Department of Health rather
65 than the Agency for Health Care Administration in
66 accordance with an issued subpoena; requiring the
67 department, rather than the agency, to make available,
68 upon written request by a practitioner against whom
69 probable cause has been found, any patient records
70 that form the basis of the determination of probable
71 cause; amending s. 395.3036, F.S.; correcting a cross-
72 reference; repealing s. 395.3037, F.S., relating to
73 redundant definitions for the Department of Health and
74 the Agency for Health Care Administration; amending s.
75 395.602, F.S.; revising the definition of the term
76 “rural hospital” to delete an obsolete provision;
77 amending s. 400.021, F.S.; revising the definitions of
78 the terms “geriatric outpatient clinic” and “resident
79 care plan”; amending s. 400.0234, F.S., relating to
80 medical records; conforming provisions to changes made
81 by the act; amending s. 400.0255, F.S.; correcting an
82 obsolete cross-reference to administrative rules;
83 amending s. 400.063, F.S.; deleting an obsolete
84 provision governing moneys received for the care of
85 residents in a nursing home facility; amending ss.
86 400.071 and 400.0712, F.S.; revising applicability of
87 general licensure requirements under part II of ch.

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

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117 authorizing a facility to charge a fee to copy a
118 resident's records; amending s. 400.142, F.S.,
119 relating to orders not to resuscitate; deleting
120 provisions relating to agency adoption of rules;
121 repealing s. 400.145, F.S., relating to requirements
122 for furnishing the records of residents in a licensed
123 nursing home to certain specified parties; amending s.
124 400.147, F.S.; revising reporting requirements for
125 licensed nursing home facilities relating to adverse
126 incidents; amending s. 400.19, F.S.; revising
127 inspection requirements for nursing homes; amending s.
128 400.23, F.S.; deleting an obsolete provision;
129 correcting a reference; deleting a requirement that
130 the rules for minimum standards of care for persons
131 under 21 years of age include a certain methodology;
132 directing the agency to adopt rules for minimum
133 staffing standards in nursing homes that serve persons
134 under 21 years of age; providing minimum staffing
135 standards; amending s. 400.275, F.S.; revising agency
136 duties with regard to training nursing home surveyor
137 teams; revising requirements for team members;
138 amending s. 400.462, F.S.; redefining the term
139 "remuneration" for purposes of the Home Health
140 Services Act; reenacting ss. 400.464(5)(b), relating
141 to home health agencies, to incorporate the amendment
142 made to s. 400.509, F.S., in references thereto;
143 amending s. 400.474, F.S.; revising the requirements
144 for a quarterly report submitted to the Agency for
145 Health Care Administration by each home health agency;

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146 amending s. 400.484, F.S.; revising the classification
147 of violations by a home health agency for which the
148 agency imposes an administrative fine; amending and
149 reenacting s. 400.506, F.S., relating to licensure of
150 nurse registries, to incorporate the amendment made to
151 s. 400.509, F.S., in a reference thereto; authorizing
152 an administrator to manage up to five nurse registries
153 under certain circumstances; requiring an
154 administrator to designate, in writing, for each
155 licensed entity, a qualified alternate administrator
156 to serve during the administrator's absence; amending
157 s. 400.509, F.S.; providing that organizations that
158 provide companion services only to persons with
159 developmental disabilities, under contract with the
160 Agency for Persons with Disabilities, are exempt from
161 registration with the Agency for Health Care
162 Administration; amending s. 400.601, F.S.; redefining
163 the term "hospice" to include a limited liability
164 company as it relates to nursing homes and related
165 health care facilities; amending s. 400.606, F.S.;
166 revising the content requirements of the plan
167 accompanying an initial or change-of-ownership
168 application for licensure of a hospice; revising
169 requirements relating to certificates of need for
170 certain hospice facilities; amending s. 400.915, F.S.;
171 correcting an obsolete cross-reference to
172 administrative rules; amending s. 400.931, F.S.;
173 requiring each applicant for initial licensure, change
174 of ownership, or license renewal to operate a licensed

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175 home medical equipment provider at a location outside
176 the state to submit documentation of accreditation, or
177 an application for accreditation, from an accrediting
178 organization that is recognized by the Agency for
179 Health Care Administration; requiring an applicant
180 that has applied for accreditation to provide proof of
181 accreditation within a specified time; deleting a
182 requirement that an applicant for a home medical
183 equipment provider license submit a surety bond to the
184 agency; amending s. 400.967, F.S.; revising the
185 classification of violations by intermediate care
186 facilities for the developmentally disabled; providing
187 a penalty for certain violations; amending s.
188 400.9905, F.S.; revising the definitions of the terms
189 “clinic” and “portable equipment provider”;
190 authorizing the Agency for Health Care Administration
191 to deny or revoke an exemption from licensure if a
192 health care clinic receives payment for health care
193 services under personal injury protection insurance
194 coverage; including health services provided at
195 multiple locations within the definition of the term
196 “portable health service or equipment provider”;
197 amending s. 400.991, F.S.; conforming terminology;
198 revising application requirements relating to
199 documentation of financial ability to operate a mobile
200 clinic; amending s. 408.033, F.S.; providing that fees
201 assessed on selected health care facilities and
202 organizations may be collected prospectively at the
203 time of licensure renewal and prorated for the

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204 licensing period; amending s. 408.034, F.S.; revising
205 agency authority relating to licensing of intermediate
206 care facilities for the developmentally disabled;
207 amending s. 408.036, F.S.; deleting an exemption from
208 certain certificate-of-need review requirements for a
209 hospice or a hospice inpatient facility; amending s.
210 408.037, F.S.; revising requirements for the financial
211 information to be included in an application for a
212 certificate of need; amending s. 408.043, F.S.;
213 revising requirements for certain freestanding
214 inpatient hospice care facilities to obtain a
215 certificate of need; amending s. 408.061, F.S.;
216 revising data reporting requirements for health care
217 facilities; amending s. 408.07, F.S.; deleting a
218 cross-reference; amending s. 408.10, F.S.; removing
219 agency authority to investigate certain consumer
220 complaints; amending s. 408.7056, F.S.; providing that
221 the Subscriber Assistance Program applies to health
222 plans that meet certain requirements; repealing s.
223 408.802(11), F.S.; removing applicability of part II
224 of ch. 408, F.S., relating to general licensure
225 requirements, to private review agents; amending s.
226 408.804, F.S.; providing penalties for altering,
227 defacing, or falsifying a license certificate issued
228 by the agency or displaying such an altered, defaced,
229 or falsified certificate; amending s. 408.806, F.S.;
230 revising agency responsibilities for notification of
231 licensees of impending expiration of a license;
232 requiring payment of a late fee for a license

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233 application to be considered complete under certain
234 circumstances; amending s. 408.8065, F.S.; revising
235 the requirements for becoming licensed as a home
236 health agency, home medical equipment provider, or
237 health care clinic; amending s. 408.809, F.S.;
238 revising provisions to include a schedule for
239 background rescreenings of certain employees; amending
240 s. 408.810, F.S.; requiring that the controlling
241 interest of a health care licensee notify the agency
242 of certain court proceedings; providing a penalty;
243 amending s. 408.813, F.S.; authorizing the agency to
244 impose fines for unclassified violations of part II of
245 ch. 408, F.S.; amending s. 409.912, F.S.; revising the
246 components of the Medicaid prescribed-drug spending-
247 control program; amending s. 409.91195, F.S.; revising
248 the membership of the Medicaid Pharmaceutical and
249 Therapeutics Committee; providing the requirements for
250 the members; providing terms of membership; requiring
251 the Agency for Health Care Administration to serve as
252 staff for the committee and assist the committee with
253 its duties; providing additional requirements for
254 presenting public testimony to include a product on a
255 preferred drug list; requiring that the committee be
256 informed in writing of the agency's action when the
257 agency does not follow the recommendation of the
258 committee; amending s. 429.294, F.S.; deleting a
259 cross-reference; amending s. 429.915, F.S.; revising
260 agency responsibilities regarding the issuance of
261 conditional licenses; amending ss. 430.80 and 430.81,

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262 F.S.; conforming cross-references; repealing s.
263 440.102(9)(d), F.S., relating to a requirement that
264 laboratories submit to the Agency for Health Care
265 Administration a monthly report containing statistical
266 information regarding the testing of employees and job
267 applicants; amending s. 483.035, F.S.; providing for a
268 clinical laboratory to be operated by certain nurses;
269 amending s. 483.051, F.S.; requiring the Agency for
270 Health Care Administration to provide for biennial
271 licensure of all nonwaived laboratories that meet
272 certain requirements; requiring the agency to
273 prescribe qualifications for such licensure; defining
274 nonwaived laboratories as laboratories that do not
275 have a certificate of waiver from the Centers for
276 Medicare and Medicaid Services; deleting requirements
277 for the registration of an alternate site testing
278 location when the clinical laboratory applies to renew
279 its license; amending s. 483.245, F.S.; prohibiting a
280 clinical laboratory from placing a specimen collector
281 or other personnel in any physician's office, unless
282 the clinical lab and the physician's office are owned
283 and operated by the same entity; authorizing a person
284 who is aggrieved by a violation to bring a civil
285 action for appropriate relief; amending s. 483.294,
286 F.S.; revising the frequency of agency inspections of
287 multiphasic health testing centers; amending s.
288 499.003, F.S.; redefining the term "wholesale
289 distribution" with regard to the Florida Drug and
290 Cosmetic Act to remove certain requirements governing

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291 prescription drug inventories; amending and creating,
292 respectively, ss. 627.602 and 627.6513, F.S.;
293 providing that the Uniform Health Carrier External
294 Review Model Act and the Employee Retirement Income
295 Security Act apply to individual and group health
296 insurance policies except those subject to the
297 Subscriber Assistance Program under s. 408.7056, F.S.;
298 creating s. 641.312, F.S.; requiring the Office of
299 Insurance Regulation within the Department of
300 Financial Services to administer the National
301 Association of Insurance Commissioners' Uniform Health
302 Carrier External Review Model Act; providing that the
303 Uniform Health Carrier External Review Model Act does
304 not apply to a health maintenance contract that is
305 subject to the Subscriber Assistance Program under s.
306 408.7056, F.S.; amending s. 651.118, F.S.; conforming
307 a cross-reference; designating the Florida
308 Hospital/Sanford-Burnham Translational Research
309 Institute as a State of Florida Resource for research
310 in diabetes diagnosis, prevention, and treatment;
311 providing that an essential provider and a hospital
312 that is necessary for a managed care plan to
313 demonstrate an adequate network as determined by the
314 Agency for Health Care Administration is part of that
315 managed care plan's network for purposes of the
316 provider's or hospital's application for enrollment or
317 expansion in the Medicaid program; requiring that a
318 managed care plan's payment under this provision to an
319 essential provider be made in accordance with s.

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320 409.975, F.S., regarding managed care plan
321 accountability; providing a directive to the Division
322 of Statutory Revision; providing effective dates.
323
324 Be It Enacted by the Legislature of the State of Florida:
325
326 Section 1. Subsection (1) of section 83.42, Florida
327 Statutes, is amended to read:
328 83.42 Exclusions from application of part.—This part does
329 not apply to:
330 (1) Residency or detention in a facility, whether public or
331 private, when residence or detention is incidental to the
332 provision of medical, geriatric, educational, counseling,
333 religious, or similar services. For residents of a facility
334 licensed under part II of chapter 400, the provisions of s.
335 400.0255 are the exclusive procedures for all transfers and
336 discharges.
337 Section 2. Present paragraphs (f) through (k) of subsection
338 (10) of section 112.0455, Florida Statutes, are redesignated as
339 paragraphs (e) through (j), respectively, and present paragraph
340 (e) of subsection (10), subsection (12), and paragraph (e) of
341 subsection (14) of that section are amended to read:
342 112.0455 Drug-Free Workplace Act.—
343 (10) EMPLOYER PROTECTION.—
344 ~~(e) Nothing in this section shall be construed to operate~~
345 ~~retroactively, and nothing in this section shall abrogate the~~
346 ~~right of an employer under state law to conduct drug tests prior~~
347 ~~to January 1, 1990. A drug test conducted by an employer prior~~
348 ~~to January 1, 1990, is not subject to this section.~~

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349 (12) DRUG-TESTING STANDARDS; LABORATORIES.—
350 (a) The requirements of part II of chapter 408 apply to the
351 provision of services that require licensure pursuant to this
352 section and part II of chapter 408 and to entities licensed by
353 or applying for such licensure from the Agency for Health Care
354 Administration pursuant to this section. A license issued by the
355 agency is required in order to operate a laboratory.
356 (b) A laboratory may analyze initial or confirmation drug
357 specimens only if:
358 1. The laboratory is licensed and approved by the Agency
359 for Health Care Administration using criteria established by the
360 United States Department of Health and Human Services as general
361 guidelines for modeling the state drug testing program and in
362 accordance with part II of chapter 408. Each applicant for
363 licensure and licensee must comply with all requirements of part
364 II of chapter 408.
365 2. The laboratory has written procedures to ensure chain of
366 custody.
367 3. The laboratory follows proper quality control
368 procedures, including, but not limited to:
369 a. The use of internal quality controls including the use
370 of samples of known concentrations which are used to check the
371 performance and calibration of testing equipment, and periodic
372 use of blind samples for overall accuracy.
373 b. An internal review and certification process for drug
374 test results, conducted by a person qualified to perform that
375 function in the testing laboratory.
376 c. Security measures implemented by the testing laboratory
377 to preclude adulteration of specimens and drug test results.

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378 d. Other necessary and proper actions taken to ensure
379 reliable and accurate drug test results.
380 (c) A laboratory shall disclose to the employer a written
381 test result report within 7 working days after receipt of the
382 sample. All laboratory reports of a drug test result shall, at a
383 minimum, state:
384 1. The name and address of the laboratory which performed
385 the test and the positive identification of the person tested.
386 2. Positive results on confirmation tests only, or negative
387 results, as applicable.
388 3. A list of the drugs for which the drug analyses were
389 conducted.
390 4. The type of tests conducted for both initial and
391 confirmation tests and the minimum cutoff levels of the tests.
392 5. Any correlation between medication reported by the
393 employee or job applicant pursuant to subparagraph (8)(b)2. and
394 a positive confirmed drug test result.
395
396 A ~~No~~ report may not ~~shall~~ disclose the presence or absence of
397 any drug other than a specific drug and its metabolites listed
398 pursuant to this section.
399 ~~(d) The laboratory shall submit to the Agency for Health~~
400 ~~Care Administration a monthly report with statistical~~
401 ~~information regarding the testing of employees and job~~
402 ~~applicants. The reports shall include information on the methods~~
403 ~~of analyses conducted, the drugs tested for, the number of~~
404 ~~positive and negative results for both initial and confirmation~~
405 ~~tests, and any other information deemed appropriate by the~~
406 ~~Agency for Health Care Administration. No monthly report shall~~

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407 ~~identify specific employees or job applicants.~~
408 (d) ~~(c)~~ Laboratories shall provide technical assistance to
409 the employer, employee, or job applicant for the purpose of
410 interpreting any positive confirmed test results which could
411 have been caused by prescription or nonprescription medication
412 taken by the employee or job applicant.
413 (14) DISCIPLINE REMEDIES.—
414 (e) Upon resolving an appeal filed pursuant to paragraph
415 (c), and finding a violation of this section, the commission may
416 order the following relief:
417 1. Rescind the disciplinary action, expunge related records
418 from the personnel file of the employee or job applicant and
419 reinstate the employee.
420 2. Order compliance with paragraph (10)(f) ~~(10)(g)~~.
421 3. Award back pay and benefits.
422 4. Award the prevailing employee or job applicant the
423 necessary costs of the appeal, reasonable attorney's fees, and
424 expert witness fees.
425 Section 3. Subsection (15) of section 318.21, Florida
426 Statutes, is amended to read:
427 318.21 Disposition of civil penalties by county courts.—All
428 civil penalties received by a county court pursuant to the
429 provisions of this chapter shall be distributed and paid monthly
430 as follows:
431 (15) Of the additional fine assessed under s. 318.18(3)(e)
432 for a violation of s. 316.1893, 50 percent of the moneys
433 received from the fines shall be remitted to the Department of
434 Revenue and deposited into the Brain and Spinal Cord Injury
435 Trust Fund of Department of Health and appropriated to the

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436 Department of Health ~~Agency for Health Care Administration~~ as
437 general revenue to ~~provide an enhanced Medicaid payment to~~
438 ~~nursing homes that~~ serve Medicaid recipients who have ~~with~~ brain
439 and spinal cord injuries that are medically complex and who are
440 technologically and respiratory dependent. The remaining 50
441 percent of the moneys received from the enhanced fine imposed
442 under s. 318.18(3)(e) shall be remitted to the Department of
443 Revenue and deposited into the Department of Health Emergency
444 Medical Services Trust Fund to provide financial support to
445 certified trauma centers in the counties where enhanced penalty
446 zones are established to ensure the availability and
447 accessibility of trauma services. Funds deposited into the
448 Emergency Medical Services Trust Fund under this subsection
449 shall be allocated as follows:
450 (a) Fifty percent shall be allocated equally among all
451 Level I, Level II, and pediatric trauma centers in recognition
452 of readiness costs for maintaining trauma services.
453 (b) Fifty percent shall be allocated among Level I, Level
454 II, and pediatric trauma centers based on each center's relative
455 volume of trauma cases as reported in the Department of Health
456 Trauma Registry.
457 Section 4. Section 383.325, Florida Statutes, is repealed.
458 Section 5. Section 385.2031, Florida Statutes, is created
459 to read:
460 385.2031 Resource for research in the prevention and
461 treatment of diabetes.—The Florida Hospital/Sanford-Burnham
462 Translational Research Institute for Metabolism and Diabetes is
463 designated as a resource in this state for research in the
464 prevention and treatment of diabetes.

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465 Section 6. Subsection (1) of section 395.002, Florida
466 Statutes, is amended to read:
467 395.002 Definitions.—As used in this chapter:
468 (1) "Accrediting organizations" means national
469 accreditation organizations that are approved by the Centers for
470 Medicare and Medicaid Services and whose standards incorporate
471 comparable licensure regulations required by the state ~~the Joint~~
472 ~~Commission on Accreditation of Healthcare Organizations, the~~
473 ~~American Osteopathic Association, the Commission on~~
474 ~~Accreditation of Rehabilitation Facilities, and the~~
475 ~~Accreditation Association for Ambulatory Health Care, Inc~~.
476 Section 7. Paragraph (c) of subsection (1) and subsection
477 (6) of section 395.003, Florida Statutes, are amended to read:
478 395.003 Licensure; denial, suspension, and revocation.—
479 (1)
480 ~~(c) Until July 1, 2006, additional emergency departments~~
481 ~~located off the premises of licensed hospitals may not be~~
482 ~~authorized by the agency.~~
483 (6) A specialty hospital may not provide any service or
484 regularly serve any population group beyond those services or
485 groups specified in its license. A specialty-licensed children's
486 hospital that is authorized to provide pediatric cardiac
487 catheterization and pediatric open-heart surgery services may
488 provide cardiovascular service to adults who, as children, were
489 previously served by the hospital for congenital heart disease,
490 or to those patients who are referred for a specialized
491 procedure only for congenital heart disease by an adult
492 hospital, without obtaining additional licensure as a provider
493 of adult cardiovascular services. The agency may request

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494 documentation as needed to support patient selection and
495 treatment. This subsection does not apply to a specialty-
496 licensed children's hospital that is already licensed to provide
497 adult cardiovascular services. A specialty-licensed children's
498 hospital that has at least 50 licensed neonatal intensive care
499 unit beds may provide obstetrical services, including labor and
500 delivery, which are restricted to the diagnosis, care, and
501 treatment of pregnant women of any age who have:
502 (a) At least one maternal or fetal characteristic or
503 condition that would characterize the pregnancy or delivery as
504 high-risk; or
505 (b) Received medical advice or a diagnosis indicating their
506 fetus will require at least one perinatal intervention.
507 Section 8. Subsection (3) of section 395.0161, Florida
508 Statutes, is amended to read:
509 395.0161 Licensure inspection.—
510 (3) In accordance with s. 408.805, an applicant or licensee
511 shall pay a fee for each license application submitted under
512 this part, part II of chapter 408, and applicable rules. With
513 the exception of state-operated licensed facilities, each
514 facility licensed under this part shall pay to the agency~~, at~~
515 ~~the time of inspection,~~ the following fees:
516 (a) *Inspection for licensure.*—A fee shall be paid which is
517 not less than $8 per hospital bed, nor more than $12 per
518 hospital bed, except that the minimum fee shall be $400 per
519 facility.
520 (b) *Inspection for lifesafety only.*—A fee shall be paid
521 which is not less than 75 cents per hospital bed, nor more than
522 $1.50 per hospital bed, except that the minimum fee shall be $40

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523 per facility.
524 Section 9. Subsections (2) and (4) of section 395.0193,
525 Florida Statutes, are amended to read:
526 395.0193 Licensed facilities; peer review; disciplinary
527 powers; agency or partnership with physicians.—
528 (2) Each licensed facility, as a condition of licensure,
529 shall provide for peer review of physicians who deliver health
530 care services at the facility. Each licensed facility shall
531 develop written, binding procedures by which such peer review
532 shall be conducted. Such procedures must ~~shall~~ include:
533 (a) Mechanism for choosing the membership of the body or
534 bodies that conduct peer review.
535 (b) Adoption of rules of order for the peer review process.
536 (c) Fair review of the case with the physician involved.
537 (d) Mechanism to identify and avoid conflict of interest on
538 the part of the peer review panel members.
539 (e) Recording of agendas and minutes which do not contain
540 confidential material, for review by the Division of Medical
541 Quality Assurance of the department ~~Health Quality Assurance of~~
542 ~~the agency~~.
543 (f) Review, at least annually, of the peer review
544 procedures by the governing board of the licensed facility.
545 (g) Focus of the peer review process on review of
546 professional practices at the facility to reduce morbidity and
547 mortality and to improve patient care.
548 (4) Pursuant to ss. 458.337 and 459.016, any disciplinary
549 actions taken under subsection (3) shall be reported in writing
550 to the Division of Medical Quality Assurance of the department
551 ~~Health Quality Assurance of the agency~~ within 30 working days

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552 after its initial occurrence, regardless of the pendency of
553 appeals to the governing board of the hospital. The notification
554 shall identify the disciplined practitioner, the action taken,
555 and the reason for such action. All final disciplinary actions
556 taken under subsection (3), if different from those which were
557 reported to the department ~~agency~~ within 30 days after the
558 initial occurrence, shall be reported within 10 working days to
559 the Division of Medical Quality Assurance of the department
560 ~~Health Quality Assurance of the agency~~ in writing and shall
561 specify the disciplinary action taken and the specific grounds
562 therefor. The division shall review each report and determine
563 whether it potentially involved conduct by the licensee that is
564 subject to disciplinary action, in which case s. 456.073 shall
565 apply. The reports are not subject to inspection under s.
566 119.07(1) even if the division's investigation results in a
567 finding of probable cause.
568 Section 10. Section 395.1023, Florida Statutes, is amended
569 to read:
570 395.1023 Child abuse and neglect cases; duties.—Each
571 licensed facility shall adopt a protocol that, at a minimum,
572 requires the facility to:
573 (1) Incorporate a facility policy that every staff member
574 has an affirmative duty to report, pursuant to chapter 39, any
575 actual or suspected case of child abuse, abandonment, or
576 neglect; and
577 (2) In any case involving suspected child abuse,
578 abandonment, or neglect, designate, at the request of the
579 Department of Children and Family Services, a staff physician to
580 act as a liaison between the hospital and the Department of

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581 Children and Family Services office which is investigating the
582 suspected abuse, abandonment, or neglect, and the child
583 protection team, as defined in s. 39.01, when the case is
584 referred to such a team.
585
586 Each general hospital and appropriate specialty hospital shall
587 comply with the provisions of this section and shall notify the
588 agency and the Department of Children and Family Services of its
589 compliance by sending a copy of its policy to the agency and the
590 Department of Children and Family Services as required by rule.
591 The failure by a general hospital or appropriate specialty
592 hospital to comply shall be punished by a fine not exceeding
593 $1,000, to be fixed, imposed, and collected by the agency. Each
594 day in violation is considered a separate offense.
595 Section 11. Subsection (2) and paragraph (d) of subsection
596 (3) of section 395.1041, Florida Statutes, are amended to read:
597 395.1041 Access to emergency services and care.—
598 (2) INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The agency
599 shall establish and maintain an inventory of hospitals with
600 emergency services. The inventory shall list all services within
601 the service capability of the hospital, and such services shall
602 appear on the face of the hospital license. Each hospital having
603 emergency services shall notify the agency of its service
604 capability in the manner and form prescribed by the agency. The
605 agency shall use the inventory to assist emergency medical
606 services providers and others in locating appropriate emergency
607 medical care. The inventory shall also be made available to the
608 general public. ~~On or before August 1, 1992, the agency shall~~
609 ~~request that each hospital identify the services which are~~

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610 ~~within its service capability. On or before November 1, 1992,~~
611 ~~the agency shall notify each hospital of the service capability~~
612 ~~to be included in the inventory. The hospital has 15 days from~~
613 ~~the date of receipt to respond to the notice. By December 1,~~
614 ~~1992, the agency shall publish a final inventory.~~ Each hospital
615 shall reaffirm its service capability when its license is
616 renewed and shall notify the agency of the addition of a new
617 service or the termination of a service prior to a change in its
618 service capability.
619 (3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF
620 FACILITY OR HEALTH CARE PERSONNEL.—
621 (d)1. Every hospital shall ensure the provision of services
622 within the service capability of the hospital, at all times,
623 either directly or indirectly through an arrangement with
624 another hospital, through an arrangement with one or more
625 physicians, or as otherwise made through prior arrangements. A
626 hospital may enter into an agreement with another hospital for
627 purposes of meeting its service capability requirement, and
628 appropriate compensation or other reasonable conditions may be
629 negotiated for these backup services.
630 2. If any arrangement requires the provision of emergency
631 medical transportation, such arrangement must be made in
632 consultation with the applicable provider and may not require
633 the emergency medical service provider to provide transportation
634 that is outside the routine service area of that provider or in
635 a manner that impairs the ability of the emergency medical
636 service provider to timely respond to prehospital emergency
637 calls.
638 3. A hospital is ~~shall~~ not ~~be~~ required to ensure service

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639 capability at all times as required in subparagraph 1. if, prior
640 to the receiving of any patient needing such service capability,
641 such hospital has demonstrated to the agency that it lacks the
642 ability to ensure such capability and it has exhausted all
643 reasonable efforts to ensure such capability through backup
644 arrangements. In reviewing a hospital's demonstration of lack of
645 ability to ensure service capability, the agency shall consider
646 factors relevant to the particular case, including the
647 following:
648 a. Number and proximity of hospitals with the same service
649 capability.
650 b. Number, type, credentials, and privileges of
651 specialists.
652 c. Frequency of procedures.
653 d. Size of hospital.
654 4. The agency shall publish ~~proposed~~ rules implementing a
655 reasonable exemption procedure ~~by November 1, 1992~~. ~~Subparagraph~~
656 ~~1. shall become effective upon the effective date of said rules~~
657 ~~or January 31, 1993, whichever is earlier. For a period not to~~
658 ~~exceed 1 year from the effective date of subparagraph 1., a~~
659 ~~hospital requesting an exemption shall be deemed to be exempt~~
660 ~~from offering the service until the agency initially acts to~~
661 ~~deny or grant the original request.~~ The agency has 45 days after
662 ~~from~~ the date of receipt of the request to approve or deny the
663 request. ~~After the first year from the effective date of~~
664 ~~subparagraph 1.,~~ If the agency fails to initially act within
665 that ~~the~~ time period, the hospital is deemed to be exempt from
666 offering the service until the agency initially acts to deny the
667 request.

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668 Section 12. Section 395.1046, Florida Statutes, is
669 repealed.
670 Section 13. Paragraph (e) of subsection (1) of section
671 395.1055, Florida Statutes, is amended to read:
672 395.1055 Rules and enforcement.—
673 (1) The agency shall adopt rules pursuant to ss. 120.536(1)
674 and 120.54 to implement the provisions of this part, which shall
675 include reasonable and fair minimum standards for ensuring that:
676 (e) Licensed facility beds conform to minimum space,
677 equipment, and furnishings standards as specified by the agency,
678 the Florida Building Code, and the Florida Fire Prevention Code
679 ~~department~~.
680 Section 14. Paragraph (e) of subsection (4) of section
681 395.3025, Florida Statutes, is amended to read:
682 395.3025 Patient and personnel records; copies;
683 examination.—
684 (4) Patient records are confidential and must not be
685 disclosed without the consent of the patient or his or her legal
686 representative, but appropriate disclosure may be made without
687 such consent to:
688 (e) The department ~~agency~~ upon subpoena issued pursuant to
689 s. 456.071.~~, but~~ The records obtained thereby must be used
690 solely for the purpose of the agency, the department, and the
691 appropriate professional board in an ~~its~~ investigation,
692 prosecution, and appeal of disciplinary proceedings. If the
693 department ~~agency~~ requests copies of the records, the facility
694 shall charge a fee pursuant to this section ~~no more than its~~
695 ~~actual copying costs, including reasonable staff time~~. The
696 records must be sealed and must not be available to the public

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697 pursuant to s. 119.07(1) or any other statute providing access
698 to records, nor may they be available to the public as part of
699 the record of investigation for and prosecution in disciplinary
700 proceedings made available to the public by the agency, the
701 department, or the appropriate regulatory board. However, the
702 department ~~agency~~ must make available, upon written request by a
703 practitioner against whom probable cause has been found, any
704 such records that form the basis of the determination of
705 probable cause.
706 Section 15. Subsection (2) of section 395.3036, Florida
707 Statutes, is amended to read:
708 395.3036 Confidentiality of records and meetings of
709 corporations that lease public hospitals or other public health
710 care facilities.—The records of a private corporation that
711 leases a public hospital or other public health care facility
712 are confidential and exempt from the provisions of s. 119.07(1)
713 and s. 24(a), Art. I of the State Constitution, and the meetings
714 of the governing board of a private corporation are exempt from
715 s. 286.011 and s. 24(b), Art. I of the State Constitution when
716 the public lessor complies with the public finance
717 accountability provisions of s. 155.40(5) with respect to the
718 transfer of any public funds to the private lessee and when the
719 private lessee meets at least three of the five following
720 criteria:
721 (2) The public lessor and the private lessee do not
722 commingle any of their funds in any account maintained by either
723 of them, other than the payment of the rent and administrative
724 fees or the transfer of funds pursuant to s. 155.40 ~~subsection~~
725 ~~(2)~~.

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726 Section 16. Section 395.3037, Florida Statutes, is
727 repealed.
728 Section 17. Paragraph (e) of subsection (2) of section
729 395.602, Florida Statutes, is amended to read:
730 395.602 Rural hospitals.—
731 (2) DEFINITIONS.—As used in this part:
732 (e) "Rural hospital" means an acute care hospital licensed
733 under this chapter, having 100 or fewer licensed beds and an
734 emergency room, which is:
735 1. The sole provider within a county with a population
736 density of no greater than 100 persons per square mile;
737 2. An acute care hospital, in a county with a population
738 density of no greater than 100 persons per square mile, which is
739 at least 30 minutes of travel time, on normally traveled roads
740 under normal traffic conditions, from any other acute care
741 hospital within the same county;
742 3. A hospital supported by a tax district or subdistrict
743 whose boundaries encompass a population of 100 persons or fewer
744 per square mile;
745 ~~4. A hospital in a constitutional charter county with a~~
746 ~~population of over 1 million persons that has imposed a local~~
747 ~~option health service tax pursuant to law and in an area that~~
748 ~~was directly impacted by a catastrophic event on August 24,~~
749 ~~1992, for which the Governor of Florida declared a state of~~
750 ~~emergency pursuant to chapter 125, and has 120 beds or less that~~
751 ~~serves an agricultural community with an emergency room~~
752 ~~utilization of no less than 20,000 visits and a Medicaid~~
753 ~~inpatient utilization rate greater than 15 percent;~~
754 4.~~5.~~ A hospital with a service area that has a population

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755 of 100 persons or fewer per square mile. As used in this
756 subparagraph, the term "service area" means the fewest number of
757 zip codes that account for 75 percent of the hospital's
758 discharges for the most recent 5-year period, based on
759 information available from the hospital inpatient discharge
760 database in the Florida Center for Health Information and Policy
761 Analysis at the Agency for Health Care Administration; or
762 5.~~6.~~ A hospital designated as a critical access hospital,
763 as defined in s. 408.07(15).
764
765 Population densities used in this paragraph must be based upon
766 the most recently completed United States census. A hospital
767 that received funds under s. 409.9116 for a quarter beginning no
768 later than July 1, 2002, is deemed to have been and shall
769 continue to be a rural hospital from that date through June 30,
770 2015, if the hospital continues to have 100 or fewer licensed
771 beds and an emergency room~~, or meets the criteria of~~
772 ~~subparagraph 4~~. An acute care hospital that has not previously
773 been designated as a rural hospital and that meets the criteria
774 of this paragraph shall be granted such designation upon
775 application, including supporting documentation to the Agency
776 for Health Care Administration.
777 Section 18. Subsections (8) and (16) of section 400.021,
778 Florida Statutes, are amended to read:
779 400.021 Definitions.—When used in this part, unless the
780 context otherwise requires, the term:
781 (8) "Geriatric outpatient clinic" means a site for
782 providing outpatient health care to persons 60 years of age or
783 older, which is staffed by a registered nurse or a physician

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784 assistant, or by a licensed practical nurse who is under the
785 direct supervision of a registered nurse, an advanced registered
786 nurse practitioner, a physician assistant, or a physician.
787 (16) "Resident care plan" means a written plan developed,
788 maintained, and reviewed not less than quarterly by a registered
789 nurse, with participation from other facility staff and the
790 resident or his or her designee or legal representative, which
791 includes a comprehensive assessment of the needs of an
792 individual resident; the type and frequency of services required
793 to provide the necessary care for the resident to attain or
794 maintain the highest practicable physical, mental, and
795 psychosocial well-being; a listing of services provided within
796 or outside the facility to meet those needs; and an explanation
797 of service goals. ~~The resident care plan must be signed by the~~
798 ~~director of nursing or another registered nurse employed by the~~
799 ~~facility to whom institutional responsibilities have been~~
800 ~~delegated and by the resident, the resident's designee, or the~~
801 ~~resident's legal representative. The facility may not use an~~
802 ~~agency or temporary registered nurse to satisfy the foregoing~~
803 ~~requirement and must document the institutional responsibilities~~
804 ~~that have been delegated to the registered nurse.~~
805 Section 19. Subsection (1) of section 400.0234, Florida
806 Statutes, is amended to read:
807 400.0234 Availability of facility records for investigation
808 of resident's rights violations and defenses; penalty.—
809 (1) Failure to provide complete copies of a resident's
810 records, including, but not limited to, all medical records and
811 the resident's chart, within the control or possession of the
812 facility ~~in accordance with s. 400.145~~ shall constitute evidence

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813 of failure of that party to comply with good faith discovery
814 requirements and shall waive the good faith certificate and
815 presuit notice requirements under this part by the requesting
816 party.
817 Section 20. Subsection (15) of section 400.0255, Florida
818 Statutes, is amended to read:
819 400.0255 Resident transfer or discharge; requirements and
820 procedures; hearings.—
821 (15)(a) The department's Office of Appeals Hearings shall
822 conduct hearings under this section. The office shall notify the
823 facility of a resident's request for a hearing.
824 (b) The department shall, by rule, establish procedures to
825 be used for fair hearings requested by residents. These
826 procedures shall be equivalent to the procedures used for fair
827 hearings for other Medicaid cases appearing in s. 409.285 and
828 applicable rules~~, chapter 10-2, part VI, Florida Administrative~~
829 ~~Code~~. The burden of proof must be clear and convincing evidence.
830 A hearing decision must be rendered within 90 days after receipt
831 of the request for hearing.
832 (c) If the hearing decision is favorable to the resident
833 who has been transferred or discharged, the resident must be
834 readmitted to the facility's first available bed.
835 (d) The decision of the hearing officer is ~~shall be~~ final.
836 Any aggrieved party may appeal the decision to the district
837 court of appeal in the appellate district where the facility is
838 located. Review procedures shall be conducted in accordance with
839 the Florida Rules of Appellate Procedure.
840 Section 21. Subsection (2) of section 400.063, Florida
841 Statutes, is amended to read:

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842 400.063 Resident protection.—
843 (2) The agency is authorized to establish for each
844 facility, subject to intervention by the agency, a separate bank
845 account for the deposit to the credit of the agency of any
846 moneys received from the Health Care Trust Fund or any other
847 moneys received for the maintenance and care of residents in the
848 facility, and the agency is authorized to disburse moneys from
849 such account to pay obligations incurred for the purposes of
850 this section. The agency is authorized to requisition moneys
851 from the Health Care Trust Fund in advance of an actual need for
852 cash on the basis of an estimate by the agency of moneys to be
853 spent under the authority of this section. Any bank account
854 established under this section need not be approved in advance
855 of its creation as required by s. 17.58, but shall be secured by
856 depository insurance equal to or greater than the balance of
857 such account or by the pledge of collateral security ~~in~~
858 ~~conformance with criteria established in s. 18.11~~. The agency
859 shall notify the Chief Financial Officer of any such account so
860 established and shall make a quarterly accounting to the Chief
861 Financial Officer for all moneys deposited in such account.
862 Section 22. Subsections (1) and (5) of section 400.071,
863 Florida Statutes, are amended to read:
864 400.071 Application for license.—
865 (1) In addition to the requirements of part II of chapter
866 408, the application for a license shall be under oath and must
867 contain the following:
868 (a) The location of the facility for which a license is
869 sought and an indication, as in the original application, that
870 such location conforms to the local zoning ordinances.

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871 ~~(b) A signed affidavit disclosing any financial or~~
872 ~~ownership interest that a controlling interest as defined in~~
873 ~~part II of chapter 408 has held in the last 5 years in any~~
874 ~~entity licensed by this state or any other state to provide~~
875 ~~health or residential care which has closed voluntarily or~~
876 ~~involuntarily; has filed for bankruptcy; has had a receiver~~
877 ~~appointed; has had a license denied, suspended, or revoked; or~~
878 ~~has had an injunction issued against it which was initiated by a~~
879 ~~regulatory agency. The affidavit must disclose the reason any~~
880 ~~such entity was closed, whether voluntarily or involuntarily.~~
881 ~~(c) The total number of beds and the total number of~~
882 ~~Medicare and Medicaid certified beds.~~
883 (b) ~~(d)~~ Information relating to the applicant and employees
884 which the agency requires by rule. The applicant must
885 demonstrate that sufficient numbers of qualified staff, by
886 training or experience, will be employed to properly care for
887 the type and number of residents who will reside in the
888 facility.
889 ~~(e) Copies of any civil verdict or judgment involving the~~
890 ~~applicant rendered within the 10 years preceding the~~
891 ~~application, relating to medical negligence, violation of~~
892 ~~residents' rights, or wrongful death. As a condition of~~
893 ~~licensure, the licensee agrees to provide to the agency copies~~
894 ~~of any new verdict or judgment involving the applicant, relating~~
895 ~~to such matters, within 30 days after filing with the clerk of~~
896 ~~the court. The information required in this paragraph shall be~~
897 ~~maintained in the facility's licensure file and in an agency~~
898 ~~database which is available as a public record.~~
899 (5) As a condition of licensure, each facility must

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900 establish ~~and submit with its application~~ a plan for quality
901 assurance and for conducting risk management.
902 Section 23. Section 400.0712, Florida Statutes, is amended
903 to read:
904 400.0712 Application for inactive license.—
905 ~~(1) As specified in this section, the agency may issue an~~
906 ~~inactive license to a nursing home facility for all or a portion~~
907 ~~of its beds. Any request by a licensee that a nursing home or~~
908 ~~portion of a nursing home become inactive must be submitted to~~
909 ~~the agency in the approved format. The facility may not initiate~~
910 ~~any suspension of services, notify residents, or initiate~~
911 ~~inactivity before receiving approval from the agency; and a~~
912 ~~licensee that violates this provision may not be issued an~~
913 ~~inactive license.~~
914 (1) ~~(2)~~ In addition to the powers granted under part II of
915 chapter 408, the agency may issue an inactive license for a
916 portion of the total beds to a nursing home that chooses to use
917 an unoccupied contiguous portion of the facility for an
918 alternative use to meet the needs of elderly persons through the
919 use of less restrictive, less institutional services.
920 (a) An inactive license issued under this subsection may be
921 granted for a period not to exceed the current licensure
922 expiration date but may be renewed by the agency at the time of
923 licensure renewal.
924 (b) A request to extend the inactive license must be
925 submitted to the agency in the approved format and approved by
926 the agency in writing.
927 (c) Nursing homes that receive an inactive license to
928 provide alternative services shall not receive preference for

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929 participation in the Assisted Living for the Elderly Medicaid
930 waiver.
931 (2) ~~(3)~~ The agency shall adopt rules pursuant to ss.
932 120.536(1) and 120.54 necessary to implement this section.
933 Section 24. Section 400.111, Florida Statutes, is amended
934 to read:
935 400.111 Disclosure of controlling interest.—In addition to
936 the requirements of part II of chapter 408, when requested by
937 the agency, the licensee shall submit a signed affidavit
938 disclosing any financial or ownership interest that a
939 controlling interest has held within the last 5 years in any
940 entity licensed by the state or any other state to provide
941 health or residential care which entity has closed voluntarily
942 or involuntarily; has filed for bankruptcy; has had a receiver
943 appointed; has had a license denied, suspended, or revoked; or
944 has had an injunction issued against it which was initiated by a
945 regulatory agency. The affidavit must disclose the reason such
946 entity was closed, whether voluntarily or involuntarily.
947 Section 25. Subsection (2) of section 400.1183, Florida
948 Statutes, is amended to read:
949 400.1183 Resident grievance procedures.—
950 (2) Each facility shall maintain records of all grievances
951 and shall retain a log for agency inspection of ~~report to the~~
952 ~~agency at the time of relicensure~~ the total number of grievances
953 handled ~~during the prior licensure period~~, a categorization of
954 the cases underlying the grievances, and the final disposition
955 of the grievances.
956 Section 26. Subsection (1) of section 400.141, Florida
957 Statutes, is amended, and subsection (3) is added to that

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958 section to read:
959 400.141 Administration and management of nursing home
960 facilities.—
961 (1) Every licensed facility shall comply with all
962 applicable standards and rules of the agency and shall:
963 (a) Be under the administrative direction and charge of a
964 licensed administrator.
965 (b) Appoint a medical director licensed pursuant to chapter
966 458 or chapter 459. The agency may establish by rule more
967 specific criteria for the appointment of a medical director.
968 (c) Have available the regular, consultative, and emergency
969 services of physicians licensed by the state.
970 (d) Provide for resident use of a community pharmacy as
971 specified in s. 400.022(1)(q). Any other law to the contrary
972 notwithstanding, a registered pharmacist licensed in Florida,
973 that is under contract with a facility licensed under this
974 chapter or chapter 429, shall repackage a nursing facility
975 resident's bulk prescription medication that ~~which~~ has been
976 packaged by another pharmacist licensed in any state in the
977 United States into a unit dose system compatible with the system
978 used by the nursing facility, if the pharmacist is requested to
979 offer such service. In order to be eligible for the repackaging,
980 a resident or the resident's spouse must receive prescription
981 medication benefits provided through a former employer as part
982 of his or her retirement benefits, a qualified pension plan as
983 specified in s. 4972 of the Internal Revenue Code, a federal
984 retirement program as specified under 5 C.F.R. s. 831, or a
985 long-term care policy as defined in s. 627.9404(1). A pharmacist
986 who correctly repackages and relabels the medication and the

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987 nursing facility that ~~which~~ correctly administers such
988 repackaged medication under this paragraph may not be held
989 liable in any civil or administrative action arising from the
990 repackaging. In order to be eligible for the repackaging, a
991 nursing facility resident for whom the medication is to be
992 repackaged shall sign an informed consent form provided by the
993 facility which includes an explanation of the repackaging
994 process and which notifies the resident of the immunities from
995 liability provided in this paragraph. A pharmacist who
996 repackages and relabels prescription medications, as authorized
997 under this paragraph, may charge a reasonable fee for costs
998 resulting from the implementation of this provision.
999 (e) Provide for the access of the facility residents to
1000 dental and other health-related services, recreational services,
1001 rehabilitative services, and social work services appropriate to
1002 their needs and conditions and not directly furnished by the
1003 licensee. When a geriatric outpatient nurse clinic is conducted
1004 in accordance with rules adopted by the agency, outpatients
1005 attending such clinic shall not be counted as part of the
1006 general resident population of the nursing home facility, nor
1007 shall the nursing staff of the geriatric outpatient clinic be
1008 counted as part of the nursing staff of the facility, until the
1009 outpatient clinic load exceeds 15 a day.
1010 (f) Be allowed and encouraged by the agency to provide
1011 other needed services under certain conditions. If the facility
1012 has a standard licensure status~~, and has had no class I or class~~
1013 ~~II deficiencies during the past 2 years or has been awarded a~~
1014 ~~Gold Seal under the program established in s. 400.235~~, it may ~~be~~
1015 ~~encouraged by the agency to~~ provide services, including, but not

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1016 limited to, respite and adult day services, which enable
1017 individuals to move in and out of the facility. A facility is
1018 not subject to any additional licensure requirements for
1019 providing these services under the following conditions:~~.~~
1020 1. Respite care may be offered to persons in need of short-
1021 term or temporary nursing home services. For each person
1022 admitted under the respite care program, the facility licensee
1023 must:
1024 a. Have a written abbreviated plan of care that, at a
1025 minimum, includes nutritional requirements, medication orders,
1026 physician orders, nursing assessments, and dietary preferences.
1027 The nursing or physician assessments may take the place of all
1028 other assessments required for full-time residents.
1029 b. Have a contract that, at a minimum, specifies the
1030 services to be provided to the respite resident, including
1031 charges for services, activities, equipment, emergency medical
1032 services, and the administration of medications. If multiple
1033 respite admissions for a single person are anticipated, the
1034 original contract is valid for 1 year after the date of
1035 execution.
1036 c. Ensure that each resident is released to his or her
1037 caregiver or an individual designated in writing by the
1038 caregiver.
1039 2. A person admitted under the respite care program is:
1040 a. Exempt from requirements in rule related to discharge
1041 planning.
1042 b. Covered by the residents' rights set forth in s.
1043 400.022(1)(a)-(o) and (r)-(t). Property or funds of a resident
1044 are not considered trust funds that are subject to the

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1045 requirements of s. 400.022(1)(h) until the resident has been in
1046 the facility for more than 14 consecutive days.
1047 c. Allowed to use his or her personal medications for the
1048 respite stay if permitted by facility policy. The facility must
1049 obtain a physician's order for the medications. The caregiver
1050 may provide information regarding the medications as part of the
1051 nursing assessment and that information must be in conformance
1052 with the physician's order. Medications shall be released with
1053 the resident upon discharge in accordance with a physician's
1054 current orders.
1055 3. A person receiving respite care is entitled to reside in
1056 the facility for a total of 60 days within a contract year or
1057 within a calendar year if the contract is for less than 12
1058 months. However, each single stay may not exceed 14 days. If a
1059 stay exceeds 14 consecutive days, the facility must comply with
1060 all requirements for assessment and care planning which apply to
1061 nursing home residents.
1062 4. A person receiving respite care must reside in a
1063 licensed nursing home bed.
1064 5. A prospective respite resident must provide medical
1065 information from a physician, a physician assistant, or a nurse
1066 practitioner and other information from the primary caregiver as
1067 may be required by the facility prior to or at the time of
1068 admission to receive respite care. The medical information must
1069 include a physician's order for respite care and proof of a
1070 physical examination by a licensed physician, physician
1071 assistant, or nurse practitioner. The physician's order and
1072 physical examination may be used to provide intermittent respite
1073 care for up to 12 months after the date the order is written.

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1074 6. The facility must assume the duties of the primary
1075 caregiver. To ensure continuity of care and services, the
1076 resident is entitled to retain his or her personal physician and
1077 must have access to medically necessary services such as
1078 physical therapy, occupational therapy, or speech therapy, as
1079 needed. The facility must arrange for transportation to these
1080 services if necessary. ~~Respite care must be provided in~~
1081 ~~accordance with this part and rules adopted by the agency.~~
1082 ~~However, the agency shall, by rule, adopt modified requirements~~
1083 ~~for resident assessment, resident care plans, resident~~
1084 ~~contracts, physician orders, and other provisions, as~~
1085 ~~appropriate, for short-term or temporary nursing home services.~~
1086 7. The agency shall allow for shared programming and staff
1087 in a facility which meets minimum standards and offers services
1088 pursuant to this paragraph, but, if the facility is cited for
1089 deficiencies in patient care, may require additional staff and
1090 programs appropriate to the needs of service recipients. A
1091 person who receives respite care may not be counted as a
1092 resident of the facility for purposes of the facility's licensed
1093 capacity unless that person receives 24-hour respite care. A
1094 person receiving either respite care for 24 hours or longer or
1095 adult day services must be included when calculating minimum
1096 staffing for the facility. Any costs and revenues generated by a
1097 nursing home facility from nonresidential programs or services
1098 shall be excluded from the calculations of Medicaid per diems
1099 for nursing home institutional care reimbursement.
1100 (g) If the facility has a standard license ~~or is a Gold~~
1101 ~~Seal facility~~, exceeds the minimum required hours of licensed
1102 nursing and certified nursing assistant direct care per resident

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1103 per day, and is part of a continuing care facility licensed
1104 under chapter 651 or a retirement community that offers other
1105 services pursuant to part III of this chapter or part I or part
1106 III of chapter 429 on a single campus, be allowed to share
1107 programming and staff. ~~At the time of inspection and in the~~
1108 ~~semiannual report required pursuant to paragraph (o),~~ A
1109 continuing care facility or retirement community that uses this
1110 option must demonstrate through staffing records that minimum
1111 staffing requirements for the facility were met. Licensed nurses
1112 and certified nursing assistants who work in the nursing home
1113 facility may be used to provide services elsewhere on campus if
1114 the facility exceeds the minimum number of direct care hours
1115 required per resident per day and the total number of residents
1116 receiving direct care services from a licensed nurse or a
1117 certified nursing assistant does not cause the facility to
1118 violate the staffing ratios required under s. 400.23(3)(a).
1119 Compliance with the minimum staffing ratios shall be based on
1120 total number of residents receiving direct care services,
1121 regardless of where they reside on campus. If the facility
1122 receives a conditional license, it may not share staff until the
1123 conditional license status ends. This paragraph does not
1124 restrict the agency’s authority under federal or state law to
1125 require additional staff if a facility is cited for deficiencies
1126 in care which are caused by an insufficient number of certified
1127 nursing assistants or licensed nurses. The agency may adopt
1128 rules for the documentation necessary to determine compliance
1129 with this provision.
1130 (h) Maintain the facility premises and equipment and
1131 conduct its operations in a safe and sanitary manner.

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1132 (i) If the licensee furnishes food service, provide a
1133 wholesome and nourishing diet sufficient to meet generally
1134 accepted standards of proper nutrition for its residents and
1135 provide such therapeutic diets as may be prescribed by attending
1136 physicians. In making rules to implement this paragraph, the
1137 agency shall be guided by standards recommended by nationally
1138 recognized professional groups and associations with knowledge
1139 of dietetics.
1140 (j) Keep full records of resident admissions and
1141 discharges; medical and general health status, including medical
1142 records, personal and social history, and identity and address
1143 of next of kin or other persons who may have responsibility for
1144 the affairs of the residents; and individual resident care plans
1145 including, but not limited to, prescribed services, service
1146 frequency and duration, and service goals. The records shall be
1147 open to inspection by the agency. The facility must maintain
1148 clinical records for each resident in accordance with accepted
1149 professional standards and practices and which are complete,
1150 accurately documented, readily accessible, and systematically
1151 organized.
1152 (k) Keep such fiscal records of its operations and
1153 conditions as may be necessary to provide information pursuant
1154 to this part.
1155 (l) Furnish copies of personnel records for employees
1156 affiliated with such facility, to any other facility licensed by
1157 this state requesting this information pursuant to this part.
1158 Such information contained in the records may include, but is
1159 not limited to, disciplinary matters and any reason for
1160 termination. Any facility releasing such records pursuant to

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1161 this part shall be considered to be acting in good faith and may
1162 not be held liable for information contained in such records,
1163 absent a showing that the facility maliciously falsified such
1164 records.
1165 (m) Publicly display a poster provided by the agency
1166 containing the names, addresses, and telephone numbers for the
1167 state's abuse hotline, the State Long-Term Care Ombudsman, the
1168 Agency for Health Care Administration consumer hotline, the
1169 Advocacy Center for Persons with Disabilities, the Florida
1170 Statewide Advocacy Council, and the Medicaid Fraud Control Unit,
1171 with a clear description of the assistance to be expected from
1172 each.
1173 ~~(n) Submit to the agency the information specified in s.~~
1174 ~~400.071(1)(b) for a management company within 30 days after the~~
1175 ~~effective date of the management agreement.~~
1176 ~~(o)1. Submit semiannually to the agency, or more frequently~~
1177 ~~if requested by the agency, information regarding facility~~
1178 ~~staff-to-resident ratios, staff turnover, and staff stability,~~
1179 ~~including information regarding certified nursing assistants,~~
1180 ~~licensed nurses, the director of nursing, and the facility~~
1181 ~~administrator. For purposes of this reporting:~~
1182 ~~a. Staff-to-resident ratios must be reported in the~~
1183 ~~categories specified in s. 400.23(3)(a) and applicable rules.~~
1184 ~~The ratio must be reported as an average for the most recent~~
1185 ~~calendar quarter.~~
1186 ~~b. Staff turnover must be reported for the most recent 12-~~
1187 ~~month period ending on the last workday of the most recent~~
1188 ~~calendar quarter prior to the date the information is submitted.~~
1189 ~~The turnover rate must be computed quarterly, with the annual~~

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1190 ~~rate being the cumulative sum of the quarterly rates. The~~
1191 ~~turnover rate is the total number of terminations or separations~~
1192 ~~experienced during the quarter, excluding any employee~~
1193 ~~terminated during a probationary period of 3 months or less,~~
1194 ~~divided by the total number of staff employed at the end of the~~
1195 ~~period for which the rate is computed, and expressed as a~~
1196 ~~percentage.~~
1197 ~~c. The formula for determining staff stability is the total~~
1198 ~~number of employees that have been employed for more than 12~~
1199 ~~months, divided by the total number of employees employed at the~~
1200 ~~end of the most recent calendar quarter, and expressed as a~~
1201 ~~percentage.~~
1202 (n)1.~~d.~~ Comply with minimum-staffing requirements. A
1203 nursing facility that fails ~~has failed~~ to comply with state
1204 minimum-staffing requirements for 2 consecutive days may not
1205 accept ~~is prohibited from accepting~~ new admissions until the
1206 facility achieves ~~has achieved~~ the minimum-staffing requirements
1207 for ~~a period of~~ 6 consecutive days. For the purposes of this
1208 subparagraph ~~sub-subparagraph~~, any person who was a resident of
1209 the facility and was absent from the facility for the purpose of
1210 receiving medical care at a separate location or was on a leave
1211 of absence is not considered a new admission. Failure to impose
1212 such an admissions moratorium is subject to a $1,000 fine
1213 ~~constitutes a class II deficiency~~.
1214 2.~~e.~~ A nursing facility that ~~which~~ does not have a
1215 conditional license may be cited for failure to comply with the
1216 standards in s. 400.23(3)(a)1.b. and c. only if it fails ~~has~~
1217 ~~failed~~ to meet those standards on 2 consecutive days or if it
1218 fails ~~has failed~~ to meet at least 97 percent of those standards

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1219 on any one day.
1220 3.~~f.~~ A facility that ~~which~~ has a conditional license must
1221 be in compliance with the standards in s. 400.23(3)(a) at all
1222 times.
1223 ~~2. This paragraph does not limit the agency's ability to~~
1224 ~~impose a deficiency or take other actions if a facility does not~~
1225 ~~have enough staff to meet the residents' needs~~.
1226 (o)~~(p)~~ Notify a licensed physician when a resident exhibits
1227 signs of dementia or cognitive impairment or has a change of
1228 condition in order to rule out the presence of an underlying
1229 physiological condition that may be contributing to such
1230 dementia or impairment. The notification must occur within 30
1231 days after the acknowledgment of such signs by facility staff.
1232 If an underlying condition is determined to exist, the facility
1233 shall arrange, with the appropriate health care provider, the
1234 necessary care and services to treat the condition.
1235 (p)~~(q)~~ If the facility implements a dining and hospitality
1236 attendant program, ensure that the program is developed and
1237 implemented under the supervision of the facility director of
1238 nursing. A licensed nurse, licensed speech or occupational
1239 therapist, or a registered dietitian must conduct training of
1240 dining and hospitality attendants. A person employed by a
1241 facility as a dining and hospitality attendant must perform
1242 tasks under the direct supervision of a licensed nurse.
1243 ~~(r) Report to the agency any filing for bankruptcy~~
1244 ~~protection by the facility or its parent corporation,~~
1245 ~~divestiture or spin-off of its assets, or corporate~~
1246 ~~reorganization within 30 days after the completion of such~~
1247 ~~activity.~~

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1248 (q) ~~(s)~~ Maintain general and professional liability
1249 insurance coverage that is in force at all times. In lieu of
1250 general and professional liability insurance coverage, a state-
1251 designated teaching nursing home and its affiliated assisted
1252 living facilities created under s. 430.80 may demonstrate proof
1253 of financial responsibility as provided in s. 430.80(3)(g).
1254 (r) ~~(t)~~ Maintain in the medical record for each resident a
1255 daily chart of certified nursing assistant services provided to
1256 the resident. The certified nursing assistant who is caring for
1257 the resident must complete this record by the end of his or her
1258 shift. This record must indicate assistance with activities of
1259 daily living, assistance with eating, and assistance with
1260 drinking, and must record each offering of nutrition and
1261 hydration for those residents whose plan of care or assessment
1262 indicates a risk for malnutrition or dehydration.
1263 (s) ~~(u)~~ Before November 30 of each year, subject to the
1264 availability of an adequate supply of the necessary vaccine,
1265 provide for immunizations against influenza viruses to all its
1266 consenting residents in accordance with the recommendations of
1267 the United States Centers for Disease Control and Prevention,
1268 subject to exemptions for medical contraindications and
1269 religious or personal beliefs. Subject to these exemptions, any
1270 consenting person who becomes a resident of the facility after
1271 November 30 but before March 31 of the following year must be
1272 immunized within 5 working days after becoming a resident.
1273 Immunization shall not be provided to any resident who provides
1274 documentation that he or she has been immunized as required by
1275 this paragraph. This paragraph does not prohibit a resident from
1276 receiving the immunization from his or her personal physician if

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1277 he or she so chooses. A resident who chooses to receive the
1278 immunization from his or her personal physician shall provide
1279 proof of immunization to the facility. The agency may adopt and
1280 enforce any rules necessary to comply with or implement this
1281 paragraph.
1282 (t) ~~(v)~~ Assess all residents for eligibility for
1283 pneumococcal polysaccharide vaccination (PPV) and vaccinate
1284 residents when indicated within 60 days after the effective date
1285 of this act in accordance with the recommendations of the United
1286 States Centers for Disease Control and Prevention, subject to
1287 exemptions for medical contraindications and religious or
1288 personal beliefs. Residents admitted after the effective date of
1289 this act shall be assessed within 5 working days after ~~of~~
1290 admission and, when indicated, vaccinated within 60 days in
1291 accordance with the recommendations of the United States Centers
1292 for Disease Control and Prevention, subject to exemptions for
1293 medical contraindications and religious or personal beliefs.
1294 Immunization shall not be provided to any resident who provides
1295 documentation that he or she has been immunized as required by
1296 this paragraph. This paragraph does not prohibit a resident from
1297 receiving the immunization from his or her personal physician if
1298 he or she so chooses. A resident who chooses to receive the
1299 immunization from his or her personal physician shall provide
1300 proof of immunization to the facility. The agency may adopt and
1301 enforce any rules necessary to comply with or implement this
1302 paragraph.
1303 (u) ~~(w)~~ Annually encourage and promote to its employees the
1304 benefits associated with immunizations against influenza viruses
1305 in accordance with the recommendations of the United States

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1306 Centers for Disease Control and Prevention. The agency may adopt
1307 and enforce any rules necessary to comply with or implement this
1308 paragraph.
1309
1310 This subsection does not limit the agency's ability to impose a
1311 penalty for a deficiency or take other actions if a facility
1312 fails to maintain an adequate number of staff to meet the
1313 residents' needs.
1314 (3) A facility may charge a reasonable fee for copying
1315 resident records. The fee may not exceed $1 per page for the
1316 first 25 pages and 25 cents per page for each page in excess of
1317 25 pages.
1318 Section 27. Subsection (3) of section 400.142, Florida
1319 Statutes, is amended to read:
1320 400.142 Emergency medication kits; orders not to
1321 resuscitate.—
1322 (3) Facility staff may withhold or withdraw cardiopulmonary
1323 resuscitation if presented with an order not to resuscitate
1324 executed pursuant to s. 401.45. ~~The agency shall adopt rules~~
1325 ~~providing for the implementation of such orders.~~ Facility staff
1326 and facilities are ~~shall~~ not ~~be~~ subject to criminal prosecution
1327 or civil liability, and are not ~~nor be~~ considered to have
1328 engaged in negligent or unprofessional conduct, for withholding
1329 or withdrawing cardiopulmonary resuscitation pursuant to such an
1330 order and rules adopted by the agency. The absence of an order
1331 not to resuscitate executed pursuant to s. 401.45 does not
1332 preclude a physician from withholding or withdrawing
1333 cardiopulmonary resuscitation as otherwise permitted by law.
1334 Section 28. Section 400.145, Florida Statutes, is repealed.

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1335 Section 29. Present subsections (9), (11), (12), (13),
1336 (14), and (15) of section 400.147, Florida Statutes, are
1337 redesignated as subsections (8), (9), (10), (11), (12), and
1338 (13), respectively, and present subsections (7), (8), and (10)
1339 of that section are amended to read:
1340 400.147 Internal risk management and quality assurance
1341 program.—
1342 (7) The facility shall initiate an investigation ~~and shall~~
1343 ~~notify the agency~~ within 1 business day after the risk manager
1344 or his or her designee has received a report pursuant to
1345 paragraph (1)(d). Each facility shall complete the investigation
1346 and submit a report to the agency within 15 calendar days if the
1347 incident is determined to be an adverse incident as defined in
1348 subsection (5). ~~The notification must be made in writing and be~~
1349 ~~provided electronically, by facsimile device or overnight mail~~
1350 ~~delivery.~~ The agency shall develop a form for reporting this
1351 information, and the notification must include the name of the
1352 risk manager of the facility, information regarding the identity
1353 of the affected resident, the type of adverse incident, the
1354 initiation of an investigation by the facility, and whether the
1355 events causing or resulting in the adverse incident represent a
1356 potential risk to any other resident. The notification is
1357 confidential as provided by law and is not discoverable or
1358 admissible in any civil or administrative action, except in
1359 disciplinary proceedings by the agency or the appropriate
1360 regulatory board. The agency may investigate, as it deems
1361 appropriate, any such incident and prescribe measures that must
1362 or may be taken in response to the incident. The agency shall
1363 review each incident and determine whether it potentially

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1364 involved conduct by the health care professional who is subject
1365 to disciplinary action, in which case the provisions of s.
1366 456.073 shall apply.
1367 ~~(8)(a) Each facility shall complete the investigation and~~
1368 ~~submit an adverse incident report to the agency for each adverse~~
1369 ~~incident within 15 calendar days after its occurrence. If, after~~
1370 ~~a complete investigation, the risk manager determines that the~~
1371 ~~incident was not an adverse incident as defined in subsection~~
1372 ~~(5), the facility shall include this information in the report.~~
1373 ~~The agency shall develop a form for reporting this information.~~
1374 ~~(b) The information reported to the agency pursuant to~~
1375 ~~paragraph (a) which relates to persons licensed under chapter~~
1376 ~~458, chapter 459, chapter 461, or chapter 466 shall be reviewed~~
1377 ~~by the agency. The agency shall determine whether any of the~~
1378 ~~incidents potentially involved conduct by a health care~~
1379 ~~professional who is subject to disciplinary action, in which~~
1380 ~~case the provisions of s. 456.073 shall apply.~~
1381 ~~(c) The report submitted to the agency must also contain~~
1382 ~~the name of the risk manager of the facility.~~
1383 ~~(d) The adverse incident report is confidential as provided~~
1384 ~~by law and is not discoverable or admissible in any civil or~~
1385 ~~administrative action, except in disciplinary proceedings by the~~
1386 ~~agency or the appropriate regulatory board.~~
1387 ~~(10) By the 10th of each month, each facility subject to~~
1388 ~~this section shall report any notice received pursuant to s.~~
1389 ~~400.0233(2) and each initial complaint that was filed with the~~
1390 ~~clerk of the court and served on the facility during the~~
1391 ~~previous month by a resident or a resident's family member,~~
1392 ~~guardian, conservator, or personal legal representative. The~~

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1393 ~~report must include the name of the resident, the resident's~~
1394 ~~date of birth and social security number, the Medicaid~~
1395 ~~identification number for Medicaid-eligible persons, the date or~~
1396 ~~dates of the incident leading to the claim or dates of~~
1397 ~~residency, if applicable, and the type of injury or violation of~~
1398 ~~rights alleged to have occurred. Each facility shall also submit~~
1399 ~~a copy of the notices received pursuant to s. 400.0233(2) and~~
1400 ~~complaints filed with the clerk of the court. This report is~~
1401 ~~confidential as provided by law and is not discoverable or~~
1402 ~~admissible in any civil or administrative action, except in such~~
1403 ~~actions brought by the agency to enforce the provisions of this~~
1404 ~~part.~~
1405 Section 30. Subsection (3) of section 400.19, Florida
1406 Statutes, is amended to read:
1407 400.19 Right of entry and inspection.—
1408 (3) The agency shall every 15 months conduct at least one
1409 unannounced inspection to determine compliance by the licensee
1410 with statutes, and with rules adopted ~~promulgated~~ under the
1411 provisions of those statutes, governing minimum standards of
1412 construction, quality and adequacy of care, and rights of
1413 residents. The survey shall be conducted every 6 months for the
1414 next 2-year period if the facility has been cited for a class I
1415 deficiency, has been cited for two or more class II deficiencies
1416 arising from separate surveys or investigations within a 60-day
1417 period, or has had three or more substantiated complaints within
1418 a 6-month period, each resulting in at least one class I or
1419 class II deficiency. In addition to any other fees or fines in
1420 this part, the agency shall assess a fine for each facility that
1421 is subject to the 6-month survey cycle. The fine for the 2-year

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1422 period shall be $6,000, one-half to be paid at the completion of
1423 each survey. The agency may adjust this fine by the change in
1424 the Consumer Price Index, based on the 12 months immediately
1425 preceding the increase, to cover the cost of the additional
1426 surveys. The agency shall verify through subsequent inspection
1427 that any deficiency identified during inspection is corrected.
1428 However, the agency may verify the correction of a class III or
1429 class IV deficiency ~~unrelated to resident rights or resident~~
1430 ~~care~~ without reinspecting the facility if adequate written
1431 documentation has been received from the facility, which
1432 provides assurance that the deficiency has been corrected. The
1433 giving or causing to be given of advance notice of such
1434 unannounced inspections by an employee of the agency to any
1435 unauthorized person shall constitute cause for suspension of not
1436 less ~~fewer~~ than 5 working days according to the provisions of
1437 chapter 110.
1438 Section 31. Subsection (5) of section 400.23, Florida
1439 Statutes, is amended to read:
1440 400.23 Rules; evaluation and deficiencies; licensure
1441 status.—
1442 (5)(a) The agency, in collaboration with the Division of
1443 Children's Medical Services Network of the Department of Health,
1444 must~~, no later than December 31, 1993,~~ adopt rules for minimum
1445 standards of care for persons under 21 years of age who reside
1446 in nursing home facilities. ~~The rules must include a methodology~~
1447 ~~for reviewing a nursing home facility under ss. 408.031-408.045~~
1448 ~~which serves only persons under 21 years of age.~~ A facility may
1449 be exempt from these standards for specific persons between 18
1450 and 21 years of age, if the person's physician agrees that

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1451 minimum standards of care based on age are not necessary.
1452 (b) The agency, in collaboration with the Division of
1453 Children's Medical Services Network, shall adopt rules for
1454 minimum staffing requirements for nursing home facilities that
1455 serve persons under 21 years of age, which shall apply in lieu
1456 of the standards contained in subsection (3).
1457 1. For persons under 21 years of age who require skilled
1458 care, the requirements shall include a minimum combined average
1459 of licensed nurses, respiratory therapists, respiratory care
1460 practitioners, and certified nursing assistants of 3.9 hours of
1461 direct care per resident per day for each nursing home facility.
1462 2. For persons under 21 years of age who are fragile, the
1463 requirements shall include a minimum combined average of
1464 licensed nurses, respiratory therapists, respiratory care
1465 practitioners, and certified nursing assistants of 5 hours of
1466 direct care per resident per day for each nursing home facility.
1467 Section 32. Subsection (1) of section 400.275, Florida
1468 Statutes, is amended to read:
1469 400.275 Agency duties.—
1470 (1) ~~The agency shall ensure that each newly hired nursing~~
1471 ~~home surveyor, as a part of basic training, is assigned full-~~
1472 ~~time to a licensed nursing home for at least 2 days within a 7-~~
1473 ~~day period to observe facility operations outside of the survey~~
1474 ~~process before the surveyor begins survey responsibilities. Such~~
1475 ~~observations may not be the sole basis of a deficiency citation~~
1476 ~~against the facility.~~ The agency may not assign an individual to
1477 be a member of a survey team for purposes of a survey,
1478 evaluation, or consultation visit at a nursing home facility in
1479 which the surveyor was an employee within the preceding 2 ~~5~~

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1480 years.
1481 Section 33. Subsection (27) of section 400.462, Florida
1482 Statutes, is amended to read:
1483 400.462 Definitions.—As used in this part, the term:
1484 (27) "Remuneration" means any payment or other benefit made
1485 directly or indirectly, overtly or covertly, in cash or in kind.
1486 <u>However, when the term is used in any provision of law relating</u>
1487 <u>to a health care provider, such term does not mean an item with</u>
1488 <u>an individual value of up to $15, including, but not limited to,</u>
1489 <u>plaques, certificates, trophies, or novelties that are intended</u>
1490 <u>solely for presentation or are customarily given away solely for</u>
1491 <u>promotional, recognition, or advertising purposes.</u>
1492 Section 34. For the purpose of incorporating the amendment
1493 made by this act to section 400.509, Florida Statutes, in a
1494 reference thereto, paragraph (b) of subsection (5) of section
1495 400.464, Florida Statutes, is reenacted and amended to read:
1496 400.464 Home health agencies to be licensed; expiration of
1497 license; exemptions; unlawful acts; penalties.—
1498 (5) The following are exempt from the licensure
1499 requirements of this part:
1500 (b) Home health services provided by a state agency, either
1501 directly or through a contractor with:
1502 1. The Department of Elderly Affairs.
1503 2. The Department of Health, a community health center, or
1504 a rural health network that furnishes home visits for the
1505 purpose of providing environmental assessments, case management,
1506 health education, personal care services, family planning, or
1507 followup treatment, or for the purpose of monitoring and
1508 tracking disease.

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1509 3. Services provided to persons with developmental
1510 disabilities, as defined in s. 393.063.
1511 4. Companion and sitter organizations that were registered
1512 under s. 400.509(1) ~~on January 1, 1999,~~ and were authorized to
1513 provide personal services under a developmental services
1514 provider certificate ~~on January 1, 1999,~~ may continue to provide
1515 such services to past, present, and future clients of the
1516 organization who need such services, notwithstanding the
1517 provisions of this act.
1518 5. The Department of Children and Family Services.
1519 Section 35. Subsection (6) of section 400.474, Florida
1520 Statutes, is amended, present subsection (7) is redesignated as
1521 subsection (8), and a new subsection (7) is added to that
1522 section, to read:
1523 400.474 Administrative penalties.—
1524 (6) The agency may deny, revoke, or suspend the license of
1525 a home health agency and shall impose a fine of $5,000 against a
1526 home health agency that:
1527 (a) Gives remuneration for staffing services to:
1528 1. Another home health agency with which it has formal or
1529 informal patient-referral transactions or arrangements; or
1530 2. A health services pool with which it has formal or
1531 informal patient-referral transactions or arrangements,
1532
1533 unless the home health agency has activated its comprehensive
1534 emergency management plan in accordance with s. 400.492. This
1535 paragraph does not apply to a Medicare-certified home health
1536 agency that provides fair market value remuneration for staffing
1537 services to a non-Medicare-certified home health agency that is

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1538 part of a continuing care facility licensed under chapter 651
1539 for providing services to its own residents if each resident
1540 receiving home health services pursuant to this arrangement
1541 attests in writing that he or she made a decision without
1542 influence from staff of the facility to select, from a list of
1543 Medicare-certified home health agencies provided by the
1544 facility, that Medicare-certified home health agency to provide
1545 the services.
1546 (b) Provides services to residents in an assisted living
1547 facility for which the home health agency does not receive fair
1548 market value remuneration.
1549 (c) Provides staffing to an assisted living facility for
1550 which the home health agency does not receive fair market value
1551 remuneration.
1552 (d) Fails to provide the agency, upon request, with copies
1553 of all contracts with assisted living facilities which were
1554 executed within 5 years before the request.
1555 (e) Gives remuneration to a case manager, discharge
1556 planner, facility-based staff member, or third-party vendor who
1557 is involved in the discharge planning process of a facility
1558 licensed under chapter 395, chapter 429, or this chapter from
1559 whom the home health agency receives referrals.
1560 ~~(f) Fails to submit to the agency, within 15 days after the~~
1561 ~~end of each calendar quarter, a written report that includes the~~
1562 ~~following data based on data as it existed on the last day of~~
1563 ~~the quarter:~~
1564 ~~1. The number of insulin-dependent diabetic patients~~
1565 ~~receiving insulin-injection services from the home health~~
1566 ~~agency;~~

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1567 ~~2. The number of patients receiving both home health~~
1568 ~~services from the home health agency and hospice services;~~
1569 ~~3. The number of patients receiving home health services~~
1570 ~~from that home health agency; and~~
1571 ~~4. The names and license numbers of nurses whose primary~~
1572 ~~job responsibility is to provide home health services to~~
1573 ~~patients and who received remuneration from the home health~~
1574 ~~agency in excess of $25,000 during the calendar quarter.~~
1575 (f) ~~(g)~~ Gives cash, or its equivalent, to a Medicare or
1576 Medicaid beneficiary.
1577 (g) ~~(h)~~ Has more than one medical director contract in
1578 effect at one time or more than one medical director contract
1579 and one contract with a physician-specialist whose services are
1580 mandated for the home health agency in order to qualify to
1581 participate in a federal or state health care program at one
1582 time.
1583 (h) ~~(i)~~ Gives remuneration to a physician without a medical
1584 director contract being in effect. The contract must:
1585 1. Be in writing and signed by both parties;
1586 2. Provide for remuneration that is at fair market value
1587 for an hourly rate, which must be supported by invoices
1588 submitted by the medical director describing the work performed,
1589 the dates on which that work was performed, and the duration of
1590 that work; and
1591 3. Be for a term of at least 1 year.
1592
1593 The hourly rate specified in the contract may not be increased
1594 during the term of the contract. The home health agency may not
1595 execute a subsequent contract with that physician which has an

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1596 increased hourly rate and covers any portion of the term that
1597 was in the original contract.
1598 (i) ~~(j)~~ Gives remuneration to:
1599 1. A physician, and the home health agency is in violation
1600 of paragraph (g) ~~(h)~~ or paragraph (h) ~~(i)~~;
1601 2. A member of the physician's office staff; or
1602 3. An immediate family member of the physician,
1603
1604 if the home health agency has received a patient referral in the
1605 preceding 12 months from that physician or physician's office
1606 staff.
1607 (j) ~~(k)~~ Fails to provide to the agency, upon request, copies
1608 of all contracts with a medical director which were executed
1609 within 5 years before the request.
1610 (k) ~~(l)~~ Demonstrates a pattern of billing the Medicaid
1611 program for services to Medicaid recipients which are medically
1612 unnecessary as determined by a final order. A pattern may be
1613 demonstrated by a showing of at least two such medically
1614 unnecessary services within one Medicaid program integrity audit
1615 period.
1616
1617 Nothing in paragraph (e) or paragraph (i) ~~(j)~~ shall be
1618 interpreted as applying to or precluding any discount,
1619 compensation, waiver of payment, or payment practice permitted
1620 by 42 U.S.C. s. 1320a-7(b) or regulations adopted thereunder,
1621 including 42 C.F.R. s. 1001.952 or s. 1395nn or regulations
1622 adopted thereunder.
1623 (7) Each home health agency shall submit to the agency,
1624 within 15 days after the end of each calendar quarter, a written

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1625 report that includes the following data as it existed on the
1626 last day of the quarter:
1627 (a) The number of insulin-dependent diabetic patients
1628 receiving insulin-injection services from the home health
1629 agency.
1630 (b) The number of patients receiving home health services
1631 from the home health agency who are also receiving hospice
1632 services.
1633 (c) The number of patients receiving home health services
1634 from the home health agency.
1635 (d) The names and license numbers of nurses whose primary
1636 job responsibility is to provide home health services to
1637 patients and who received remuneration from the home health
1638 agency in excess of $25,000 during the calendar quarter.
1639 (e) The number of physicians who were paid by the home
1640 health agency for professional services of any kind during the
1641 calendar quarter, the amount paid to each physician, and the
1642 number of hours each physician spent performing those services.
1643
1644 If the quarterly report is not received by the agency on or
1645 before the deadline, the agency shall impose a fine in the
1646 amount of $200 for each day that the report is late, which may
1647 not exceed $5,000 per quarter.
1648 Section 36. Section 400.484, Florida Statutes, is amended
1649 to read:
1650 400.484 Right of inspection; violations ~~deficiencies~~;
1651 fines.—
1652 (1) In addition to the requirements of s. 408.811, the
1653 agency may make such inspections and investigations as are

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1654 necessary in order to determine the state of compliance with
1655 this part, part II of chapter 408, and applicable rules.
1656 (2) The agency shall impose fines for various classes of
1657 violations ~~deficiencies~~ in accordance with the following
1658 schedule:
1659 (a) A class I violation is defined in s. 408.813 ~~deficiency~~
1660 ~~is any act, omission, or practice that results in a patient's~~
1661 ~~death, disablement, or permanent injury, or places a patient at~~
1662 ~~imminent risk of death, disablement, or permanent injury~~. Upon
1663 finding a class I violation ~~deficiency~~, the agency shall impose
1664 an administrative fine in the amount of $15,000 for each
1665 occurrence and each day that the violation ~~deficiency~~ exists.
1666 (b) A class II violation is defined in s. 408.813
1667 ~~deficiency is any act, omission, or practice that has a direct~~
1668 ~~adverse effect on the health, safety, or security of a patient~~.
1669 Upon finding a class II violation ~~deficiency~~, the agency shall
1670 impose an administrative fine in the amount of $5,000 for each
1671 occurrence and each day that the violation ~~deficiency~~ exists.
1672 (c) A class III violation is defined in s. 408.813
1673 ~~deficiency is any act, omission, or practice that has an~~
1674 ~~indirect, adverse effect on the health, safety, or security of a~~
1675 ~~patient~~. Upon finding an uncorrected or repeated class III
1676 violation ~~deficiency~~, the agency shall impose an administrative
1677 fine not to exceed $1,000 for each occurrence and each day that
1678 the uncorrected or repeated violation ~~deficiency~~ exists.
1679 (d) A class IV violation is defined in s. 408.813
1680 ~~deficiency is any act, omission, or practice related to required~~
1681 ~~reports, forms, or documents which does not have the potential~~
1682 ~~of negatively affecting patients~~. These violations are of a type

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1683 that the agency determines do not threaten the health, safety,
1684 or security of patients. Upon finding an uncorrected or repeated
1685 class IV violation ~~deficiency~~, the agency shall impose an
1686 administrative fine not to exceed $500 for each occurrence and
1687 each day that the uncorrected or repeated violation ~~deficiency~~
1688 exists.
1689 (3) In addition to any other penalties imposed pursuant to
1690 this section or part, the agency may assess costs related to an
1691 investigation that results in a successful prosecution,
1692 excluding costs associated with an attorney's time.
1693 Section 37. For the purpose of incorporating the amendment
1694 made by this act to section 400.509, Florida Statutes, in a
1695 reference thereto, paragraph (a) of subsection (6) of section
1696 400.506 is reenacted, present subsection (17) of that section is
1697 renumbered as subsection (18), and a new subsection (17) is
1698 added to that section, to read:
1699 400.506 Licensure of nurse registries; requirements;
1700 penalties.—
1701 (6)(a) A nurse registry may refer for contract in private
1702 residences registered nurses and licensed practical nurses
1703 registered and licensed under part I of chapter 464, certified
1704 nursing assistants certified under part II of chapter 464, home
1705 health aides who present documented proof of successful
1706 completion of the training required by rule of the agency, and
1707 companions or homemakers for the purposes of providing those
1708 services authorized under s. 400.509(1). A licensed nurse
1709 registry shall ensure that each certified nursing assistant
1710 referred for contract by the nurse registry and each home health
1711 aide referred for contract by the nurse registry is adequately

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1712 trained to perform the tasks of a home health aide in the home
1713 setting. Each person referred by a nurse registry must provide
1714 current documentation that he or she is free from communicable
1715 diseases.
1716 (17) An administrator may manage only one nurse registry,
1717 except that an administrator may manage up to five registries if
1718 all five registries have identical controlling interests as
1719 defined in s. 408.803 and are located within one agency
1720 geographic service area or within an immediately contiguous
1721 county. An administrator shall designate, in writing, for each
1722 licensed entity, a qualified alternate administrator to serve
1723 during the administrator's absence.
1724 Section 38. Subsection (1) of section 400.509, Florida
1725 Statutes, is amended to read:
1726 400.509 Registration of particular service providers exempt
1727 from licensure; certificate of registration; regulation of
1728 registrants.—
1729 (1) Any organization that provides companion services or
1730 homemaker services and does not provide a home health service to
1731 a person is exempt from licensure under this part. However, any
1732 organization that provides companion services or homemaker
1733 services must register with the agency. An organization under
1734 contract with the Agency for Persons with Disabilities which
1735 provides companion services only for persons with a
1736 developmental disability, as defined in s. 393.063, is exempt
1737 from registration.
1738 Section 39. Subsection (3) of section 400.601, Florida
1739 Statutes, is amended to read:
1740 400.601 Definitions.—As used in this part, the term:

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1741 (3) "Hospice" means a centrally administered corporation or
1742 a limited liability company that provides ~~providing~~ a continuum
1743 of palliative and supportive care for the terminally ill patient
1744 and his or her family.
1745 Section 40. Paragraph (i) of subsection (1) and subsection
1746 (4) of section 400.606, Florida Statutes, are amended to read:
1747 400.606 License; application; renewal; conditional license
1748 or permit; certificate of need.—
1749 (1) In addition to the requirements of part II of chapter
1750 408, the initial application and change of ownership application
1751 must be accompanied by a plan for the delivery of home,
1752 residential, and homelike inpatient hospice services to
1753 terminally ill persons and their families. Such plan must
1754 contain, but need not be limited to:
1755 ~~(i) The projected annual operating cost of the hospice.~~
1756
1757 If the applicant is an existing licensed health care provider,
1758 the application must be accompanied by a copy of the most recent
1759 profit-loss statement and, if applicable, the most recent
1760 licensure inspection report.
1761 (4) A freestanding hospice facility that is ~~primarily~~
1762 engaged in providing inpatient and related services and that is
1763 not otherwise licensed as a health care facility shall ~~be~~
1764 ~~required to~~ obtain a certificate of need. However, a
1765 freestanding hospice facility that has ~~with~~ six or fewer beds is
1766 ~~shall~~ not ~~be~~ required to comply with institutional standards
1767 such as, but not limited to, standards requiring sprinkler
1768 systems, emergency electrical systems, or special lavatory
1769 devices.

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1770 Section 41. Section 400.915, Florida Statutes, is amended
1771 to read:
1772 400.915 Construction and renovation; requirements.—The
1773 requirements for the construction or renovation of a PPEC center
1774 shall comply with:
1775 (1) The provisions of chapter 553, which pertain to
1776 building construction standards, including plumbing, electrical
1777 code, glass, manufactured buildings, accessibility for the
1778 physically disabled;
1779 (2) The provisions of s. 633.022 and applicable rules
1780 pertaining to physical ~~minimum~~ standards for nonresidential
1781 child care ~~physical~~ facilities ~~in rule 10M-12.003, Florida~~
1782 ~~Administrative Code, Child Care Standards~~; and
1783 (3) The standards or rules adopted pursuant to this part
1784 and part II of chapter 408.
1785 Section 42. Section 400.931, Florida Statutes, is amended
1786 to read:
1787 400.931 Application for license; fee~~; provisional license;~~
1788 ~~temporary permit~~.—
1789 (1) In addition to the requirements of part II of chapter
1790 408, the applicant must file with the application satisfactory
1791 proof that the home medical equipment provider is in compliance
1792 with this part and applicable rules, including:
1793 (a) A report, by category, of the equipment to be provided,
1794 indicating those offered either directly by the applicant or
1795 through contractual arrangements with existing providers.
1796 Categories of equipment include:
1797 1. Respiratory modalities.
1798 2. Ambulation aids.

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1799 3. Mobility aids.
1800 4. Sickroom setup.
1801 5. Disposables.
1802 (b) A report, by category, of the services to be provided,
1803 indicating those offered either directly by the applicant or
1804 through contractual arrangements with existing providers.
1805 Categories of services include:
1806 1. Intake.
1807 2. Equipment selection.
1808 3. Delivery.
1809 4. Setup and installation.
1810 5. Patient training.
1811 6. Ongoing service and maintenance.
1812 7. Retrieval.
1813 (c) A listing of those with whom the applicant contracts,
1814 both the providers the applicant uses to provide equipment or
1815 services to its consumers and the providers for whom the
1816 applicant provides services or equipment.
1817 (2) An applicant for initial licensure, change of
1818 ownership, or license renewal to operate a licensed home medical
1819 equipment provider at a location outside the state must submit
1820 documentation of accreditation or an application for
1821 accreditation from an accrediting organization that is
1822 recognized by the agency. An applicant that has applied for
1823 accreditation must provide proof of accreditation that is not
1824 conditional or provisional within 120 days after the date the
1825 agency receives the application for licensure or the application
1826 shall be withdrawn from further consideration. Such
1827 accreditation must be maintained by the home medical equipment

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1828 provider in order to maintain licensure. ~~As an alternative to~~
1829 ~~submitting proof of financial ability to operate as required in~~
1830 ~~s. 408.810(8), the applicant may submit a $50,000 surety bond to~~
1831 ~~the agency.~~
1832 (3) As specified in part II of chapter 408, the home
1833 medical equipment provider must also obtain and maintain
1834 professional and commercial liability insurance. Proof of
1835 liability insurance, as defined in s. 624.605, must be submitted
1836 with the application. The agency shall set the required amounts
1837 of liability insurance by rule, but the required amount must not
1838 be less than $250,000 per claim. In the case of contracted
1839 services, it is required that the contractor have liability
1840 insurance not less than $250,000 per claim.
1841 (4) When a change of the general manager of a home medical
1842 equipment provider occurs, the licensee must notify the agency
1843 of the change within 45 days.
1844 (5) In accordance with s. 408.805, an applicant or a
1845 licensee shall pay a fee for each license application submitted
1846 under this part, part II of chapter 408, and applicable rules.
1847 The amount of the fee shall be established by rule and may not
1848 exceed $300 per biennium. The agency shall set the fees in an
1849 amount that is sufficient to cover its costs in carrying out its
1850 responsibilities under this part. However, state, county, or
1851 municipal governments applying for licenses under this part are
1852 exempt from the payment of license fees.
1853 (6) An applicant for initial licensure, renewal, or change
1854 of ownership shall also pay an inspection fee not to exceed
1855 $400, which shall be paid by all applicants except those not
1856 subject to licensure inspection by the agency as described in s.

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1857 400.933.
1858 Section 43. Section 400.967, Florida Statutes, is amended
1859 to read:
1860 400.967 Rules and classification of violations
1861 ~~deficiencies~~.~~—~~
1862 (1) It is the intent of the Legislature that rules adopted
1863 and enforced under this part and part II of chapter 408 include
1864 criteria by which a reasonable and consistent quality of
1865 resident care may be ensured, the results of such resident care
1866 can be demonstrated, and safe and sanitary facilities can be
1867 provided.
1868 (2) Pursuant to the intention of the Legislature, the
1869 agency, in consultation with the Agency for Persons with
1870 Disabilities and the Department of Elderly Affairs, shall adopt
1871 and enforce rules to administer this part and part II of chapter
1872 408, which shall include reasonable and fair criteria governing:
1873 (a) The location and construction of the facility;
1874 including fire and life safety, plumbing, heating, cooling,
1875 lighting, ventilation, and other housing conditions that ensure
1876 the health, safety, and comfort of residents. The agency shall
1877 establish standards for facilities and equipment to increase the
1878 extent to which new facilities and a new wing or floor added to
1879 an existing facility after July 1, 2000, are structurally
1880 capable of serving as shelters only for residents, staff, and
1881 families of residents and staff, and equipped to be self-
1882 supporting during and immediately following disasters. The
1883 agency shall update or revise the criteria as the need arises.
1884 All facilities must comply with those lifesafety code
1885 requirements and building code standards applicable at the time

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1886 of approval of their construction plans. The agency may require
1887 alterations to a building if it determines that an existing
1888 condition constitutes a distinct hazard to life, health, or
1889 safety. The agency shall adopt fair and reasonable rules setting
1890 forth conditions under which existing facilities undergoing
1891 additions, alterations, conversions, renovations, or repairs are
1892 required to comply with the most recent updated or revised
1893 standards.
1894 (b) The number and qualifications of all personnel,
1895 including management, medical nursing, and other personnel,
1896 having responsibility for any part of the care given to
1897 residents.
1898 (c) All sanitary conditions within the facility and its
1899 surroundings, including water supply, sewage disposal, food
1900 handling, and general hygiene, which will ensure the health and
1901 comfort of residents.
1902 (d) The equipment essential to the health and welfare of
1903 the residents.
1904 (e) A uniform accounting system.
1905 (f) The care, treatment, and maintenance of residents and
1906 measurement of the quality and adequacy thereof.
1907 (g) The preparation and annual update of a comprehensive
1908 emergency management plan. The agency shall adopt rules
1909 establishing minimum criteria for the plan after consultation
1910 with the Division of Emergency Management. At a minimum, the
1911 rules must provide for plan components that address emergency
1912 evacuation transportation; adequate sheltering arrangements;
1913 postdisaster activities, including emergency power, food, and
1914 water; postdisaster transportation; supplies; staffing;

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1915 emergency equipment; individual identification of residents and
1916 transfer of records; and responding to family inquiries. The
1917 comprehensive emergency management plan is subject to review and
1918 approval by the local emergency management agency. During its
1919 review, the local emergency management agency shall ensure that
1920 the following agencies, at a minimum, are given the opportunity
1921 to review the plan: the Department of Elderly Affairs, the
1922 Agency for Persons with Disabilities, the Agency for Health Care
1923 Administration, and the Division of Emergency Management. Also,
1924 appropriate volunteer organizations must be given the
1925 opportunity to review the plan. The local emergency management
1926 agency shall complete its review within 60 days and either
1927 approve the plan or advise the facility of necessary revisions.
1928 (h) The use of restraint and seclusion. Such rules must be
1929 consistent with recognized best practices; prohibit inherently
1930 dangerous restraint or seclusion procedures; establish
1931 limitations on the use and duration of restraint and seclusion;
1932 establish measures to ensure the safety of clients and staff
1933 during an incident of restraint or seclusion; establish
1934 procedures for staff to follow before, during, and after
1935 incidents of restraint or seclusion, including individualized
1936 plans for the use of restraints or seclusion in emergency
1937 situations; establish professional qualifications of and
1938 training for staff who may order or be engaged in the use of
1939 restraint or seclusion; establish requirements for facility data
1940 collection and reporting relating to the use of restraint and
1941 seclusion; and establish procedures relating to the
1942 documentation of the use of restraint or seclusion in the
1943 client’s facility or program record.

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1944 (3) The agency shall adopt rules to provide that, when the
1945 criteria established under this part and part II of chapter 408
1946 are not met, such violations ~~deficiencies~~ shall be classified
1947 according to the nature of the violation ~~deficiency~~. The agency
1948 shall indicate the classification on the face of the notice of
1949 violation ~~deficiencies~~ as follows:
1950 (a) A class I violation is defined in s. 408.813
1951 ~~deficiencies are those which the agency determines present an~~
1952 ~~imminent danger to the residents or guests of the facility or a~~
1953 ~~substantial probability that death or serious physical harm~~
1954 ~~would result therefrom~~. ~~The condition or practice constituting a~~
1955 ~~class I violation must be abated or eliminated immediately,~~
1956 ~~unless a fixed period of time, as determined by the agency, is~~
1957 ~~required for correction.~~ A class I violation ~~deficiency~~ is
1958 subject to a civil penalty in an amount not less than $5,000 and
1959 not exceeding $10,000 for each violation ~~deficiency~~. A fine may
1960 be levied notwithstanding the correction of the violation
1961 ~~deficiency~~.
1962 (b) A class II violation is defined in s. 408.813
1963 ~~deficiencies are those which the agency determines have a direct~~
1964 ~~or immediate relationship to the health, safety, or security of~~
1965 ~~the facility residents, other than class I deficiencies~~. A class
1966 II violation ~~deficiency~~ is subject to a civil penalty in an
1967 amount not less than $1,000 and not exceeding $5,000 for each
1968 violation ~~deficiency~~. A citation for a class II violation
1969 ~~deficiency~~ shall specify the time within which the violation
1970 ~~deficiency~~ must be corrected. If a class II violation ~~deficiency~~
1971 is corrected within the time specified, no civil penalty shall
1972 be imposed, unless it is a repeated offense.

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1973 (c) A class III violation is defined in s. 408.813
1974 ~~deficiencies are those which the agency determines to have an~~
1975 ~~indirect or potential relationship to the health, safety, or~~
1976 ~~security of the facility residents, other than class I or class~~
1977 ~~II deficiencies~~. A class III violation ~~deficiency~~ is subject to
1978 a civil penalty of not less than $500 and not exceeding $1,000
1979 for each violation ~~deficiency~~. A citation for a class III
1980 violation ~~deficiency~~ shall specify the time within which the
1981 violation ~~deficiency~~ must be corrected. If a class III violation
1982 ~~deficiency~~ is corrected within the time specified, no civil
1983 penalty shall be imposed, unless it is a repeated offense.
1984 (d) A class IV violation is defined in s. 408.813. Upon
1985 finding an uncorrected or repeated class IV violation, the
1986 agency shall impose an administrative fine not to exceed $500
1987 for each occurrence and each day that the uncorrected or
1988 repeated violation exists.
1989 (4) The agency shall approve or disapprove the plans and
1990 specifications within 60 days after receipt of the final plans
1991 and specifications. The agency may be granted one 15-day
1992 extension for the review period, if the secretary of the agency
1993 so approves. If the agency fails to act within the specified
1994 time, it is deemed to have approved the plans and
1995 specifications. When the agency disapproves plans and
1996 specifications, it must set forth in writing the reasons for
1997 disapproval. Conferences and consultations may be provided as
1998 necessary.
1999 (5) The agency may charge an initial fee of $2,000 for
2000 review of plans and construction on all projects, no part of
2001 which is refundable. The agency may also collect a fee, not to

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2002 exceed 1 percent of the estimated construction cost or the
2003 actual cost of review, whichever is less, for the portion of the
2004 review which encompasses initial review through the initial
2005 revised construction document review. The agency may collect its
2006 actual costs on all subsequent portions of the review and
2007 construction inspections. Initial fee payment must accompany the
2008 initial submission of plans and specifications. Any subsequent
2009 payment that is due is payable upon receipt of the invoice from
2010 the agency. Notwithstanding any other provision of law, all
2011 money received by the agency under this section shall be deemed
2012 to be trust funds, to be held and applied solely for the
2013 operations required under this section.
2014 Section 44. Subsections (4) and (7) of section 400.9905,
2015 Florida Statutes, are amended to read:
2016 400.9905 Definitions.—
2017 (4) "Clinic" means an entity at which health care services
2018 are provided to individuals and which tenders charges for
2019 reimbursement for such services, including a mobile clinic and a
2020 portable health service or equipment provider. For purposes of
2021 this part, the term does not include and the licensure
2022 requirements of this part do not apply to:
2023 (a) Entities licensed or registered by the state under
2024 chapter 395; or entities licensed or registered by the state and
2025 providing only health care services within the scope of services
2026 authorized under their respective licenses granted under ss.
2027 383.30-383.335, chapter 390, chapter 394, chapter 397, this
2028 chapter except part X, chapter 429, chapter 463, chapter 465,
2029 chapter 466, chapter 478, part I of chapter 483, chapter 484, or
2030 chapter 651; end-stage renal disease providers authorized under

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2031 42 C.F.R. part 405, subpart U; or providers certified under 42
2032 C.F.R. part 485, subpart B or subpart H; or any entity that
2033 provides neonatal or pediatric hospital-based health care
2034 services or other health care services by licensed practitioners
2035 solely within a hospital licensed under chapter 395.
2036 (b) Entities that own, directly or indirectly, entities
2037 licensed or registered by the state pursuant to chapter 395; or
2038 entities that own, directly or indirectly, entities licensed or
2039 registered by the state and providing only health care services
2040 within the scope of services authorized pursuant to their
2041 respective licenses granted under ss. 383.30-383.335, chapter
2042 390, chapter 394, chapter 397, this chapter except part X,
2043 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
2044 part I of chapter 483, chapter 484, chapter 651; end-stage renal
2045 disease providers authorized under 42 C.F.R. part 405, subpart
2046 U; or providers certified under 42 C.F.R. part 485, subpart B or
2047 subpart H; or any entity that provides neonatal or pediatric
2048 hospital-based health care services by licensed practitioners
2049 solely within a hospital licensed under chapter 395.
2050 (c) Entities that are owned, directly or indirectly, by an
2051 entity licensed or registered by the state pursuant to chapter
2052 395; or entities that are owned, directly or indirectly, by an
2053 entity licensed or registered by the state and providing only
2054 health care services within the scope of services authorized
2055 pursuant to their respective licenses granted under ss. 383.30-
2056 383.335, chapter 390, chapter 394, chapter 397, this chapter
2057 except part X, chapter 429, chapter 463, chapter 465, chapter
2058 466, chapter 478, part I of chapter 483, chapter 484, or chapter
2059 651; end-stage renal disease providers authorized under 42

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2060 C.F.R. part 405, subpart U; or providers certified under 42
2061 C.F.R. part 485, subpart B or subpart H; or any entity that
2062 provides neonatal or pediatric hospital-based health care
2063 services by licensed practitioners solely within a hospital
2064 under chapter 395.
2065 (d) Entities that are under common ownership, directly or
2066 indirectly, with an entity licensed or registered by the state
2067 pursuant to chapter 395; or entities that are under common
2068 ownership, directly or indirectly, with an entity licensed or
2069 registered by the state and providing only health care services
2070 within the scope of services authorized pursuant to their
2071 respective licenses granted under ss. 383.30-383.335, chapter
2072 390, chapter 394, chapter 397, this chapter except part X,
2073 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
2074 part I of chapter 483, chapter 484, or chapter 651; end-stage
2075 renal disease providers authorized under 42 C.F.R. part 405,
2076 subpart U; or providers certified under 42 C.F.R. part 485,
2077 subpart B or subpart H; or any entity that provides neonatal or
2078 pediatric hospital-based health care services by licensed
2079 practitioners solely within a hospital licensed under chapter
2080 395.
2081 (e) An entity that is exempt from federal taxation under 26
2082 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
2083 under 26 U.S.C. s. 409 that has a board of trustees not less
2084 than two-thirds of which are Florida-licensed health care
2085 practitioners and provides only physical therapy services under
2086 physician orders, any community college or university clinic,
2087 and any entity owned or operated by the federal or state
2088 government, including agencies, subdivisions, or municipalities

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2089 thereof.
2090 (f) A sole proprietorship, group practice, partnership, or
2091 corporation that provides health care services by physicians
2092 covered by s. 627.419, that is directly supervised by one or
2093 more of such physicians, and that is wholly owned by one or more
2094 of those physicians or by a physician and the spouse, parent,
2095 child, or sibling of that physician.
2096 (g) A sole proprietorship, group practice, partnership, or
2097 corporation that provides health care services by licensed
2098 health care practitioners under chapter 457, chapter 458,
2099 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
2100 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
2101 chapter 490, chapter 491, or part I, part III, part X, part
2102 XIII, or part XIV of chapter 468, or s. 464.012, which are
2103 wholly owned by one or more licensed health care practitioners,
2104 or the licensed health care practitioners set forth in this
2105 paragraph and the spouse, parent, child, or sibling of a
2106 licensed health care practitioner, so long as one of the owners
2107 who is a licensed health care practitioner is supervising the
2108 business activities and is legally responsible for the entity's
2109 compliance with all federal and state laws. However, a health
2110 care practitioner may not supervise services beyond the scope of
2111 the practitioner's license, except that, for the purposes of
2112 this part, a clinic owned by a licensee in s. 456.053(3)(b) that
2113 provides only services authorized pursuant to s. 456.053(3)(b)
2114 may be supervised by a licensee specified in s. 456.053(3)(b).
2115 (h) Clinical facilities affiliated with an accredited
2116 medical school at which training is provided for medical
2117 students, residents, or fellows.

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2118 (i) Entities that provide only oncology or radiation
2119 therapy services by physicians licensed under chapter 458 or
2120 chapter 459 or entities that provide oncology or radiation
2121 therapy services by physicians licensed under chapter 458 or
2122 chapter 459 which are owned by a corporation whose shares are
2123 publicly traded on a recognized stock exchange.
2124 (j) Clinical facilities affiliated with a college of
2125 chiropractic accredited by the Council on Chiropractic Education
2126 at which training is provided for chiropractic students.
2127 (k) Entities that provide licensed practitioners to staff
2128 emergency departments or to deliver anesthesia services in
2129 facilities licensed under chapter 395 and that derive at least
2130 90 percent of their gross annual revenues from the provision of
2131 such services. Entities claiming an exemption from licensure
2132 under this paragraph must provide documentation demonstrating
2133 compliance.
2134 (l) Orthotic, ~~or~~ prosthetic, pediatric cardiology, or
2135 perinatology clinical facilities or anesthesia clinical
2136 facilities that are not otherwise exempt under paragraph (a) or
2137 paragraph (k) and that are a publicly traded corporation or ~~that~~
2138 are wholly owned, directly or indirectly, by a publicly traded
2139 corporation. As used in this paragraph, a publicly traded
2140 corporation is a corporation that issues securities traded on an
2141 exchange registered with the United States Securities and
2142 Exchange Commission as a national securities exchange.
2143 (m) Entities that are owned or controlled, directly or
2144 indirectly, by a publicly traded entity with $100 million or
2145 more, in the aggregate, in total annual revenues derived from
2146 providing health care services by licensed health care

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2147 practitioners that are employed or contracted by an entity
2148 described in this paragraph.
2149 (7) "Portable health service or equipment provider" means
2150 an entity that contracts with or employs persons to provide
2151 portable health services at or equipment to multiple locations
2152 ~~performing treatment or diagnostic testing of individuals~~, that
2153 bills third-party payors for those services, and that otherwise
2154 meets the definition of a clinic in subsection (4).
2155 Section 45. Paragraph (b) of subsection (1) and subsection
2156 (4) of section 400.991, Florida Statutes, are amended to read:
2157 400.991 License requirements; background screenings;
2158 prohibitions.—
2159 (1)
2160 (b) Each mobile clinic must obtain a separate health care
2161 clinic license and must provide to the agency, at least
2162 quarterly, its projected street location to enable the agency to
2163 locate and inspect such clinic. A portable health service or
2164 equipment provider must obtain a health care clinic license for
2165 a single administrative office and is not required to submit
2166 quarterly projected street locations.
2167 (4) In addition to the requirements of part II of chapter
2168 408, the applicant must file with the application satisfactory
2169 proof that the clinic is in compliance with this part and
2170 applicable rules, including:
2171 (a) A listing of services to be provided either directly by
2172 the applicant or through contractual arrangements with existing
2173 providers;
2174 (b) The number and discipline of each professional staff
2175 member to be employed; and

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2176 (c) Proof of financial ability to operate as required under
2177 ss. ~~s.~~ 408.810(8) and 408.8065. ~~As an alternative to submitting~~
2178 ~~proof of financial ability to operate as required under s.~~
2179 ~~408.810(8), the applicant may file a surety bond of at least~~
2180 ~~$500,000 which guarantees that the clinic will act in full~~
2181 ~~conformity with all legal requirements for operating a clinic,~~
2182 ~~payable to the agency. The agency may adopt rules to specify~~
2183 ~~related requirements for such surety bond.~~
2184 Section 46. Paragraph (a) of subsection (2) of section
2185 408.033, Florida Statutes, is amended to read:
2186 408.033 Local and state health planning.—
2187 (2) FUNDING.—
2188 (a) The Legislature intends that the cost of local health
2189 councils be borne by assessments on selected health care
2190 facilities subject to facility licensure by the Agency for
2191 Health Care Administration, including abortion clinics, assisted
2192 living facilities, ambulatory surgical centers, birthing
2193 centers, clinical laboratories except community nonprofit blood
2194 banks and clinical laboratories operated by practitioners for
2195 exclusive use regulated under s. 483.035, home health agencies,
2196 hospices, hospitals, intermediate care facilities for the
2197 developmentally disabled, nursing homes, health care clinics,
2198 and multiphasic testing centers and by assessments on
2199 organizations subject to certification by the agency pursuant to
2200 chapter 641, part III, including health maintenance
2201 organizations and prepaid health clinics. Fees assessed may be
2202 collected prospectively at the time of licensure renewal and
2203 prorated for the licensure period.
2204 Section 47. Subsection (2) of section 408.034, Florida

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2205 Statutes, is amended to read:
2206 408.034 Duties and responsibilities of agency; rules.—
2207 (2) In the exercise of its authority to issue licenses to
2208 health care facilities and health service providers, as provided
2209 under chapters 393 and 395 and parts II, ~~and~~ IV, and VIII of
2210 chapter 400, the agency may not issue a license to any health
2211 care facility or health service provider that fails to receive a
2212 certificate of need or an exemption for the licensed facility or
2213 service.
2214 Section 48. Paragraph (d) of subsection (1) of section
2215 408.036, Florida Statutes, is amended to read:
2216 408.036 Projects subject to review; exemptions.—
2217 (1) APPLICABILITY.—Unless exempt under subsection (3), all
2218 health-care-related projects, as described in paragraphs (a)-
2219 (g), are subject to review and must file an application for a
2220 certificate of need with the agency. The agency is exclusively
2221 responsible for determining whether a health-care-related
2222 project is subject to review under ss. 408.031-408.045.
2223 (d) The establishment of a hospice or hospice inpatient
2224 facility~~, except as provided in s. 408.043~~.
2225 Section 49. Paragraph (c) of subsection (1) of section
2226 408.037, Florida Statutes, is amended to read:
2227 408.037 Application content.—
2228 (1) Except as provided in subsection (2) for a general
2229 hospital, an application for a certificate of need must contain:
2230 (c) An audited financial statement of the applicant or the
2231 applicant's parent corporation if audited financial statements
2232 of the applicant do not exist. In an application submitted by an
2233 existing health care facility, health maintenance organization,

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2234 or hospice, financial condition documentation must include, but
2235 need not be limited to, a balance sheet and a profit-and-loss
2236 statement of the 2 previous fiscal years' operation.
2237 Section 50. Subsection (2) of section 408.043, Florida
2238 Statutes, is amended to read:
2239 408.043 Special provisions.—
2240 (2) HOSPICES.—When an application is made for a certificate
2241 of need to establish or to expand a hospice, the need for such
2242 hospice shall be determined on the basis of the need for and
2243 availability of hospice services in the community. The formula
2244 on which the certificate of need is based shall discourage
2245 regional monopolies and promote competition. The inpatient
2246 hospice care component of a hospice which is a freestanding
2247 facility, or a part of a facility, ~~which is primarily engaged in~~
2248 ~~providing inpatient care and related services~~ and is not
2249 licensed as a health care facility shall also be required to
2250 obtain a certificate of need. Provision of hospice care by any
2251 current provider of health care is a significant change in
2252 service and therefore requires a certificate of need for such
2253 services.
2254 Section 51. Paragraph (a) of subsection (1) of section
2255 408.061, Florida Statutes, is amended to read:
2256 408.061 Data collection; uniform systems of financial
2257 reporting; information relating to physician charges;
2258 confidential information; immunity.—
2259 (1) The agency shall require the submission by health care
2260 facilities, health care providers, and health insurers of data
2261 necessary to carry out the agency's duties. Specifications for
2262 data to be collected under this section shall be developed by

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2263 the agency with the assistance of technical advisory panels
2264 including representatives of affected entities, consumers,
2265 purchasers, and such other interested parties as may be
2266 determined by the agency.
2267 (a) Data submitted by health care facilities, including the
2268 facilities as defined in chapter 395, shall include, but are not
2269 limited to: case-mix data, patient admission and discharge data,
2270 hospital emergency department data which shall include the
2271 number of patients treated in the emergency department of a
2272 licensed hospital reported by patient acuity level, data on
2273 hospital-acquired infections as specified by rule, data on
2274 complications as specified by rule, data on readmissions as
2275 specified by rule, with patient and provider-specific
2276 identifiers included, actual charge data by diagnostic groups,
2277 financial data, accounting data, operating expenses, expenses
2278 incurred for rendering services to patients who cannot or do not
2279 pay, interest charges, depreciation expenses based on the
2280 expected useful life of the property and equipment involved, and
2281 demographic data. The agency shall adopt nationally recognized
2282 risk adjustment methodologies or software consistent with the
2283 standards of the Agency for Healthcare Research and Quality and
2284 as selected by the agency for all data submitted as required by
2285 this section. Data may be obtained from documents such as, but
2286 not limited to: leases, contracts, debt instruments, itemized
2287 patient bills, medical record abstracts, and related diagnostic
2288 information. Reported data elements shall be reported
2289 electronically and ~~in accordance with rule 59E-7.012, Florida~~
2290 ~~Administrative Code. Data submitted shall be~~ certified by the
2291 chief executive officer or an appropriate and duly authorized

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2292 representative or employee of the licensed facility that the
2293 information submitted is true and accurate.
2294 Section 52. Subsection (43) of section 408.07, Florida
2295 Statutes, is amended to read:
2296 408.07 Definitions.—As used in this chapter, with the
2297 exception of ss. 408.031-408.045, the term:
2298 (43) "Rural hospital" means an acute care hospital licensed
2299 under chapter 395, having 100 or fewer licensed beds and an
2300 emergency room, and which is:
2301 (a) The sole provider within a county with a population
2302 density of no greater than 100 persons per square mile;
2303 (b) An acute care hospital, in a county with a population
2304 density of no greater than 100 persons per square mile, which is
2305 at least 30 minutes of travel time, on normally traveled roads
2306 under normal traffic conditions, from another acute care
2307 hospital within the same county;
2308 (c) A hospital supported by a tax district or subdistrict
2309 whose boundaries encompass a population of 100 persons or fewer
2310 per square mile;
2311 (d) A hospital with a service area that has a population of
2312 100 persons or fewer per square mile. As used in this paragraph,
2313 the term "service area" means the fewest number of zip codes
2314 that account for 75 percent of the hospital's discharges for the
2315 most recent 5-year period, based on information available from
2316 the hospital inpatient discharge database in the Florida Center
2317 for Health Information and Policy Analysis at the Agency for
2318 Health Care Administration; or
2319 (e) A critical access hospital.
2320

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2321 Population densities used in this subsection must be based upon
2322 the most recently completed United States census. A hospital
2323 that received funds under s. 409.9116 for a quarter beginning no
2324 later than July 1, 2002, is deemed to have been and shall
2325 continue to be a rural hospital from that date through June 30,
2326 2015, if the hospital continues to have 100 or fewer licensed
2327 beds and an emergency room~~, or meets the criteria of s.~~
2328 ~~395.602(2)(e)4~~. An acute care hospital that has not previously
2329 been designated as a rural hospital and that meets the criteria
2330 of this subsection shall be granted such designation upon
2331 application, including supporting documentation, to the Agency
2332 for Health Care Administration.
2333 Section 53. Section 408.10, Florida Statutes, is amended to
2334 read:
2335 408.10 Consumer complaints.—The agency shall~~:~~
2336 ~~(1)~~ publish and make available to the public a toll-free
2337 telephone number for the purpose of handling consumer complaints
2338 and shall serve as a liaison between consumer entities and other
2339 private entities and governmental entities for the disposition
2340 of problems identified by consumers of health care.
2341 ~~(2) Be empowered to investigate consumer complaints~~
2342 ~~relating to problems with health care facilities' billing~~
2343 ~~practices and issue reports to be made public in any cases where~~
2344 ~~the agency determines the health care facility has engaged in~~
2345 ~~billing practices which are unreasonable and unfair to the~~
2346 ~~consumer.~~
2347 Section 54. Effective May 1, 2012, subsection (15) is added
2348 to section 408.7056, Florida Statutes, to read:
2349 408.7056 Subscriber Assistance Program.—

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2350 (15) This section applies only to health plans that meet
2351 the requirements of 45 C.F.R. 147.140.
2352 Section 55. Subsection (11) of section 408.802, Florida
2353 Statutes, is repealed.
2354 Section 56. Subsection (3) is added to section 408.804,
2355 Florida Statutes, to read:
2356 408.804 License required; display.—
2357 (3) Any person who knowingly alters, defaces, or falsifies
2358 a license certificate issued by the agency, or causes or
2359 procures any person to commit such an offense, commits a
2360 misdemeanor of the second degree, punishable as provided in s.
2361 775.082 or s. 775.083. Any licensee or provider who displays an
2362 altered, defaced, or falsified license certificate is subject to
2363 the penalties set forth in s. 408.815 and an administrative fine
2364 of $1,000 for each day of illegal display.
2365 Section 57. Paragraph (d) of subsection (2) of section
2366 408.806, Florida Statutes, is amended, and paragraph (e) is
2367 added to that subsection, to read:
2368 408.806 License application process.—
2369 (2)
2370 (d) ~~The agency shall notify the licensee by mail or~~
2371 ~~electronically at least 90 days before the expiration of a~~
2372 ~~license that a renewal license is necessary to continue~~
2373 ~~operation.~~ The licensee's failure to timely file ~~submit~~ a
2374 renewal application and license application fee with the agency
2375 shall result in a $50 per day late fee charged to the licensee
2376 by the agency; however, the aggregate amount of the late fee may
2377 not exceed 50 percent of the licensure fee or $500, whichever is
2378 less. The agency shall provide a courtesy notice to the licensee

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2379 by United States mail, electronically, or by any other manner at
2380 its address of record or mailing address, if provided, at least
2381 90 days before the expiration of a license. This courtesy notice
2382 must inform the licensee of the expiration of the license. If
2383 the agency does not provide the courtesy notice or the licensee
2384 does not receive the courtesy notice, the licensee continues to
2385 be legally obligated to timely file the renewal application and
2386 license application fee with the agency and is not excused from
2387 the payment of a late fee. If an application is received after
2388 the required filing date and exhibits a hand-canceled postmark
2389 obtained from a United States post office dated on or before the
2390 required filing date, no fine will be levied.
2391 (e) The applicant must pay the late fee before a late
2392 application is considered complete and failure to pay the late
2393 fee is considered an omission from the application for licensure
2394 pursuant to paragraph (3)(b).
2395 Section 58. Paragraph (b) of subsection (1) of section
2396 408.8065, Florida Statutes, is amended to read:
2397 408.8065 Additional licensure requirements for home health
2398 agencies, home medical equipment providers, and health care
2399 clinics.—
2400 (1) An applicant for initial licensure, or initial
2401 licensure due to a change of ownership, as a home health agency,
2402 home medical equipment provider, or health care clinic shall:
2403 (b) Submit projected ~~pro forma~~ financial statements,
2404 including a balance sheet, income and expense statement, and a
2405 statement of cash flows for the first 2 years of operation which
2406 provide evidence that the applicant has sufficient assets,
2407 credit, and projected revenues to cover liabilities and

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2408 expenses.
2409
2410 All documents required under this subsection must be prepared in
2411 accordance with generally accepted accounting principles and may
2412 be in a compilation form. The financial statements must be
2413 signed by a certified public accountant.
2414 Section 59. Section 408.809, Florida Statutes, is amended
2415 to read:
2416 408.809 Background screening; prohibited offenses.—
2417 (1) Level 2 background screening pursuant to chapter 435
2418 must be conducted through the agency on each of the following
2419 persons, who are considered employees for the purposes of
2420 conducting screening under chapter 435:
2421 (a) The licensee, if an individual.
2422 (b) The administrator or a similarly titled person who is
2423 responsible for the day-to-day operation of the provider.
2424 (c) The financial officer or similarly titled individual
2425 who is responsible for the financial operation of the licensee
2426 or provider.
2427 (d) Any person who is a controlling interest if the agency
2428 has reason to believe that such person has been convicted of any
2429 offense prohibited by s. 435.04. For each controlling interest
2430 who has been convicted of any such offense, the licensee shall
2431 submit to the agency a description and explanation of the
2432 conviction at the time of license application.
2433 (e) Any person, as required by authorizing statutes,
2434 seeking employment with a licensee or provider who is expected
2435 to, or whose responsibilities may require him or her to, provide
2436 personal care or services directly to clients or have access to

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2437 client funds, personal property, or living areas; and any
2438 person, as required by authorizing statutes, contracting with a
2439 licensee or provider whose responsibilities require him or her
2440 to provide personal care or personal services directly to
2441 clients. Evidence of contractor screening may be retained by the
2442 contractor’s employer or the licensee.
2443 (2) Every 5 years following his or her licensure,
2444 employment, or entry into a contract in a capacity that under
2445 subsection (1) would require level 2 background screening under
2446 chapter 435, each such person must submit to level 2 background
2447 rescreening as a condition of retaining such license or
2448 continuing in such employment or contractual status. For any
2449 such rescreening, the agency shall request the Department of Law
2450 Enforcement to forward the person’s fingerprints to the Federal
2451 Bureau of Investigation for a national criminal history record
2452 check. If the fingerprints of such a person are not retained by
2453 the Department of Law Enforcement under s. 943.05(2)(g), the
2454 person must file a complete set of fingerprints with the agency
2455 and the agency shall forward the fingerprints to the Department
2456 of Law Enforcement for state processing, and the Department of
2457 Law Enforcement shall forward the fingerprints to the Federal
2458 Bureau of Investigation for a national criminal history record
2459 check. The fingerprints may be retained by the Department of Law
2460 Enforcement under s. 943.05(2)(g). The cost of the state and
2461 national criminal history records checks required by level 2
2462 screening may be borne by the licensee or the person
2463 fingerprinted. Proof of compliance with level 2 screening
2464 standards submitted within the previous 5 years to meet any
2465 provider or professional licensure requirements of the agency,

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2466 the Department of Health, the Agency for Persons with
2467 Disabilities, the Department of Children and Family Services, or
2468 the Department of Financial Services for an applicant for a
2469 certificate of authority or provisional certificate of authority
2470 to operate a continuing care retirement community under chapter
2471 651 satisfies the requirements of this section if the person
2472 subject to screening has not been unemployed for more than 90
2473 days and such proof is accompanied, under penalty of perjury, by
2474 an affidavit of compliance with the provisions of chapter 435
2475 and this section using forms provided by the agency.
2476 (3) All fingerprints must be provided in electronic format.
2477 Screening results shall be reviewed by the agency with respect
2478 to the offenses specified in s. 435.04 and this section, and the
2479 qualifying or disqualifying status of the person named in the
2480 request shall be maintained in a database. The qualifying or
2481 disqualifying status of the person named in the request shall be
2482 posted on a secure website for retrieval by the licensee or
2483 designated agent on the licensee’s behalf.
2484 (4) In addition to the offenses listed in s. 435.04, all
2485 persons required to undergo background screening pursuant to
2486 this part or authorizing statutes must not have an arrest
2487 awaiting final disposition for, must not have been found guilty
2488 of, regardless of adjudication, or entered a plea of nolo
2489 contendere or guilty to, and must not have been adjudicated
2490 delinquent and the record not have been sealed or expunged for
2491 any of the following offenses or any similar offense of another
2492 jurisdiction:
2493 (a) Any authorizing statutes, if the offense was a felony.
2494 (b) This chapter, if the offense was a felony.

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2495 (c) Section 409.920, relating to Medicaid provider fraud.
2496 (d) Section 409.9201, relating to Medicaid fraud.
2497 (e) Section 741.28, relating to domestic violence.
2498 (f) Section 817.034, relating to fraudulent acts through
2499 mail, wire, radio, electromagnetic, photoelectronic, or
2500 photooptical systems.
2501 (g) Section 817.234, relating to false and fraudulent
2502 insurance claims.
2503 (h) Section 817.505, relating to patient brokering.
2504 (i) Section 817.568, relating to criminal use of personal
2505 identification information.
2506 (j) Section 817.60, relating to obtaining a credit card
2507 through fraudulent means.
2508 (k) Section 817.61, relating to fraudulent use of credit
2509 cards, if the offense was a felony.
2510 (l) Section 831.01, relating to forgery.
2511 (m) Section 831.02, relating to uttering forged
2512 instruments.
2513 (n) Section 831.07, relating to forging bank bills, checks,
2514 drafts, or promissory notes.
2515 (o) Section 831.09, relating to uttering forged bank bills,
2516 checks, drafts, or promissory notes.
2517 (p) Section 831.30, relating to fraud in obtaining
2518 medicinal drugs.
2519 (q) Section 831.31, relating to the sale, manufacture,
2520 delivery, or possession with the intent to sell, manufacture, or
2521 deliver any counterfeit controlled substance, if the offense was
2522 a felony.
2523 (5) A person who serves as a controlling interest of, is

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2524 employed by, or contracts with a licensee on July 31, 2010, who
2525 has been screened and qualified according to standards specified
2526 in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,
2527 in accordance with the schedule provided in paragraphs (a)-(c).
2528 ~~The agency may adopt rules to establish a schedule to stagger~~
2529 ~~the implementation of the required rescreening over the 5-year~~
2530 ~~period, beginning July 31, 2010, through July 31, 2015.~~ If, upon
2531 rescreening, such person has a disqualifying offense that was
2532 not a disqualifying offense at the time of the last screening,
2533 but is a current disqualifying offense and was committed before
2534 the last screening, he or she may apply for an exemption from
2535 the appropriate licensing agency and, if agreed to by the
2536 employer, may continue to perform his or her duties until the
2537 licensing agency renders a decision on the application for
2538 exemption if the person is eligible to apply for an exemption
2539 and the exemption request is received by the agency within 30
2540 days after receipt of the rescreening results by the person. The
2541 rescreening schedule shall be as follows:
2542 (a) Individuals whose last screening was conducted before
2543 December 31, 2003, must be rescreened by July 31, 2013.
2544 (b) Individuals whose last screening was conducted between
2545 January 1, 2004, through December 31, 2007, must be rescreened
2546 by July 31, 2014.
2547 (c) Individuals whose last screening was conducted between
2548 January 1, 2008, through July 31, 2010, must be rescreened by
2549 July 31, 2015.
2550 (6) ~~(5)~~ The costs associated with obtaining the required
2551 screening must be borne by the licensee or the person subject to
2552 screening. Licensees may reimburse persons for these costs. The

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2553 Department of Law Enforcement shall charge the agency for
2554 screening pursuant to s. 943.053(3). The agency shall establish
2555 a schedule of fees to cover the costs of screening.
2556 (7) ~~(6)~~ (a) As provided in chapter 435, the agency may grant
2557 an exemption from disqualification to a person who is subject to
2558 this section and who:
2559 1. Does not have an active professional license or
2560 certification from the Department of Health; or
2561 2. Has an active professional license or certification from
2562 the Department of Health but is not providing a service within
2563 the scope of that license or certification.
2564 (b) As provided in chapter 435, the appropriate regulatory
2565 board within the Department of Health, or the department itself
2566 if there is no board, may grant an exemption from
2567 disqualification to a person who is subject to this section and
2568 who has received a professional license or certification from
2569 the Department of Health or a regulatory board within that
2570 department and that person is providing a service within the
2571 scope of his or her licensed or certified practice.
2572 (8) ~~(7)~~ The agency and the Department of Health may adopt
2573 rules pursuant to ss. 120.536(1) and 120.54 to implement this
2574 section, chapter 435, and authorizing statutes requiring
2575 background screening and to implement and adopt criteria
2576 relating to retaining fingerprints pursuant to s. 943.05(2).
2577 (9) ~~(8)~~ There is no unemployment compensation or other
2578 monetary liability on the part of, and no cause of action for
2579 damages arising against, an employer that, upon notice of a
2580 disqualifying offense listed under chapter 435 or this section,
2581 terminates the person against whom the report was issued,

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2582 whether or not that person has filed for an exemption with the
2583 Department of Health or the agency.
2584 Section 60. Subsection (9) of section 408.810, Florida
2585 Statutes, is amended to read:
2586 408.810 Minimum licensure requirements.—In addition to the
2587 licensure requirements specified in this part, authorizing
2588 statutes, and applicable rules, each applicant and licensee must
2589 comply with the requirements of this section in order to obtain
2590 and maintain a license.
2591 (9) A controlling interest may not withhold from the agency
2592 any evidence of financial instability, including, but not
2593 limited to, checks returned due to insufficient funds,
2594 delinquent accounts, nonpayment of withholding taxes, unpaid
2595 utility expenses, nonpayment for essential services, or adverse
2596 court action concerning the financial viability of the provider
2597 or any other provider licensed under this part that is under the
2598 control of the controlling interest. A controlling interest
2599 shall notify the agency within 10 days after a court action to
2600 initiate bankruptcy, foreclosure, or eviction proceedings
2601 concerning the provider in which the controlling interest is a
2602 petitioner or defendant. Any person who violates this subsection
2603 commits a misdemeanor of the second degree, punishable as
2604 provided in s. 775.082 or s. 775.083. Each day of continuing
2605 violation is a separate offense.
2606 Section 61. Subsection (3) is added to section 408.813,
2607 Florida Statutes, to read:
2608 408.813 Administrative fines; violations.—As a penalty for
2609 any violation of this part, authorizing statutes, or applicable
2610 rules, the agency may impose an administrative fine.

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2611 (3) The agency may impose an administrative fine for a
2612 violation that is not designated as a class I, class II, class
2613 III, or class IV violation. Unless otherwise specified by law,
2614 the amount of the fine may not exceed $500 for each violation.
2615 Unclassified violations include:
2616 (a) Violating any term or condition of a license.
2617 (b) Violating any provision of this part, authorizing
2618 statutes, or applicable rules.
2619 (c) Exceeding licensed capacity.
2620 (d) Providing services beyond the scope of the license.
2621 (e) Violating a moratorium imposed pursuant to s. 408.814.
2622 Section 62. Paragraph (a) of subsection (37) of section
2623 409.912, Florida Statutes, is amended to read:
2624 409.912 Cost-effective purchasing of health care.—The
2625 agency shall purchase goods and services for Medicaid recipients
2626 in the most cost-effective manner consistent with the delivery
2627 of quality medical care. To ensure that medical services are
2628 effectively utilized, the agency may, in any case, require a
2629 confirmation or second physician's opinion of the correct
2630 diagnosis for purposes of authorizing future services under the
2631 Medicaid program. This section does not restrict access to
2632 emergency services or poststabilization care services as defined
2633 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2634 shall be rendered in a manner approved by the agency. The agency
2635 shall maximize the use of prepaid per capita and prepaid
2636 aggregate fixed-sum basis services when appropriate and other
2637 alternative service delivery and reimbursement methodologies,
2638 including competitive bidding pursuant to s. 287.057, designed
2639 to facilitate the cost-effective purchase of a case-managed

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2640 continuum of care. The agency shall also require providers to
2641 minimize the exposure of recipients to the need for acute
2642 inpatient, custodial, and other institutional care and the
2643 inappropriate or unnecessary use of high-cost services. The
2644 agency shall contract with a vendor to monitor and evaluate the
2645 clinical practice patterns of providers in order to identify
2646 trends that are outside the normal practice patterns of a
2647 provider’s professional peers or the national guidelines of a
2648 provider’s professional association. The vendor must be able to
2649 provide information and counseling to a provider whose practice
2650 patterns are outside the norms, in consultation with the agency,
2651 to improve patient care and reduce inappropriate utilization.
2652 The agency may mandate prior authorization, drug therapy
2653 management, or disease management participation for certain
2654 populations of Medicaid beneficiaries, certain drug classes, or
2655 particular drugs to prevent fraud, abuse, overuse, and possible
2656 dangerous drug interactions. The Pharmaceutical and Therapeutics
2657 Committee shall make recommendations to the agency on drugs for
2658 which prior authorization is required. The agency shall inform
2659 the Pharmaceutical and Therapeutics Committee of its decisions
2660 regarding drugs subject to prior authorization. The agency is
2661 authorized to limit the entities it contracts with or enrolls as
2662 Medicaid providers by developing a provider network through
2663 provider credentialing. The agency may competitively bid single-
2664 source-provider contracts if procurement of goods or services
2665 results in demonstrated cost savings to the state without
2666 limiting access to care. The agency may limit its network based
2667 on the assessment of beneficiary access to care, provider
2668 availability, provider quality standards, time and distance

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2669 standards for access to care, the cultural competence of the
2670 provider network, demographic characteristics of Medicaid
2671 beneficiaries, practice and provider-to-beneficiary standards,
2672 appointment wait times, beneficiary use of services, provider
2673 turnover, provider profiling, provider licensure history,
2674 previous program integrity investigations and findings, peer
2675 review, provider Medicaid policy and billing compliance records,
2676 clinical and medical record audits, and other factors. Providers
2677 are not entitled to enrollment in the Medicaid provider network.
2678 The agency shall determine instances in which allowing Medicaid
2679 beneficiaries to purchase durable medical equipment and other
2680 goods is less expensive to the Medicaid program than long-term
2681 rental of the equipment or goods. The agency may establish rules
2682 to facilitate purchases in lieu of long-term rentals in order to
2683 protect against fraud and abuse in the Medicaid program as
2684 defined in s. 409.913. The agency may seek federal waivers
2685 necessary to administer these policies.
2686 (37)(a) The agency shall implement a Medicaid prescribed-
2687 drug spending-control program that includes the following
2688 components:
2689 1. A Medicaid preferred drug list, which shall be a listing
2690 of cost-effective therapeutic options recommended by the
2691 Medicaid Pharmacy and Therapeutics Committee established
2692 pursuant to s. 409.91195 and adopted by the agency for each
2693 therapeutic class on the preferred drug list. At the discretion
2694 of the committee, and when feasible, the preferred drug list
2695 should include at least two products in a therapeutic class. The
2696 agency may post the preferred drug list and updates to the list
2697 on an Internet website without following the rulemaking

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2698 procedures of chapter 120. Antiretroviral agents are excluded
2699 from the preferred drug list. The agency shall also limit the
2700 amount of a prescribed drug dispensed to no more than a 34-day
2701 supply unless the drug products' smallest marketed package is
2702 greater than a 34-day supply, or the drug is determined by the
2703 agency to be a maintenance drug in which case a 100-day maximum
2704 supply may be authorized. The agency may seek any federal
2705 waivers necessary to implement these cost-control programs and
2706 to continue participation in the federal Medicaid rebate
2707 program, or alternatively to negotiate state-only manufacturer
2708 rebates. The agency may adopt rules to administer this
2709 subparagraph. The agency shall continue to provide unlimited
2710 contraceptive drugs and items. The agency must establish
2711 procedures to ensure that:
2712 a. There is a response to a request for prior consultation
2713 by telephone or other telecommunication device within 24 hours
2714 after receipt of a request for prior consultation; and
2715 b. A 72-hour supply of the drug prescribed is provided in
2716 an emergency or when the agency does not provide a response
2717 within 24 hours as required by sub-subparagraph a.
2718 2. Reimbursement to pharmacies for Medicaid prescribed
2719 drugs shall be set at the lowest of: the average wholesale price
2720 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
2721 plus 1.5 percent, the federal upper limit (FUL), the state
2722 maximum allowable cost (SMAC), or the usual and customary (UAC)
2723 charge billed by the provider.
2724 3. The agency shall develop and implement a process for
2725 managing the drug therapies of Medicaid recipients who are using
2726 significant numbers of prescribed drugs each month. The

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2727 management process may include, but is not limited to,
2728 comprehensive, physician-directed medical-record reviews, claims
2729 analyses, and case evaluations to determine the medical
2730 necessity and appropriateness of a patient's treatment plan and
2731 drug therapies. The agency may contract with a private
2732 organization to provide drug-program-management services. The
2733 Medicaid drug benefit management program shall include
2734 initiatives to manage drug therapies for HIV/AIDS patients,
2735 patients using 20 or more unique prescriptions in a 180-day
2736 period, and the top 1,000 patients in annual spending. The
2737 agency shall enroll any Medicaid recipient in the drug benefit
2738 management program if he or she meets the specifications of this
2739 provision and is not enrolled in a Medicaid health maintenance
2740 organization.
2741 4. The agency may limit the size of its pharmacy network
2742 based on need, competitive bidding, price negotiations,
2743 credentialing, or similar criteria. The agency shall give
2744 special consideration to rural areas in determining the size and
2745 location of pharmacies included in the Medicaid pharmacy
2746 network. A pharmacy credentialing process may include criteria
2747 such as a pharmacy's full-service status, location, size,
2748 patient educational programs, patient consultation, disease
2749 management services, and other characteristics. The agency may
2750 impose a moratorium on Medicaid pharmacy enrollment if it is
2751 determined that it has a sufficient number of Medicaid-
2752 participating providers. The agency must allow dispensing
2753 practitioners to participate as a part of the Medicaid pharmacy
2754 network regardless of the practitioner's proximity to any other
2755 entity that is dispensing prescription drugs under the Medicaid

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2756 program. A dispensing practitioner must meet all credentialing
2757 requirements applicable to his or her practice, as determined by
2758 the agency.
2759 5. The agency shall develop and implement a program that
2760 requires Medicaid practitioners who prescribe drugs to use a
2761 counterfeit-proof prescription pad for Medicaid prescriptions.
2762 The agency shall require the use of standardized counterfeit-
2763 proof prescription pads by Medicaid-participating prescribers or
2764 prescribers who write prescriptions for Medicaid recipients. The
2765 agency may implement the program in targeted geographic areas or
2766 statewide.
2767 6. The agency may enter into arrangements that require
2768 manufacturers of generic drugs prescribed to Medicaid recipients
2769 to provide rebates of at least 15.1 percent of the average
2770 manufacturer price for the manufacturer's generic products.
2771 These arrangements shall require that if a generic-drug
2772 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2773 at a level below 15.1 percent, the manufacturer must provide a
2774 supplemental rebate to the state in an amount necessary to
2775 achieve a 15.1-percent rebate level.
2776 7. The agency may establish a preferred drug list as
2777 described in this subsection, and, pursuant to the establishment
2778 of such preferred drug list, negotiate supplemental rebates from
2779 manufacturers that are in addition to those required by Title
2780 XIX of the Social Security Act and at no less than 14 percent of
2781 the average manufacturer price as defined in 42 U.S.C. s. 1936
2782 on the last day of a quarter unless the federal or supplemental
2783 rebate, or both, equals or exceeds 29 percent. There is no upper
2784 limit on the supplemental rebates the agency may negotiate. The

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2785 agency may determine that specific products, brand-name or
2786 generic, are competitive at lower rebate percentages. Agreement
2787 to pay the minimum supplemental rebate percentage guarantees a
2788 manufacturer that the Medicaid Pharmaceutical and Therapeutics
2789 Committee will consider a product for inclusion on the preferred
2790 drug list. However, a pharmaceutical manufacturer is not
2791 guaranteed placement on the preferred drug list by simply paying
2792 the minimum supplemental rebate. Agency decisions will be made
2793 on the clinical efficacy of a drug and recommendations of the
2794 Medicaid Pharmaceutical and Therapeutics Committee, as well as
2795 the price of competing products minus federal and state rebates.
2796 The agency may contract with an outside agency or contractor to
2797 conduct negotiations for supplemental rebates. For the purposes
2798 of this section, the term “supplemental rebates” means cash
2799 rebates. Value-added programs as a substitution for supplemental
2800 rebates are prohibited. The agency may seek any federal waivers
2801 to implement this initiative.
2802 8. The agency shall expand home delivery of pharmacy
2803 products. The agency may amend the state plan and issue a
2804 procurement, as necessary, in order to implement this program.
2805 The procurements must include agreements with a pharmacy or
2806 pharmacies located in the state to provide mail order delivery
2807 services at no cost to the recipients who elect to receive home
2808 delivery of pharmacy products. The procurement must focus on
2809 serving recipients with chronic diseases for which pharmacy
2810 expenditures represent a significant portion of Medicaid
2811 pharmacy expenditures or which impact a significant portion of
2812 the Medicaid population. The agency may seek and implement any
2813 federal waivers necessary to implement this subparagraph.

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2814 9. The agency shall limit to one dose per month any drug
2815 prescribed to treat erectile dysfunction.
2816 10.a. The agency may implement a Medicaid behavioral drug
2817 management system. The agency may contract with a vendor that
2818 has experience in operating behavioral drug management systems
2819 to implement this program. The agency may seek federal waivers
2820 to implement this program.
2821 b. The agency, in conjunction with the Department of
2822 Children and Family Services, may implement the Medicaid
2823 behavioral drug management system that is designed to improve
2824 the quality of care and behavioral health prescribing practices
2825 based on best practice guidelines, improve patient adherence to
2826 medication plans, reduce clinical risk, and lower prescribed
2827 drug costs and the rate of inappropriate spending on Medicaid
2828 behavioral drugs. The program may include the following
2829 elements:
2830 (I) Provide for the development and adoption of best
2831 practice guidelines for behavioral health-related drugs such as
2832 antipsychotics, antidepressants, and medications for treating
2833 bipolar disorders and other behavioral conditions; translate
2834 them into practice; review behavioral health prescribers and
2835 compare their prescribing patterns to a number of indicators
2836 that are based on national standards; and determine deviations
2837 from best practice guidelines.
2838 (II) Implement processes for providing feedback to and
2839 educating prescribers using best practice educational materials
2840 and peer-to-peer consultation.
2841 (III) Assess Medicaid beneficiaries who are outliers in
2842 their use of behavioral health drugs with regard to the numbers

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2843 and types of drugs taken, drug dosages, combination drug
2844 therapies, and other indicators of improper use of behavioral
2845 health drugs.
2846 (IV) Alert prescribers to patients who fail to refill
2847 prescriptions in a timely fashion, are prescribed multiple same-
2848 class behavioral health drugs, and may have other potential
2849 medication problems.
2850 (V) Track spending trends for behavioral health drugs and
2851 deviation from best practice guidelines.
2852 (VI) Use educational and technological approaches to
2853 promote best practices, educate consumers, and train prescribers
2854 in the use of practice guidelines.
2855 (VII) Disseminate electronic and published materials.
2856 (VIII) Hold statewide and regional conferences.
2857 (IX) Implement a disease management program with a model
2858 quality-based medication component for severely mentally ill
2859 individuals and emotionally disturbed children who are high
2860 users of care.
2861 11. The agency shall implement a Medicaid prescription drug
2862 management system.
2863 a. The agency may contract with a vendor that has
2864 experience in operating prescription drug management systems in
2865 order to implement this system. Any management system that is
2866 implemented in accordance with this subparagraph must rely on
2867 cooperation between physicians and pharmacists to determine
2868 appropriate practice patterns and clinical guidelines to improve
2869 the prescribing, dispensing, and use of drugs in the Medicaid
2870 program. The agency may seek federal waivers to implement this
2871 program.

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2872 b. The drug management system must be designed to improve
2873 the quality of care and prescribing practices based on best
2874 practice guidelines, improve patient adherence to medication
2875 plans, reduce clinical risk, and lower prescribed drug costs and
2876 the rate of inappropriate spending on Medicaid prescription
2877 drugs. The program must:
2878 (I) Provide for the adoption of best practice guidelines
2879 for the prescribing and use of drugs in the Medicaid program,
2880 including translating best practice guidelines into practice;
2881 reviewing prescriber patterns and comparing them to indicators
2882 that are based on national standards and practice patterns of
2883 clinical peers in their community, statewide, and nationally;
2884 and determine deviations from best practice guidelines.
2885 (II) Implement processes for providing feedback to and
2886 educating prescribers using best practice educational materials
2887 and peer-to-peer consultation.
2888 (III) Assess Medicaid recipients who are outliers in their
2889 use of a single or multiple prescription drugs with regard to
2890 the numbers and types of drugs taken, drug dosages, combination
2891 drug therapies, and other indicators of improper use of
2892 prescription drugs.
2893 (IV) Alert prescribers to recipients who fail to refill
2894 prescriptions in a timely fashion, are prescribed multiple drugs
2895 that may be redundant or contraindicated, or may have other
2896 potential medication problems.
2897 12. The agency may contract for drug rebate administration,
2898 including, but not limited to, calculating rebate amounts,
2899 invoicing manufacturers, negotiating disputes with
2900 manufacturers, and maintaining a database of rebate collections.

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2901 13. The agency may specify the preferred daily dosing form
2902 or strength for the purpose of promoting best practices with
2903 regard to the prescribing of certain drugs as specified in the
2904 General Appropriations Act and ensuring cost-effective
2905 prescribing practices.
2906 14. The agency may require prior authorization for
2907 Medicaid-covered prescribed drugs. The agency may prior-
2908 authorize the use of a product:
2909 a. For an indication not approved in labeling;
2910 b. To comply with certain clinical guidelines; or
2911 c. If the product has the potential for overuse, misuse, or
2912 abuse.
2913
2914 The agency may require the prescribing professional to provide
2915 information about the rationale and supporting medical evidence
2916 for the use of a drug. The agency may post prior authorization
2917 and step-edit criteria, ~~and~~ protocol, and updates to the list of
2918 drugs that are subject to prior authorization on the agency's ~~an~~
2919 Internet website within 21 days after the prior authorization
2920 criteria, protocol, or updates are approved by the agency
2921 ~~without amending its rule or engaging in additional rulemaking~~.
2922 15. The agency, in conjunction with the Pharmaceutical and
2923 Therapeutics Committee, may require age-related prior
2924 authorizations for certain prescribed drugs. The agency may
2925 preauthorize the use of a drug for a recipient who may not meet
2926 the age requirement or may exceed the length of therapy for use
2927 of this product as recommended by the manufacturer and approved
2928 by the Food and Drug Administration. Prior authorization may
2929 require the prescribing professional to provide information

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2930 about the rationale and supporting medical evidence for the use
2931 of a drug.
2932 16. The agency shall implement a step-therapy prior
2933 authorization approval process for medications excluded from the
2934 preferred drug list. Medications listed on the preferred drug
2935 list must be used within the previous 12 months before the
2936 alternative medications that are not listed. The step-therapy
2937 prior authorization may require the prescriber to use the
2938 medications of a similar drug class or for a similar medical
2939 indication unless contraindicated in the Food and Drug
2940 Administration labeling. The trial period between the specified
2941 steps may vary according to the medical indication. The step-
2942 therapy approval process shall be developed in accordance with
2943 the committee as stated in s. 409.91195(7) and (8). A drug
2944 product may be approved without meeting the step-therapy prior
2945 authorization criteria if the prescribing physician provides the
2946 agency with additional written medical or clinical documentation
2947 that the product is medically necessary because:
2948 a. There is not a drug on the preferred drug list to treat
2949 the disease or medical condition which is an acceptable clinical
2950 alternative;
2951 b. The alternatives have been ineffective in the treatment
2952 of the beneficiary’s disease; or
2953 c. Based on historic evidence and known characteristics of
2954 the patient and the drug, the drug is likely to be ineffective,
2955 or the number of doses have been ineffective.
2956
2957 The agency shall work with the physician to determine the best
2958 alternative for the patient. The agency may adopt rules waiving

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2959 the requirements for written clinical documentation for specific
2960 drugs in limited clinical situations.
2961 17. The agency shall implement a return and reuse program
2962 for drugs dispensed by pharmacies to institutional recipients,
2963 which includes payment of a $5 restocking fee for the
2964 implementation and operation of the program. The return and
2965 reuse program shall be implemented electronically and in a
2966 manner that promotes efficiency. The program must permit a
2967 pharmacy to exclude drugs from the program if it is not
2968 practical or cost-effective for the drug to be included and must
2969 provide for the return to inventory of drugs that cannot be
2970 credited or returned in a cost-effective manner. The agency
2971 shall determine if the program has reduced the amount of
2972 Medicaid prescription drugs which are destroyed on an annual
2973 basis and if there are additional ways to ensure more
2974 prescription drugs are not destroyed which could safely be
2975 reused.
2976 Section 63. Subsections (1), (7), and (8) of section
2977 409.91195, Florida Statutes, are amended to read:
2978 409.91195 Medicaid Pharmaceutical and Therapeutics
2979 Committee.—There is created a Medicaid Pharmaceutical and
2980 Therapeutics Committee within the agency for the purpose of
2981 developing a Medicaid preferred drug list.
2982 (1)(a) The committee shall be composed of 11 members
2983 appointed by the Governor as follows: one member licensed under
2984 chapter 458 or chapter 459 who is nominated by the Florida
2985 Medical Association; one member licensed under chapter 459 who
2986 is nominated by the Florida Osteopathic Medical Association; one
2987 member licensed under chapter 458 or chapter 459 who is

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2988 nominated by the American Academy of Family Physicians, Florida
2989 Chapter; one member licensed under chapter 458 or chapter 459
2990 who is nominated by the American Academy of Pediatrics, Florida
2991 Chapter; one member licensed under chapter 458 or chapter 459
2992 nominated by the Florida Psychiatric Society; one member
2993 licensed under chapter 465 who is nominated by the Florida
2994 Pharmacy Association; one member licensed under chapter 465 who
2995 is nominated by the Florida Society of Health System
2996 Pharmacists, Inc.; one member licensed under chapter 465 who is
2997 nominated by the Florida Retail Federation; one member licensed
2998 under chapter 465 who works in a retail setting for an
2999 independent, nonchain pharmacy; one member licensed under
3000 chapter 458 or chapter 459 who is nominated by the Florida
3001 Academy of Physician Assistants; and one consumer representative
3002 who represents a patient advocacy group.
3003 (b) Each member of the committee, except the consumer
3004 representative, must practice in this state and participate in
3005 the Florida Medicaid Fee for Service Pharmacy Program.
3006 (c) The Governor shall appoint the members for 2-year
3007 terms. Members may be appointed to more than one term. The
3008 agency shall serve as staff for the committee and assist the
3009 members with administrative duties. ~~Four members shall be~~
3010 ~~physicians, licensed under chapter 458; one member licensed~~
3011 ~~under chapter 459; five members shall be pharmacists licensed~~
3012 ~~under chapter 465; and one member shall be a consumer~~
3013 ~~representative. The members shall be appointed to serve for~~
3014 ~~terms of 2 years from the date of their appointment. Members may~~
3015 ~~be appointed to more than one term. The agency shall serve as~~
3016 ~~staff for the committee and assist them with all ministerial~~

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3017 ~~duties. The Governor shall ensure that at least some of the~~
3018 ~~members of the committee represent Medicaid participating~~
3019 ~~physicians and pharmacies serving all segments and diversity of~~
3020 ~~the Medicaid population, and have experience in either~~
3021 ~~developing or practicing under a preferred drug list. At least~~
3022 ~~one of the members shall represent the interests of~~
3023 ~~pharmaceutical manufacturers.~~
3024 (7) The committee shall ensure that interested parties,
3025 including pharmaceutical manufacturers agreeing to provide a
3026 supplemental rebate as outlined in this chapter, have an
3027 opportunity to present public testimony to the committee with
3028 information or evidence supporting inclusion of a product on the
3029 preferred drug list. Such public testimony shall occur prior to
3030 any recommendations made by the committee for inclusion or
3031 exclusion from the preferred drug list, allow for members of the
3032 committee to ask questions of the presenters of the public
3033 testimony, and allow for 3 minutes of testimony for each drug
3034 reviewed. The agency may not limit the number of interested
3035 parties that provide public testimony. Upon timely notice, the
3036 agency shall ensure that any drug that has been approved or had
3037 any of its particular uses approved by the United States Food
3038 and Drug Administration under a priority review classification
3039 will be reviewed by the committee at the next regularly
3040 scheduled meeting following 3 months of distribution of the drug
3041 to the general public.
3042 (8) The committee shall develop its preferred drug list
3043 recommendations by considering the clinical efficacy, safety,
3044 and cost-effectiveness of a product. If the agency does not
3045 follow a recommendation of the committee, the committee members

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3046 must be informed in writing of the agency's action at the next
3047 meeting of the committee following the reversal of its
3048 recommendation.
3049 Section 64. Subsection (1) of section 429.294, Florida
3050 Statutes, is amended to read:
3051 429.294 Availability of facility records for investigation
3052 of resident's rights violations and defenses; penalty.—
3053 (1) Failure to provide complete copies of a resident's
3054 records, including, but not limited to, all medical records and
3055 the resident's chart, within the control or possession of the
3056 facility within 10 days~~, in accordance with the provisions of s.~~
3057 ~~400.145,~~ shall constitute evidence of failure of that party to
3058 comply with good faith discovery requirements and shall waive
3059 the good faith certificate and presuit notice requirements under
3060 this part by the requesting party.
3061 Section 65. Section 429.915, Florida Statutes, is amended
3062 to read:
3063 429.915 Conditional license.—In addition to the license
3064 categories available in part II of chapter 408, the agency may
3065 issue a conditional license to an applicant for license renewal
3066 or change of ownership if the applicant fails to meet all
3067 standards and requirements for licensure. A conditional license
3068 issued under this subsection must be limited to a specific
3069 period not exceeding 6 months, as determined by the agency~~, and~~
3070 ~~must be accompanied by an approved plan of correction~~.
3071 Section 66. Subsection (3) of section 430.80, Florida
3072 Statutes, is amended to read:
3073 430.80 Implementation of a teaching nursing home pilot
3074 project.—

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3075 (3) To be designated as a teaching nursing home, a nursing
3076 home licensee must, at a minimum:
3077 (a) Provide a comprehensive program of integrated senior
3078 services that include institutional services and community-based
3079 services;
3080 (b) Participate in a nationally recognized accreditation
3081 program and hold a valid accreditation, such as the
3082 accreditation awarded by the Joint Commission on Accreditation
3083 of Healthcare Organizations, or, at the time of initial
3084 designation, possess a Gold Seal Award as conferred by the state
3085 on its licensed nursing home;
3086 (c) Have been in business in this state for a minimum of 10
3087 consecutive years;
3088 (d) Demonstrate an active program in multidisciplinary
3089 education and research that relates to gerontology;
3090 (e) Have a formalized contractual relationship with at
3091 least one accredited health profession education program located
3092 in this state;
3093 (f) Have senior staff members who hold formal faculty
3094 appointments at universities, which must include at least one
3095 accredited health profession education program; and
3096 (g) Maintain insurance coverage pursuant to s.
3097 400.141(1)(q) ~~s. 400.141(1)(s)~~ or proof of financial
3098 responsibility in a minimum amount of $750,000. Such proof of
3099 financial responsibility may include:
3100 1. Maintaining an escrow account consisting of cash or
3101 assets eligible for deposit in accordance with s. 625.52; or
3102 2. Obtaining and maintaining pursuant to chapter 675 an
3103 unexpired, irrevocable, nontransferable and nonassignable letter

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3104 of credit issued by any bank or savings association organized
3105 and existing under the laws of this state or any bank or savings
3106 association organized under the laws of the United States that
3107 has its principal place of business in this state or has a
3108 branch office which is authorized to receive deposits in this
3109 state. The letter of credit shall be used to satisfy the
3110 obligation of the facility to the claimant upon presentment of a
3111 final judgment indicating liability and awarding damages to be
3112 paid by the facility or upon presentment of a settlement
3113 agreement signed by all parties to the agreement when such final
3114 judgment or settlement is a result of a liability claim against
3115 the facility.
3116 Section 67. Paragraph (h) of subsection (2) of section
3117 430.81, Florida Statutes, is amended to read:
3118 430.81 Implementation of a teaching agency for home and
3119 community-based care.—
3120 (2) The Department of Elderly Affairs may designate a home
3121 health agency as a teaching agency for home and community-based
3122 care if the home health agency:
3123 (h) Maintains insurance coverage pursuant to s.
3124 400.141(1)(q) ~~s. 400.141(1)(s)~~ or proof of financial
3125 responsibility in a minimum amount of $750,000. Such proof of
3126 financial responsibility may include:
3127 1. Maintaining an escrow account consisting of cash or
3128 assets eligible for deposit in accordance with s. 625.52; or
3129 2. Obtaining and maintaining, pursuant to chapter 675, an
3130 unexpired, irrevocable, nontransferable, and nonassignable
3131 letter of credit issued by any bank or savings association
3132 authorized to do business in this state. This letter of credit

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3133 shall be used to satisfy the obligation of the agency to the
3134 claimant upon presentation of a final judgment indicating
3135 liability and awarding damages to be paid by the facility or
3136 upon presentment of a settlement agreement signed by all parties
3137 to the agreement when such final judgment or settlement is a
3138 result of a liability claim against the agency.
3139 Section 68. Paragraph (d) of subsection (9) of section
3140 440.102, Florida Statutes, is repealed.
3141 Section 69. Subsection (1) of section 483.035, Florida
3142 Statutes, is amended to read:
3143 483.035 Clinical laboratories operated by practitioners for
3144 exclusive use; licensure and regulation.—
3145 (1) A clinical laboratory operated by one or more
3146 practitioners licensed under chapter 458, chapter 459, chapter
3147 460, chapter 461, chapter 462, ~~or~~ chapter 466, or as an advanced
3148 registered nurse practitioner licensed under part I in chapter
3149 464, exclusively in connection with the diagnosis and treatment
3150 of their own patients, must be licensed under this part and must
3151 comply with the provisions of this part, except that the agency
3152 shall adopt rules for staffing, for personnel, including
3153 education and training of personnel, for proficiency testing,
3154 and for construction standards relating to the licensure and
3155 operation of the laboratory based upon and not exceeding the
3156 same standards contained in the federal Clinical Laboratory
3157 Improvement Amendments of 1988 and the federal regulations
3158 adopted thereunder.
3159 Section 70. Subsections (1) and (9) of section 483.051,
3160 Florida Statutes, are amended to read:
3161 483.051 Powers and duties of the agency.—The agency shall

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3162 adopt rules to implement this part, which rules must include,
3163 but are not limited to, the following:
3164 (1) LICENSING; QUALIFICATIONS.—The agency shall provide for
3165 biennial licensure of all nonwaived clinical laboratories
3166 meeting the requirements of this part and shall prescribe the
3167 qualifications necessary for such licensure, including, but not
3168 limited to, application for or proof of a federal Clinical
3169 Laboratory Improvement Amendment (CLIA) certificate. For
3170 purposes of this section, the term "nonwaived clinical
3171 laboratories" means laboratories that perform any test that the
3172 Centers for Medicare and Medicaid Services has determined does
3173 not qualify for a certificate of waiver under the Clinical
3174 Laboratory Improvement Amendments of 1988 and the federal rules
3175 adopted thereunder.
3176 (9) ALTERNATE-SITE TESTING.—The agency, in consultation
3177 with the Board of Clinical Laboratory Personnel, shall adopt, by
3178 rule, the criteria for alternate-site testing to be performed
3179 under the supervision of a clinical laboratory director. The
3180 elements to be addressed in the rule include, but are not
3181 limited to: a hospital internal needs assessment; a protocol of
3182 implementation including tests to be performed and who will
3183 perform the tests; criteria to be used in selecting the method
3184 of testing to be used for alternate-site testing; minimum
3185 training and education requirements for those who will perform
3186 alternate-site testing, such as documented training, licensure,
3187 certification, or other medical professional background not
3188 limited to laboratory professionals; documented inservice
3189 training as well as initial and ongoing competency validation;
3190 an appropriate internal and external quality control protocol;

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3191 an internal mechanism for identifying and tracking alternate-
3192 site testing by the central laboratory; and recordkeeping
3193 requirements. ~~Alternate-site testing locations must register~~
3194 ~~when the clinical laboratory applies to renew its license.~~ For
3195 purposes of this subsection, the term "alternate-site testing"
3196 means any laboratory testing done under the administrative
3197 control of a hospital, but performed out of the physical or
3198 administrative confines of the central laboratory.
3199 Section 71. Section 483.245, Florida Statutes, is amended
3200 to read:
3201 483.245 Rebates prohibited; penalties; private action.—
3202 (1) It is unlawful for any person to pay or receive any
3203 commission, bonus, kickback, or rebate or engage in any split-
3204 fee arrangement in any form whatsoever with any dialysis
3205 facility, physician, surgeon, organization, agency, or person,
3206 either directly or indirectly, for patients referred to a
3207 clinical laboratory licensed under this part. A clinical
3208 laboratory licensed under this part is prohibited from placing,
3209 directly or indirectly, through an independent staffing company
3210 or lease arrangement, or otherwise, a specimen collector or
3211 other personnel in any physician's office, unless the clinical
3212 lab and the physician's office are owned and operated by the
3213 same entity.
3214 (2) The agency shall adopt rules that assess administrative
3215 penalties for acts prohibited by subsection (1). In the case of
3216 an entity licensed by the agency, such penalties may include any
3217 disciplinary action available to the agency under the
3218 appropriate licensing laws. In the case of an entity not
3219 licensed by the agency, such penalties may include:

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3220 (a) A fine not to exceed $1,000;
3221 (b) If applicable, a recommendation by the agency to the
3222 appropriate licensing board that disciplinary action be taken.
3223 (3) Any person aggrieved by a violation of this section may
3224 bring a civil action for appropriate relief, including an action
3225 for a declaratory judgment, injunctive relief, and actual
3226 damages.
3227 Section 72. Section 483.294, Florida Statutes, is amended
3228 to read:
3229 483.294 Inspection of centers.—In accordance with s.
3230 408.811, the agency shall biennially~~, at least once annually,~~
3231 inspect the premises and operations of all centers subject to
3232 licensure under this part.
3233 Section 73. Paragraph (a) of subsection (54) of section
3234 499.003, Florida Statutes, is amended to read:
3235 499.003 Definitions of terms used in this part.—As used in
3236 this part, the term:
3237 (54) "Wholesale distribution" means distribution of
3238 prescription drugs to persons other than a consumer or patient,
3239 but does not include:
3240 (a) Any of the following activities, which is not a
3241 violation of s. 499.005(21) if such activity is conducted in
3242 accordance with s. 499.01(2)(g):
3243 1. The purchase or other acquisition by a hospital or other
3244 health care entity that is a member of a group purchasing
3245 organization of a prescription drug for its own use from the
3246 group purchasing organization or from other hospitals or health
3247 care entities that are members of that organization.
3248 2. The sale, purchase, or trade of a prescription drug or

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3249 an offer to sell, purchase, or trade a prescription drug by a
3250 charitable organization described in s. 501(c)(3) of the
3251 Internal Revenue Code of 1986, as amended and revised, to a
3252 nonprofit affiliate of the organization to the extent otherwise
3253 permitted by law.
3254 3. The sale, purchase, or trade of a prescription drug or
3255 an offer to sell, purchase, or trade a prescription drug among
3256 hospitals or other health care entities that are under common
3257 control. For purposes of this subparagraph, “common control”
3258 means the power to direct or cause the direction of the
3259 management and policies of a person or an organization, whether
3260 by ownership of stock, by voting rights, by contract, or
3261 otherwise.
3262 4. The sale, purchase, trade, or other transfer of a
3263 prescription drug from or for any federal, state, or local
3264 government agency or any entity eligible to purchase
3265 prescription drugs at public health services prices pursuant to
3266 Pub. L. No. 102-585, s. 602 to a contract provider or its
3267 subcontractor for eligible patients of the agency or entity
3268 under the following conditions:
3269 a. The agency or entity must obtain written authorization
3270 for the sale, purchase, trade, or other transfer of a
3271 prescription drug under this subparagraph from the State Surgeon
3272 General or his or her designee.
3273 b. The contract provider or subcontractor must be
3274 authorized by law to administer or dispense prescription drugs.
3275 c. In the case of a subcontractor, the agency or entity
3276 must be a party to and execute the subcontract.
3277 ~~d. A contract provider or subcontractor must maintain~~

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3278 ~~separate and apart from other prescription drug inventory any~~
3279 ~~prescription drugs of the agency or entity in its possession.~~
3280 d.~~e.~~ The contract provider and subcontractor must maintain
3281 and produce immediately for inspection all records of movement
3282 or transfer of all the prescription drugs belonging to the
3283 agency or entity, including, but not limited to, the records of
3284 receipt and disposition of prescription drugs. Each contractor
3285 and subcontractor dispensing or administering these drugs must
3286 maintain and produce records documenting the dispensing or
3287 administration. Records that are required to be maintained
3288 include, but are not limited to, a perpetual inventory itemizing
3289 drugs received and drugs dispensed by prescription number or
3290 administered by patient identifier, which must be submitted to
3291 the agency or entity quarterly.
3292 e.~~f.~~ The contract provider or subcontractor may administer
3293 or dispense the prescription drugs only to the eligible patients
3294 of the agency or entity or must return the prescription drugs
3295 for or to the agency or entity. The contract provider or
3296 subcontractor must require proof from each person seeking to
3297 fill a prescription or obtain treatment that the person is an
3298 eligible patient of the agency or entity and must, at a minimum,
3299 maintain a copy of this proof as part of the records of the
3300 contractor or subcontractor required under sub-subparagraph e.
3301 f.~~g.~~ In addition to the departmental inspection authority
3302 set forth in s. 499.051, the establishment of the contract
3303 provider and subcontractor and all records pertaining to
3304 prescription drugs subject to this subparagraph shall be subject
3305 to inspection by the agency or entity. All records relating to
3306 prescription drugs of a manufacturer under this subparagraph

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3307 shall be subject to audit by the manufacturer of those drugs,
3308 without identifying individual patient information.
3309 Section 74. Effective May 1, 2012, paragraph (h) is added
3310 to subsection (1) of section 627.602, Florida Statutes, to read:
3311 627.602 Scope, format of policy.—
3312 (1) Each health insurance policy delivered or issued for
3313 delivery to any person in this state must comply with all
3314 applicable provisions of this code and all of the following
3315 requirements:
3316 (h) Section 641.312 and the provisions of the Employee
3317 Retirement Income Security Act of 1974, as implemented by 29
3318 C.F.R. s. 2560.503-1, relating to internal grievances. This
3319 paragraph does not apply to a health insurance policy that is
3320 subject to the Subscriber Assistance Program in s. 408.7056.
3321 Section 75. Effective May 1, 2012, section 627.6513,
3322 Florida Statutes, is created to read:
3323 627.6513 Section 641.312 and the provisions of the Employee
3324 Retirement Income Security Act of 1974, as implemented by 29
3325 C.F.R. s. 2560.503-1, relating to internal grievances, apply to
3326 all group health insurance policies issued under this part. This
3327 section does not apply to a group health insurance policy that
3328 is subject to the Subscriber Assistance Program in s. 408.7056.
3329 Section 76. Effective May 1, 2012, section 641.312, Florida
3330 Statutes, is created to read:
3331 641.312 The Office of Insurance Regulation within the
3332 Department of Financial Services shall adopt rules to administer
3333 the provisions of the National Association of Insurance
3334 Commissioners' Uniform Health Carrier External Review Model Act,
3335 dated April 2010. This section does not apply to a health

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3336 maintenance contract that is subject to the Subscriber
3337 Assistance Program in s. 408.7056.
3338 Section 77. Subsection (13) of section 651.118, Florida
3339 Statutes, is amended to read:
3340 651.118 Agency for Health Care Administration; certificates
3341 of need; sheltered beds; community beds.—
3342 (13) Residents, as defined in this chapter, are not
3343 considered new admissions for the purpose of s. 400 141(1)(n)1.d
3344 ~~s. 400.141(1)(o)1.d~~.
3345 Section 78. The Florida Hospital/Sanford-Burnham
3346 Translational Research Institute is designated as a State of
3347 Florida Resource for research in diabetes diagnosis, prevention,
3348 and treatment.
3349 Section 79. Notwithstanding s. 409.975, Florida Statutes,
3350 and before the selection of managed care plans as specified in
3351 s. 409.966, Florida Statutes, each essential provider and each
3352 hospital that are necessary in order for a managed care plan to
3353 demonstrate an adequate network, as determined by the Agency for
3354 Health Care Administration, are a part of that managed care
3355 plan’s network for purposes of the provider’s or hospital’s
3356 application for enrollment or expansion in the Medicaid program.
3357 A managed care plan’s payment under this section to an essential
3358 provider must be made in accordance with s. 409.975, Florida
3359 Statutes. This section takes effect upon this act becoming law.
3360 Section 80. In the interim between this act becoming law
3361 and the 2013 Regular Session of the Legislature, the Division of
3362 Statutory Revision shall provide the relevant substantive
3363 committees of the Senate and the House of Representatives with
3364 assistance, upon request, to enable such committees to prepare

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3365 draft legislation to correct the names of accrediting
3366 organizations in the related Florida Statutes.
3367 Section 81. Except as otherwise expressly provided in this
3368 act, and except for this section, which shall take effect upon
3369 this act becoming a law, this act shall take effect July 1,
3370 2012.

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