By Senator Forman

32-33B-98

A bill to be entitled

An act relating to health quality assurance; amending s. 20.42, F.S.; deleting the responsibility of the Division of Health Policy and Cost Control within the Agency for Health Care Administration for reviewing hospital budgets; abolishing the Health Care Board; amending s. 112.0455, F.S., relating to the Drug-Free Workplace Act; requiring background screening for an applicant for licensure of certain laboratories; authorizing the use of certain body hair for drug testing; amending s. 154.304, F.S., relating to health care for indigent persons; revising definitions; amending s. 381.026, F.S.; requiring that a patient's bill of rights be made available by a facility that provides emergency services or outpatient services; amending s. 381.0261, F.S.; requiring that a patient's bill of rights includes additional information; creating s. 381.60225, F.S.; requiring background screening for an applicant for certification to operate an organ procurement organization, a tissue bank, or an eye bank; amending s. 383.302, F.S., relating to the regulation of birth centers; revising definitions to reflect the transfer of regulatory authority from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; amending s. 383.305, F.S.; requiring background screening for an applicant

for licensure of a birth center; amending ss. 383.308, 383.309, 383.31, 383.312, 383.313, 383.318, 383.32, 383.324, 383.325, 383.327, 383.33, 383.331, F.S., relating to the regulation of birth centers; conforming provisions to reflect the transfer of regulatory authority to the Agency for Health Care Administration; amending s. 390.015, F.S.; requiring background screening for an applicant for licensure of an abortion clinic; amending s. 391.206, F.S.; requiring background screening for an applicant for licensure to operate a pediatric extended care center; amending s. 393.063, F.S., relating to developmental disabilities; providing a definition; amending s. 393.067, F.S.; requiring background screening for an applicant for licensure to operate an intermediate care facility for the developmentally disabled; amending s. 394.4787, F.S., relating to the regulation of mental health facilities; conforming a cross-reference to changes made by the act; amending s. 394.4788, F.S., relating to mental health services; updating provisions relating to duties of the agency formerly performed by the Health Care Cost Containment Board; amending s. 394.67, F.S., relating to community alcohol, drug abuse, and mental health services; revising definitions; amending s. 394.875, F.S.; requiring background screening for an applicant for licensure of a

crisis stabilization unit or residential treatment facility; amending ss. 394.876, 394.877, 394.878, 394.879, 394.90, 394.902, 394.903, 394.904, 394.907, F.S., relating to the regulation of mental health facilities; conforming provisions to reflect the transfer of regulatory authority to the Agency for Health Care Administration; amending s. 395.002, F.S., relating to hospital licensing and regulation; providing definitions; creating s. 395.0055, F.S.; requiring background screening for an applicant for licensure of a facility operated under ch. 395, F.S.; amending s. 395.0163, F.S.; requiring that the agency review plans and specifications for certain outpatient facilities; amending s. 395.0193, F.S.; revising certain requirements for peer review of physicians; providing requirements for reporting disciplinary actions to the agency; authorizing the agency to levy administrative fines; amending s. 395.0197, F.S.; revising provisions relating to internal risk management; defining the term "adverse incident"; requiring certain reports to the agency; including minors in provisions relating to notification of sexual misconduct or abuse; requiring facility corrective action plans; providing penalties; amending s. 395.0199, F.S.; requiring background screening for an applicant for registration as a utilization review agent; amending s. 395.1055, F.S.;

requiring the Agency for Health Care Administration to adopt rules to assure that, following a disaster, licensed hospital facilities are capable of serving as shelters only for patients, staff, and the families of staff; providing for applicability; providing for a report by the agency to the Governor and Legislature; transferring, renumbering, and amending ss. 626.941, 626.942, 626.943, 626.944, 626.945, F.S., relating to the regulation of health care risk managers; conforming provisions to reflect the transfer of regulatory authority from the Department of Insurance to the Agency for Health Care Administration; providing for the Health Care Risk Manager Advisory Council to be appointed by the Director of Health Care Administration; amending s. 395.401, F.S.; providing for certain reports relating to charity care and formerly made to the Health Care Board to be made to the agency; amending s. 395.602, F.S., relating to rural hospitals; conforming a cross-reference to changes made by the act; amending s. 395.701, F.S., relating to the Public Medical Assistance Trust Fund; revising definitions; amending s. 400.051, F.S.; conforming a cross-reference; amending s. 400.071, F.S.; requiring background screening for an applicant for licensure of a nursing home; amending s. 400.411, F.S.; requiring background screening for an applicant for

licensure of an assisted living facility; amending ss. 400.414, 400.417, 400.4174, 400.4176, F.S., relating to the regulation of assisted living facilities; providing additional grounds for denial, revocation, or suspension of a license; requiring background screening for employees hired on or after a specified date; amending ss. 400.461, 400.462, F.S., relating to the regulation of home health agencies; conforming a cross-reference; revising definitions; amending s. 400.464, F.S.; revising licensure requirements for home health agencies; specifying services that are exempt from the licensure requirements; amending s. 400.471, F.S.; requiring background screening for an applicant for licensure of a home health agency; revising requirements for license renewal; amending s. 400.474, F.S.; providing penalties for operating a home health agency without a license; amending s. 400.484, F.S.; providing a schedule for the agency to use in imposing fines for various classes of violations; amending s. 400.487, F.S.; revising requirements for patient assessment and services; amending s. 400.491, F.S.; revising requirements for maintaining patient records; amending s. 400.497, F.S.; revising requirements for the agency in establishing minimum standards; amending s. 400.506, F.S.; requiring background screening for an applicant for licensure of a nurse registry; amending s.

400.509, F.S.; requiring background screening for an applicant for registration as a service provider who is exempt from licensure; amending s. 400.512, F.S.; revising screening requirements for home health agency personnel; amending s. 400.555, F.S.; requiring background screening for an applicant for licensure of an adult day care center; creating s. 400.5572, F.S.; requiring background screening for employees of an adult day care center hired on or after a specified date; amending s. 400.606, F.S.; requiring background screening for an applicant for licensure of a hospice; amending s. 400.619, F.S.; revising background screening requirements for an applicant for licensure of an adult family care home; providing screening requirements for designated relief persons; amending s. 400.702, F.S.; deleting a requirement that certain intermediate-level care facilities accept only certain low-income residents who receive subsidized housing vouchers; amending s. 400.801, F.S.; requiring background screening for an applicant for licensure of a home for special services; amending s. 400.805, F.S.; requiring background screening for an applicant for licensure of a transitional living facility; amending ss. 408.05, 408.061, 408.062, 408.063, F.S., relating to the State Center for Health Statistics and the collection and dissemination of health care information; updating provisions

to reflect the assumption by the Agency for Health Care Administration of duties formerly performed by the Health Care Board and the former Department of Health and Rehabilitative Services; authorizing the agency to conduct data-based studies and make recommendations; deleting obsolete provisions; amending s. 408.07, F.S.; deleting definitions made obsolete by the repeal of requirements with respect to hospital budget reviews; amending s. 408.08, F.S.; deleting provisions requiring the Health Care Board to review the budgets of certain hospitals; deleting requirements that a hospital file budget letters; deleting certain administrative penalties; amending s. 408.40, F.S.; removing a reference to the duties of the Public Counsel with respect to hospital budget review proceedings; amending ss. 409.2673, 409.9113, F.S., relating to health care programs for low-income persons and the disproportionate share program for teaching hospitals; updating provisions to reflect the abolishment of the Health Care Cost Containment Board and the assumption of its duties by the agency; amending ss. 409.905, 440.13, 455.654, F.S., relating to mandatory Medicaid services, medical services and supplies, and referring health care providers; conforming cross-references to changes made by the act; amending ss. 458.331, 459.015, 461.013, 468.505, F.S., relating to disciplinary action

against certain medical professionals and activities exempt from regulation; updating provisions and conforming cross-references; amending s. 483.101, F.S.; requiring background screening for an applicant for licensure of a clinical laboratory; amending s. 483.106, F.S., relating to a certificate of exemption; correcting terminology; amending s. 483.30, F.S.; requiring background screening for an applicant for licensure of a multiphasic health testing center; amending ss. 641.55, 766.1115, F.S., relating to internal risk management programs and contracts with governmental contractors; updating provisions and conforming cross-references to changes made by the act; repealing ss. 395.403(9), 407.61, 408.003, 408.072, 408.085, 455.661, F.S., relating to reimbursement of state-sponsored trauma centers, studies by the Health Care Board, appointment of members to the Health Care Board, review of hospital budgets, budget reviews of comprehensive inpatient rehabilitation hospitals, and designated health care services; providing for retroactive application of provisions of the act relating to repeal of review of hospital budgets; transferring the internal risk manager licensure program from the Department of Insurance to the Agency for Health Care Administration; providing appropriations and

authorizing positions; providing effective dates.

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

Section 1. Paragraphs (b), (d), and (e) of subsection (2) and subsections (6) and (7) of section 20.42, Florida Statutes, are amended to read:

20.42 Agency for Health Care Administration.--There is created the Agency for Health Care Administration within the Department of Business and Professional Regulation. The agency shall be a separate budget entity, and the director of the agency shall be the agency head for all purposes. The agency shall not be subject to control, supervision, or direction by the Department of Business and Professional Regulation in any manner, including, but not limited to, personnel, purchasing, transactions involving real or personal property, and budgetary matters.

(2) ORGANIZATION OF THE AGENCY.--The agency shall be organized as follows:

(b) The Division of Health Policy and Cost Control, which shall be responsible for health policy, the State Center for Health Statistics, the development of The Florida Health Plan, certificate of need, ~~hospital budget review,~~ state and local health planning under s. 408.033, and research and analysis.

~~(d) The Health Care Board, which shall be responsible for hospital budget review, nursing home financial analysis, and special studies as assigned by the secretary or the Legislature.~~

(d)~~(e)~~ The Division of Administrative Services, which shall be responsible for revenue management, budget, personnel, and general services.

~~(6) HEALTH CARE BOARD.--The Health Care Board shall be composed of 11 members appointed by the Governor, subject to confirmation by the Senate. The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall be responsible for hospital budget review, nursing home financial review and analysis, and special studies requested by the Governor, the Legislature, or the director.~~

(6)~~(7)~~ DEPUTY DIRECTOR OF ADMINISTRATIVE SERVICES.--The director shall appoint a Deputy Director of Administrative Services who shall serve at the pleasure of, and be directly responsible to, the director. The deputy director shall be responsible for the Division of Administrative Services.

Section 2. Subsection (12) and paragraph (b) of subsection (13) of section 112.0455, Florida Statutes, are amended to read:

112.0455 Drug-Free Workplace Act.--

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

(a) A laboratory may analyze initial or confirmation drug specimens only if:

1. The laboratory is licensed and approved by the Agency for Health Care Administration using criteria established by the United States Department of Health and Human Services as general guidelines for modeling the state drug testing program. Each applicant for licensure must comply with the following requirements:

a. Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual responsible for the daily operation of the laboratory, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the laboratory, including billings for services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

b. The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

c. Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of screening requirements.

d. A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation

background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

e. Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

f. Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no

financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this sub-subparagraph.

g. A license may not be granted to any applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

h. The agency may deny or revoke licensure if the applicant:

(I) Has falsely represented a material fact in the application required by sub-subparagraph e. or sub-subparagraph f., or has omitted any material fact from the application required by sub-subparagraph e. or sub-subparagraph f.; or

(II) Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in sub-subparagraph e.

i. An application for license renewal must contain the information required under sub-subparagraphs e. and f.

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

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

a. The use of internal quality controls including the use of samples of known concentrations which are used to check

the performance and calibration of testing equipment, and periodic use of blind samples for overall accuracy.

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

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

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

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

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

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

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

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

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

No report shall disclose the presence or absence of any drug other than a specific drug and its metabolites listed pursuant to this section.

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

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

(13) RULES.--

(b) The following standards and procedures are established related to hair testing:

1. Hair cutoff levels for initial drug-screening tests.--The following initial cutoff levels must be used when screening hair specimens to determine whether they are negative for these drugs or their metabolites:

a. Marijuana: 10 pg/10 mg of hair;

b. Cocaine: 5 ng/10 mg of hair; and

c. Opiate/synthetic narcotics and metabolites: 5 ng/10 mg of hair. For the purpose of this section, opiate and metabolites include the following:

(I) Codeine;

(II) Heroin, <u>monoacetylmorphine</u> ~~monoacitylmorphine~~ (heroin metabolites);

(III) Morphine;

d. Phencyclidine: 3 ng/10 mg of hair; and

e. Amphetamines: 5 ng/10 mg of hair. For the purpose of this section, amphetamines include the following:

(I) Amphetamines;

(II) Methamphetamine;

2. Hair cutoff levels for drug confirmation testing.--

a. All specimens identified as positive on the initial test must be confirmed using gas chromatography/mass spectrometry (GC/MS), mass spectrometry/mass spectrometry (MS/MS) at the following cutoff levels for these drugs on their metabolites. All confirmations must be by quantitative analysis.

(I) Marijuana metabolites: 1 pg/10 mg of hair (Delta-9-tetrahydrocannabinol-0-carboxylic acid).

(II) Cocaine: must be at or above 5 ng/10 mg of hair. Cocaine metabolites if present will be recorded at the following minimum levels:

(A) Benzoylecgonine at 1 ng/10 mg of hair; and

(B) Cocaethlyene at 1 ng/10 mg of hair.

(III) Opiate/synthetic narcotics and metabolites: 5 ng/10 mg of hair; opiate and metabolites include the following:

(A) Codeine;

(B) 6-Monoacetylmorphine (heroin metabolite); and

(C) Morphine.

(IV) Phencyclidine: 3 ng/10 mg of hair.

(V) Amphetamines: 5 ng/10 mg of hair. For the purpose of this section, amphetamines include the following:

(A) Amphetamines; and

(B) Methamphetamines.

b. All hair specimens undergoing confirmation must be decontaminated using a wash procedure which has been published in the peer-reviewed literature which, as a minimum, has an initial 15-minute organic solvent wash followed by multiple (minimum of three) 30-minute aqueous washes.

c. After hair is washed, the drug entrapped in the hair is released either by digestion (chemical or enzymatic) or by multiple solvent extractions. The resulting digest or pooled solvent extracts are then screened and confirmed by approved methods.

d. All confirmation analysis methods must eliminate the melanin fraction of the hair before analysis. If a nondigestion method is used, the laboratory must present published data in the peer-reviewed literature from a large population study which indicates that the method of extraction does not possess a statistically significant hair-color bias.

e. Additional hair samples may be collected to reconfirm the initial report. The recollected sample shall be retested as specified; however, the confirmation analysis must be performed even if the screening test is negative. A second positive report must be made if the drug concentration in the digest by confirmation methods exceeds the limit of quantitation of the testing laboratory's method. A second test must be offered to anyone disputing a positive hair test result.

3. Hair specimen collection procedures.--

a. Designation of collection site.--Each drug-testing program shall have one or more designated collection sites which have all necessary personnel, materials, equipment, facilities, and supervision to provide for the collection,

security, temporary storage, and shipping or transportation of hair specimens to a licensed drug-testing facility.

b. Security.--While security is important with any collection, in the case of hair, only the temporary storage area in the designated collection site needs to be secure.

c. Chain of custody.--Chain-of-custody standardized forms shall be properly executed by authorized collection site personnel upon receipt of specimens. Handling and transportation of hair specimens from one authorized individual or place to another shall always be accomplished through chain-of-custody procedures. Every effort shall be made to minimize the number of persons handling specimens.

d. Access to authorized personnel only.--The hair collection site need be off limits to unauthorized personnel only during the actual collection of specimens.

e. Privacy.--Procedures for collecting hair should be performed on one individual at a time to prevent substitutions or interference with the collection of reliable samples. Procedures must ensure that the hair collection does not infringe on the individual's privacy.

f. Integrity and identity of specimen.--Precautions must be taken to ensure that the root end of a hair specimen is indicated for the laboratory which performs the testing. The maximum length of hair that shall be tested is 3.9 cm distal from the head, which on average represents a 3-month time window. The following minimum precautions must be taken when collecting a hair specimen to ensure that specimens are obtained and correctly identified:

(I) When an individual arrives at the collection site, the collection site personnel shall request the individual to present photo identification. If the individual does not have

proper photo identification, the collection site personnel shall contact the supervisor of the individual, the coordinator of the drug testing program, or any other employer official who can positively identify the individual. If the individual's identity cannot be established, the collection site personnel shall not proceed with the collection.

(II) If the individual fails to arrive at the assigned time, the collection site personnel shall contact the appropriate authority to obtain guidance on the action to be taken.

(III) The collection site personnel shall note any unusual behavior or appearance on the chain-of-custody form.

(IV) Hair shall be cut as close to the scalp <u>or body, excluding the pubic area,</u>as possible. Upon taking the specimen from the individual, the collection site personnel shall determine that it contains approximately 1/2 -inch of hair when fanned out on a ruler (about 40 mg of hair).

(V) Both the individual being tested and the collection site personnel shall keep the specimen in view at all times prior to the specimen container being sealed with a tamper-resistant seal and labeled with the individual's specimen number and other required information.

(VI) The collection site personnel shall label the container which contains the hair with the date, the individual's specimen number, and any other identifying information provided or required by the drug-testing program.

(VII) The individual shall initial the container for the purpose of certifying that it is the specimen collected from the individual.

(VIII) The collection site personnel shall indicate on the chain-of-custody form all information identifying the

specimen. The collection site personnel shall sign the chain-of-custody form next to the identifying information or the chain of custody on the specimen container.

(IX) The individual must be asked to read and sign a statement certifying that the specimen identified as having been collected from the individual is in fact that specimen the individual provided.

(X) The collection site personnel shall complete the chain-of-custody form.

g. Collection control.--To the maximum extent possible, collection site personnel shall keep the individual's specimen container within sight both before and after collection. After the specimen is collected, it must be properly sealed and labeled. An approved chain-of-custody form must be used for maintaining control and accountability of each specimen from the point of collection to final disposition of the specimen. The date and purpose must be documented on an approved chain-of-custody form each time a specimen is handled or transferred and every individual in the chain must be identified. Every effort must be made to minimize the number of persons handling specimens.

h. Transportation to the testing facility.--Collection site personnel shall arrange to transport the collected specimens to the drug-testing facility. The specimens shall be placed in containers which shall be securely sealed to eliminate the possibility of undetected tampering. The collection site personnel shall ensure that the chain-of-custody documentation is sealed separately from the specimen and placed inside the container sealed for transfer to the drug-testing facility.

4. Quality assurance and quality control.--

a. Quality assurance.--Testing facilities shall have a quality assurance program which encompasses all aspects of the testing process, including, but not limited to, specimen acquisition, chain of custody, security and reporting of results, initial and confirmatory testing, and validation of analytical procedures. Quality assurance procedures shall be designed, implemented, and reviewed to monitor the conduct of each step of the process of testing for drugs.

b. Quality control.--

(I) Each analytical run of specimens to be screened shall include:

(A) Hair specimens certified to contain no drug;

(B) Hair specimens fortified with known standards; and

(C) Positive controls with the drug or metabolite at or near the threshold (cutoff).

(II) In addition, with each batch of samples, a sufficient number of standards shall be included to ensure and document the linearity of the assay method over time in the concentration area of the cutoff. After acceptable values are obtained for the known standards, those values must be used to calculate sample data. Implementation of procedures to ensure that carryover does not contaminate the testing of an individual's specimen must be documented. A minimum of 5 percent of all test samples must be quality control specimens. The testing facility's quality control samples, prepared from fortified hair samples of determined concentration, must be included in the run and must appear as normal samples to drug-screen testing facility analysis. One percent of each run, with a minimum of at least one sample, must be the testing facility's own quality control samples.

5.a. Proficiency testing.--

(I) Each hair drug-testing facility shall enroll and demonstrate satisfactory performance in a proficiency-testing program established by an independent group.

(II) The drug-testing facility shall maintain records which document the handling, processing, and examination of all proficiency-testing samples for a minimum of 2 years from the date of testing.

(III) The drug-testing facility shall ensure that proficiency-testing samples are analyzed at least three times each year using the same techniques as those employed for unknown specimens.

(IV) The proficiency-testing samples must be included with the routine sample run and tested with the same frequency as unknown samples by the individuals responsible for testing unknown specimens.

(V) The drug-testing facility may not engage in discussions or communications concerning proficiency-testing results with other drug-testing facilities, nor may they send proficiency-testing samples or portions of the samples to another drug-testing facility for analysis.

b. Satisfactory performance.--

(I) The drug-testing facility shall maintain an overall testing-event score equivalent to passing proficiency scores for other drug-testing matrices.

(II) Failure to participate in a proficiency-testing event shall result in a score of 0 percent for that testing event.

c. Unsuccessful performance.--Failure to achieve satisfactory performance in two consecutive testing events, or two out of three consecutive testing events, is determined to be unsuccessful performance.

This section shall not be construed to eliminate the bargainable rights as provided in the collective bargaining process where applicable.

Section 3. Subsections (1) and (8) of section 154.304, Florida Statutes, are amended to read:

154.304 Definitions.--For the purpose of this act:

(1) "Agency" means the Agency for Health Care Administration~~"Board" means the Health Care Board as established in chapter 408~~.

(8) "Participating hospital" means a hospital which is eligible to receive reimbursement under the provisions of this act because it has been certified by the agency ~~board~~ as having met its charity care obligation and has either:

(a) A formal signed agreement with a county or counties to treat such county's indigent patients; or

(b) Demonstrated to the agency ~~board~~ that at least 2.5 percent of its uncompensated charity care, as reported to the board, is generated by out-of-county residents.

Section 4. Subsection (6) of section 381.026, Florida Statutes, is amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.--

(6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.--Any health care provider who treats a patient in an office or any health care facility licensed under chapter 395 that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient ~~public~~, in writing, a statement of the rights and responsibilities of patients, including:

SUMMARY OF THE FLORIDA PATIENT'S BILL
OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Section 5. Section 381.0261, Florida Statutes, is amended to read:

381.0261 ~~Distribution of~~ Summary <u>of patient's bill of rights; distribution; penalty</u>.--

<u>(1)</u> The <u>Agency for Health Care Administration</u> ~~Department of Health and Rehabilitative Services~~ shall have printed and made continuously available to health care facilities licensed under chapter 395, physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, and podiatrists licensed under chapter 461 a summary of the Florida Patient's Bill of Rights and Responsibilities. In adopting and making <u>available to</u>

patients ~~public~~ the summary of the Florida Patient's Bill of Rights and Responsibilities, health care providers and health care facilities are not limited to the format in which the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ prints and distributes the summary.

(2) Health care providers and health care facilities, if requested, shall inform patients of the address and telephone number of each state agency responsible for responding to patient complaints about a health care provider or health care facility's alleged noncompliance with state licensing requirements established pursuant to law.

(3) Health care facilities shall adopt policies and procedures to ensure that inpatients are provided the opportunity during the course of admission to receive information regarding their rights and how to file complaints with the facility and appropriate state agencies.

(4) An administrative fine may be imposed by the agency when any health care provider or health care facility fails to make available to patients a summary of their rights, pursuant to s. 381.026 and this section. Initial nonwillful violations are subject to corrective action and are not subject to an administrative fine. The agency may levy a fine of up to $5,000 for repeated nonwillful violations, and up to $25,000 for intentional and willful violations. Each intentional and willful violation constitutes a separate violation and is subject to a separate fine.

(5) In determining the amount of fine to be levied for a violation, as provided in subsection (4), the following factors shall be considered:

(a) The scope and severity of the violation, including the number of patients found to have not received notice of

patient rights, and whether the failure to provide notice to patients was willful.

(b) Actions taken by the health care provider or health care facility to correct the violations or to remedy complaints.

(c) Any previous violations of this section by the health care provider or health care facility.

Section 6. Section 381.60225, Florida Statutes, is created to read:

381.60225 Background screening.--

(1) Each applicant for certification must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the Agency for Health Care Administration shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual responsible for the daily operation of the organization, agency, or entity, and financial officer, or other similarly titled individual who is responsible for the financial operation of the organization, agency, or entity, including billings for services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The Agency for Health Care Administration may require background screening of any other individual who is an applicant if the Agency for Health Care Administration has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional certification may be granted to the organization, agency, or entity when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard certification may be granted to the organization, agency, or entity upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions,

permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) The agency may not certify any organization, agency, or entity if any applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke certification of any organization, agency, or entity if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for renewal of certification must contain the information required under paragraphs (e) and (f).

(2) An organ procurement organization, tissue bank, or eye bank certified by the Agency for Health Care Administration in accordance with ss. 381.6021 and 381.6022 is not subject to the requirements of this section if the entity has no direct patient-care responsibilities and does not bill patients or insurers directly for services under the Medicare or Medicaid programs, or for privately insured services.

Section 7. Section 383.302, Florida Statutes, is amended to read:

383.302 Definitions of terms used in ss. 383.30-383.335.--As used in ss. 383.30-383.335, ~~unless the context otherwise requires,~~ the term:

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

(2)~~(1)~~ "Birth center" means any facility, institution, or place, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

(3)~~(2)~~ "Clinical staff" means individuals employed full time or part time by a birth center who are licensed or certified to provide care at childbirth.

(4)~~(3)~~ "Consultant" means a physician licensed pursuant to chapter 458 or chapter 459 who agrees to provide advice and services to a birth center and who either:

(a) Is certified or eligible for certification by the American Board of Obstetrics and Gynecology, or

(b) Has hospital obstetrical privileges.

~~(4) "Department" means the Department of Health.~~

(5) "Governing body" means any individual, group, corporation, or institution which is responsible for the overall operation and maintenance of a birth center.

(6) "Governmental unit" means the state or any county, municipality, or other political subdivision or any department, division, board, or other agency of any of the foregoing.

(7) "Licensed facility" means a facility licensed in accordance with s. 383.305.

(8) "Low-risk pregnancy" means a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.

(9) "Person" means any individual, firm, partnership, corporation, company, association, institution, or joint stock association and means any legal successor of any of the foregoing.

(10) "Premises" means those buildings, beds, and facilities located at the main address of the licensee and all other buildings, beds, and facilities for the provision of maternity care located in such reasonable proximity to the

main address of the licensee as to appear to the public to be under the dominion and control of the licensee.

Section 8. Section 383.305, Florida Statutes, is amended to read:

383.305 Licensure; issuance, renewal, denial, suspension, revocation; fees; background screening.--

(1)(a) Upon receipt of an application for a license and the license fee, the agency ~~department~~ shall issue a license if the applicant and facility have received all approvals required by law and meet the requirements established under ss. 383.30-383.335 and by rules promulgated hereunder.

(b) A provisional license may be issued to any birth center that is in substantial compliance with ss. 383.30-383.335 and with the rules of the agency ~~department~~. A provisional license may be granted for a period of no more than 1 year from the effective date of rules adopted by the agency ~~department~~, shall expire automatically at the end of its term, and may not be renewed.

(c) A license, unless sooner suspended or revoked, automatically expires 1 year from its date of issuance and is renewable upon application for renewal and payment of the fee prescribed, provided the applicant and the birth center meet the requirements established under ss. 383.30-383.335 and by rules promulgated hereunder. A complete application for renewal of a license shall be made 90 days prior to expiration of the license on forms provided by the agency ~~department~~.

(2) An application for a license, or renewal thereof, shall be made to the agency ~~department~~ upon forms provided by it and shall contain such information as the agency ~~department~~

reasonably requires, which may include affirmative evidence of ability to comply with applicable laws and rules.

(3)(a) Each application for a birth center license, or renewal thereof, shall be accompanied by a license fee. Fees shall be established by rule of the agency ~~department~~. Such fees are payable to the agency ~~department~~ and shall be deposited in a trust fund administered by the agency ~~department~~, to be used for the sole purpose of carrying out the provisions of ss. 383.30-383.335.

(b) The fees established pursuant to ss. 383.30-383.335 shall be based on actual costs incurred by the agency ~~department~~ in the administration of its duties under such sections.

(4) Each license is valid only for the person or governmental unit to whom or which it is issued; is not subject to sale, assignment, or other transfer, voluntary or involuntary; and is not valid for any premises other than those for which it was originally issued.

(5) Each license shall be posted in a conspicuous place on the licensed premises.

(6) Whenever the agency ~~department~~ finds that there has been a substantial failure to comply with the requirements established under ss. 383.30-383.335 or in rules adopted under those sections ~~promulgated hereunder~~, it is authorized to deny, suspend, or revoke a license.

(7) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly

titled individual who is responsible for the daily operation of the center, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the center, including billings for patient care and services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which

confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the

director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

Section 9. Paragraph (a) of subsection (2) of section 383.308, Florida Statutes, is amended to read:

383.308 Birth center facility and equipment; requirements.--

(2)(a) A birth center shall be equipped with those items needed to provide low-risk maternity care and readily available equipment to initiate emergency procedures in life-threatening events to mother and baby, as defined by rule of the agency ~~department~~.

Section 10. Section 383.309, Florida Statutes, is amended to read:

383.309 Minimum standards for birth centers; rules and enforcement.--

(1) The agency ~~department~~ shall adopt~~, amend, promulgate,~~ and enforce rules to administer ss. 383.30-383.335 ~~implement the provisions of this act~~, which rules shall include, but are not limited to, reasonable and fair minimum standards for ensuring that:

(a) Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety.

(b) Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented.

(c) Construction, maintenance, repair, and renovation of licensed facilities are governed by rules of the agency ~~department~~ which use ~~utilize~~ the most recently adopted, nationally recognized codes wherever feasible. Facilities licensed under s. 383.305 are exempt from local construction standards to the extent that those standards are in conflict with the standards adopted by rule of the agency ~~department~~.

(d) Licensed facilities are established, organized, and operated consistent with established programmatic standards.

(2) Any licensed facility that ~~which~~ is in operation at the time of adoption ~~promulgation~~ of any applicable rule under ss. 383.30-383.335 shall be given a reasonable time under the particular circumstances, not to exceed 1 year after

~~from~~ the date of such adoption ~~promulgation~~, within which to comply with such rule.

Section 11. Paragraph (b) of subsection (1) and paragraph (b) of subsection (2) of section 383.31, Florida Statutes, are amended to read:

383.31 Selection of clients; informed consent.--

(1)

(b) The criteria for the selection of clients and the establishment of risk status shall be defined by rule of the agency ~~department~~.

(2)

(b) The agency ~~department~~ shall develop a client informed-consent form to be used by the center to inform the client of the benefits and risks related to childbirth outside a hospital.

Section 12. Subsection (1) of section 383.312, Florida Statutes, is amended to read:

383.312 Prenatal care of birth center clients.--

(1) A birth center shall ensure that its clients have adequate prenatal care, as defined by the agency ~~department~~, and shall ensure that serological tests are administered as required by this chapter.

Section 13. Subsection (1) of section 383.313, Florida Statutes, is amended to read:

383.313 Performance of laboratory and surgical services; use of anesthetic and chemical agents.--

(1) LABORATORY SERVICES.--A birth center may collect specimens for those tests that are requested under protocol. A birth center may perform simple laboratory tests, as defined by rule of the agency ~~department~~, and is exempt from the requirements of chapter 483, provided no more than five

physicians are employed by the birth center and testing is conducted exclusively in connection with the diagnosis and treatment of clients of the birth center.

Section 14. Subsection (1) of section 383.318, Florida Statutes, is amended to read:

383.318 Postpartum care for birth center clients and infants.--

(1) A mother and her infant shall be dismissed from the birth center within 24 hours after the birth of the infant, except in unusual circumstances as defined by rule of the agency ~~department~~. If a mother or infant is retained at the birth center for more than 24 hours after the birth, a report shall be filed with the agency ~~department~~ within 48 hours of the birth describing the circumstances and the reasons for the decision.

Section 15. Subsection (3) of section 383.32, Florida Statutes, is amended to read:

383.32 Clinical records.--

(3) Clinical records shall be kept confidential in accordance with s. 455.241 and exempt from the provisions of s. 119.07(1). A client's clinical records shall be open to inspection only under the following conditions:

(a) A consent to release information has been signed by the client; or

(b) The review is made by the agency ~~department~~ for a licensure survey or complaint investigation.

Section 16. Section 383.324, Florida Statutes, is amended to read:

383.324 Inspections and investigations; inspection fees.--

(1) The agency ~~department~~ shall make or cause to be made such inspections and investigations as it deems necessary.

(2) Each facility licensed under s. 383.305 shall pay to the agency ~~department~~, at the time of inspection, an inspection fee established by rule of the agency ~~department~~.

(3) The agency ~~department~~ shall coordinate all periodic inspections for licensure made by the agency ~~department~~ to ensure that the cost to the facility of such inspections and the disruption of services by such inspections is minimized.

Section 17. Subsection (3) of section 383.325, Florida Statutes, is amended to read:

383.325 Inspection reports.--

(3) A licensed facility shall, upon the request of any person who has completed a written application with intent to be admitted to such facility or any person who is a patient of such facility, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report issued by the agency ~~department~~ or an accrediting organization, whichever is most recent, pertaining to the licensed facility, as provided in subsection (1), provided the person requesting such report agrees to pay a reasonable charge to cover copying costs.

Section 18. Subsection (4) of section 383.327, Florida Statutes, is amended to read:

383.327 Birth and death records; reports.--

(4) A report shall be submitted annually to the agency ~~department~~. The contents of the report shall be prescribed by rule of the agency ~~department~~.

Section 19. Section 383.33, Florida Statutes, is amended to read:

383.33 Administrative penalties; emergency orders; moratorium on admissions.--

(1)(a) The agency ~~department~~ may deny, revoke, or suspend a license, or impose an administrative fine not to exceed $500 per violation per day, for the violation of any provision of ss. 383.30-383.335 or any rule adopted under ss. 383.30-383.335 ~~promulgated hereunder~~. Each day of violation constitutes a separate violation and is subject to a separate fine.

(b) In determining the amount of the fine to be levied for a violation, as provided in paragraph (a), the following factors shall be considered:

1. The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted; the severity of the actual or potential harm; and the extent to which the provisions of ss. 383.30-383.335 ~~this act~~ were violated.

2. Actions taken by the licensee to correct the violations or to remedy complaints.

3. Any previous violations by the licensee.

(c) All amounts collected pursuant to this section shall be deposited into a trust fund administered by the agency ~~department~~ to be used for the sole purpose of carrying out the provisions of ss. 383.30-383.335.

(2) The agency ~~department~~ may issue an emergency order immediately suspending or revoking a license when it determines that any condition in the licensed facility presents a clear and present danger to the public health and safety.

(3) The agency ~~department~~ may impose an immediate moratorium on elective admissions to any licensed facility, building or portion thereof, or service when the agency ~~department~~ determines that any condition in the facility presents a threat to the public health or safety.

Section 20. Section 383.331, Florida Statutes, is amended to read:

383.331 Injunctive relief.--Notwithstanding the existence or pursuit of any other remedy, the agency ~~department~~ may maintain an action in the name of the state for injunction or other process to enforce the provisions of ss. 383.30-383.335 and the rules adopted ~~promulgated~~ under such sections.

Section 21. Subsection (3) is added to section 390.015, Florida Statutes, to read:

390.015 Application for license.--

(3) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the clinic, and financial officer, or other similarly titled individual who is responsible for the financial operation of the clinic, including billings for patient care and services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been

convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435,

unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

Section 22. Subsection (5) is added to section 391.206, Florida Statutes, to read:

391.206 Initial application for license.--

(5) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the operator, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the center, including billings for patient care and services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense

prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435,

unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

Section 23. Present subsections (2) through (53) of section 393.063, Florida Statutes, are renumbered as subsections (3) through (54), respectively, and a new subsection (2) is added to that section, to read:

393.063 Definitions.--For the purposes of this chapter:

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

Section 24. Present subsections (6) through (18) of section 393.067, Florida Statutes, are renumbered as subsections (7) through (19), respectively, and a new subsection (6) is added to that section, to read:

393.067 Licensure of residential facilities and comprehensive transitional education programs.--

(6) Each applicant for licensure as an intermediate care facility for the developmentally disabled must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the facility, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the center, including billings for resident care and services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard

license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization,

receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

Section 25. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:

394.4787 Definitions.--As used in this section and ss. 394.4786, 394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(28)~~s. 395.002(27)~~as a specialty psychiatric hospital.

Section 26. Subsections (2) and (3) of section 394.4788, Florida Statutes, are amended to read:

394.4788 Use of certain PMATF funds for the purchase of acute care mental health services.--

(2) ~~By October 1, 1989, and annually thereafter,~~The agency shall annually calculate a per diem reimbursement rate for each specialty psychiatric hospital to be paid to the specialty psychiatric hospitals for the provision of acute mental health services provided to indigent mentally ill patients who meet the criteria in subsection (1). After the first rate period, providers shall be notified of new reimbursement rates for each new state fiscal year by June 1. The new reimbursement rates shall commence July 1.

(3) Reimbursement rates shall be calculated using the most recent audited actual costs received by the agency. Cost data received ~~as of August 15, 1989, and~~ each April 15 ~~thereafter~~ shall be used in the calculation of the rates. Historic costs shall be inflated from the midpoint of a hospital's fiscal year to the midpoint of the state fiscal year. The inflation adjustment shall be made utilizing the latest available projections as of March 31 for the Data Resources Incorporated National and Regional Hospital Input Price Indices as calculated by the Medicaid program office.

Section 27. Section 394.67, Florida Statutes, is amended to read:

394.67 Definitions.--As ~~When~~ used in this part, ~~unless the context clearly requires otherwise,~~the term:

(1) "Advisory council" means a district advisory council.

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

~~(2) "Alcohol, drug abuse, and mental health planning council" or "council" means the council within a Department of Health and Rehabilitative Services district or subdistrict established in accordance with the provisions of this part for the purpose of assessing the alcohol, drug abuse, and mental health needs of the community and developing a plan to address those needs.~~

(3) "Applicant" means an individual applicant, or any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder having an ownership interest equal to a 5-percent or greater interest in the corporation, partnership, or other business entity.

(4) "Client" means any individual receiving services in any alcohol, drug abuse, or mental health facility, program, or service, which facility, program, or service is operated, funded, or regulated by the agency and the department or regulated by the agency.

(5) "Crisis stabilization unit" means a program that provides an alternative to inpatient hospitalization and that provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state.

(6)~~(3)~~ "Department" means the Department of Children and Family ~~Health and Rehabilitative~~ Services.

(7) "Director" means any member of the official board of directors reported in the organization's annual corporate report to the Florida Department of State, or, if no such

report is made, any member of the operating board of directors. The term excludes members of separate, restricted boards that serve only in an advisory capacity to the operating board.

(8)~~(4)~~ "District administrator" means the person appointed by the Secretary of Children and Family ~~Health and Rehabilitative~~ Services for the purpose of administering a department service district as set forth in s. 20.19.

(9)~~(5)~~ "District plan" or "plan" means the combined district alcohol, drug abuse, and mental health plan ~~prepared by the alcohol, drug abuse, and mental health planning council and~~ approved by the district administrator and governing bodies in accordance with this part.

(10)~~(6)~~ "Federal funds" means funds from federal sources for alcohol, drug abuse, or mental health facilities and programs, exclusive of federal funds that are deemed eligible by the Federal Government, and are eligible through state regulation, for matching purposes.

(11)~~(7)~~ "Governing body" means the chief legislative body of a county, a board of county commissioners, or boards of county commissioners in counties acting jointly, or their counterparts in a charter government.

(12) "Licensed facility" means a facility licensed in accordance with this chapter.

(13)~~(8)~~ "Local matching funds" means funds received from governing bodies of local government, including city commissions, county commissions, district school boards, special tax districts, private hospital funds, private gifts, both individual and corporate, and bequests and funds received from community drives or any other sources.

(14) "Managing employee" means the administrator or other similarly titled individual who is responsible for the daily operation of the facility.

(15)~~(9)~~ "Patient fees" means compensation received by a community alcohol, drug abuse, or mental health facility for services rendered to clients from any source of funds, including city, county, state, federal, and private sources.

(16) "Premises" means those buildings, beds, and facilities located at the main address of the licensee and all other buildings, beds, and facilities for the provision of acute or residential care which are located in such reasonable proximity to the main address of the licensee as to appear to the public to be under the dominion and control of the licensee.

(17)~~(10)~~ "Program office" means the Alcohol, Drug Abuse, and Mental Health Program Office of the Department of Children and Family ~~Health and Rehabilitative~~ Services.

(18) "Residential treatment facility" means a facility providing residential care and treatment to individuals exhibiting symptoms of mental illness who are in need of a 24-hour-per-day, 7-day-a-week structured living environment, respite care, or long-term community placement. The term also includes short-term residential treatment facilities for treatment of mental illness.

(19)~~(11)~~ "Service district" means a community service district as established by the department under s. 20.19 for the purpose of providing community alcohol, drug abuse, and mental health services.

(20)~~(12)~~ "Service provider" means any agency in which all or any portion of the programs or services set forth in s. 394.675 are carried out.

~~(13) "Crisis stabilization unit" means a program providing an alternative to inpatient hospitalization and which provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state.~~

~~(14) "Residential treatment facility" means a facility providing residential care and treatment to individuals exhibiting symptoms of mental illness who are in need of a 24-hour, 7-day-a-week structured living environment, respite care, or long-term community placement. Residential treatment facility shall also include short-term residential treatment facilities for treatment of mental illness.~~

~~(15) "Licensed facility" means a facility licensed in accordance with this chapter.~~

~~(16) "Premises" means those buildings, beds, and facilities located at the main address of the licensee and all other buildings, beds, and facilities for the provision of acute or residential care located in such reasonable proximity to the main address of the licensee as to appear to the public to be under the dominion and control of the licensee.~~

~~(17) "Client" means any individual receiving services in any alcohol, drug abuse, or mental health facility, program, or service, which facility, program, or service is operated, funded, or regulated by the Department of Health and Rehabilitative Services.~~

Section 28. Section 394.875, Florida Statutes, is amended to read:

394.875 Crisis stabilization units and residential treatment facilities; authorized services; license required; penalties.--

(1)(a) The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay and shall be limited in size to a maximum of 30 beds.

(b) The purpose of a residential treatment facility is to be a part of a comprehensive treatment program for mentally ill individuals in a community-based residential setting.

(2) ~~After July 1, 1986,~~It is unlawful for any entity to hold itself out as a crisis stabilization unit or a residential treatment facility, or to act as a crisis stabilization unit or a residential treatment facility, unless it is licensed by the agency ~~department~~ pursuant to this chapter.

(3) Any person who violates subsection (2) is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(4) The agency ~~department~~ may maintain an action in circuit court to enjoin the unlawful operation of a crisis stabilization unit or a residential treatment facility if the agency ~~department~~ first gives the violator 14 days' notice of its intention to maintain such action and if the violator fails to apply for licensure within such 14-day period.

(5) Subsection (2) does not apply to:

(a) Homes for special services licensed under chapter 400;

(b) Nursing homes licensed under chapter 400; or

(c) Residential child caring facilities licensed under s. 409.175.

(6) The agency ~~department~~ may establish multiple license classifications for residential treatment facilities.

(7) The agency may ~~department shall~~ not issue a license to a crisis stabilization unit unless the unit receives state mental health funds and is affiliated with a designated public receiving facility.

(8) The agency ~~department~~ may issue a license for a crisis stabilization unit or short-term residential treatment facility, certifying the number of authorized beds for such facility as indicated by existing need and available appropriations. The agency ~~department~~ may disapprove an application for such a license if it determines that a facility should not be licensed pursuant to the provisions of this chapter. Any facility operating beds in excess of those authorized by the agency ~~department~~ shall, upon demand of the agency ~~department~~, reduce the number of beds to the authorized number, forfeit its license, or provide evidence of a license issued pursuant to chapter 395 for the excess beds.

(9) A children's crisis stabilization unit which does not exceed 20 licensed beds and which provides separate facilities or a distinct part of a facility, separate staffing, and treatment exclusively for minors may be located on the same premises as a crisis stabilization unit serving adults. The agency ~~department~~ shall adopt ~~promulgate~~ rules governing facility construction, staffing and licensure requirements, and the operation of such units for minors.

(10) Notwithstanding the provisions of subsection (8), crisis stabilization units may not exceed their licensed capacity by more than 10 percent, nor may they exceed their licensed capacity for more than 3 consecutive working days or for more than 7 days in 1 month.

(11) Notwithstanding the other provisions of this section, any facility licensed under chapters 396 and 397 for detoxification, residential level I care, and outpatient treatment may elect to license concurrently all of the beds at such facility both for that purpose and as a long-term residential treatment facility pursuant to this section, if all of the following conditions are met:

(a) The licensure application is received by the department prior to January 1, 1993.

(b) On January 1, 1993, the facility was licensed under chapters 396 and 397 as a facility for detoxification, residential level I care, and outpatient treatment of substance abuse.

(c) The facility restricted its practice to the treatment of law enforcement personnel for a period of at least 12 months beginning after January 1, 1992.

(d) The number of beds to be licensed under chapter 394 is equal to or less than the number of beds licensed under chapters 396 and 397 as of January 1, 1993.

(e) The licensee agrees in writing to a condition placed upon the license that the facility will limit its treatment exclusively to law enforcement personnel and their immediate families who are seeking admission on a voluntary basis and who are exhibiting symptoms of posttraumatic stress disorder or other mental health problems, including drug or alcohol abuse, which are directly related to law enforcement

work and which are amenable to verbal treatment therapies; the licensee agrees to coordinate the provision of appropriate postresidential care for discharged individuals; and the licensee further agrees in writing that a failure to meet any condition specified in this paragraph shall constitute grounds for a revocation of the facility's license as a residential treatment facility.

(f) The licensee agrees that the facility will meet all licensure requirements for a residential treatment facility, including minimum standards for compliance with lifesafety requirements, except those licensure requirements which are in express conflict with the conditions and other provisions specified in this subsection.

(g) The licensee agrees that the conditions stated in this subsection must be agreed to in writing by any person acquiring the facility by any means.

Any facility licensed under this subsection is not required to provide any services to any persons except those included in the specified conditions of licensure, and is exempt from any requirements related to the 60-day or greater average length of stay imposed on community-based residential treatment facilities otherwise licensed under this chapter.

(12) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee and financial officer, or other similarly titled individual who is responsible for the financial operation of the facility,

including billings for client care and services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other healthcare licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her

capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

Section 29. Section 394.876, Florida Statutes, is amended to read:

394.876 Applications.--

(1) Any person desiring to be licensed under this chapter shall apply to the agency ~~department~~ on forms provided by the agency ~~department~~. The application shall contain the following:

(a) The name and address of the applicant, the name of the unit or facility, and the address of the unit or facility.

(b)1. If the applicant is a partnership, association, or other form of entity other than an individual or a corporation, the name and address of each member or owner of the entity.

2. If the applicant is a corporation, the name and address of each director or officer and the name and address of each person holding at least 5 ~~10~~ percent ownership interest in the corporation.

~~(c) Such information as the department determines to be necessary to establish the character and competency of the applicant and of the person who is or will be administrator of the unit or facility.~~

(c)~~(d)~~ Such information as the agency ~~department~~ determines necessary to determine the ability of the applicant to carry out its responsibilities under this chapter.

(2) The applicant shall furnish proof satisfactory to the agency ~~department~~ of its financial ability to operate the unit or facility in accordance with this chapter. An applicant for an original license shall submit a balance sheet and a statement projecting revenues, expenses, taxes, extraordinary items, and other credits and charges for the first 6 months of operation.

(3) The applicant shall provide proof of liability insurance coverage in amounts set by the agency ~~department~~ by rule.

(4) The agency ~~department~~ shall accept proof of accreditation by the Joint Commission on Accreditation of Hospitals in lieu of the information required by subsection (1).

Section 30. Subsection (1) of section 394.877, Florida Statutes, is amended to read:

394.877 Fees.--

(1) Each application for licensure or renewal shall be accompanied by a fee set by the agency ~~department~~ by rule.

Such fees shall be reasonably calculated to cover only the cost of regulation under this chapter.

Section 31. Subsections (1), (2), (5), and (6) of section 394.878, Florida Statutes, are amended to read:

394.878 Issuance and renewal of licenses.--

(1) Upon review of the application for licensure and receipt of appropriate fees, the agency ~~department~~ shall issue an original or renewal license to any applicant that meets the requirements of this chapter.

(2) A license is valid for a period of 1 year. An applicant for renewal of a license shall apply to the agency ~~department~~ no later than 90 days before expiration of the current license.

(5) The agency ~~department~~ may issue a probationary license to an applicant that has completed the application requirements of this chapter but has not, at the time of the application, developed an operational crisis stabilization unit or residential treatment facility. The probationary license shall expire 90 days after issuance and may once be renewed for an additional 90-day period. The agency ~~department~~ may cancel a probationary license at any time.

(6) The agency ~~department~~ may issue an interim license to an applicant that has substantially completed all application requirements and has initiated action to fully meet such requirements. The interim license shall expire 90 days after issuance and, in cases of extreme hardship, may once be renewed for an additional 90-day period.

Section 32. Section 394.879, Florida Statutes, is amended to read:

394.879 Rules; enforcement.--

(1) The agency ~~department~~ shall adopt reasonable rules to implement this chapter, including, at a minimum, rules providing standards to ensure that:

(a) Sufficient numbers and types of qualified personnel are on duty and available at all times to provide necessary and adequate client safety and care.

(b) Adequate space is provided each client of a licensed facility.

(c) Licensed facilities are limited to an appropriate number of beds.

(d) Each licensee establishes and implements adequate infection control, housekeeping, sanitation, disaster planning, and medical recordkeeping.

(e) Licensed facilities are established, organized, and operated in accordance with programmatic standards of the agency ~~department~~.

(2) Minimum firesafety standards shall be established and enforced by the State Fire Marshal in cooperation with the agency ~~department~~. Such standards shall be included in the rule adopted by the agency ~~department~~ after consultation with the State Fire Marshal.

(3) The agency ~~department~~ shall allow any licensed facility in operation at the time of adoption of any rule a reasonable period, not to exceed 1 year, to bring itself into compliance with such rule.

(4) The agency ~~department~~ may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend or revoke the license or deny the renewal application of such licensee. In imposing such penalty, the agency ~~department~~ shall consider the severity of the violation,

actions taken by the licensee to correct the violation, and previous violations by the licensee. Fines collected under this subsection shall be deposited in the Mental Health Facility Licensing Trust Fund.

Section 33. Section 394.90, Florida Statutes, is amended to read:

394.90 Inspection; right of entry; records.--

(1)(a) The agency ~~department~~ may enter and inspect at any time a licensed facility to determine whether the facility is in compliance with this chapter and the rules of the agency ~~department~~.

(b) The agency ~~department~~ may enter and inspect any premises that it has probable cause to suspect may be operating as an unlicensed crisis stabilization unit or residential treatment facility; however, such entry and inspection shall be made only with the permission of the person in charge of such premises or pursuant to warrant.

(c) Any application for licensure under this chapter constitutes full permission for the agency ~~department~~ to enter and inspect the premises of the applicant or licensee at any time.

(2) For purposes of monitoring and investigation, the department and the Agency for Health Care Administration shall have access to the clinical records of any client of a licensee or designated facility, the provisions of s. 394.4615 to the contrary notwithstanding.

(3) The agency ~~department~~ shall schedule periodic inspections of licensees so as to minimize the cost to the licensees and the disruption of the licensees' programs. This subsection shall not be construed to limit the authority of

the agency ~~department~~ to inspect the facilities of a licensee at any time.

(4) Each licensee shall maintain as public information, available to any person upon request, copies of all reports of inspections of the licensee filed with or issued by any governmental agency during the preceding 5-year period. The licensee shall furnish a copy of the most recent inspection report of the agency ~~department~~ to any person upon payment of a reasonable charge for copying.

(5)(a) The agency ~~department~~ may accept, in lieu of its own inspections for licensure, the survey or inspection of an accrediting organization, if the provider is accredited and the agency ~~department~~ receives the report of the accrediting organization. The agency ~~department~~ shall develop, and adopt by rule, specific criteria for assuring that the accrediting organization has specific standards and experience related to the program area being licensed, specific criteria for accepting the standards and survey methodologies of an accrediting organization, delineations of the obligations of accrediting organizations to assure adherence to those standards, criteria for receiving, accepting and maintaining the confidentiality of the survey and corrective action reports, and allowance for the agency's ~~department's~~ participation in surveys.

(b) The agency ~~department~~ shall conduct compliance investigations and sample validation inspections to evaluate the inspection process of accrediting organizations to ensure minimum standards are maintained as provided in Florida statute and rule. The agency ~~department~~ may conduct a lifesafety inspection in calendar years in which an accrediting organization survey is not conducted and shall

conduct a full state inspection, including a lifesafety inspection, if an accrediting organization survey has not been conducted within the previous 36 months. The agency ~~department~~, by accepting the survey or inspection of an accrediting organization, does not forfeit its right to perform inspections.

Section 34. Section 394.902, Florida Statutes, is amended to read:

394.902 Denial, suspension, and revocation; other remedies.--

(1) The agency ~~department~~ may issue an emergency order suspending or revoking a license if the agency ~~department~~ determines that the continued operation of the licensed facility presents a clear and present danger to the public health or safety.

(2) The agency ~~department~~ may impose a moratorium on elective admissions to a licensee or any program or portion of a licensed facility if the agency ~~department~~ determines that any condition in the facility presents a threat to the public health or safety.

(3) If the agency ~~department~~ determines that an applicant or licensee is not in compliance with this chapter or the rules adopted under this chapter, the agency ~~department~~ may deny, suspend, or revoke the license or application or may suspend, revoke, or impose reasonable restrictions on any portion of the license. If a license is revoked, the licensee is barred from submitting any application for licensure to the agency ~~department~~ for a period of 6 months following revocation.

(4) The agency ~~department~~ may maintain an action in circuit court to enjoin the operation of any licensed or

unlicensed facility in violation of this chapter or the rules adopted under this chapter.

(5) License denial, suspension, or revocation procedures shall be in accordance with chapter 120.

Section 35. Subsections (1) and (2) of section 394.903, Florida Statutes, are amended to read:

394.903 Receivership proceedings.--

(1) The agency ~~department~~ may petition a court of competent jurisdiction for the appointment of a receiver for a crisis stabilization unit or a residential treatment facility when any of the following conditions exist:

(a) Any person is operating a unit or facility without a license and refuses to make application for a license as required by this part.

(b) The licensee is closing the unit or facility or has informed the agency ~~department~~ that it intends to close and adequate arrangements have not been made for relocation of the residents within 7 days, exclusive of weekends and holidays, of the closing of the unit or facility.

(c) The agency ~~department~~ determines that conditions exist in the unit or facility which present an imminent danger to the health, safety, or welfare of the residents of the unit or facility or a substantial probability that death or serious physical harm would result therefrom. The agency ~~department~~ shall, whenever possible, facilitate the continued operation of the program.

(d) The licensee cannot meet its financial obligations for providing food, shelter, care, and utilities. Issuance of bad checks or accumulation of delinquent bills for such items as personnel salaries, food, drugs, or utilities constitutes ~~shall constitute~~ prima facie evidence that the ownership of

the unit or facility lacks the financial ability to operate the unit or facility in accordance with the requirements of this chapter and all rules adopted under this chapter ~~hereunder~~.

(2) Petitions for receivership shall take precedence over other court business unless the court determines that some other pending proceeding, having similar statutory precedence, shall have priority. A hearing shall be conducted within 5 days after ~~of~~ the filing of the petition, at which time all interested parties shall have the opportunity to present evidence pertaining to the petition. The agency ~~department~~ shall notify the owner or operator of the unit or facility named in the petition of its filing and the dates for the hearing. The court shall grant the petition only upon finding that the health, safety, and welfare of residents of the unit or facility would be threatened if a condition existing at the time the petition was filed is permitted to continue. A receiver shall not be appointed ex parte unless the court determines that one or more of the conditions of subsection (1) exist and that the owner or operator cannot be found, that all reasonable means of locating the owner or operator and notifying him or her of the petition and hearing have been exhausted, or that the owner or operator after notification of the hearing chooses not to attend. After such findings, the court may appoint any person qualified by education, training, or experience to carry out the responsibilities of receiver pursuant to this section, except that it shall not appoint any owner or affiliate of the unit or facility which is in receivership. Prior to the appointment as receiver of a person who is the operator, manager, or supervisor of another unit or facility, the court

shall determine that the person can reasonably operate, manage, or supervise more than one unit or facility. The receiver may be appointed for up to 90 days, with the option of petitioning the court for 30-day extensions. The receiver may be selected from a list of persons qualified to act as receivers developed by the agency ~~department~~ and presented to the court with each petition for receivership. ~~Under no circumstances shall~~ The agency, ~~department~~ or a designated ~~departmental~~ employee of the agency, may not be appointed as a receiver for more than 60 days; however, such ~~the departmental~~ receiver may petition the court for 30-day extensions. The agency ~~department~~ may petition the court to appoint a substitute receiver. The court shall grant the extension upon a showing of good cause. During the first 60 days of the receivership, the agency may ~~department shall~~ not take action to decertify or revoke the license of a unit or facility unless conditions causing imminent danger to the health and welfare of the residents exist and a receiver has been unable to remove those conditions. After the first 60 days of receivership, and every 60 days thereafter until the receivership is terminated, the agency ~~department~~ shall submit to the court the results of an assessment of the unit's or facility's ability to assure the safety and care of the residents. If the conditions at the unit or facility or the intentions of the owner indicate that the purpose of the receivership is to close the unit or facility rather than to facilitate its continued operations, the agency ~~department~~ shall place the residents in appropriate alternative residential settings as quickly as possible. If, in the opinion of the court, the agency ~~department~~ has not been diligent in its efforts to make adequate placement

arrangements, the court may find the agency ~~department~~ to be in contempt and shall order the agency ~~department~~ to submit its plans for moving the residents.

Section 36. Section 394.904, Florida Statutes, is amended to read:

394.904 Mental Health Facility Licensing Trust Fund.--There is created in the State Treasury the Mental Health Facility Licensing Trust Fund. All moneys collected by the agency ~~department~~ pursuant to this chapter shall be deposited in the trust fund. Moneys in the trust fund shall be appropriated to the agency ~~department~~ for the purpose of covering the cost of regulation of facilities licensed under this chapter and any other purpose related to enforcement of this chapter.

Section 37. Subsections (1), (2), (3), (7), (8), and (9) of section 394.907, Florida Statutes, are amended to read:

394.907 Community mental health centers; quality assurance programs.--

(1) As used in this section, the term "community mental health center" means a publicly funded, not-for-profit center that ~~which~~ contracts with the agency ~~department~~ for the provision of inpatient, outpatient, day treatment, or emergency services.

(2) ~~Effective April 1, 1989,~~Any community mental health center and any facility licensed pursuant to s. 394.875 shall have an ongoing quality assurance program. The purpose of the quality assurance program shall be to objectively and systematically monitor and evaluate the appropriateness and quality of client care, to ensure that services are rendered consistent with reasonable, prevailing professional standards and to resolve identified problems.

(3) Each facility shall develop a written plan that ~~which~~ addresses the minimum guidelines for the quality assurance program. Such guidelines shall include, but are not limited to:

(a) Standards for the provision of client care and treatment practices;

(b) Procedures for the maintenance of client records;

(c) Policies and procedures for staff development;

(d) Standards for facility safety and maintenance;

(e) Procedures for peer review and resource utilization;

(f) Policies and procedures for adverse incident reporting to include verification of corrective action to remediate or minimize incidents and for reporting such incidents to the agency ~~department~~ by a timeframe as prescribed by rule.

Such plan shall be submitted to the governing board for approval and a copy provided to the agency ~~department~~.

(7) The agency ~~department~~ shall have access to all records necessary to determine agency compliance with the provisions of this section. The records of quality assurance programs which relate solely to actions taken in carrying out the provisions of this section, and records obtained by the agency ~~department~~ to determine ~~agency~~ compliance with ~~the provisions of~~ this section, are confidential and exempt from ~~the provisions of~~ s. 119.07(1). Such records are not admissible in any civil or administrative action, except in disciplinary proceedings by the Department of Business and Professional Regulation and the appropriate regulatory board, nor shall such records be available to the public as part of

the record of investigation for, and prosecution in disciplinary proceedings made available to the public by the Department of Business and Professional Regulation or the appropriate regulatory board. Meetings or portions of meetings of quality assurance program committees that relate solely to actions taken pursuant to this section are exempt from ~~the provisions of~~ s. 286.011.

(8) The agency ~~department~~ shall adopt ~~promulgate~~ rules to carry out ~~the provisions of~~ this section.

(9) ~~The provisions of~~ This section does ~~shall~~ not apply to hospitals licensed pursuant to chapter 395 or programs operated within such hospitals.

Section 38. Section 395.002, Florida Statutes, is amended to read:

395.002 Definitions.--As used in this chapter:

(1) "Accrediting organizations" means the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care, Inc.

~~(2) "Adverse or untoward incident," for purposes of reporting to the agency, means an event over which health care personnel could exercise control, which is probably associated in whole or in part with medical intervention rather than the condition for which such intervention occurred, and which causes injury to a patient, and which:~~

~~(a) Is not consistent with or expected to be a consequence of such medical intervention;~~

~~(b) Occurs as a result of medical intervention to which the patient has not given his or her informed consent;~~

~~(c) Occurs as the result of any other action or lack of any other action on the part of the hospital or personnel of the hospital;~~

~~(d) Results in a surgical procedure being performed on the wrong patient; or~~

~~(e) Results in a surgical procedure being performed that is unrelated to the patient's diagnosis or medical needs.~~

(2)~~(3)~~ "Agency" means the Agency for Health Care Administration.

(3)~~(4)~~ "Ambulatory surgical center" means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003.

(4) "Applicant" means an individual applicant, or any officer, director, or agent, or any partner or shareholder having an ownership interest equal to a 5-percent or greater interest in the corporation, partnership, or other business entity.

(5) "Biomedical waste" means any solid or liquid waste as defined in s. 381.0098(2)(a).

(6) "Clinical privileges" means the privileges granted to a physician or other licensed health care practitioner to render patient care services in a hospital, but does not include the privilege of admitting patients.

(7) "Department" means the Department of Health ~~and Rehabilitative Services~~.

(8) "Director" means any member of the official board of directors as reported in the organization's annual corporate report to the Florida Department of State, or, if no such report is made, any member of the operating board of directors. The term excludes members of separate, restricted boards that serve only in an advisory capacity to the operating board.

(9)~~(8)~~ "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(10)~~(9)~~ "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(11)~~(10)~~ "General hospital" means any facility which meets the provisions of subsection(13)~~(12)~~and which regularly makes its facilities and services available to the general population.

(12)~~(11)~~ "Governmental unit" means the state or any county, municipality, or other political subdivision, or any department, division, board, or other agency of any of the foregoing.

(13)~~(12)~~ "Hospital" means any establishment that:

(a) Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and

(b) Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent.

However, the provisions of this chapter do not apply to any institution conducted by or for the adherents of any well-recognized church or religious denomination that depends

exclusively upon prayer or spiritual means to heal, care for, or treat any person. For purposes of local zoning matters, the term "hospital" includes a medical office building located on the same premises as a hospital facility, provided the land on which the medical office building is constructed is zoned for use as a hospital; provided the premises were zoned for hospital purposes on January 1, 1992.

(14)~~(13)~~ "Hospital bed" means a hospital accommodation which is ready for immediate occupancy, or is capable of being made ready for occupancy within 48 hours, excluding provision of staffing, and which conforms to minimum space, equipment, and furnishings standards as specified by rule of the department for the provision of services specified in this section to a single patient.

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

~~(15) "Injury," for purposes of reporting to the agency, means any of the following outcomes if caused by an adverse or untoward incident:~~

~~(a) Death;~~

~~(b) Brain damage;~~

~~(c) Spinal damage;~~

~~(d) Permanent disfigurement;~~

~~(e) Fracture or dislocation of bones or joints;~~

~~(f) Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition;~~

~~(g) Any condition requiring surgical intervention to correct or control;~~

~~(h) Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care;~~

~~(i) Any condition that extends the patient's length of stay; or~~

~~(j) Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.~~

(16) "Intensive residential treatment programs for children and adolescents" means a specialty hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations which provides 24-hour care and which has the primary functions of diagnosis and treatment of patients under the age of 18 having psychiatric disorders in order to restore such patients to an optimal level of functioning.

(17) "Licensed facility" means a hospital or ambulatory surgical center licensed in accordance with this chapter.

(18) "Lifesafety" means the control and prevention of fire and other life-threatening conditions on a premises for the purpose of preserving human life.

(19) "Managing employee" means the administrator or other similarly titled individual who is responsible for the daily operation of the facility.

(20)~~(19)~~ "Medical staff" means physicians licensed under chapter 458 or chapter 459 with privileges in a licensed facility, as well as other licensed health care practitioners

with clinical privileges as approved by a licensed facility's governing board.

(21)~~(20)~~ "Medically necessary transfer" means a transfer made necessary because the patient is in immediate need of treatment for an emergency medical condition for which the facility lacks service capability or is at service capacity.

(22)~~(21)~~ "Person" means any individual, partnership, corporation, association, or governmental unit.

(23)~~(22)~~ "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital or ambulatory surgical care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee.

(24)~~(23)~~ "Private review agent" means any person or entity which performs utilization review services for third-party payors on a contractual basis for outpatient or inpatient services. However, the term shall not include full-time employees, personnel, or staff of health insurers, health maintenance organizations, or hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, when performing utilization review for their respective hospitals, health maintenance organizations, or insureds of the same insurance group. For this purpose, health insurers, health maintenance organizations, and hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, include such entities engaged as administrators of self-insurance as defined in s. 624.031.

(25)~~(24)~~ "Service capability" means all services offered by the facility where identification of services offered is evidenced by the appearance of the service in a patient's medical record or itemized bill.

(26)~~(25)~~ "At service capacity" means the temporary inability of a hospital to provide a service which is within the service capability of the hospital, due to maximum use of the service at the time of the request for the service.

(27)~~(26)~~ "Specialty bed" means a bed, other than a general bed, designated on the face of the hospital license for a dedicated use.

(28)~~(27)~~ "Specialty hospital" means any facility which meets the provisions of subsection(13)~~(12)~~, and which regularly makes available either:

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

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

(c) Intensive residential treatment programs for children and adolescents as defined in subsection (16).

(29)~~(28)~~ "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the patient from a hospital.

(30)~~(29)~~ "Utilization review" means a system for reviewing the medical necessity or appropriateness in the

allocation of health care resources of hospital services given or proposed to be given to a patient or group of patients.

(31)~~(30)~~ "Utilization review plan" means a description of the policies and procedures governing utilization review activities performed by a private review agent.

(32)~~(31)~~ "Validation inspection" means an inspection of the premises of a licensed facility by the agency to assess whether a review by an accrediting organization has adequately evaluated the licensed facility according to minimum state standards.

Section 39. Section 395.0055, Florida Statutes, is created to read:

395.0055 Background screening.--Each applicant for licensure must comply with the following requirements:

(1) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the managing employee in accordance with the level 2 standards for screening set forth in chapter 435.

(2) The agency may require background screening for a member of the board of directors of the licensee, or an officer or an individual owning 5 percent or more of the licensee, if the agency reasonably suspects that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(3) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of subsection (1).

(4) A provisional license may be granted to an applicant when each individual required by this section to

undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation; however, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(5) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(6) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a

member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement shall not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this subsection.

(7) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(8) The agency may deny or revoke licensure if the applicant:

(a) Has falsely represented a material fact in the application required by subsection (5) or subsection (6), or has omitted any material fact from the application required by subsection (5) or subsection (6); or

(b) Has had prior Medicaid or Medicare action taken against the applicant as set forth in subsection (5).

(9) An application for license renewal must contain the information required under subsections (5) and (6).

Section 40. Subsection (1) of section 395.0163, Florida Statutes, is amended to read:

395.0163 Construction inspections; plan submission and approval; fees.--

(1)(a) The agency shall make, or cause to be made, such construction inspections and investigations as it deems necessary. The agency may prescribe by rule that any licensee or applicant desiring to make specified types of alterations or additions to its facilities or to construct new facilities shall, before commencing such alteration, addition, or new construction, submit plans and specifications therefor to the agency for preliminary inspection and approval or recommendation with respect to compliance with agency rules and standards. The agency shall approve or disapprove the plans and specifications within 60 days after receipt of the fee for review of plans as required in subsection (2). The agency may be granted one 15-day extension for the review period if the director of the agency approves the extension. If the agency fails to act within the specified time, it shall be deemed to have approved the plans and specifications. When the agency disapproves plans and specifications, it shall set forth in writing the reasons for its disapproval. Conferences and consultations may be provided as necessary.

(b) All outpatient facilities that provide surgical treatments requiring general anesthesia or IV conscious sedation, that provide cardiac catheterization services, or that are to be licensed as ambulatory surgical centers shall submit plans and specifications to the agency for review under this section. All other outpatient facilities must be

reviewed under this section, except that those that are physically detached from, and have no utility connections with, the hospital and that do not block emergency egress from or create a fire hazard to the hospital are exempt from review under this section. This section applies to applications for which review is pending on or after July 1, 1998.

Section 41. Section 395.0193, Florida Statutes, is amended to read:

395.0193 Licensed facilities; peer review; disciplinary powers; agency or partnership with physicians.--

(1) It is the intent of the Legislature that good faith participants in the process of investigating and disciplining physicians pursuant to the state-mandated peer review process shall, in addition to receiving immunity from retaliatory tort suits pursuant to s. 455.225(12), be protected from federal antitrust suits filed under the Sherman Anti-Trust Act, 15 U.S.C.A. ss. 1 et seq. Such intent is within the public policy of the state to secure the provision of quality medical services to the public.

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

(a) A mechanism for choosing the membership of the body or bodies that conduct peer review.

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

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

(d) A mechanism to identify and avoid any conflict of interest on the part of the peer review panel members.

(e) Recording of agendas and minutes that ~~which~~ do not contain confidential material, for review by the Division of Health Quality Assurance of the agency.

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

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

(3) If reasonable belief exists that conduct by a staff member or physician who delivers health care services at the licensed facility may constitute one or more grounds for discipline as provided in this subsection, a peer review panel shall investigate and determine whether grounds for discipline exist with respect to such staff member or physician. The governing board of any licensed facility, after considering the recommendations of its peer review panel, shall suspend, deny, revoke, or curtail the privileges, or reprimand, counsel, or require education, of any such staff member or physician after a final determination has been made that one or more of the following grounds exist:

(a) Incompetence.

(b) Being found to be a habitual user of intoxicants or drugs to the extent that he or she is ~~deemed~~ dangerous to himself, herself, or others.

(c) Mental or physical impairment that could ~~which may~~ adversely affect patient care.

(d) Being found liable by a court of competent jurisdiction for medical negligence or malpractice involving negligent conduct.

(e) One or more settlements exceeding $10,000 for medical negligence or malpractice involving negligent conduct by the staff member.

(f) Medical negligence other than as specified in paragraph (d) or paragraph (e).

(g) Failure to comply with the policies, procedures, or directives of the risk management program or any quality assurance committees of any licensed facility.

However, the grounds specified in paragraphs (a)-(g) are not the only grounds for discipline of a practitioner.~~procedures for such actions shall comply with the standards outlined by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, the Accreditation Association for Ambulatory Health Care, Inc., and the "Medicare/Medicaid Conditions of Participation," and rules of the agency and the department. The procedures shall be adopted pursuant to hospital bylaws.~~

(4) Pursuant to ss. 458.337 and 459.016, any disciplinary action taken under subsection (3) shall be reported in writing to the Division of Health Quality Assurance of the agency within 30 working days after its initial occurrence, regardless of the pendency of appeals to the governing board of the hospital. The notification shall identify the disciplined practitioner, the action taken, and the reason for such action.All final disciplinary actions taken under subsection (3), if different from those that were reported to the agency within 30 days after the initial occurrence, must ~~shall~~ be reported within 10 working days to the Division of Health Quality Assurance of the agency in

writing and must ~~shall~~ specify the disciplinary action taken and the specific grounds therefor. The division shall review each report and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case s. 455.225 shall apply. These reports are ~~The report shall~~ not ~~be~~ subject to inspection under s. 119.07(1) even if the division's investigation results in a finding of probable cause.

(5) There is ~~shall be~~ no monetary liability on the part of, and no cause of action for damages against, any licensed facility, its governing board or governing board members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, or employees; a committee of a hospital, a physician-hospital organization, or an integrated delivery system; ~~,~~ or any other person, for any action taken without intentional fraud in carrying out the provisions of this section.

(6) For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency shall first seek to obtain corrective action by the facility. If correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section, the agency may impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of this section. The administrative fine for repeated nonwillful violations may not exceed $10,000 for any violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation, per day. A fine for an intentional and willful violation of this section may not exceed $250,000. In determining the amount of

fine to be levied, the agency shall be guided by s. 395.1065(2)(b).

(7)~~(6)~~ The proceedings and records of peer review panels, committees, and governing boards or agent thereof which relate solely to actions taken in carrying out this section are not subject to inspection under s. 119.07(1); and meetings held pursuant to achieving the objectives of such panels, committees, and governing boards are not open to the public under the provisions of chapter 286.

(8)~~(7)~~ The investigations, proceedings, and records of the peer review panel, a committee of a hospital, a physician-hospital organization, an integrated delivery system, a disciplinary board, or a governing board, or agent thereof with whom there is a specific written contract for that purpose, as described in this section are ~~shall~~ not ~~be~~ subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services arising out of the matters that ~~which~~ are the subject of evaluation and review by such a group or its agent, and a person who was in attendance at a meeting of such group or its agent may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during the proceedings of such a group or its agent or as to any findings, recommendations, evaluations, opinions, or other actions of such a group or its agent or any members thereof. However, information, documents, or records otherwise available from original sources are not ~~to be construed as~~ immune from discovery or use in any such civil or administrative action merely because they were presented during proceedings of such group, and any person who testifies

before such group or who is a member of such group may not be prevented from testifying as to matters within his or her knowledge, but such a witness may not be asked about his or her testimony before such a group or about opinions that he or she formed ~~by him or her~~ as a result of those ~~such~~ group hearings.

(9)~~(8)~~(a) If the defendant prevails in an action brought by a staff member or physician who delivers health care services at the licensed facility against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section, the court must ~~shall~~ award reasonable attorney's fees and costs to the defendant.

(b) As a condition of any staff member or physician bringing any action against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section and before any responsive pleading is due, the staff member or physician must ~~shall~~ post a bond or other security, as set by the court having jurisdiction of the action, in an amount sufficient to pay the costs and attorney's fees.

(10)~~(9)~~(a) A hospital's compliance with the requirements of this chapter or s. 766.110(1) may not be the sole basis to establish an agency or partnership relationship between the hospital and physicians who provide services within the hospital.

(b) A hospital may create an agency relationship with a physician by written contract signed by the hospital and:

1. The physician;

2. A health care professional association; or

3. A corporate medical group and its employees.

A written contract is not the exclusive means to establish an agency or partnership relationship between a hospital and any other person described in this paragraph.

Section 42. Section 395.0197, Florida Statutes, is amended to read:

395.0197 Internal risk management program.--

(1) Every licensed facility shall, as a part of its administrative functions, establish an internal risk management program that includes all of the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents ~~causing injury~~ to patients.

(b) The development of appropriate measures to minimize the risk of ~~injuries and~~ adverse incidents to patients, including, but not limited to:

1. Risk management and risk prevention education and training of all nonphysician personnel as follows:

a. Such education and training of all nonphysician personnel as part of their initial orientation; and

b. At least 1 hour of such education and training annually for all nonphysician personnel of the licensed facility working in clinical areas and providing patient care.

2. A prohibition, except when emergency circumstances require otherwise, against a staff member of the licensed facility attending a patient in the recovery room, unless the staff member is authorized to attend the patient in the recovery room and is in the company of at least one other person. However, a licensed facility ~~hospital~~ is exempt from the two-person requirement if it has:

a. Live visual observation;

b. Electronic observation; or

c. Any other reasonable measure taken to ensure patient protection and privacy.

(c) The analysis of patient grievances that relate to patient care and the quality of medical services.

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report an adverse incident ~~incidents~~ to the risk manager, or to his or her designee, within 3 business days after its occurrence.

(2) The internal risk management program is the responsibility of the governing board of the health care facility. Each licensed facility shall hire a risk manager, licensed under part IX of chapter 626, who is responsible for implementation and oversight of such facility's internal risk management program as required by this section. A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.

(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims must ~~shall~~ be encouraged and their implementation and operation facilitated. Such additional approaches may include extending internal risk management programs to health care providers' offices and the assuming of

provider liability by a licensed health care facility for acts or omissions occurring within the licensed facility.

(4) The agency shall, after consulting with the Department of Insurance, adopt rules governing the establishment of internal risk management programs to meet the needs of individual licensed facilities. Each internal risk management program must ~~shall~~ include the use of incident reports to be filed with an individual of responsibility who is competent in risk management techniques in the employ of each licensed facility, such as an insurance coordinator, or who is retained by the licensed facility as a consultant. The individual responsible for the risk management program shall have free access to all medical records of the licensed facility. The incident reports are part of the workpapers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery, but are not admissible as evidence in court. A person filing an incident report is not subject to civil suit by virtue of such incident report. As a part of each internal risk management program, the incident reports must ~~shall~~ be used to develop categories of incidents which identify problem areas. Once problem areas are identified, procedures must ~~shall~~ be adjusted to correct the problem areas.

(5) For purposes of reporting to the agency pursuant to subsections (6), (7), and (8), the term "adverse incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which:

(a) Results in one of the following injuries:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. A resulting limitation of neurological, physical, or sensory function which exists upon discharge from the facility;

6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient had not given his or her informed consent; or

7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident rather than to the patient's condition prior to the adverse incident;

(b) Was the performance of a surgical procedure on the wrong patient; a wrong surgical procedure; a wrong-site surgical procedure; or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;

(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk as disclosed to the patient on the informed consent form; or

(d) Was a procedure to remove foreign objects unintentionally left inside the patient during a surgical procedure.

(6)~~(5)~~(a) Each licensed facility subject to this section shall submit an annual report to the agency summarizing the incident reports that have been filed in the facility for that year. The report shall include:

1. The total number of adverse incidents ~~causing injury to patients~~.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries, and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. A code number using the health care professional's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents ~~causing injury~~ to patients, the relationship of the individual to the licensed facility, and the number of incidents in which each individual has been directly involved. Each licensed facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

5. A description of all malpractice claims filed against the licensed facility, including the total number of pending and closed claims and the nature of the incident <u>that</u> ~~which~~ led to, the persons involved in, and the status and disposition of each claim. Each report <u>must</u> ~~shall~~ update status and disposition for all prior reports.

~~6. A report of all disciplinary actions pertaining to patient care taken against any medical staff member, including the nature and cause of the action.~~

(b) The information reported to the agency pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 <u>must</u> ~~shall~~ be reviewed by the agency. The agency shall determine whether

any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case ~~the provisions of~~ s. 455.225 applies ~~shall apply~~.

(c) The report submitted to the agency must ~~shall~~ also contain the name and license number of the risk manager of the licensed facility, a copy of its policy and procedures which govern the measures taken by the facility and its risk manager to reduce the risk of injuries and adverse ~~or untoward~~ incidents, and the results of such measures. The annual report is confidential and is not available to the public pursuant to s. 119.07(1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The annual report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

(7) The licensed facility shall notify the agency no later than 1 business day after the risk manager or his or her designee has received a report pursuant to paragraph (1)(d) and is able to determine within 1 business day that any of the following adverse incidents has occurred, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility. Notification is not

required if the risk manager is unable to determine within 1 business day that any of the following incidents occurred:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

(c) The performance of a surgical procedure on the wrong patient;

(d) The performance of a wrong-site surgical procedure; or

(e) The performance of a wrong surgical procedure.

The notification must be made in writing and be provided by facsimile device or overnight mail delivery. The notification must include information regarding the identity of the affected patient, the type of adverse incident, the initiation of an investigation by the facility, and whether the events causing or resulting in the adverse incident represent a potential risk to other patients.

(8)~~(6)~~ Any of the following adverse incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, shall be reported by the facility to the agency within 15 calendar days after its occurrence ~~If an adverse or untoward incident, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, results in~~:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

(c) The performance of a surgical procedure on the wrong patient; ~~or~~

(d) The performance of a wrong-site surgical procedure;

(e) The performance of a wrong surgical procedure;

(f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;

(g) The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk as disclosed to the patient on the informed consent form; or

(h) The performance of procedures to remove foreign objects remaining from a surgical procedure.

~~(d) A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient, including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong site or wrong procedure surgeries, and procedures to remove foreign objects remaining from surgical procedures,~~

The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by the facility administrator to the agency.~~the licensed facility shall report this incident to the agency within 15 calendar days after its occurrence.~~The agency may require an additional, final report. These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make

available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(9)~~(7)~~ The internal risk manager of each licensed facility shall:

~~(a) Notify the family or guardian of the victim, if a minor, that an allegation of sexual misconduct has been made and that an investigation is being conducted;~~

(a)~~(b)~~ Investigate every allegation of sexual misconduct which is made against a member of the facility's personnel who has direct patient contact, when the allegation is that the sexual misconduct occurred at the facility or on the grounds of the facility; ~~and~~

(b)~~(c)~~ Report every allegation of sexual misconduct to the administrator of the licensed facility; and~~.~~

(c) Notify the family or guardian of the victim, if a minor, that an allegation of sexual misconduct has been made and that an investigation is being conducted.

(10)~~(8)~~ Any witness who witnessed or who possesses actual knowledge of the act that is the basis of an allegation of sexual abuse shall:

(a) Notify the local police; and

(b) Notify the hospital risk manager and the administrator.

For purposes of this subsection, the term "sexual abuse" means acts of a sexual nature committed for the sexual gratification of anyone upon, or in the presence of, a vulnerable adult, without the vulnerable adult's informed consent, or a minor. "Sexual abuse" includes, but is not limited to, the acts defined in s. 794.011(1)(h), fondling, exposure of a vulnerable adult's or minor's sexual organs, or the use of the vulnerable adult or minor to solicit for or engage in prostitution or sexual performance. "Sexual abuse" does not include any act intended for a valid medical purpose or any act which may reasonably be construed to be a normal caregiving action.

(11)~~(9)~~ A person who, with malice or with intent to discredit or harm a licensed facility or any person, makes a false allegation of sexual misconduct against a member of a licensed facility's personnel is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(12)~~(10)~~ In addition to any penalty imposed pursuant to this section, the agency shall require a written plan of correction from the facility ~~may impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of this section~~. For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency shall first seek to obtain corrective action by the facility. If the correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section, the agency may impose an administrative fine, not to exceed $5,000, for any

violation of the reporting requirements of this section. The administrative fine for repeated nonwillful violations may not exceed $10,000 for any violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation, per day. A fine for an intentional and willful violation of this section may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b).

(13)~~(11)~~ The agency shall have access to all licensed facility records necessary to carry out the provisions of this section. The records obtained are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall records obtained pursuant to s. 455.223 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, s. 766.101 controls.

(14)~~(12)~~ The meetings of the committees and governing board of a licensed facility held solely for the purpose of achieving the objectives of risk management as provided by this section shall not be open to the public under the provisions of chapter 286. The records of such meetings are confidential and exempt from s. 119.07(1), except as provided in subsection(13)~~(11)~~.

(15)~~(13)~~ The agency shall review, as part of its licensure inspection process, the internal risk management program at each licensed facility regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under subsections (5),~~and~~ (6), (7), and (8).

(16)~~(14)~~ There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager, licensed under part IX of chapter 626, for the implementation and oversight of the internal risk management program in a facility licensed under this chapter or chapter 390 as required by this section, for any act or proceeding undertaken or performed within the scope of the functions of such internal risk management program if the risk manager acts without intentional fraud.

(17)~~(15)~~ If the agency, through its receipt of the annual reports prescribed in subsection(6)~~(5)~~or through any investigation, has a reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate regulatory board, the agency shall report this fact to such regulatory board.

(18)~~(16)~~ The agency shall annually publish a report summarizing the information contained in the annual incident reports submitted by licensed facilities under subsection (6), ~~and~~ any serious incident reports submitted by licensed facilities under subsection (7), and disciplinary actions reported to the agency under s. 395.0193. The report must, at a minimum, summarize:

(a) Adverse and serious incidents, ~~by service district of the department as defined in s. 20.19,~~ by category of reported incident~~,~~ and by type of professional involved.

(b) Types of malpractice claims filed, ~~by service district of the department as defined in s. 20.19, and~~ by type of professional involved.

(c) Disciplinary actions taken against professionals, ~~by service district of the department as defined in s. 20.19, and~~ by type of professional involved.

Section 43. Present subsections (4), (5), (6), (7), (8), and (9) of section 395.0199, Florida Statutes, are renumbered as subsections (5), (6), (7), (8), (9), and (10), respectively, and a new subsection (4) is added to that section, to read:

395.0199 Private utilization review.--

(4) Each applicant for registration must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee or other similarly titled individual who is responsible for the operation of the entity. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant, if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional registration may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard registration may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from

the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A registration may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke the registration if any applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for registration renewal must contain the information required under paragraphs (e) and (f).

Section 44. Paragraph (d) of subsection (1) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.--

(1) The agency shall adopt, amend, promulgate, and enforce rules to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(d) New facilities and a new wing or floor added to an existing facility after July 1, 1999, are structurally capable of serving as shelters only for patients, staff, and families of staff, and equipped to be self-supporting during and immediately following disasters.

Section 45. The Agency for Health Care Administration shall work with persons affected by section 44 of this act and report to the Governor and Legislature by March 1, 1999, its recommendations for cost-effective renovation standards to be applied to existing facilities.

Section 46. Effective January 1, 1999, section 626.941, Florida Statutes, is transferred, renumbered as section 395.10971, Florida Statutes, and amended to read:

395.10971 ~~626.941~~ Purpose.--The Legislature finds that control and prevention of medical accidents and injuries are

~~is~~ a significant public health and safety concern. An essential method of controlling medical injuries is a comprehensive program of risk management, as required by s. 395.0197. The key to such a program is a competent and qualified health care risk manager. It is the intent of the Legislature to establish certain minimum standards for health care risk managers to ensure the public welfare.

Section 47. Effective January 1, 1999, section 626.942, Florida Statutes, is transferred, renumbered as section 395.10972, Florida Statutes, and amended to read:

395.10972 ~~626.942~~ Health Care Risk Manager Advisory Council.--The Director of Health Care Administration ~~Insurance Commissioner~~ may appoint a five-member advisory council to advise the agency ~~department~~ on matters pertaining to health care risk managers. The members of the council shall serve at the pleasure of the director ~~Insurance Commissioner~~. The council shall designate a chair. The council shall meet at the call of the director ~~Insurance Commissioner~~ or at those times that are ~~as may be~~ required by rule of the agency ~~department~~. The members of the advisory council shall receive no compensation for their services, but shall be reimbursed for travel expenses as provided in s. 112.061. The council must ~~shall~~ consist of individuals who represent ~~representing~~ the following areas:

(1) Two members must ~~shall~~ be active health care risk managers.

(2) One member must ~~shall~~ be an active hospital administrator.

(3) One member must ~~shall~~ be an employee of an insurer or self-insurer of medical malpractice coverage.

(4) One member must ~~shall~~ be a representative of the health-care-consuming public.

Section 48. Effective January 1, 1999, section 626.943, Florida Statutes, is transferred, renumbered as section 395.10973, Florida Statutes, and amended to read:

395.10973 ~~626.943~~ Powers and duties of the agency ~~department~~.--It is the function of the agency ~~department~~ to:

(1) Adopt ~~Promulgate~~ rules necessary to carry out the duties conferred upon it under this part to protect the public health, safety, and welfare.

(2) Develop, impose, and enforce specific standards within the scope of the general qualifications established by this part which must be met by individuals in order to receive licenses as health care risk managers. These standards shall be designed to ensure that health care risk managers are individuals of good character and otherwise suitable and, by training or experience in the field of health care risk management, qualified in accordance with the provisions of this part to serve as health care risk managers, within statutory requirements.

(3) Develop a method for determining whether an individual meets the standards set forth in s. 395.10974 ~~s. 626.944~~.

(4) Issue licenses~~, beginning on June 1, 1986,~~to qualified individuals who meet ~~meeting~~ the standards set forth in s. 395.10974 ~~s. 626.944~~.

(5) Receive, investigate, and take appropriate action with respect to any charge or complaint filed with the agency ~~department~~ to the effect that a certified health care risk manager has failed to comply with the requirements or

standards adopted by rule by the agency ~~department~~ or to comply with ~~the provisions of~~ this part.

(6) Establish procedures for providing ~~the Department of Health and Rehabilitative Services with~~ periodic reports on persons certified or disciplined by the agency ~~department~~ under this part.

(7) Develop a model risk management program for health care facilities which will satisfy the requirements of s. 395.0197.

Section 49. Effective January 1, 1999, section 626.944, Florida Statutes, is transferred, renumbered as section 395.10974, Florida Statutes, and amended to read:

395.10974 ~~626.944~~ Qualifications for health care risk managers.--

(1) Any person desiring to be licensed as a health care risk manager shall submit an application on a form provided by the agency ~~department~~. In order to qualify, the applicant must ~~shall~~ submit evidence satisfactory to the agency ~~department~~ which demonstrates the applicant's competence, by education or experience, in the following areas:

(a) Applicable standards of health care risk management.

(b) Applicable federal, state, and local health and safety laws and rules.

(c) General risk management administration.

(d) Patient care.

(e) Medical care.

(f) Personal and social care.

(g) Accident prevention.

(h) Departmental organization and management.

(i) Community interrelationships.

(j) Medical terminology.

The agency ~~department~~ may require such additional information, from the applicant or any other person, as is ~~may be~~ reasonably required to verify the information contained in the application.

(2) The agency may ~~department shall~~ not grant or issue a license as a health care risk manager to any individual unless from the application it affirmatively appears that the applicant:

(a) Is 18 years of age or over;

(b) Is a high school graduate or equivalent; and

(c)1. Has fulfilled the requirements of a 1-year program or its equivalent in health care risk management training which may be developed or approved by the agency ~~department~~;

2. Has completed 2 years of college-level studies which would prepare the applicant for health care risk management, to be further defined by rule; or

3. Has obtained 1 year of practical experience in health care risk management.

(3) The agency ~~department~~ shall issue a license~~,~~ ~~beginning on June 1, 1986,~~ to practice health care risk management to any applicant who qualifies under this section and submits an application fee of not more than $75, a fingerprinting fee of not more than $75, and a license fee of not more than $100. The agency shall by rule establish fees and procedures for the issuance and cancellation of licenses ~~the license fee as set forth in s. 624.501~~. ~~Licenses shall be~~

~~issued and canceled in the same manner as provided in part I of this chapter.~~

(4) The agency ~~department~~ shall renew a health care risk manager license upon receipt of a biennial renewal application and fees ~~in accordance with procedures prescribed in s. 626.381 for agents in general~~. The agency shall, by rule, establish a procedure for the biennial renewal of licenses.

Section 50. Effective January 1, 1999, section 626.945, Florida Statutes, is transferred, renumbered as section 395.10975, Florida Statutes, and amended to read:

395.10975 ~~626.945~~ Grounds for denial, suspension, or revocation of a health care risk manager's license; administrative fine.--

(1) The agency ~~department~~ may, in its discretion, deny, suspend, revoke, or refuse to renew or continue the license of any health care risk manager or applicant, if it finds that as to such applicant or licensee any one or more of the following grounds exist:

(a) Any cause for which issuance of the license could have been refused had it then existed and been known to the agency ~~department~~.

(b) Giving false or forged evidence to the agency ~~department~~ for the purpose of obtaining a license.

(c) Having been found guilty of, or having pleaded guilty or nolo contendere to, a crime in this state or any other state relating to the practice of risk management or the ability to practice risk management, whether or not a judgment or conviction has been entered.

(d) Having been found guilty of, or having pleaded guilty or nolo contendere to, a felony, or a crime involving

moral turpitude punishable by imprisonment of 1 year or more under the law of the United States, under the law of any state, or under the law of any other country, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.

(e) Making or filing a report or record which the licensee knows to be false; or intentionally failing to file a report or record required by state or federal law; or willfully impeding or obstructing, or inducing another person to impede or obstruct, the filing of a report or record required by state or federal law. Such reports or records shall include only those which are signed in the capacity of a licensed health care risk manager.

(f) Fraud or deceit, negligence, incompetence, or misconduct in the practice of health care risk management.

(g) Violation of any provision of this part or any other law applicable to the business of health care risk management.

(h) Violation of any lawful order or rule of the agency ~~department~~ or failure to comply with a lawful subpoena issued by the agency ~~department~~.

(i) Practicing with a revoked or suspended health care risk manager license.

(j) Repeatedly acting in a manner inconsistent with the health and safety of the patients of the licensed facility in which the licensee is the health care risk manager.

(k) Being unable to practice health care risk management with reasonable skill and safety to patients by reason of illness; drunkenness; or use of drugs, narcotics, chemicals, or any other material or substance or as a result of any mental or physical condition. Any person affected

under this paragraph shall have the opportunity, at reasonable intervals, to demonstrate that he or she can resume the competent practices of health care risk manager with reasonable skill and safety to patients.

(l) Willfully permitting unauthorized disclosure of information relating to a patient or a patient's records.

(m) Discriminating in respect to patients, employees, or staff on account of race, religion, color, sex, or national origin.

(2) If the agency ~~department~~ finds that one or more of the grounds set forth in subsection (1) exist, it may, in lieu of or in addition to suspension or revocation, enter an order imposing one or more of the following penalties:

(a) Imposition of an administrative fine not to exceed $2,500 for each count or separate offense.

(b) Issuance of a reprimand.

(c) Placement of the licensee on probation for a period of time and subject to such conditions as the agency specifies ~~department may specify~~, including requiring the licensee to attend continuing education courses or to work under the supervision of another licensee.

(3) The agency ~~department~~ may reissue the license of a disciplined licensee in accordance with ~~the provisions of~~ this part.

Section 51. Paragraphs (a) and (b) of subsection (1) of section 395.401, Florida Statutes, are amended to read:

395.401 Trauma services system plans; verification of trauma centers and pediatric trauma referral centers; procedures; renewal.--

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

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

(b) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the agency ~~board~~ for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds 4 times the federal poverty level for a family of four be considered charity.

Section 52. Paragraph (c) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.--

(2) DEFINITIONS.--As used in this part:

(c) "Inactive rural hospital bed" means a licensed acute care hospital bed, as defined in s. 395.002(14)~~s. 395.002(13)~~, that is inactive in that it cannot be occupied by acute care inpatients.

Section 53. Subsections (1), (2), (3), and (4) of section 395.701, Florida Statutes, are amended to read:

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

(1) For the purposes of this section, the term:

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

(b)~~(a)~~ "Gross operating revenue" or "gross revenue" means the sum of daily hospital service charges, ambulatory

service charges, ancillary service charges, and other operating revenue.

~~(b) "Health Care Board" or "board" means the Health Care Board created by s. 20.42.~~

(c) "Hospital" means a health care institution as defined in s. 395.002(13)~~s. 395.002(12)~~, but does not include any hospital operated by the agency or the Department of Corrections.

(d) "Net operating revenue" or "net revenue" means gross revenue less deductions from revenue.

(e) "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.

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

this subsection shall be deposited into the Public Medical Assistance Trust Fund.

(3) The agency ~~department~~ shall impose an administrative fine, not to exceed $500 per day, for failure of any hospital to pay its assessment by the first day of the calendar quarter on which it is due. The failure of a hospital to pay its assessment within 30 days after the assessment is due is ground for the agency ~~department~~ to impose an administrative fine not to exceed $5,000 per day.

(4) The purchaser, successor, or assignee of a facility subject to the agency's ~~board's~~ jurisdiction shall assume full liability for any assessments, fines, or penalties of the facility or its employees, regardless of when identified. Such assessments, fines, or penalties shall be paid by the employee, owner, or licensee who incurred them, within 15 days of the sale, transfer, or assignment. However, the purchaser, successor, or assignee of the facility may withhold such assessments, fines, or penalties from purchase moneys or payment due to the seller, transferor, or employee, and shall make such payment on behalf of the seller, transferor, or employee. Any employer, purchaser, successor, or assignee who fails to withhold sufficient funds to pay assessments, fines, or penalties arising under the provisions of chapter 408 shall make such payments within 15 days of the date of the transfer, purchase, or assignment. Failure by the transferee to make payments as provided in this subsection shall subject such transferee to the penalties and assessments provided in chapter 408. Further, in the event of sale, transfer, or assignment of any facility under the agency's ~~board's~~ jurisdiction, future assessments shall be based upon the most recently available prior year report or audited

actual experience for the facility. It shall be the responsibility of the new owner or licensee to require the production of the audited financial data for the period of operation of the prior owner. If the transferee fails to obtain current audited financial data from the previous owner or licensee, the new owner shall be assessed based upon the most recent year of operation for which 12 months of audited actual experience are available or upon a reasonable estimate of 12 months of full operation as calculated by the agency ~~board~~.

Section 54. Paragraph (b) of subsection (1) of section 400.051, Florida Statutes, is amended to read:

400.051 Homes or institutions exempt from the provisions of this part.--

(1) The following shall be exempt from the provisions of this part:

(b) Any hospital, as defined in s. 395.002(11)~~s. 395.002(10)~~, that is licensed under chapter 395.

Section 55. Paragraph (a) of subsection (2) of section 400.071, Florida Statutes, is amended, present subsections (4), (5), (6), (7), and (8) of that section are redesignated as subsections (5), (6), (7), (8), and (9), respectively, and a new subsection (4) is added to that section, to read:

400.071 Application for license.--

(2) The application shall be under oath and shall contain the following:

(a) The name, address, and social security number of the applicant if an individual; if the applicant is a firm, partnership, or association, its name, address, and employer identification number (EIN), and the name and address of every member; if the applicant is a corporation, its name, address,

and employer identification number (EIN), and the name and address of its director and officers and of each person having at least a 5-percent ~~10-percent~~ interest in the corporation; and the name by which the facility is to be known.

(4) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the facility administrator, or similarly titled individual who is responsible for the day-to-day operation of the licensed facility, and the facility financial officer, or similarly titled individual who is responsible for the financial operation of the licensed facility.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency reasonably suspects that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a). Proof of compliance with background screening which has been submitted within the previous 5 years to fulfill the requirements of the Department of Insurance pursuant to chapter 651 as part of an application for a certificate of authority to operate a

continuing care retirement community is acceptable in fulfillment of the Department of Law Enforcement and Federal Bureau of Investigation background check.

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation; however, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of

the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement shall not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) An application for license renewal must contain the information required under paragraphs (e) and (f).

Section 56. Present subsections (3), (4), (5), (6), (7), (8), (9), and (10) of section 400.411, Florida Statutes, are redesignated as subsections (4), (5), (6), (7), (8), (9), (10), and (11), respectively, and a new subsection (3) is added to that section, to read:

400.411 Initial application for license; provisional license.--

(3) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the facility administrator, or similarly titled individual who is responsible for the day-to-day operation of the licensed facility, and the facility financial officer, or similarly titled individual who is responsible for the financial operation of the licensed facility.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency reasonably suspects that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a). Proof of compliance with background screening which has been submitted within the previous 5 years to fulfill the requirements of the Department of Insurance pursuant to chapter 651 as part of an application for a certificate of authority to operate a continuing care retirement community is acceptable in fulfillment of the Department of Law Enforcement and Federal Bureau of Investigation background check.

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the

abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation; however, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its

officers, or any individual owning 5 percent or more of the applicant. This requirement shall not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant, administrator, or financial officer has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior Medicaid or Medicare action taken against the applicant as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

Section 57. Paragraph (b) of subsection (2) of section 400.414, Florida Statutes, is amended, and paragraph (j) is added to that subsection, to read:

400.414 Denial, revocation, or suspension of license; imposition of administrative fine; grounds.--

(2) Any of the following actions by a facility or its employee shall be grounds for action by the agency against a licensee:

(b) The determination by the agency that any person specified in s. 400.411(3)~~the facility owner or administrator~~ is not of suitable character or competency in accordance with level 2 standards for screening set forth in chapter 435, or that the owner lacks the financial ability, to provide continuing adequate care to residents~~, pursuant to the information obtained through s. 400.411, s. 400.417, or s. 400.434~~.

(j) A facility owner's or administrator's retention of an employee who performs personal care or nursing care and who is not of suitable character or competency in accordance with level 1 standards for screening set forth in chapter 435, as indicated by the results of the employee's criminal-history background screening.

Section 58. Present subsections (2) and (3) of section 400.417, Florida Statutes, are renumbered as subsections (3) and (4), respectively, and a new subsection (2) is added to that section, to read:

400.417 Expiration of license; renewal; conditional license.--

(2) An applicant for renewal who has not completed the initial background screening requirements specified in s. 400.411 must complete the required screening. After the

initial background screening is completed, each applicant for renewal must submit to the agency, under penalty of perjury, a notarized affidavit of compliance with the background screening provisions.

Section 59. Section 400.4174, Florida Statutes, is amended to read:

400.4174 Background screening;reports of abuse in facilities.--

(1) The facility owner or administrator shall conduct level 1 background screening, as set forth in chapter 435, on all employees hired on or after October 1, 1998, who perform personal services as defined in s. 400.402(16). The agency may exempt an individual from employment disqualification as set forth in chapter 435.

(2) Proof of compliance with the level 1 background screening requirements of chapter 435 may be satisfied as follows:

(a) The employee or applicant for employment has had a level 1 background screening to qualify for a professional license in this state. Proof of compliance with the level 1 screening requirement must be accompanied, under penalty of perjury, by a copy of the applicant's current professional license and an affidavit of compliance with the level 1 screening requirement.

(b) The employee or applicant for employment has been continuously employed in the same type of occupation for which the person is seeking employment without a breach in service that exceeds 180 days and proof of compliance with the level 1 screening requirement is no more than 2 years old. Proof of compliance shall be provided directly from one employer or contractor to another, and no potential employer or contractor

shall accept any proof of compliance directly from the person who was screened. Upon request, proof of completion of the level 1 screening requirement of this section shall be provided by the employer retaining documentation of the screening to the person who was screened.

(c) The employee or applicant seeking employment is employed by a corporation or business entity or related corporation or business entity that owns, operates, or manages more than one facility or agency licensed under chapter 400 for whom a level 1 screening was conducted by the corporation or business entity as a condition of initial employment or continued employment.

(3) When an employee, volunteer, administrator, or owner of a facility has a confirmed report of adult abuse, neglect, or exploitation, as defined in s. 415.102, ~~or child abuse or neglect, as defined in s. 415.503,~~ and the protective investigator knows that the individual is an employee, volunteer, administrator, or owner of a facility, the agency shall be notified of the confirmed report.

Section 60. Section 400.4176, Florida Statutes, is amended to read:

400.4176 Notice of change of administrator.--If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 45 days thereof and must provide documentation that the new administrator has completed the applicable core educational requirements under s. 400.452. Background screening shall be completed on any new administrator to establish that the individual is of suitable character as specified in s. 400.411(2)(c) and (3)~~ss. 400.411(2)(c) and 400.456~~.

Section 61. Section 400.461, Florida Statutes, is amended to read:

400.461 Short title; purpose.--

(1) This part, consisting of ss. 400.461-400.518 ~~ss. 400.461-400.515~~, may be cited as the "Home Health Services Act."

(2) The purpose of this part is to provide for the licensure of every home health agency and to provide for the development, establishment, and enforcement of basic standards that will ensure the safe and adequate care of persons receiving health services in their own homes.

Section 62. Section 400.462, Florida Statutes, is amended to read:

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

(1) "Administrator" means a direct employee to whom the governing body has delegated the responsibility for the day-to-day administration of a home health agency or nurse registry. The administrator must be a licensed physician, physician assistant, or registered nurse licensed to practice in this state, or an individual who has at least 1 year of supervisory or administrative experience in home health care or in a facility licensed under part II, part III, or part IV of chapter 400 or chapter 395. An employee of the governing body may administer a maximum of five licensed home health agencies or nurse registries operated by a related business entity and located within one agency service district or within an immediately contiguous county. An administrator shall designate, in writing for each licensed entity, a qualified alternate administrator to serve during the administrator's absence. If the home health agency is licensed under this chapter and is part of a retirement community that

provides multiple levels of care, an employee of the retirement community may administer the home health agency and up to a maximum of four entities licensed under this chapter which are located on the same campus and owned, operated, or managed by the same corporate entity.

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

(3)~~(1)~~ "Certified nursing assistant" means any person who has been issued a certificate under ~~after fulfilling the requirements of~~ s. 400.211. A licensed home health agency or licensed nurse registry shall ensure that any certified nursing assistant employed by or under contract with the home health agency or licensed nurse registry is adequately trained to perform the tasks of a home health aide in the home setting.

(4) "Client" means an elderly, handicapped, or convalescent individual who receives personal care services, companion services, or homemaker services in the individual's home or place of residence.

(5)~~(2)~~ "Companion" ~~or "sitter"~~means a person who cares for an elderly, handicapped, or convalescent individual and accompanies such individual on trips and outings and may prepare and serve meals to such individual. A companion may not provide hands-on personal care to the client.

(6)~~(3)~~ "Department" means the Department of Children and Family ~~Health and Rehabilitative~~ Services.

(7) "Director of nursing" means a registered nurse, and direct employee of the agency, who is a graduate of an approved school of nursing and is licensed in this state; who has at least 1 year of supervisory experience as a registered nurse and experience in a licensed home health agency, a

facility licensed under chapter 395, or a facility licensed under part II, part III, or part VI of chapter 400; and who is responsible for overseeing the professional nursing and home health aid delivery of services of the agency. An employee may be the director of nursing of a maximum of five licensed home health agencies operated by a related business entity. If a home health agency is licensed under this chapter and is part of a retirement community that provides multiple levels of care, an employee of the retirement community may serve as the director of nursing for the home health agency and up to four additional entities licensed under chapter 400 if the entities are located on the same campus and are owned, operated, or managed by the same corporate entity. A director of nursing shall designate, in writing for each agency, a qualified alternate registered nurse to serve during the absence of the director of nursing.

(8)~~(4)~~ "Home health agency" means an organization that provides home health services and staffing services ~~for health care facilities~~.

(9)~~(5)~~ "Home health agency personnel" means persons who are employed by or under contract with a home health agency and enter the home or place of residence of patients at any time in the course of their employment or contract.

(10)~~(6)~~ "Home health services" means health and medical services and medical supplies furnished by an organization to an individual ~~by home health agency personnel or by others under arrangements with the agency, on a visiting basis,~~ in the individual's home or place of residence. The term includes organizations that provide one or more of~~, but is not limited to,~~ the following:

(a) Nursing care.

(b) Physical, occupational, respiratory, or speech therapy.

(c) Home health aide services.

(d) Dietetics and nutrition practice and nutrition counseling ~~Nutritional guidance~~.

(e) Medical supplies, restricted to drugs and biologicals prescribed by a physician.

(11) "Home health aide" means a person who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, or supervises the self-administration of medications, and for which the person has received training established by the agency pursuant to s. 400.497(1).

(12)~~(7)~~ "Homemaker" means a person who performs household chores that include housekeeping, meal planning and preparation, shopping assistance, and routine household activities for an elderly, handicapped, or convalescent individual. A homemaker may not provide hands-on personal care to a client.

(13) "Home infusion therapy provider" means an organization that employs, contracts with, or refers a licensed professional who has received advanced training and experience in intravenous infusion therapy and who administers infusion therapy to a patient in the patient's home or place of residence.

(14) "Home infusion therapy" means the administration of intravenous pharmacological or nutritional products to a patient in the patient's home.

(15)~~(8)~~ "Nurse registry" means any person that procures, offers, promises, or attempts to secure health-care-related contracts for registered nurses, licensed

practical nurses, certified nursing assistants, home health aides ~~sitters~~, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to health care facilities licensed under chapter 395 or this chapter or to other business entities.

(16) "Organization" means a corporation, government or governmental subdivision or agency, partnership or association, two or more persons having a joint or common interest, or any other legal or commercial entity. The term does not include an entity that provides services using only volunteers.

(17)~~(9)~~ "Patient" means any person who receives home health services in his or her home or place of residence.

(18) "Personal care" includes, but is not limited to, assisting a patient in the activities of daily living, such as dressing, grooming, bathing, eating, or personal hygiene; assisting in physical transfer and ambulation; and supervising the self-administration of medications.

(19) "Physician" means a person licensed under chapter 458, chapter 459, chapter 460, or chapter 461.

(20)~~(10)~~ "Screening" means the assessment of the background of home health agency personnel, nurse registry personnel, and persons registered under s. 400.509 and includes employment history checks, records checks of the department's central abuse hotline under chapter 415 relating to vulnerable adults, and statewide criminal records correspondence checks through the Department of Law Enforcement.

(21) "Skilled care" means nursing services or therapeutic services delivered by a health care professional who is licensed under chapter 464; parts I, III, or V of chapter 468; or chapter 486, and who is employed by or under contract with a licensed home health agency or is referred by a licensed nurse registry.

(22)~~(11)~~ "Staffing services" means services provided to a ~~health care~~ facility or other business entity on a temporary basis by licensed health care personnel, including certified nursing assistants and home health aides who are employed by or work under the auspices of a licensed home health agency or who are registered with a licensed nurse registry.

Section 63. Section 400.464, Florida Statutes, is amended to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.--

(1) Any home health agency must be licensed by the agency ~~for Health Care Administration~~ to operate in this state. A license issued to a home health agency, unless sooner suspended or revoked, expires 1 year after its date of issuance. ~~However, any home health agency that is operated by the Federal Government is exempt from this part.~~

(2) If the licensed home health agency operates related offices, each related office outside the county where the main office is located must be separately licensed. The counties where the related offices are operating must be specified on the license in the main office.

(3) An entity that receives a certificate-of-need exemption under s. 408.0366 may request one home health agency license to provide Medicare and non-Medicare home health

services to residents of the facility and non-Medicare home health services to persons in one or more counties within the agency service district where the main office of the home health agency is located.

~~(3) The furnishing of only home dialysis services, supplies, or equipment, or personal care services as provided by a community-care-for-the-elderly lead agency under s. 430.205, or personal care services provided through a community-care-for-disabled-adults program under s. 410.604, is exempt from this part. The personal care services exemptions apply only to community-care-for-the-elderly lead agencies and community-care-for-disabled-adults programs that directly provide only personal care services to their clients and do not provide other home health services.~~

~~(4) Any program offered through a county health department that makes home visits for the purpose of providing only environmental assessments, case management, health education, or personal care services is exempt from this part.~~

~~(5)(a) It is unlawful for any person to offer or advertise home health services to the public unless he or she has a valid license under this part. It is unlawful for any holder of a license issued under this part to advertise or indicate to the public that it holds a home health agency license other than the one it has been issued.~~

~~(b) A person who violates paragraph (a) is subject to an injunctive proceeding under s. 400.515. A violation of paragraph (a) is a deceptive and unfair trade practice and constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act.~~

~~(c) A person who violates paragraph (a) commits a misdemeanor of the second degree, punishable as provided in s.~~

~~775.082 or s. 775.083. Any person who commits a second or subsequent violation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.~~

~~Each day of continuing violation constitutes a separate offense.~~

(4)~~(6)~~ Any home infusion therapy provider shall be licensed as a home health agency or nurse registry. Any home infusion therapy provider currently authorized to receive Medicare reimbursement under a DME - Part B Provider number for the provision of infusion therapy shall be licensed as a noncertified home health agency. Such a provider shall continue to receive that specified Medicare reimbursement without being certified so long as the reimbursement is limited to those items authorized pursuant to the DME - Part B Provider Agreement and the agency is licensed in compliance with the other provisions of this part.

(5)(a) An organization may not provide, offer, or advertise home health services to the public unless the organization has a valid license or is specifically exempt under this part. An organization that offers or advertises to the public any service for which licensure or registration is required under this part must include in the advertisement the license number or registration number issued to the organization by the agency. The agency shall assess a fine of not less than $100 to any licensee or registrant who fails to include the license or registration number when submitting an advertisement for publication, broadcast, or printing. The holder of a license issued under this part may not advertise or indicate to the public that it holds a home health agency

license or a nurse registry license other than the one it has been issued.

(b) A person who violates the provisions of paragraph (a) is subject to an injunctive proceeding under s. 400.515. A violation of paragraph (a) is a deceptive and unfair trade practice and constitutes a violation of the Florida Unfair and Deceptive Trade Practices Act.

(c) A person who violates the provisions of paragraph (a) commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Any person who commits a second or subsequent violation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation constitutes a separate offense.

(6) The following are exempt from the licensure requirements of this part:

(a) A home health agency operated by the Federal Government.

(b) The following home health services provided by a state agency, either directly or through a contract:

1. Personal care services provided through a program or contract of the Department of Elderly Affairs and personal care services provided through a program of community care for disabled adults under s. 410.604. The exemptions provided in this subparagraph apply only to programs or contracts that do not provide home health services other than directly provided personal care services.

2. Any program offered through the Department of Health, a community health center, or a rural health network which furnishes home visits for the purpose of providing environmental assessments, case management, health education,

personal care services, family planning, or follow-up treatment or for the purpose of monitoring and tracking disease.

3. Services provided to persons who have developmental disabilities, as defined in s. 393.063(11).

(c) A health care professional, whether or not incorporated, who is licensed under chapter 458, chapter 459, chapter 464, parts I, III, V, or X of chapter 468, chapter 486, chapter 490, or chapter 491, and who is acting alone within the scope of his or her professional license to provide care to patients in their homes.

(d) A home health aide, or certified nursing assistant, who acts in his or her individual capacity within the definitions and standards of his or her respective occupation, and who provides hands-on care to patients in their homes.

(e) An individual who acts alone, in his or her individual capacity, and who is not employed by, or affiliated with, a licensed home health agency or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

(f) The delivery of instructional services in home dialysis and home dialysis supplies or equipment.

(g) The delivery of nursing home services, for which the nursing home is licensed under part II of this chapter, to serve its residents in its facility.

(h) The delivery of assisted living facility services, for which the assisted living facility is licensed under part III of this chapter, to serve its residents in its facility.

(i) The delivery of hospice services, for which the hospice is licensed under part VI of this chapter, to serve hospice patients admitted to its service.

(j) A hospital that provides services for which it is licensed under chapter 395.

(k) The delivery of community residential services, for which the community residential home is licensed under chapter 419, to serve the residents in its facility.

(l) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.

(m) Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

(n) The delivery of adult family-care home services, for which the adult family-care home is licensed under part VII of this chapter, to serve the residents in its facility.

Section 64. Section 400.471, Florida Statutes, is amended to read:

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

(1) Application for an initial license or for renewal of an existing license must be made under oath to the agency ~~for Health Care Administration~~ on forms furnished by it and must be accompanied by the appropriate license fee as provided in subsection (8)~~subsection (7)~~. The agency must take final action on an initial licensure application within 90 ~~60~~ days after receipt of all required documentation.

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

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

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

(c) Proof of financial ability to operate.

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

(3) An applicant for initial licensure must demonstrate financial ability to operate by submitting a balance sheet and income and expense statement for the first 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses. The applicant shall have demonstrated financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses. All documents required under this subsection must be prepared in accordance with generally accepted accounting principles and the financial statement must be signed by a certified public accountant.

(4) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this

subsection, the term "applicant" means the administrator, or a similarly titled person who is responsible for the day-to-day operation of the licensed home health agency, and the financial officer, or similarly titled individual who is responsible for the financial operation of the licensed home health agency.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency reasonably suspects that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a). Proof of compliance with background screening which has been submitted within the previous 5 years to fulfill the requirements of the Department of Insurance pursuant to chapter 651 as part of an application for a certificate of authority to operate a continuing care retirement community is acceptable in fulfillment of the Department of Law Enforcement and Federal Bureau of Investigation background check.

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation. A standard license may be granted to the

licensee upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the licensee or potential licensee from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interest under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the

corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant, administrator, or financial officer has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has been or is currently excluded, suspended, terminated from, or has involuntarily withdrawn from participation in this state's Medicaid program, or the Medicaid program of any other state, or from participation in the Medicare program or any other governmental or private health care or health insurance program.

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(5)~~(4)~~ The home health agency must ~~also~~ obtain and maintain the following ~~liability~~ insurance coverages, in an~~.~~ ~~Proof of liability insurance, as defined in s. 624.605, must~~

~~be submitted with the application. The Agency for Health Care Administration shall set the required amounts of liability insurance by rule, but the required~~ amount of ~~must~~ not ~~be~~ less than $250,000 per claim, and the home health agency must submit proof of coverage with an initial application for licensure and with each annual application for license renewal:~~.~~

(a) Malpractice insurance, as defined in s. 624.605(1)(k); and

(b) Liability insurance, as defined in s. 624.605(1)(b).

(6)~~(5)~~ Ninety ~~Sixty~~ days before the expiration date, an application for renewal must be submitted to the agency ~~for Health Care Administration~~ under oath on forms furnished by it, and a license must be renewed if the applicant has met the requirements established under this part and applicable rules. The home health agency must file with the application satisfactory proof that it is in compliance with this part and applicable rules. If there is evidence of financial instability, the home health agency must submit satisfactory proof of its financial ability to comply with the requirements of this part.

(7)~~(6)~~ When transferring the ownership of a home health agency, the transferee must submit an application for a license at least 60 days before the effective date of the transfer. If the home health agency is being leased, a copy of the lease agreement must be filed with the application.

(8)~~(7)~~ The license fee and annual renewal fee required of a home health agency are ~~is~~ nonrefundable. The agency ~~for Health Care Administration~~ shall set the fees in an amount that is sufficient to cover its costs in carrying out its

responsibilities under this part, but not to exceed $1,000. However, state, county, or municipal governments applying for licenses under this part are exempt from the payment of license fees. All fees collected under this part must be deposited in the Health Care Trust Fund for the administration of this part.

(9)~~(8)~~ The license must be displayed in a conspicuous place in the administrative office of the home health agency and is valid only while in the possession of the person to which it is issued. The license may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily, and is valid only for the home health agency and location for which originally issued.

(10)~~(9)~~ A home health agency against whom a revocation or suspension proceeding is pending at the time of license renewal may be issued a provisional license effective until final disposition by the agency ~~for Health Care Administration~~ of such proceedings. If judicial relief is sought from the final disposition, the court that has jurisdiction may issue a temporary permit for the duration of the judicial proceeding.

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

(12) The agency may not issue a license to an agency that has any unpaid fines assessed under this part.

Section 65. Section 400.474, Florida Statutes, is amended to read:

400.474 Denial, suspension, revocation of license; injunction; grounds.--

(1) The agency ~~for Health Care Administration~~ may deny, revoke, or suspend a license, or impose an administrative fine in the manner provided in chapter 120, or initiate injunctive proceedings under s. 400.515.

(2) Any of the following actions by a home health agency ~~or its employee~~ is grounds for disciplinary action by the agency ~~for Health Care Administration~~:

(a) Violation of this part or of applicable rules.

(b) An intentional, reckless, or negligent act that materially affects the health or safety of a patient.

(3) The agency may impose the following penalties for operating without a license upon an owner who has in the past operated, or who currently operates, a licensed home health agency:

(a) If a home health agency that is found to be operating without a license wishes to apply for a license, the home health agency may submit an application only after the agency has verified that the home health agency no longer operates an unlicensed agency.

(b) Any person, partnership, or corporation that violates paragraph (a) and that previously operated a licensed home health agency or concurrently operates both a licensed home health agency and an unlicensed home health agency commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If an owner has an interest in more than one home health agency and fails to license any one of those agencies, the agency shall issue a cease and desist order for the activities of the unlicensed home health agency and impose a moratorium on any or all of

the licensed agencies until the unlicensed home health agency is licensed.

(c) If any home health agency meets the criteria in paragraph (a) or paragraph (b) and that home health agency has received any government reimbursement for services provided by an unlicensed home health agency, the agency shall make a fraud referral to the appropriate government reimbursement program.

(4) The agency may deny, revoke, or suspend the license of a home health agency, or may impose on a home health agency administrative fines not to exceed the aggregate sum of $5,000, if:

(a) A home health agency fails to provide at least one of the services listed in s. 400.462(10) directly to patients for a period of 6 consecutive months.

(b) The agency is unable to obtain entry to the home health agency to conduct a licensure survey, complaint investigation, surveillance visit, or monitoring visit.

(c) An applicant or a licensed home health agency has falsely represented a material fact in the application, or has omitted from the application any material fact, including, but not limited to, the fact that the controlling or ownership interest is held by any officer, director, agent, manager, employee, affiliated person, partner, or shareholder who may not be eligible to participate.

(d) An applicant, owner, or person who has a 5 percent or greater interest in a licensed entity:

1. Has been previously found by any licensing, certifying, or professional standards board or agency to have violated standards or conditions that relate to home

health-related licensure or certification, or to the quality of home health-related services provided.

2. Has been or is currently excluded, suspended, or terminated from, or has involuntarily withdrawn from, participation in the Medicaid program of this state or any other state, the Medicare program, or any other governmental health care or health insurance program.

Section 66. Section 400.484, Florida Statutes, is amended to read:

400.484 Right of inspection.--

(1) Any duly authorized officer or employee of the agency ~~for Health Care Administration~~ may make such inspections and investigations as are necessary in order to determine the state of compliance with this part and with applicable rules. The right of inspection extends to any business that the agency ~~for Health Care Administration~~ has reason to believe is being operated as a home health agency without a license, but such inspection of any such business may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part or for license renewal constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.

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

(a) A class I deficiency is any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at imminent risk of death, disablement, or permanent injury. Upon finding a class I deficiency, the agency must impose an administrative fine in

the amount of $5,000 for each occurrence and each day that the deficiency exists. In addition, the agency may immediately revoke the license, or impose a moratorium on the admission of new patients, until the factors causing the deficiency have been corrected.

(b) A class II deficiency is any act, omission, or practice that has a direct adverse effect on the health, safety, or security of a patient. Upon finding a class II deficiency, the agency must impose an administrative fine in the amount of $1,000 for each occurrence and each day that the deficiency exists. In addition, the agency may suspend the license, or impose a moratorium on the admission of new patients, until the factors causing the deficiency have been corrected.

(c) A class III deficiency is any act, omission, or practice that has an indirect adverse effect on the health, safety, or security of a patient. Upon finding an uncorrected or repeated class III deficiency, the agency may impose an administrative fine not to exceed $500 for each occurrence and each day that the uncorrected or repeated deficiency exists.

(d) A class IV deficiency is any act, omission, or practice related to a required report, form, or document which does not have the potential to negatively affect a patient. A class IV deficiency is a deficiency that the agency determines does not threaten the health, safety, or security of a patient. Upon finding an uncorrected or repeated class IV deficiency, the agency may impose an administrative fine not to exceed $200 for each occurrence and each day that the uncorrected or repeated deficiency exists.

Section 67. Section 400.487, Florida Statutes, is amended to read:

400.487 Patient assessment; establishment and review of plan of care; provision of services.--

(1) The home health agency providing skilled care ~~and treatment~~ must make an assessment of the patient's needs within 48 hours after the start of services.

(2) The attending physician for a patient who is to receive skilled ~~receiving~~ care ~~or treatment provided by a licensed nurse or by a physical, occupational, or speech therapist~~ must establish treatment orders ~~a plan of care for the patient on behalf of the home health agency that provides services to the patient~~. The ~~original plan of~~ treatment orders must be signed by the physician within 21 days after the start of care and reviewed, at least every 62 days or more frequently if the patient's illness requires, by the physician in consultation with home health agency personnel that provide services to the patient. Based on the assessment and the treatment orders, the home health agency shall prepare a plan of care that describes the services to be provided, the frequency of service provision, and any other information required by rule. The treatment orders and plan of care may be incorporated into one document.

(3) If a client is accepted for home health aide services, homemaker services, or companion services and such services do not require a physician's order, the home health agency shall establish a service-provision plan and maintain a record of the services provided.

(4)~~(3)~~ Each patient or client has the right to be informed of and to participate in the planning of his or her care. Each patient must be provided, upon request, a copy of the plan of care or service-provision plan established and

maintained for that patient or client by the home health agency.

~~(4) Home health services that are provided to a patient must be evaluated in the patient's home by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 or by a registered nurse licensed under chapter 464 as frequently as necessary to assure safe and adequate care, but not less frequently than once every 62 days.~~

(5) In the case of nursing services delivered by a home health agency to a patient, the home health agency to which a patient has been admitted for care must provide the initial admission visit, all service evaluation visits, and the discharge visit by qualified personnel who are on the payroll of, and to whom an IRS payroll form W-2 will be issued by, the home health agency ~~at least one home health service to patients for whom it has agreed to provide care~~. Services provided by others under contractual arrangements to a home health agency ~~agency's patients~~ must be monitored and managed ~~controlled~~ by the admitting home health agency. The home health agency is fully responsible for ensuring that all care provided through its employees or contract staff is delivered in accordance with this part and applicable rules.

(6) The skilled care ~~services~~ provided by a home health agency, directly or under contract, must be supervised and coordinated in accordance with the plan of care.

Section 68. Section 400.491, Florida Statutes, is amended to read:

400.491 Clinical records.--

(1) The home health agency must maintain for each patient who receives skilled care a clinical record that includes ~~the services the home health agency provides directly~~

~~and those provided through arrangement with another health care provider, except for those services provided by persons referred under s. 400.509. Such records must contain~~ pertinent past and current medical, nursing, social and other therapeutic information, the plan of treatment, and other such information as is necessary for the safe and adequate care of the patient. When home health services are terminated, the record must show the date and reason for termination. Such records are considered patient records under s. 455.241 ~~s. 400.241~~, and must be maintained by the home health agency for 5 years following termination of services. If a patient transfers to another home health agency, a copy of his or her record must be provided to the other home health agency upon request.

(2) The home health agency must maintain for each client who receives nonskilled care a service-provision plan. Such records must be maintained by the home health agency for 1 year following termination of services.

Section 69. Section 400.497, Florida Statutes, is amended to read:

400.497 Rules establishing minimum standards.--The agency ~~for Health Care Administration~~ shall adopt, publish, and enforce rules to implement this part, including, as applicable, ss. 400.506 and 400.509, which ~~must~~ provide reasonable and fair minimum standards relating to:

~~(1) Scope of home health services to be provided.~~

(1)~~(2)~~ The qualifications, ~~and~~ minimum training requirements, and supervision requirements of all home health agency personnel, including aides. The agency shall allow shared staffing if the home health agency is part of a retirement community that provides multiple levels of care, is

located on one campus, is licensed under this chapter, and otherwise meets the requirements of law and rule.

(2)~~(3)~~ Requirements for prospective employees ~~Procedures for maintaining a record of the employment history of all home health agency personnel. A home health agency must require its personnel~~ to submit an employment history to the home health agency, and verification of ~~it must verify~~ the employment history unless through diligent efforts such verification is not possible. The agency ~~for Health Care Administration~~ shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made. ~~The administrator of a home health agency must review the employment history and references of home health agency personnel and applicants for employment. The Agency for Health Care Administration must review the employment history and references of each administrator of a home health agency.~~ There is no monetary liability on the part of, and no cause of action for damages arises against, a former employer of a prospective employee of or prospective independent contractor with a licensed home health agency who reasonably and in good faith communicates his or her honest opinions about the former employee's job performance. This subsection does not affect the official immunity of an officer or employee of a public corporation.

(3)~~(4)~~ Licensure application and renewal.

(4)~~(5)~~ The administration of the home health agency, including requirements for onsite and electronic accessibility of supervisory personnel.

(5)~~(6)~~ Procedures for administering drugs and biologicals.

(6)~~(7)~~ Procedures for maintaining patients'~~patient~~ records.

(7)~~(8)~~ Provision of ~~Ensuring that the~~ home health services ~~provided~~ by a home health agency ~~are~~ in accordance with the plan of care ~~treatment~~ established for each patient for whom a plan of care is required.

(8)~~(9)~~ Geographic service areas.

(9)~~(10)~~ Standards for contractual arrangements for the provision of home health services by providers not employed by the home health agency providing for the patient's care and treatment.

Section 70. Subsection (1) of section 400.506, Florida Statutes, is amended, present subsections (2), (3), (4), (5), (6), (7), (8), (10), (11), (12), (13), (14), (15), and (16) of that section are redesignated as subsections (3), (4), (5), (6), (7), (8), (9), (11), (12), (13), (14), (15), (16), and (17), respectively, present subsection (9) of that section is redesignated as subsection (10) and amended, and a new subsection (2) is added to that section, to read:

400.506 Licensure of nurse registries; requirements; penalties.--

(1) A nurse registry is exempt from the licensing requirements of a home health agency, but must be licensed as a nurse registry. Each operational site of a nurse registry must be licensed unless the nurse registry operates more than one site within a county. If the nurse registry operates more than one site within a county, only one license is required for the sites within that county and each operational site shall be listed on the license.

(2) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the nurse registry, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the registry, including billings for patient care and services. The applicant shall comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check but the agency has not yet received background screening results from the Federal Bureau of Investigation. A standard license may be granted to the applicant upon the agency's receipt of a report of the results

of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no

financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke the license if any applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(10)~~(9)~~(a) A nurse registry may refer for contract in private residences registered nurses and licensed practical nurses registered and licensed under chapter 464, certified nursing assistants certified under s. 400.211, home health aides who present documented proof of successful completion of the training required by rule of the agency, and ~~sitters,~~ companions~~,~~ or homemakers for the purposes of providing those

services authorized under s. 400.509(1). A person referred by a nurse registry must provide current documentation that he or she is free from any communicable disease.

(b) A certified nursing assistant or home health aide may be referred for a contract to provide care to a patient in his or her home only if that patient is under a physician's care. A certified nursing assistant, or home health aide, referred for contract in a private residence shall be limited to assisting a patient with bathing, dressing, toileting, grooming, eating, physical transfer, and those normal daily routines the patient could perform for himself or herself were he or she physically capable. A certified nursing assistant or home health aide may not provide medical or other health care services that require specialized training and that may be performed only by licensed health care professionals. The nurse registry shall obtain the name and address of the attending physician and send written notification to the physician within 48 hours after a contract is concluded that a certified nursing assistant or home health aide will be providing care for that patient.

(c) A registered nurse shall make monthly visits to the patient's home to assess the patient's condition and quality of care being provided by the certified nursing assistant or home health aide. Any condition which in the professional judgment of the nurse requires further medical attention shall be reported to the attending physician and the nurse registry. The assessment shall become a part of the patient's file with the nurse registry and may be reviewed by the Agency for Health Care Administration during their survey procedure.

~~(d) In order to refer for contract in private residences a certified nursing assistant or any person specified in s. 400.509(1), the nurse registry and such person registered with the nurse registry must also be registered under s. 400.509. Any person registered as an independent contractor with a nurse registry for the purpose of providing services authorized under s. 400.509(1) on or before October 1, 1990, is exempt from registration under s. 400.509 so long as such person remains continuously registered with that nurse registry.~~

Section 71. Subsections (1) and (2) of section 400.509, Florida Statutes, are amended, present subsections (3), (6), (7), (8), (9), (10), (11), (12), and (13) of that section are redesignated as subsections (4), (7), (8), (9), (10), (11), (12), (13), and (14), respectively, subsections (4) and (5) of that section are redesignated as subsections (5) and (6), respectively, and amended, and a new subsection (3) is added to that section, to read:

400.509 Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.--

(1) Any person who ~~that~~ provides domestic maid services, ~~sitter services,~~companion services, or homemaker services and does not provide a home health service to a person is exempt from licensure under this part. However, any person who ~~that~~ provides ~~sitter services for adults,~~companion services~~,~~or homemaker services must register with the Agency for Health Care Administration. This section does not apply to an individual who provides services under a contract with the Department of Children and Family Services and who has undergone screening under s. 393.0655.

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

(2) Registration consists of annually filing with the agency ~~for Health Care Administration~~, under oath, on forms provided by it, the following information:

(a) The name, address, date of birth, and social security number of the individual~~, or the name and address of the person,~~providing the service.

(b) If the registrant is a firm or partnership, the name, address, date of birth, and social security number of every member.

(c) If the registrant is a corporation or association, its name and address, the name, address, date of birth, and social security number of each of its directors and officers, and the name and address of each person having at least a 5-percent ~~10-percent~~ interest in the corporation or association.

(d) The name, address, date of birth, and social security number of each person employed or under contract.

(3) Each applicant for registration must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 1 standards for screening set forth in chapter 435, of the individual providing the service. If the applicant is a firm or partnership, the agency shall require background screening of the managing employee, or other similarly titled individual who is responsible for the operation of the entity, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the entity, including billings for client services, in accordance with level 2 standards for background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other healthcare or assisted living licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional registration may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check but the agency has not yet received background screening results from the Federal Bureau of Investigation. A standard registration may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and

a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A registration may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the

level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke the registration if any applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for registration renewal must contain the information required under paragraphs (e) and (f).

(5)~~(4)~~ Each registrant must establish the employment history of persons employed or under contract having contact at any time with clients ~~patients~~ in their homes by:

(a) Requiring persons employed or under contract to submit an employment history to the registrant; and

(b) Verifying the employment history, unless through diligent efforts such verification is not possible. The agency ~~for Health Care Administration~~ shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.

There is no monetary liability on the part of, and no cause of action for damages arises against, a former employer of a prospective employee of or prospective independent contractor with a registrant who reasonably and in good faith communicates his or her honest opinions about the former employee's job performance. This subsection does not affect

the official immunity of an officer or employee of a public corporation.

(6)~~(5)~~ On or before the first day on which services are provided to a client ~~patient~~, any registrant under this part must inform the client ~~patient~~ and his or her immediate family, if appropriate, of the right to report abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse registry must be provided to patients in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free ...(phone number)...." Registrants must establish appropriate policies and procedures for providing such notice to clients ~~patients~~.

Section 72. Section 400.512, Florida Statutes, is amended to read:

400.512 Screening of home health agency personnel; nurse registry personnel; and ~~sitters,~~companions~~,~~and homemakers.--The agency ~~for Health Care Administration~~ shall require employment, or contractor, screening as provided in chapter 435, using the level 1 standards for screening set forth in that chapter, for home health agency personnel; persons referred for contract ~~employment~~ by nurse registries; and persons employed or referred by ~~sitter,~~companion~~,~~or homemaker services registered under s. 400.509.

(1) The agency ~~for Health Care Administration~~ may grant exemptions from disqualification from employment under this section as provided in s. 435.07.

(2) The administrator of each home health agency, nurse registry, or ~~sitter,~~companion~~,~~or homemaker service registered under s. 400.509 must sign an affidavit annually, under penalty of perjury, stating that all personnel hired, or

registered,on or after October 1, 1994 ~~1989~~, who enter the home of a patient or client in ~~the capacity of~~ their service capacity ~~employment~~ have been screened and that its remaining personnel have worked for the home health agency or registrant, or have been registered with the nurse registry, continuously since before October 1, 1994 ~~1989~~.

(3) As a prerequisite to operating as a home health agency, or ~~sitter,~~companion~~,~~or homemaker service under s. 400.509, the administrator must submit to the agency his or her ~~for Health Care Administration their~~ name and any other information necessary to conduct a complete screening according to this section. The agency ~~for Health Care Administration~~ shall submit the information to the Department of Law Enforcement and the department's abuse hotline for state processing. The agency ~~for Health Care Administration~~ shall review the record of the administrator with respect to the offenses specified in this section and shall notify the owner of its findings. If disposition information is missing on a criminal record, the administrator, upon request of the agency ~~for Health Care Administration~~, must obtain and supply within 30 days the missing disposition information to the agency ~~for Health Care Administration~~. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information will result in automatic disqualification.

(4) Proof of compliance with the screening requirements of chapter 435 shall be accepted in lieu of the requirements of this section if the ~~provided that such~~ person has been continuously employed, or registered,without a breach in service that exceeds 180 days, the proof of compliance is not more than 2 years old, and the person has

been screened through the central abuse registry and tracking system of the department and by the Department of Law Enforcement. An employer or registry shall directly provide proof of compliance to another home health agency or registry, and a potential home health agency or registry may not accept any proof of compliance directly from the person who requires screening.Proof of compliance with the screening requirements of this section shall be provided upon request to the person screened by the home health agencies; nurse registries; or ~~sitter,~~companion~~,~~or homemaker services registered under s. 400.509.

(5) There is no monetary liability on the part of, and no cause of action for damages arises against, a licensed home health agency, licensed nurse registry,or ~~sitter,~~companion~~,~~ or homemaker service registered under s. 400.509, that, upon notice of a confirmed report of adult abuse, neglect, or exploitation ~~under paragraph (2)(b)~~, terminates the employee, or removes from the licensed nurse registry the person, against whom the report was issued, whether or not the employee or contractor has filed for an exemption with the agency in accordance with chapter 435 ~~for Health Care Administration under subparagraph (3)(a)5.~~and whether or not the time for filing has expired.

(6) The costs of processing the statewide correspondence criminal records checks and the search of the department's central abuse hotline must be borne by the home health agency; the nurse registry; or the ~~sitter,~~companion~~,~~ or homemaker service registered under s. 400.509, or by the person being screened, at the discretion of the home health agency, nurse registry, or s. 400.509 registrant.

~~(7) The Agency for Health Care Administration; the home health agency; nurse registry; or sitter, companion, or homemaker service registered under s. 400.509 may not use the criminal records, juvenile records, or central abuse hotline information of a person for any purpose other than determining whether that person meets minimum standards of good moral character for home health agency personnel. The criminal records, juvenile records, or central abuse hotline information obtained by the Agency for Health Care Administration; home health agency; nurse registry; or sitter, companion, or homemaker service for determining the moral character of such personnel are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.~~

~~(8)(a) It is a misdemeanor of the first degree, punishable under s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:~~

~~1. Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for voluntary or paid employment a material fact used in making a determination as to such person's qualifications to be an employee under this section;~~

~~2. Operate or attempt to operate an entity licensed or registered under this part with persons who do not meet the minimum standards for good moral character as contained in this section; or~~

~~3. Use information from the criminal records or central abuse hotline obtained under this section for any purpose other than screening that person for employment as specified in this section or release such information to any~~

~~other person for any purpose other than screening for employment under this section.~~

~~(b) It is a felony of the third degree, punishable under s. 775.082, s. 775.083, or s. 775.084, for any person willfully, knowingly, or intentionally to use information from the juvenile records of a person obtained under this section for any purpose other than screening for employment under this section.~~

Section 73. Subsections (3), (4), (5), (6), (7), (8), (9), (10), and (11) are added to section 400.555, Florida Statutes, to read:

400.555 Application for licensure.--

(3) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the facility administrator or similarly titled individual who is responsible for the day-to-day operation of the licensed facility and the facility financial officer or similarly titled individual who is responsible for the financial operation of the licensed facility.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency reasonably suspects that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other healthcare or assisted living licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions,

permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement shall not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant, operator, or financial officer has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

Section 74. Section 400.5572, Florida Statutes, is created to read:

400.5572 Background screening.--

(1) The center owner or operator shall conduct level 1 background screening, as set forth in chapter 435, on all employees hired on or after October 1, 1998, who perform basic or supportive and optional services defined in s. 400.551. The agency may exempt an individual from employment disqualification as set forth in chapter 435.

(2) Proof of compliance with the level 1 background screening requirements of chapter 435 may be satisfied as follows:

(a) The employee or applicant for employment has had a level 1 background screening to qualify for a professional license in this state. Proof of compliance with the level 1 screening requirements must be accompanied, under penalty of perjury, by a copy of the applicant's current professional license and an affidavit of compliance with the level 1 screening requirements.

(b) The employee or applicant for employment has been continuously employed in the same type of occupation for which the person is seeking employment without a breach in service that exceeds 180 days, and proof of compliance with the level 1 screening requirement is no more than 2 years old. Proof of compliance shall be provided directly from one employer or contractor to another, and a potential employer or contractor may not accept any proof of compliance directly from the person who was screened. Upon request, proof of completion of the level 1 screening requirements of this section shall be provided by the employer retaining documentation of the screening to the person who was screened.

(c) The employee or applicant seeking employment is employed by a corporation or business entity or related corporation or business entity that owns, operates, or manages more than one facility or agency licensed under chapter 400 for whom a level 1 screening was conducted by the corporation or business entity as a condition of initial employment or continued employment.

(3) When an employee, volunteer, operator, or owner of a facility has a confirmed report of adult abuse, neglect, or exploitation, as defined in s. 415.102, and the protective investigator knows that the individual is an employee, volunteer, operator, or owner of a center, the agency must be notified of the confirmed report.

Section 75. Section 400.606, Florida Statutes, is amended to read:

400.606 License; application; provisional license renewal; conditional license or permit; certificate of need.--

(1) A license application must be filed on a form provided by the agency and must be accompanied by the

appropriate license fee as well as satisfactory proof that the hospice is in compliance with this part and any rules adopted by the department and proof of financial ability to operate and conduct the hospice in accordance with the requirements of this part. The initial application must be accompanied by a plan for the delivery of home, residential, and homelike inpatient hospice services to terminally ill persons and their families. Such plan must contain, but need not be limited to:

(a) The estimated average number of terminally ill persons to be served monthly.

(b) The geographic area in which hospice services will be available.

(c) A listing of services which are or will be provided, either directly by the applicant or through contractual arrangements with existing providers.

(d) Provisions for the implementation of hospice home care within 3 months after licensure.

(e) Provisions for the implementation of hospice homelike inpatient care within 12 months after licensure.

(f) The number and disciplines of professional staff to be employed.

(g) The name and qualifications of any existing or potential contractee.

(h) A plan for attracting and training volunteers.

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

(j) A statement of financial resources and personnel available to the applicant to deliver hospice care.

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

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

(2) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the facility administrator or similarly titled individual who is responsible for the day-to-day operation of the licensed facility and the facility financial officer or similarly titled individual who is responsible for the financial operation of the licensed facility.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency reasonably suspects that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check but the agency has not yet received background screening results from the Federal Bureau

of Investigation. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization,

receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant, managing employee, or financial officer has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(3)~~(2)~~ A license issued for the operation of a hospice, unless sooner suspended or revoked, shall expire automatically 1 year from the date of issuance. Sixty days prior to the expiration date, a hospice wishing to renew its license shall submit an application for renewal to the agency

on forms furnished by the agency. The agency shall renew the license if the applicant has first met the requirements established under this part and all applicable rules and has provided the information described in subsection (1) in addition to the application. However, the application for license renewal shall be accompanied by an update of the plan for delivery of hospice care only if information contained in the plan submitted pursuant to subsection (1) is no longer applicable.

(4)~~(3)~~ A hospice against which a revocation or suspension proceeding is pending at the time of license renewal may be issued a conditional license by the agency effective until final disposition of such proceeding. If judicial relief is sought from the final agency action, the court having jurisdiction may issue a conditional permit for the duration of the judicial proceeding.

(5)~~(4)~~ The agency shall not issue a license to a hospice that fails to receive a certificate of need under the provisions of ss. 408.031-408.045. A licensed hospice is a health care facility as that term is used in s. 408.039(5) and is entitled to initiate or intervene in an administrative hearing.

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

Section 76. Subsection (4) of section 400.619, Florida Statutes, is amended, present subsections (5), (6), (7), (8), (9), (10), (12), and (13) of that section are redesignated as subsections (11), (12), (13), (14), (15), (16), (18) and (19), respectively, present subsection (11) is redesignated as subsection (17) and amended, and new subsections (5), (6), (7), (8), (9), and (10), are added to that section, to read:

400.619 Licensure requirements.--

(4) Upon receipt of a completed, signed, and dated license application and the fee, the agency must initiate background screening using the level 1 standards for screening which are set forth in chapter 435 for ~~check with the abuse registry and the Department of Law Enforcement concerning~~ the adult family-care home applicant, designated relief persons, all adult household members, and all staff members. The applicant must comply with the procedures for background screening as set forth in chapter 435.The agency shall also conduct an onsite visit to the home that is to be licensed.

(5) Proof of compliance with the level 1 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other healthcare or assisted living licensure requirements of this state is acceptable in fulfillment of the required level 1 background screening of the applicant.

(6) Proof of compliance with the level 1 background screening requirements of chapter 435 may be satisfied as follows:

(a) The applicant, adult household member, staff person, or designated relief person has had a level 1 background screening to qualify for a professional license in this state. Proof of compliance with the level 1 screening

requirement must be accompanied, under penalty of perjury, by a copy of the applicant's current professional license and an affidavit of compliance with the level 1 screening requirement.

(b) The applicant, adult household member, staff person, or designated relief person has been continuously employed in the same type of occupation for which the person is seeking employment without a breach in service that exceeds 180 days, and proof of compliance with the level 1 screening requirement is no more than 2 years old. Proof of compliance shall be provided directly from one employer or contractor to another, and a potential employer or contractor may not accept any proof of compliance directly from the person who was screened. Upon request, proof of completion of the level 1 screening requirement of this section shall be provided by the employer retaining documentation of the screening to the person who was screened.

(7) The application must be accompanied by an affidavit, under penalty of perjury, providing the following information regarding the applicant:

(a) A description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from participation in the Medicaid or Medicare programs or any other governmental healthcare or governmental health insurance program.

(b) Proof of compliance by the applicant with the level 1 background screening standards as set forth in chapter 435, and by all adult household members, all staff, and all relief persons with the level 1 background screening standards set forth in chapter 435.

(8) A license may not be granted to any applicant if the applicant, adult household member, staff member, or designated relief person has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 1 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(17)~~(11)~~ The agency may deny, suspend, or revoke a license for any of the following reasons:

(a) A confirmed report, obtained under s. 415.1075, of abuse, neglect, or exploitation, or conviction of a crime related to abuse, neglect, or exploitation.

(b) A proposed confirmed report that remains unserved and is maintained in the central abuse registry and tracking system pursuant to s. 415.1065(2)(c).

(c) An intentional or negligent act materially affecting the health, safety, or welfare of the adult family-care home residents.

(d) A violation of ss. 400.616-400.629 or rules adopted under ss. 400.616-400.629, including the failure to comply with any restrictions specified in the license.

(e) Submission of fraudulent or inaccurate information to the agency.

(f) Conviction of a felony involving violence to a person.

(g) Failure to pay a civil penalty assessed under this part.

(h) Has had prior Medicaid or Medicare action taken against the applicant as set forth in subsection (8).

Section 77. Subsection (1) of section 400.702, Florida Statutes, is amended to read:

400.702 Development of intermediate care facilities.--

(1) The Department of Health and Rehabilitative Services is directed to issue a request for proposals, pursuant to the provisions of chapter 287, for a pilot program of intermediate-level care facilities. The development of intermediate-level care facilities under this pilot program shall be limited to four projects in geographic locations distributed in the south, north, and central part of the state and shall not exceed a total of 120 beds in each location. None of the projects may accept residents prior to July 1, 1990. The intermediate-level care facilities shall:

(a) Provide care to residents whose condition requires intermediate care services, including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and treatment provided in a hospital or that which meets the criteria for skilled nursing services.

~~(b) Accept only low-income residents who receive subsidized housing vouchers through the United States Department of Housing and Urban Development or other subsidized housing programs.~~

(b)~~(c)~~ Accept only low-income residents who are Medicaid recipients or Medicaid-eligible recipients.

(c)~~(d)~~ Be exempt from all requirements to obtain a certificate of need pursuant to ss. 408.031-408.045; however, the beds so utilized will be counted in the total bed supply for determination of nursing home bed needs.

(d)~~(e)~~ Be licensed as a nursing home pursuant to part II and ss. 408.061, 408.08, and 408.20, except that the

department is given the authority to waive any requirement that unnecessarily restricts the development of intermediate care facilities, provided such waiver does not contravene federal or state law. The department shall, however, ensure that the health and safety of residents of intermediate care facilities are adequately protected.

Section 78. Section 400.801, Florida Statutes, is amended to read:

400.801 Homes for special services.--

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

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

(b) "Home for special services" means a site where specialized health care services are provided, including personal and custodial care, but not continuous nursing services.

(2) A person must obtain a license from the agency to operate a home for special services. A license is valid for 1 year.

(3) The application for a license under this section must be made on a form provided by the agency. A nonrefundable license fee of not more than $1,000 must be submitted with the license application.

(4) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the facility, and of the financial officer, or other

similarly titled individual who is responsible for the financial operation of the facility, including billings for client care and services, in accordance with the level 2 standards for screening set forth in chapter 435. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which

confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the

director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(5)~~(4)~~ Application for license renewal must be submitted 90 days before the expiration of the license.

(6)~~(5)~~ A change of ownership or control of a home for special services must be reported to the agency in writing at least 60 days before the change is scheduled to take effect.

(7)~~(6)~~ The agency shall adopt rules for implementing and enforcing this section.

(8)~~(7)~~(a) It is unlawful for any person to establish, conduct, manage, or operate a home for special services without obtaining a license from the agency.

(b) It is unlawful for any person to offer or advertise to the public, in any medium whatever, specialized health care services without obtaining a license from the agency.

(c) It is unlawful for a holder of a license issued under this section to advertise or represent to the public that it holds a license for a type of facility other than the facility for which its license is issued.

(9)~~(8)~~(a) A violation of any provision of this section or rules adopted by the agency for implementing this section is punishable by payment of an administrative fine not to exceed $5,000.

(b) A violation of subsection(8)~~(7)~~or rules adopted under that subsection is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation is a separate offense.

Section 79. Present subsections (4), (5), and (6) of section 400.805, Florida Statutes, are redesignated as subsections (5), (6), and (7), respectively, present subsections (3) and (7) of that section are redesignated as subsections (4) and (8), respectively, and amended, and a new subsection (3) is added to that section, to read:

400.805 Transitional living facilities.--

(3) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth

in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the facility, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the facility, including billings for client care and services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of

Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no

financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(4)~~(3)~~ An application for renewal of license must be submitted 90 days before the expiration of the license. Upon renewal of licensure, each applicant must submit to the agency, under penalty of perjury, an affidavit as set forth in s. 400.805(3)(d).

(8)~~(7)~~(a) A violation of any provision of this section or rules adopted by the agency or division under this section

is punishable by payment of an administrative or a civil penalty fine not to exceed $5,000.

(b) A violation of subsection (7) ~~(6)~~ or rules adopted under that subsection is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of a continuing violation is a separate offense.

Section 80. Subsection (1), paragraphs (e) and (f) of subsection (3), subsection (6), and paragraphs (c) and (d) of subsection (7) of section 408.05, Florida Statutes, are amended to read:

408.05 State Center for Health Statistics.--

(1) ESTABLISHMENT.--The agency ~~department~~ shall establish a State Center for Health Statistics. The center shall establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics. The center shall be staffed with public health experts, biostatisticians, information system analysts, health policy experts, economists, and other staff necessary to carry out its functions.

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to produce comparable and uniform health information and statistics, the agency shall perform the following functions:

(e) The agency ~~department~~ shall establish by rule the types of data collected, compiled, processed, used, or shared. Decisions regarding center data sets should be made based on consultation with the Comprehensive Health Information System Advisory Council and other public and private users regarding the types of data which should be collected and their uses.

(f) The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the agency ~~department~~.

(6) PROVIDER DATA REPORTING.--This section does not confer on the agency ~~department~~ the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law.

(7) BUDGET; FEES; TRUST FUND.--

(c) The center may charge such reasonable fees for services as the agency ~~department~~ prescribes by rule. The established fees may ~~shall~~ not exceed the reasonable cost for such services. Fees collected may not be used to offset annual appropriations from the General Revenue Fund.

(d) The agency ~~department~~ shall establish a Comprehensive Health Information System Trust Fund as the repository of all funds appropriated to, and fees and grants collected for, services of the State Center for Health Statistics. Any funds, other than funds appropriated to the center from the General Revenue Fund, which are raised or collected by the agency ~~department~~ for the operation of the center and which are not needed to meet the expenses of the center for its current fiscal year shall be available to the agency ~~board~~ in succeeding years.

Section 81. Subsections (10) and (11) of section 408.061, Florida Statutes, are amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidentiality of patient records; immunity.--

(10) No health care facility, health care provider, health insurer, or other reporting entity or its employees or agents shall be held liable for civil damages or subject to criminal penalties either for the reporting of patient data to the agency ~~board~~ or for the release of such data by the agency ~~board~~ as authorized by this chapter.

(11) The agency shall be the primary source for collection and dissemination of health care data. No other agency of state government may gather data from a health care provider licensed or regulated under this chapter without first determining if the data is currently being collected by the agency and affirmatively demonstrating that it would be more cost-effective for an agency of state government other than the agency to gather the health care data. The director ~~secretary~~ shall ensure that health care data collected by the divisions within the agency is coordinated. It is the express intent of the Legislature that all health care data be collected by a single source within the agency and that other divisions within the agency, and all other agencies of state government, obtain data for analysis, regulation, and public dissemination purposes from that single source. Confidential information may be released to other governmental entities or to parties contracting with the agency to perform agency duties or functions as needed in connection with the performance of the duties of the receiving entity. The receiving entity or party shall retain the confidentiality of such information as provided for herein.

Section 82. Subsections (2) and (5) of section 408.062, Florida Statutes, are amended to read:

408.062 Research, analyses, studies, and reports.--

(2) The agency ~~board~~ shall evaluate data from nursing home financial reports and shall document and monitor:

(a) Total revenues, annual change in revenues, and revenues by source and classification, including contributions for a resident's care from the resident's resources and from the family and contributions not directed toward any specific resident's care.

(b) Average resident charges by geographic region, payor, and type of facility ownership.

(c) Profit margins by geographic region and type of facility ownership.

(d) Amount of charity care provided by geographic region and type of facility ownership.

(e) Resident days by payor category.

(f) Experience related to Medicaid conversion as reported under s. 408.061.

(g) Other information pertaining to nursing home revenues and expenditures.

The findings of the agency ~~board~~ shall be included in an annual report to the Governor and Legislature by January 1 each year.

(5)(a) The agency may conduct data-based studies and evaluations and make recommendations to the Legislature and the Governor concerning exemptions, the effectiveness of limitations of referrals, restrictions on investment interests and compensation arrangements, and the effectiveness of public disclosure. Such analysis may include, but need not be limited to, utilization of services, cost of care, quality of care, and access to care. The agency may require the submission of data necessary to carry out such investigations,

which may include, but need not be limited to, data concerning ownership, Medicare and Medicaid, charity care, types of services offered to patients, revenues and expenses, patient-encounter data, and other data reasonably necessary to study utilization patterns and the impact of health care provider ownership interests in health-care-related entities on the cost, quality, and accessibility of health care.

(b) The agency may collect such data from any health facility as a special study. ~~The board is directed to research hospital financial and nonfinancial data in order to determine the need for establishing a category of inpatient hospital patients defined as medically indigent. For purposes of this section, a medically indigent patient is an individual who is admitted as an inpatient to a hospital, who is not classified as a Medicare beneficiary, a Medicaid recipient, or a charity care patient, but who has insufficient financial resources to pay for needed medical care. In its determination of the need for establishing a category of medically indigent patients, the board shall consider the creation of income and asset levels that would establish a person as medically indigent. The board shall submit a report and recommendations to the Governor and the Legislature on the establishment of a category of medically indigent inpatient hospital patients on or before January 1, 1994. If the board recommends the establishment of a category of medically indigent patients, it shall provide a specific recommendation for the eligibility determination process to be used in classifying a patient as medically indigent.~~

Section 83. Subsection (1) of section 408.063, Florida Statutes, is amended to read:

408.063 Dissemination of health care information.--

(1) The agency, relying on data collected pursuant to this chapter, shall establish a reliable, timely, and consistent information system which distributes information and serves as the basis for the agency's ~~board's~~ public education programs. The agency shall seek advice from consumers, health care purchasers, health care providers, health care facilities, health insurers, and local health councils in the development and implementation of its information system. Whenever appropriate, the agency shall use the local health councils for the dissemination of information and education of the public.

Section 84. Section 408.07, Florida Statutes, is amended to read:

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

(1) "Accepted" means that the agency ~~board~~ has found that a report or data submitted by a health care facility or a health care provider contains all schedules and data required by the agency ~~board~~ and has been prepared in the format specified by the agency ~~board~~, and otherwise conforms to applicable rule or Florida Hospital Uniform Reporting System manual requirements regarding reports in effect at the time such report was submitted, and the data are mathematically reasonable and accurate.

(2) "Adjusted admission" means the sum of acute and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues. If a hospital reports only subacute admissions, then "adjusted admission" means the sum of subacute admissions divided by the ratio of total inpatient revenues to gross revenues.

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

(4) "Alcohol or chemical dependency treatment center" means an organization licensed under chapter 397.

(5) "Ambulatory care center" means an organization which employs or contracts with licensed health care professionals to provide diagnosis or treatment services predominantly on a walk-in basis and the organization holds itself out as providing care on a walk-in basis. Such an organization is not an ambulatory care center if it is wholly owned and operated by five or fewer health care providers.

(6) "Ambulatory surgical center" means a facility licensed as an ambulatory surgical center under chapter 395.

~~(7) "Applicable rate of increase" means the maximum allowable rate of increase (MARI) when applied to gross revenue per adjusted admission, unless the board has approved a different rate of increase, in which case the board-approved rate of increase shall apply.~~

(7)~~(8)~~ "Audited actual data" means information contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards, but does not include data within a financial statement about which the certified public accountant does not express an opinion or issues a disclaimer.

~~(9) "Banked points" means the percentage points earned by a hospital when the actual rate of increase in gross revenue per adjusted admission (GRAA) is less than the maximum allowable rate of increase (MARI) or the actual rate of increase in the net revenue per adjusted admission (NRAA) is less than the market basket index.~~

(8)~~(10)~~ "Birth center" means an organization licensed under s. 383.305.

~~(11) "Board" means the Health Care Board established under s. 408.003.~~

~~(12) "Budget" means the projections by the hospital, for a specified future time period, of expenditures and revenues, with supporting statistical indicators, or a budget letter verified by the board pursuant to s. 408.072(3)(a).~~

(9)~~(13)~~ "Cardiac catheterization laboratory" means a freestanding facility that ~~which~~ employs or contracts with licensed health care professionals to provide diagnostic or therapeutic services for cardiac conditions such as cardiac catheterization or balloon angioplasty.

(10)~~(14)~~ "Case mix" means a calculated index for each health care facility or health care provider, based on patient data, reflecting the relative costliness of the mix of cases to that facility or provider compared to a state or national mix of cases.

(11)~~(15)~~ "Clinical laboratory" means a facility licensed under s. 483.091, excluding: any hospital laboratory defined under s. 483.041(5); any clinical laboratory operated by the state or a political subdivision of the state; any blood or tissue bank where the majority of revenues are received from the sale of blood or tissue and where blood, plasma, or tissue is procured from volunteer donors and donated, processed, stored, or distributed on a nonprofit basis; and any clinical laboratory which is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice, and at which no clinical laboratory work is

performed for patients referred by any health care provider who is not a member of that same group practice.

(12)~~(16)~~ "Comprehensive rehabilitative hospital" or "rehabilitative hospital" means a hospital licensed by the agency ~~for Health Care Administration~~ as a specialty hospital as defined in s. 395.002; provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the hospital are classified as "comprehensive rehabilitative beds" pursuant to s. 395.003(4), and are not classified as "general beds."

(13)~~(17)~~ "Consumer" means any person other than a person who administers health activities, is a member of the governing body of a health care facility, provides health services, has a fiduciary interest in a health facility or other health agency or its affiliated entities, or has a material financial interest in the rendering of health services.

(14)~~(18)~~ "Continuing care facility" means a facility licensed under chapter 651.

(15)~~(19)~~ "Cross-subsidization" means that the revenues from one type of hospital service are sufficiently higher than the costs of providing such service as to offset some of the costs of providing another type of service in the hospital. Cross-subsidization results from the lack of a direct relationship between charges and the costs of providing a particular hospital service or type of service.

(16)~~(20)~~ "Deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. For

hospitals, such reductions include contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.

(17)~~(21)~~ "Diagnostic-imaging center" means a freestanding outpatient facility that provides specialized services for the diagnosis of a disease by examination and also provides radiological services. Such a facility is not a diagnostic-imaging center if it is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice and no diagnostic-imaging work is performed at such facility for patients referred by any health care provider who is not a member of that same group practice.

(18)~~(22)~~ "FHURS" means the Florida Hospital Uniform Reporting System developed by the agency ~~board~~.

(19)~~(23)~~ "Freestanding" means that a health facility bills and receives revenue which is not directly subject to the hospital assessment for the Public Medical Assistance Trust Fund as described in s. 395.701.

(20)~~(24)~~ "Freestanding radiation therapy center" means a facility where treatment is provided through the use of radiation therapy machines that are registered under s. 404.22 and the provisions of the Florida Administrative Code implementing s. 404.22. Such a facility is not a freestanding radiation therapy center if it is wholly owned and operated by physicians licensed pursuant to chapter 458 or chapter 459 who practice within the specialty of diagnostic or therapeutic radiology.

(21)~~(25)~~ "GRAA" means gross revenue per adjusted admission.

(22)~~(26)~~ "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue. Gross revenues do not include contributions, donations, legacies, or bequests made to a hospital without restriction by the donors.

(23)~~(27)~~ "Health care facility" means an ambulatory surgical center, a hospice, a nursing home, a hospital, a diagnostic-imaging center, a freestanding or hospital-based therapy center, a clinical laboratory, a home health agency, a cardiac catheterization laboratory, a medical equipment supplier, an alcohol or chemical dependency treatment center, a physical rehabilitation center, a lithotripsy center, an ambulatory care center, a birth center, or a nursing home component licensed under chapter 400 within a continuing care facility licensed under chapter 651.

(24)~~(28)~~ "Health care provider" means a health care professional licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 464, chapter 465, chapter 466, part I, part III, part IV, part V, or part X of chapter 468, chapter 483, chapter 484, chapter 486, chapter 490, or chapter 491.

(25)~~(29)~~ "Health care purchaser" means an employer in the state, other than a health care facility, health insurer, or health care provider, who provides health care coverage for her or his employees.

(26)~~(30)~~ "Health insurer" means any insurance company authorized to transact health insurance in the state, any insurance company authorized to transact health insurance or casualty insurance in the state that is offering a minimum

premium plan or stop-loss coverage for any person or entity providing health care benefits, any self-insurance plan as defined in s. 624.031, any health maintenance organization authorized to transact business in the state pursuant to part I of chapter 641, any prepaid health clinic authorized to transact business in the state pursuant to part II of chapter 641, any multiple-employer welfare arrangement authorized to transact business in the state pursuant to ss. 624.436-624.45, or any fraternal benefit society providing health benefits to its members as authorized pursuant to chapter 632.

(27)~~(31)~~ "Home health agency" means an organization licensed under part IV of chapter 400.

(28)~~(32)~~ "Hospice" means an organization licensed under part VI of chapter 400.

(29)~~(33)~~ "Hospital" means a health care institution licensed by the Agency for Health Care Administration as a hospital under chapter 395.

(30)~~(34)~~ "Lithotripsy center" means a freestanding facility that ~~which~~ employs or contracts with licensed health care professionals to provide diagnosis or treatment services using electro-hydraulic shock waves.

(31)~~(35)~~ "Local health council" means the agency defined in s. 408.033.

(32)~~(36)~~ "Market basket index" means the Florida hospital input price index (FHIPI), which is a statewide market basket index used to measure inflation in hospital input prices weighted for the Florida-specific experience which uses multistate regional and state-specific price measures, when available. The index shall be constructed in the same manner as the index employed by the Secretary of the United States Department of Health and Human Services for

determining the inflation in hospital input prices for purposes of Medicare reimbursement.

~~(37) "Maximum allowable rate of increase" or "MARI" means the maximum rate at which a hospital is normally expected to increase its average gross revenues per adjusted admission for a given period. The board, using the most recent audited actual data for each hospital, shall calculate the MARI for each hospital as follows: The projected rate of increase in the market basket index shall be divided by a number which is determined by subtracting the sum of one-half of the proportion of Medicare days plus one-half of the proportion of CHAMPUS days plus the proportion of Medicaid days plus 1.5 times the proportion of charity care days from the number one. The formula to be employed by the board to calculate the MARI shall take the following form:~~

$$MARI = \frac{FHIPI}{1-[(Me \times 0.5) + (Cp \times 0.5) + Md + (Cc \times 1.5)]}$$

~~where:~~

~~MARI = maximum allowable rate of increase applied to gross revenue.~~

~~FHIPI = Florida hospital input price index, which shall be the projected rate of change in the market basket index.~~

~~Me = proportion of Medicare days, including when available and reported to the board Medicare HMO days, to total days.~~

~~Cp = proportion of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) days to total days.~~

~~Md = proportion of Medicaid days, including when available and reported to the board Medicaid HMO days, to total days.~~

~~Cc = proportion of charity care days to total days with a 50-percent offset for restricted grants for charity care and unrestricted grants from local governments.~~

(33)~~(38)~~ "Medical equipment supplier" means an organization that ~~which~~ provides medical equipment and supplies used by health care providers and health care facilities in the diagnosis or treatment of disease.

(34)~~(39)~~ "Net revenue" means gross revenue minus deductions from revenue.

(35)~~(40)~~ "New hospital" means a hospital in its initial year of operation as a licensed hospital and does not include any facility which has been in existence as a licensed hospital, regardless of changes in ownership, for over 1 calendar year.

(36)~~(41)~~ "Nursing home" means a facility licensed under s. 400.062 or, for resident level and financial data collection purposes only, any institution licensed under chapter 395 and which has a Medicare or Medicaid certified distinct part used for skilled nursing home care, but does not include a facility licensed under chapter 651.

(37)~~(42)~~ "Operating expenses" means total expenses excluding income taxes.

(38)~~(43)~~ "Other operating revenue" means all revenue generated from hospital operations other than revenue directly associated with patient care.

(39)~~(44)~~ "Physical rehabilitation center" means an organization that ~~which~~ employs or contracts with health care professionals licensed under part I or part III of chapter 468

or chapter 486 to provide speech, occupational, or physical therapy services on an outpatient or ambulatory basis.

(40)~~(45)~~ "Prospective payment arrangement" means a financial agreement negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payor which contains, at a minimum, the elements provided for in s. 408.50.

(41)~~(46)~~ "Rate of return" means the financial indicators used to determine or demonstrate reasonableness of the financial requirements of a hospital. Such indicators shall include, but not be limited to: return on assets, return on equity, total margin, and debt service coverage.

(42)~~(47)~~ "Rural hospital" means an acute care hospital licensed under chapter 395, with 85 licensed beds or fewer, which has an emergency room and is located in an area defined as rural by the United States Census, and which is:

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

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

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.

(43)~~(48)~~ "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the agency ~~for Health Care Administration~~ in meeting its responsibilities pursuant to this chapter.

(44)~~(49)~~ "Teaching hospital" means any hospital formally affiliated with an accredited medical school which ~~that~~ exhibits activity in the area of medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

Section 85. Section 408.08, Florida Statutes, is amended to read:

408.08 Inspections and audits; violations; penalties; fines; enforcement.--

(1) The agency may inspect and audit books and records of individual or corporate ownership, including books and records of related organizations with which a health care provider or a health care facility had transactions, for compliance with this chapter. Upon presentation of a written request for inspection to a health care provider or a health care facility by the agency or its staff, the health care provider or the health care facility shall make available to the agency or its staff for inspection, copying, and review all books and records relevant to the determination of whether the health care provider or the health care facility has complied with this chapter.

~~(2) The board shall annually compare the audited actual experience of each hospital to the audited actual experience of that hospital for the previous year.~~

~~(a) For a hospital submitting a budget letter, if the board determines that the audited actual experience of the hospital exceeded its previous year's audited actual experience by more than the maximum allowable rate of increase as certified in the budget letter plus any banked points utilized in the budget letter, the amount of such excess shall~~

~~be determined by the board and a penalty shall be levied against such hospital pursuant to subsection (3).~~

~~(b) For a hospital subject to budget review, if the board determines that the audited actual experience of the hospital exceeded its previous year's audited actual experience by more than the most recent approved budget or the most recent approved budget as amended, the amount of such excess shall be determined by the board, and a penalty shall be levied against such hospital pursuant to subsection (3).~~

~~(c) For a hospital submitting a budget letter and for a hospital subject to budget review, the board shall annually compare each hospital's audited actual experience for net revenues per adjusted admission to the hospital's audited actual experience for net revenues per adjusted admission for the previous year. If the rate of increase in net revenues per adjusted admission between the previous year and the current year was less than the market basket index, the hospital may carry forward the difference and earn up to a cumulative maximum of 3 banked net revenue percentage points. Such banked net revenue percentage points shall be available to the hospital to offset, in any future year, penalties for exceeding the approved budget or the maximum allowable rate of increase as set forth in subsection (3). Nothing in this paragraph shall be used by a hospital to justify the approval of a budget or a budget amendment by the board in excess of the maximum allowable rate of increase pursuant to s. 408.072.~~

~~(3) Penalties shall be assessed as follows:~~

~~(a) For the first occurrence within a 5-year period, the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 5 percent; and, if such excess is greater than 5 percent over the maximum~~

~~allowable rate of increase, any amount in excess of 5 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund.~~

~~(b) For the second occurrence with the 5-year period following the first occurrence as set forth in paragraph (a), the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 2 percent; and, if such excess is greater than 2 percent over the maximum allowable rate of increase, any amount in excess of 2 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund.~~

~~(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall:~~

~~1. Levy a fine against the hospital in the total amount of the excess, to be deposited in the Public Medical Assistance Trust Fund.~~

~~2. Notify the agency of the violation, whereupon the agency shall not accept any application for a certificate of need pursuant to ss. 408.031-408.045 from or on behalf of such hospital until such time as the hospital has demonstrated to the satisfaction of the board that, following the date the penalty was imposed under subparagraph 1., the hospital has stayed within its projected or amended budget or its applicable maximum allowable rate of increase for a period of at least 1 year. However, this provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.~~

~~3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the agency, whereupon the agency shall initiate disciplinary proceedings~~

~~to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.~~

~~The determination of the amount of any such excess shall be based upon net revenues per adjusted admission, excluding funds distributed to the hospital from the Public Medical Assistance Trust Fund. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.701 minus the amount of revenues received by the hospital through the Public Medical Assistance Trust Fund. It is the responsibility of the hospital to demonstrate to the satisfaction of the board its entitlement to such reduction. It is the intent of the Legislature that the Health Care Board, in levying any penalty imposed against a hospital for exceeding its maximum allowable rate of increase or its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital and in the hospital's intensity and severity of illness as measured by changes in the hospital's actual proportion of outlier cases to total cases and dollar increases in outlier cases' average charge per case. It is the responsibility of the hospital to demonstrate to the satisfaction of the board any change in its case mix and in its intensity and severity of illness. For psychiatric hospitals and other hospitals not reimbursed under a prospective payment system by the Federal Government, until a proxy for case mix is available, the board shall also reduce the amount of excess by the change in a hospital's audited actual average length of stay without any thresholds or limitations.~~

~~(4) The following factors may be used by the board to reduce the amount of excess of the hospital as determined pursuant to this section:~~

~~(a) Unforeseen and unforeseeable events which affect the net revenue per adjusted admission and which are beyond the control of the hospital, such as prior year Medicare cost report settlements, retroactive changes in Medicare reimbursement methodology, and increases in malpractice insurance premiums, which occurred in the last 3 months of the hospital fiscal year during which the hospital generated the excess; or~~

~~(b) Imposition of the penalty would have a severe adverse effect which would jeopardize the continued existence of an otherwise economically viable hospital.~~

~~(5) The board shall reduce the amount of the excess for hospitals submitting budget letters pursuant to s. 408.072(3)(a) by the amount of any documented costs from financial assistance provided to expand or supplement the curriculum of a community college, university, or vocational training school for the purpose of training nurses or other health professionals, not including physicians. Financial assistance would include, but not be limited to, the direct costs for faculty salaries and expenses, books, equipment, recruiting efforts, tuition assistance, and hospital internships. The reduction would be based on actual documented expenses increased by the gross revenues necessary to generate net revenues sufficient to cover the expenses.~~

~~(6) If the board finds that any hospital chief executive officer or any person who is in charge of hospital administration or operations has knowingly and willfully allowed or authorized actual operating revenues or~~

~~expenditures that are in excess of projected operating revenues or expenditures in the hospital's approved budget, the board shall order such officer or person to pay an administrative fine not to exceed $5,000.~~

~~(7) For hospitals filing budget letters, the board shall annually compare the audited actual experience of each hospital for the year under review to the audited actual experience of that hospital for the previous year. For hospitals which submitted detailed budgets or budget amendments, the board shall compare the audited actual experience of each hospital for the year under review to its approved gross revenue per adjusted admission for the year under review, for purposes of levying an administrative fine.~~

~~(a) For a hospital submitting a budget letter pursuant to s. 408.072(3)(a), if the board determines that the audited actual experience for the year under review exceeded the hospital's previous year's audited actual experience by more than the maximum allowable rate of increase as certified in the budget letter plus any banked points utilized in the budget letter, the amount of the excess shall be determined and an administrative fine shall be levied against such hospital pursuant to subsection (8).~~

~~(b) For a hospital which submitted a budget pursuant to s. 408.072(1), or a budget amendment pursuant to s. 408.072(6), if the board determines that the gross revenue per adjusted admission contained in the hospital's audited actual experience exceeded its board-approved gross revenue per adjusted admission, the amount of the excess shall be determined and an administrative fine shall be levied against such hospital pursuant to subsection (8).~~

~~(8) If the board determines that an excess exists pursuant to subsection (7), the board shall multiply the excess by the number of actual adjusted admissions contained in the year at issue to determine the amount of the base fine. The base fine shall be multiplied by the applicable occurrence factor to determine the amount of the administrative fine levied against the hospital.~~

~~(a) For the first occurrence within a 5-year period, the applicable occurrence factor shall be 0.25. For the second occurrence within a 5-year period, the applicable occurrence factor shall be 0.55. For the third occurrence within a 5-year period, the applicable occurrence factor shall be 1.0.~~

~~(b) In no event shall any administrative fine levied pursuant to this subsection exceed $365,000.~~

~~(9) In levying any administrative fine against a hospital pursuant to subsection (8), the board shall consider the effect of any changes in the hospital's case mix, and in the hospital's intensity and severity of illness as measured by changes in the hospital's actual proportion of outlier cases to total cases and dollar increases in outlier cases' average charge per case. The board shall adjust the amount of any excess by the changes in the hospital's case mix and in its intensity and severity of illness, based upon certified hospital patient discharge data provided to the board pursuant to s. 408.061. For psychiatric hospitals and other hospitals not reimbursed under a prospective payment system by the Federal Government, until a proxy for case mix is available, the board shall adjust the amount of any excess by the change in a hospital's audited actual average length of stay without any thresholds or limitation.~~

~~(10) In levying any administrative fine against a hospital pursuant to subsection (8), it is the intent of the Legislature that if a hospital can demonstrate to the satisfaction of the board that it operated within its approved gross revenue per adjusted admission for the first 8 months of its fiscal year and did not increase its prices, except for exceptions determined by the board during the last 5 months of its fiscal year, it shall not be subject to any administrative fine levied pursuant to subsection (8).~~

~~(11) It is the further intent of the Legislature that if a hospital can demonstrate to the satisfaction of the board that it did not increase its prices on average in excess of the MARI for the prior year, it shall not be subject to any administrative fine levied pursuant to subsection (8).~~

~~(12) If the board finds that any hospital chief executive officer or any person who is in charge of hospital administration or operations has knowingly and willfully allowed or authorized gross revenue per adjusted admission, net revenue per adjusted admission, or rates of increase that are in excess of gross or net revenue per adjusted admission, or rates of increase in the hospital's approved budget, budget amendment, or budget letter, the agency shall order such officer or person to pay an administrative fine not to exceed $5,000.~~

(2)~~(13)~~ Any health care facility that refuses to file a report, fails to timely file a report, files a false report, or files an incomplete report and upon notification fails to timely file a complete report required under ~~this section and~~ s. 408.061; that violates ~~any provision of~~ this section, s. 408.061, or s. 408.20, or rule adopted thereunder; or that fails to provide documents or records requested by the agency

under ~~the provisions of~~ this chapter shall be punished by a fine not exceeding $1,000 per day for each day in violation, to be imposed and collected by the agency.

(3)~~(14)~~ Any health care provider that refuses to file a report, fails to timely file a report, files a false report, or files an incomplete report and upon notification fails to timely file a complete report required under ~~this section and~~ s. 408.061; that violates ~~any provision of~~ this section, s. 408.061, or s. 408.20, or rule adopted thereunder; or that fails to provide documents or records requested by the agency under ~~the provisions of~~ this chapter shall be referred to the appropriate licensing board which shall take appropriate action against the health care provider.

(4)~~(15)~~ If ~~In the event that~~ a health insurer does not comply with the requirements of s. 408.061, the agency shall report a health insurer's failure to comply to the Department of Insurance, which shall take into account the failure by the health insurer to comply in conjunction with its approval authority under s. 627.410. The agency shall adopt any rules necessary to carry out its responsibilities required by this subsection.

(5)~~(16)~~ Refusal to file, failure to timely file, or filing false or incomplete reports or other information required to be filed under the provisions of this chapter, failure to pay or failure to timely pay any assessment authorized to be collected by the agency, or violation of any other provision of this chapter or lawfully entered order of the agency or rule adopted under this chapter, shall be punished by a fine not exceeding $1,000 a day for each day in violation, to be fixed, imposed, and collected by the agency. Each day in violation shall be considered a separate offense.

(6)~~(17)~~ Notwithstanding any other provisions of this chapter, when a hospital alleges that a factual determination made by the agency ~~board~~ is incorrect, the burden of proof shall be on the hospital to demonstrate that such determination is, in light of the total record, not supported by a preponderance of the evidence. The burden of proof remains with the hospital in all cases involving administrative agency action.

Section 86. Section 408.40, Florida Statutes, 1996 Supplement, is amended to read:

408.40 ~~Budget review proceedings; duty of~~ Public Counsel.--

(1) Notwithstanding any other provisions of this chapter, ~~it shall be the duty of~~ the Public Counsel shall ~~to~~ represent the ~~general~~ public ~~of the state~~ in any proceeding before the agency or its advisory panels in any administrative hearing conducted pursuant to ~~the provisions of~~ chapter 120 or before any other state and federal agencies and courts in any issue before the agency, any court, or any agency. With respect to any such proceeding, the Public Counsel is subject to the provisions of and may use ~~utilize~~ the powers granted to him or her by ss. 350.061-350.0614.

(2) The Public Counsel shall:

(a) Recommend to the agency, by petition, the commencement of any proceeding or action or to appear, in the name of the state or its citizens, in any proceeding or action before the agency and urge therein any position that ~~which~~ he or she deems to be in the public interest, whether consistent or inconsistent with positions previously adopted by the agency, and use ~~utilize~~ therein all forms of discovery available to attorneys in civil actions generally, subject to

protective orders of the agency, which shall be reviewable by summary procedure in the circuit courts of this state.

(b) Have access to and use of all files, records, and data of the agency available to any other attorney representing parties in a proceeding before the agency.

(c) In any proceeding in which he or she has participated as a party, seek review of any determination, finding, or order of the agency, or of any administrative law judge, or any hearing officer or hearing examiner designated by the agency, in the name of the state or its citizens.

(d) Prepare and issue reports, recommendations, and proposed orders to the agency, the Governor, and the Legislature on any matter or subject within the jurisdiction of the agency, and to make such recommendations as he or she deems appropriate for legislation relative to agency procedures, rules, jurisdiction, personnel, and functions.

(e) Appear before other state agencies, federal agencies, and state and federal courts in connection with matters under the jurisdiction of the agency, in the name of the state or its citizens.

Section 87. Paragraph (e) of subsection (10) and subsection (14) of section 409.2673, Florida Statutes, are amended to read:

409.2673 Shared county and state health care program for low-income persons; trust fund.--

(10) Under the shared county and state program, reimbursement to a hospital for services for an eligible person must:

(e) Be conditioned, for tax district hospitals that deliver services as part of this program, on the delivery of charity care, as defined in the rules of the Agency for Health

Care Administration ~~Health Care Cost Containment Board~~, which equals a minimum of 2.5 percent of the tax district hospital's net revenues; however, those tax district hospitals which by virtue of the population within the geographic boundaries of the tax district can not feasibly provide this level of charity care shall assure an "open door" policy to those residents of the geographic boundaries of the tax district who would otherwise be considered charity cases.

(14) Any dispute among a county, the Agency for Health Care Administration ~~Health Care Cost Containment Board~~, the department, or a participating hospital shall be resolved by order as provided in chapter 120. Hearings held under this subsection shall be conducted in the same manner as provided in ss. 120.569 and 120.57, except that the administrative law judge's or hearing officer's order constitutes final agency action. Cases filed under chapter 120 may combine all relevant disputes between parties.

Section 88. Subsection (8) of section 409.905, Florida Statutes, is amended to read:

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

the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(8) NURSING FACILITY SERVICES.--The agency shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital, as defined by s. 395.002(13)~~s. 395.002(10)~~, that is licensed under part I of chapter 395, and in accordance with provisions set forth in s. 409.908(2)(a), which services are ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another nursing facility is not available, the agency must pay for similar services temporarily in a hospital licensed under part I of chapter 395 provided federal funding is approved and available.

Section 89. Section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.--In addition to the payments made under ss. 409.911 and 409.9112, the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding ~~the provisions of~~ s. 409.915, counties are exempt from

contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the agency ~~department~~ shall distribute to each statutory teaching hospital, as defined in s. 408.07, an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals.

(b) The number of full-time equivalent trainees in the hospital, which comprises two components:

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of the year during which each trainee is primarily

assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

2. The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

(c) A service index that ~~which~~ comprises three components:

1. The Agency for Health Care Administration ~~Health Care Cost Containment Board~~ Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration ~~Health Care Cost Containment Board~~ to services offered by the given hospital, as reported on ~~the Health Care Cost Containment Board~~ Worksheet A-2 for the last fiscal year reported to the agency

~~board~~ before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Administration ~~Health Care Cost Containment Board~~ Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration ~~Health Care Cost Containment Board~~ to the volume of each service, expressed in terms of the standard units of measure reported on ~~the Health Care Cost Containment Board~~ Worksheet A-2 for the last fiscal year reported to the agency ~~board~~ before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals.

3. Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all state statutory teaching hospitals.

The primary factor for the service index is computed as the sum of these three components, divided by three.

(2) By October 1 of each year, the agency shall use the following formula ~~shall be utilized by the department~~ to

calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

~~(3) The Health Care Cost Containment Board shall report to the department the statutory teaching hospital allocation fraction prior to October 1 of each year.~~

Section 90. Paragraph (g) of subsection (1) of section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.--

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

(g) "Emergency services and care" means emergency services and care as defined in s. 395.002(10)~~s. 395.002(9)~~.

Section 91. Paragraphs (i) and (k) of subsection (3) of section 455.654, Florida Statutes, are amended to read:

455.654 Financial arrangements between referring health care providers and providers of health care services.--

(3) DEFINITIONS.--For the purpose of this section, the word, phrase, or term:

(i) "Investment interest" means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity

interests or debt instruments. ~~Except for purposes of s. 455.661,~~ The following investment interests shall be excepted from this definition:

1. An investment interest in an entity that is the sole provider of designated health services in a rural area;

2. An investment interest in notes, bonds, debentures, or other debt instruments issued by an entity which provides designated health services, as an integral part of a plan by such entity to acquire such investor's equity investment interest in the entity, provided that the interest rate is consistent with fair market value, and that the maturity date of the notes, bonds, debentures, or other debt instruments issued by the entity to the investor is not later than October 1, 1996.

3. An investment interest in real property resulting in a landlord-tenant relationship between the health care provider and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant or exceeds fair market value; or

4. An investment interest in an entity which owns or leases and operates a hospital licensed under chapter 395 or a nursing home facility licensed under chapter 400.

(k) "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service; or

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

3. ~~Except for the purposes of s. 455.661,~~The following orders, recommendations, or plans of care shall not constitute a referral by a health care provider:

a. By a radiologist for diagnostic-imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.

d. By a cardiologist for cardiac catheterization services.

e. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 395.

h. By a health care provider for diagnostic clinical laboratory services where such services are directly related to renal dialysis.

i. By a urologist for lithotripsy services.

j. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

k. By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

l. By a nephrologist for renal dialysis services and supplies.

Section 92. Subsections (7) and (9) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.--

(7) Upon the department's receipt from the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ pursuant to s. 395.0197 of the name of a physician whose conduct may constitute grounds for disciplinary action by the department, the department shall investigate the occurrences upon which the report was based and determine if action by the department against the physician is warranted.

(9) When an investigation of a physician is undertaken, the department shall promptly furnish to the physician or the physician's attorney a copy of the complaint or document that ~~which~~ resulted in the initiation of the investigation. For purposes of this subsection, such documents include, but are not limited to: the pertinent

portions of an annual report submitted to the department pursuant to s. 395.0197(6)~~s. 395.0197(5)(b)~~; a report of an adverse ~~or untoward~~ incident which is provided to the department pursuant to the provisions of s. 395.0197(8)~~s. 395.0197(6)~~; a report of peer review disciplinary action submitted to the department pursuant to the provisions of s. 395.0193(4) or s. 458.337, providing that the investigations, proceedings, and records relating to such peer review disciplinary action shall continue to retain their privileged status even as to the licensee who is the subject of the investigation, as provided by ss. 395.0193(8)~~ss. 395.0193(7)~~ and 458.337(3); a report of a closed claim submitted pursuant to s. 627.912; a presuit notice submitted pursuant to s. 766.106(2); and a petition brought under the Florida Birth-Related Neurological Injury Compensation Plan, pursuant to s. 766.305(2). The physician may submit a written response to the information contained in the complaint or document which resulted in the initiation of the investigation within 45 days after service to the physician of the complaint or document. The physician's written response shall be considered by the probable cause panel.

Section 93. Subsections (7) and (9) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action by the board.--

(7) Upon the department's receipt from the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ pursuant to s. 395.0197 of the name of an osteopathic physician whose conduct may constitute grounds for disciplinary action by the department, the department shall investigate the occurrences upon which the report was

based and determine if action by the department against the osteopathic physician is warranted.

(9) When an investigation of an osteopathic physician is undertaken, the department shall promptly furnish to the osteopathic physician or his or her attorney a copy of the complaint or document that ~~which~~ resulted in the initiation of the investigation. For purposes of this subsection, such documents include, but are not limited to: the pertinent portions of an annual report submitted to the department pursuant to s. 395.0197(6)~~s. 395.0197(5)(b)~~; a report of an adverse ~~or untoward~~ incident which is provided to the department pursuant to the provisions of s. 395.0197(8)~~s. 395.0197(6)~~; a report of peer review disciplinary action submitted to the department pursuant to the provisions of s. 395.0193(4) or s. 459.016, provided that the investigations, proceedings, and records relating to such peer review disciplinary action shall continue to retain their privileged status even as to the licensee who is the subject of the investigation, as provided by ss. 395.0193(8)~~ss. 395.0193(7)~~ and 459.016(3); a report of a closed claim submitted pursuant to s. 627.912; a presuit notice submitted pursuant to s. 766.106(2); and a petition brought under the Florida Birth-Related Neurological Injury Compensation Plan, pursuant to s. 766.305(2). The osteopathic physician may submit a written response to the information contained in the complaint or document which resulted in the initiation of the investigation within 45 days after service to the osteopathic physician of the complaint or document. The osteopathic physician's written response shall be considered by the probable cause panel.

Section 94. Paragraph (b) of subsection (5) of section 461.013, Florida Statutes, is amended to read:

461.013 Grounds for disciplinary action; action by the board; investigations by department.--

(5)

(b) Upon the department's receipt from the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ pursuant to s. 395.0197 of the name of the podiatrist whose conduct may constitute grounds for disciplinary action by the department, the department shall investigate the occurrences upon which the report was based and determine if action by the department against the podiatrist is warranted.

Section 95. Subsection (1) of section 468.505, Florida Statutes, is amended to read:

468.505 Exemptions; exceptions.--

(1) Nothing in this part may be construed as prohibiting or restricting the practice, services, or activities of:

(a) A person licensed in this state under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, chapter 480, chapter 490, or chapter 491, when engaging in the profession or occupation for which he or she is licensed, or of any person employed by and under the supervision of the licensee when rendering services within the scope of the profession or occupation of the licensee.~~;~~

(b) A person employed as a dietitian by the government of the United States, if the person engages in dietetics solely under direction or control of the organization by which the person is employed.~~;~~

(c) A person employed as a cooperative extension home economist.~~;~~

(d) A person pursuing a course of study leading to a degree in dietetics and nutrition from a program or school accredited pursuant to s. 468.509(2), if the activities and services constitute a part of a supervised course of study and if the person is designated by a title that clearly indicates the person's status as a student or trainee.~~;~~

(e) A person fulfilling the supervised experience component of s. 468.509, if the activities and services constitute a part of the experience necessary to meet the requirements of s. 468.509.~~;~~

(f) Any dietitian or nutritionist from another state practicing dietetics or nutrition incidental to a course of study when taking or giving a postgraduate course or other course of study in this state, provided such dietitian or nutritionist is licensed in another jurisdiction or is a registered dietitian or holds an appointment on the faculty of a school accredited pursuant to s. 468.509(2).~~;~~

(g) A person who markets or distributes food, food materials, or dietary supplements, or any person who engages in the explanation of the use and benefits of those products or the preparation of those products, if that person does not engage for a fee in dietetics and nutrition practice or nutrition counseling.~~;~~

(h) A person who markets or distributes food, food materials, or dietary supplements, or any person who engages in the explanation of the use of those products or the preparation of those products, as an employee of an establishment permitted pursuant to chapter 465.~~;~~

(i) An educator who is in the employ of a nonprofit organization approved by the council; a federal, state, county, or municipal agency, or other political subdivision; an elementary or secondary school; or an accredited institution of higher education the definition of which, as provided in s. 468.509(2), applies to other sections of this part, insofar as the activities and services of the educator are part of such employment.~~;~~

(j) Any person who provides weight control services or related weight control products, provided the program has been reviewed by, consultation is available from, and no program change can be initiated without prior approval by a licensed dietitian/nutritionist, a dietitian or nutritionist licensed in another state that has licensure requirements considered by the council to be at least as stringent as the requirements for licensure under this part, or a registered dietitian.~~;~~

(k) A person employed by a hospital licensed under chapter 395, or by a nursing home or assisted living facility licensed under part II or part III of chapter 400, or by a continuing care facility certified under chapter 651, if the person is employed in compliance with the laws and rules adopted thereunder regarding the operation of its dietetic department.~~;~~

(l) A person employed by a nursing facility exempt from licensing under s. 395.002(13)~~s. 395.002(12)~~, or a person exempt from licensing under s. 464.022.~~; or~~

(m) A person employed as a dietetic technician.

Section 96. Section 483.101, Florida Statutes, is amended to read:

483.101 Application for clinical laboratory license.--

(1) An application for a clinical laboratory license must be made under oath by the owner or director ~~operator~~ of the clinical laboratory or by the public official responsible for operating a state, municipal, or county clinical laboratory or institution that contains a clinical laboratory, upon forms provided by the agency.

(2) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the director and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the laboratory, including billings for patient services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the

abuse registry background check and the Department of Law Enforcement background check but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its

officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(3) A license must be issued authorizing the performance of one or more clinical laboratory procedures or one or more tests on each specialty or subspecialty. A separate license is required of all laboratories maintained on separate premises even if the laboratories are operated under the same management. Upon receipt of a request for an application for a clinical laboratory license, the agency shall provide to the applicant a copy of the rules relating to licensure and operations applicable to the laboratory for which licensure is sought.

Section 97. Section 483.106, Florida Statutes, is amended to read:

483.106 Application for a certificate of exemption.--An application for a certificate of exemption must be made under oath by the owner or director ~~operator~~ of a clinical laboratory that performs only waived tests as defined in s. 483.041. A certificate of exemption authorizes a clinical laboratory to perform waived tests. Laboratories maintained on separate premises and operated under the same management may apply for a single certificate of exemption or multiple certificates of exemption. The agency shall, by rule, specify the process for biennially issuing certificates of exemption. Sections 483.011, 483.021, 483.031, 483.041, 483.172, 483.23, and 483.25 apply to a clinical laboratory that obtains a certificate of exemption under this section.

Section 98. Section 483.30, Florida Statutes, is amended to read:

483.30 Licensing of centers.--

(1) A person may not conduct, maintain, or operate a multiphasic health testing center in this state without obtaining a multiphasic health testing center license from the agency. The license is valid only for the person or persons to whom it is issued and may not be sold, assigned, or transferred, voluntarily or involuntarily. A license is not valid for any premises other than the center for which it is issued. However, a new license may be secured for the new location for a fixed center before the actual change, if the contemplated change is in compliance with this part and the rules adopted under this part. A center must be relicensed if a change of ownership occurs. Application for relicensure must be made 60 days before the change of ownership.

(2) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the center, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the center, including billings for patient services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense

prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse registry background check and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435,

unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

Section 99. Effective January 1, 1999, subsection (2) of section 641.55, Florida Statutes, is amended to read:

641.55 Internal risk management program.--

(2) The risk management program shall be the responsibility of the governing authority or board of the organization. Every organization which has an annual premium volume of $10 million or more and which directly provides health care in a building owned or leased by the organization shall hire a risk manager, certified under ss. 395.10971-395.10975 ~~ss. 626.941-626.945~~, who shall be responsible for implementation of the organization's risk management program required by this section. A part-time risk manager shall not be responsible for risk management programs in more than four organizations or facilities. Every organization which does not directly provide health care in a building owned or leased by the organization and every organization with an annual premium volume of less than $10

million shall designate an officer or employee of the organization to serve as the risk manager.

The gross data compiled under this section or s. 395.0197 shall be furnished by the agency upon request to organizations to be utilized for risk management purposes. The agency shall adopt rules necessary to carry out the provisions of this section.

Section 100. Paragraph (c) of subsection (4) of section 766.1115, Florida Statutes, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.--

(4) CONTRACT REQUIREMENTS.--A health care provider that executes a contract with a governmental contractor to deliver health care services on or after April 17, 1992, as an agent of the governmental contractor is an agent for purposes of s. 768.28(9), while acting within the scope of duties pursuant to the contract, if the contract complies with the requirements of this section. A health care provider under contract with the state may not be named as a defendant in any action arising out of the medical care or treatment provided on or after April 17, 1992, pursuant to contracts entered into under this section. The contract must provide that:

(c) Adverse incidents and information on treatment outcomes must be reported by any health care provider to the governmental contractor if such incidents and information pertain to a patient treated pursuant to the contract. The health care provider shall annually submit an adverse incident report that includes all information required by s. 395.0197(6)~~s. 395.0197(5)(a)~~, unless the adverse incident involves a result described by s. 395.0197(8)~~s. 395.0197(6)~~,

in which case it shall be reported within 15 days of the occurrence of such incident. If an incident involves a professional licensed by the Department of Health ~~Business and Professional Regulation~~ or a facility licensed by the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~, the governmental contractor shall submit such incident reports to the appropriate department or agency, which shall review each incident and determine whether it involves conduct by the licensee that is subject to disciplinary action. All patient medical records and any identifying information contained in adverse incident reports and treatment outcomes which are obtained by governmental entities pursuant to this paragraph are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

Section 101. Subsection (9) of section 395.403, Florida Statutes, and sections 407.61, 408.003, 408.072, 408.085, and 455.661, Florida Statutes, are repealed.

Section 102. The repeal of laws governing the review of hospital budgets and related penalties contained in this act operates retroactively and applies to any hospital budget prepared for a fiscal year that ended during the 1995 calendar year.

Section 103. Effective January 1, 1999, all powers, duties, and functions and all rules, records, personnel, property, and unexpended balances of appropriations,

allocations, or other funds of the Department of Insurance related to the health care risk manager licensure program, as established in part IX of chapter 626, Florida Statutes, are transferred by a type two transfer, as defined in section 20.06(2), Florida Statutes, from the Department of Insurance to the Agency for Health Care Administration.

Section 104. There is appropriated $143,510 from the Health Care Trust Fund to the Agency for Health Care Administration for the purpose of funding two full-time positions to administer the health care risk manager licensure program.

Section 105. Two full-time positions are allocated to the Agency for Health Care Administration to implement and administer a background screening exemption program pursuant to section 400.4174, Florida Statutes, as amended by this act, section 400.5572, Florida Statutes, as created by this act, and chapter 435, Florida Statutes, and the sum of $127,350 is appropriated from the Health Care Trust Fund for this purpose.

Section 106. The provisions of this act which require an applicant for licensure, certification, or registration to undergo background screening shall apply to any individual or entity that applies, on or after July 1, 1998, for renewal of a license, certificate, or registration that is subject to the background screening required by this act.

Section 107. Except as otherwise expressly provided in this act, this act shall take effect July 1, 1998.

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SENATE SUMMARY

Provides for health care quality assurance by requiring background screening of specified personnel associated with certain entities that provide health care services. Specifies standards for such screening. Transfers duties pertaining to health care risk management from the Insurance Commissioner to the Director for Health Care Administration. Removes and repeals provisions relating to the Health Care Board and review of hospital budgets. Revises, updates, and conforms various provisions to reflect the assumption by the Agency for Health Care Administration of the duties of the Health Care Board and the former Health Care Cost Containment Board and duties of the former Department of Health and Rehabilitative Services relating to indigent medical care and the State Center for Health Statistics. Requires licensed hospital facilities to be capable of serving as disaster shelters for patients, staff, and families of staff only, limits applicability of the requirement to new facilities and new wings or floors of existing facilities, and requires the agency to recommend to the Governor and Legislature cost-effective renovation standards for existing hospital facilities. Authorizes the agency to conduct data-based studies and evaluations and make certain recommendations to the Governor and Legislature. (See bill for details.)