1 A bill to be entitled
2 An act relating to health care; amending s. 112.0455,
3 F.S., relating to the Drug-Free Workplace Act; deleting an
4 obsolete provision; amending s. 318.21, F.S.; revising
5 distribution of funds from civil penalties imposed for
6 traffic infractions by county courts; amending s.
7 381.00315, F.S.; directing the Department of Health to
8 accept funds from counties, municipalities, and certain
9 other entities for the purchase of certain products made
10 available under a contract of the United States Department
11 of Health and Human Services for the manufacture and
12 delivery of such products in response to a public health
13 emergency; amending s. 381.0072, F.S.; limiting Department
14 of Health food service inspections in nursing homes;
15 requiring the department to coordinate inspections with
16 the Agency for Health Care Administration; repealing s.
17 383.325, F.S., relating to confidentiality of inspection
18 reports of licensed birth center facilities; amending s.
19 395.002, F.S.; revising and deleting definitions
20 applicable to regulation of hospitals and other licensed
21 facilities; conforming a cross-reference; amending s.
22 395.003, F.S.; deleting an obsolete provision; conforming
23 a cross-reference; amending s. 395.0193, F.S.; requiring a
24 licensed facility to report certain peer review
25 information and final disciplinary actions to the Division
26 of Medical Quality Assurance of the Department of Health
27 rather than the Division of Health Quality Assurance of
28 the Agency for Health Care Administration; amending s.

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

29 395.1023, F.S.; providing for the Department of Children
30 and Family Services rather than the Department of Health
31 to perform certain functions with respect to child
32 protection cases; requiring certain hospitals to notify
33 the Department of Children and Family Services of
34 compliance; amending s. 395.1041, F.S., relating to
35 hospital emergency services and care; deleting obsolete
36 provisions; repealing s. 395.1046, F.S., relating to
37 complaint investigation procedures; amending s. 395.1055,
38 F.S.; requiring licensed facility beds to conform to
39 standards specified by the Agency for Health Care
40 Administration, the Florida Building Code, and the Florida
41 Fire Prevention Code; amending s. 395.10972, F.S.;
42 revising a reference to the Florida Society of Healthcare
43 Risk Management to conform to the current designation;
44 amending s. 395.2050, F.S.; revising a reference to the
45 federal Health Care Financing Administration to conform to
46 the current designation; amending s. 395.3036, F.S.;
47 correcting a reference; repealing s. 395.3037, F.S.,
48 relating to redundant definitions; amending ss. 154.11,
49 394.741, 395.3038, 400.925, 400.9935, 408.05, 440.13,
50 627.645, 627.668, 627.669, 627.736, 641.495, and 766.1015,
51 F.S.; revising references to the Joint Commission on
52 Accreditation of Healthcare Organizations, the Commission
53 on Accreditation of Rehabilitation Facilities, and the
54 Council on Accreditation to conform to their current
55 designations; amending s. 395.602, F.S.; revising the
56 definition of the term "rural hospital" to delete an

57 obsolete provision; amending s. 400.021, F.S.; revising
58 the definition of the term "geriatric outpatient clinic";
59 amending s. 400.0255, F.S.; correcting an obsolete cross-
60 reference to administrative rules; amending s. 400.063,
61 F.S.; deleting an obsolete provision; amending ss. 400.071
62 and 400.0712, F.S.; revising applicability of general
63 licensure requirements under part II of ch. 408, F.S., to
64 applications for nursing home licensure; revising
65 provisions governing inactive licenses; amending s.
66 400.111, F.S.; providing for disclosure of controlling
67 interest of a nursing home facility upon request by the
68 Agency for Health Care Administration; amending s.
69 400.1183, F.S.; revising grievance record maintenance and
70 reporting requirements for nursing homes; amending s.
71 400.141, F.S.; providing criteria for the provision of
72 respite services by nursing homes; requiring a written
73 plan of care; requiring a contract for services; requiring
74 resident release to caregivers to be designated in
75 writing; providing an exemption to the application of
76 discharge planning rules; providing for residents' rights;
77 providing for use of personal medications; providing terms
78 of respite stay; providing for communication of patient
79 information; requiring a physician order for care and
80 proof of a physical examination; providing for services
81 for respite patients and duties of facilities with respect
82 to such patients; conforming a cross-reference; requiring
83 facilities to maintain clinical records that meet
84 specified standards; providing a fine relating to an

85 admissions moratorium; deleting requirement for facilities
86 to submit certain information related to management
87 companies to the agency; deleting a requirement for
88 facilities to notify the agency of certain bankruptcy
89 filings to conform to changes made by the act; amending s.
90 400.142, F.S.; deleting language relating to agency
91 adoption of rules; amending 400.147, F.S.; revising
92 reporting requirements for licensed nursing home
93 facilities relating to adverse incidents; repealing s.
94 400.148, F.S., relating to the Medicaid "Up-or-Out"
95 Quality of Care Contract Management Program; amending s.
96 400.162, F.S., requiring nursing homes to provide a
97 resident property statement annually and upon request;
98 amending s. 400.179, F.S.; revising requirements for
99 nursing home lease bond alternative fees; deleting an
100 obsolete provision; amending s. 400.19, F.S.; revising
101 inspection requirements; repealing s. 400.195, F.S.,
102 relating to agency reporting requirements; amending s.
103 400.23, F.S.; deleting an obsolete provision; correcting a
104 reference; directing the agency to adopt rules for minimum
105 staffing standards in nursing homes that serve persons
106 under 21 years of age; providing minimum staffing
107 standards; amending s. 400.275, F.S.; revising agency
108 duties with regard to training nursing home surveyor
109 teams; revising requirements for team members; amending s.
110 400.484, F.S.; revising the schedule of home health agency
111 inspection violations; amending s. 400.606, F.S.; revising
112 the content requirements of the plan accompanying an

113 initial or change-of-ownership application for licensure
114 of a hospice; revising requirements relating to
115 certificates of need for certain hospice facilities;
116 amending s. 400.607, F.S.; revising grounds for agency
117 action against a hospice; amending s. 400.915, F.S.;
118 correcting an obsolete cross-reference to administrative
119 rules; amending s. 400.931, F.S.; deleting a requirement
120 that an applicant for a home medical equipment provider
121 license submit a surety bond to the agency; amending s.
122 400.932, F.S.; revising grounds for the imposition of
123 administrative penalties for certain violations by an
124 employee of a home medical equipment provider; amending s.
125 400.967, F.S.; revising the schedule of inspection
126 violations for intermediate care facilities for the
127 developmentally disabled; providing a penalty for certain
128 violations; amending s. 400.9905, F.S.; providing that
129 part X of ch, 400, F.S., the Health Care Clinic Act, does
130 not apply to an entity owned by a corporation with a
131 specified amount of annual sales of health care services
132 under certain circumstances or to an entity owned or
133 controlled by a publicly traded entity with a specified
134 amount of annual revenues; amending s. 400.991, F.S.;
135 conforming terminology; revising application requirements
136 relating to documentation of financial ability to operate
137 a mobile clinic; amending s. 408.034, F.S.; revising
138 agency authority relating to licensing of intermediate
139 care facilities for the developmentally disabled; amending
140 s. 408.036, F.S.; deleting an exemption from certain

141 certificate-of-need review requirements for a hospice or a
142 hospice inpatient facility; amending s. 408.043, F.S.;
143 revising requirements for certain freestanding inpatient
144 hospice care facilities to obtain a certificate of need;
145 amending s. 408.061, F.S.; revising health care facility
146 data reporting requirements; amending s. 408.10, F.S.;
147 removing agency authority to investigate certain consumer
148 complaints; amending s. 408.802, F.S.; removing
149 applicability of part II of ch. 408, F.S., relating to
150 general licensure requirements, to private review agents;
151 amending s. 408.804, F.S.; providing penalties for
152 altering, defacing, or falsifying a license certificate
153 issued by the agency or displaying such an altered,
154 defaced, or falsified certificate; amending s. 408.806,
155 F.S.; revising agency responsibilities for notification of
156 licensees of impending expiration of a license; requiring
157 payment of a late fee for a license application to be
158 considered complete under certain circumstances; amending
159 s. 408.810, F.S.; revising provisions relating to
160 information required for licensure; requiring proof of
161 submission of notice to a mortgagor or landlord regarding
162 provision of services requiring licensure; requiring
163 disclosure of information by a controlling interest of
164 certain court actions relating to financial instability
165 within a specified time period; amending s. 408.813, F.S.;
166 authorizing the agency to impose fines for unclassified
167 violations of part II of ch. 408, F.S.; amending s.
168 408.815, F.S.; authorizing the agency to extend a license

169 expiration date under certain circumstances; amending s.
170 409.221, F.S.; deleting a reporting requirement relating
171 to the consumer-directed care program; amending s.
172 409.91196, F.S.; conforming a cross-reference; amending s.
173 409.912, F.S.; revising procedures for implementation of a
174 Medicaid prescribed-drug spending-control program;
175 amending s. 429.07, F.S.; deleting the requirement for an
176 assisted living facility to obtain an additional license
177 in order to provide limited nursing services; deleting the
178 requirement for the agency to conduct quarterly monitoring
179 visits of facilities that hold a license to provide
180 extended congregate care services; deleting the
181 requirement for the department to report annually on the
182 status of and recommendations related to extended
183 congregate care; deleting the requirement for the agency
184 to conduct monitoring visits at least twice a year to
185 facilities providing limited nursing services; increasing
186 the licensure fees and the maximum fee required for the
187 standard license; increasing the licensure fees for the
188 extended congregate care license; eliminating the license
189 fee for the limited nursing services license; transferring
190 from another provision of law the requirement that a
191 biennial survey of an assisted living facility include
192 specific actions to determine whether the facility is
193 adequately protecting residents' rights; providing that an
194 assisted living facility that has a class I or class II
195 violation is subject to monitoring visits; requiring a
196 registered nurse to participate in certain monitoring

197 visits; amending s. 429.11, F.S.; revising licensure
198 application requirements for assisted living facilities to
199 eliminate provisional licenses; amending s. 429.12, F.S.;
200 revising notification requirements for the sale or
201 transfer of ownership of an assisted living facility;
202 amending s. 429.14, F.S.; removing a ground for the
203 imposition of an administrative penalty; clarifying
204 provisions relating to a facility's request for a hearing
205 under certain circumstances; authorizing the agency to
206 provide certain information relating to the licensure
207 status of assisted living facilities electronically or
208 through the agency's Internet website; amending s. 429.17,
209 F.S.; deleting provisions relating to the limited nursing
210 services license; revising agency responsibilities
211 regarding the issuance of conditional licenses; amending
212 s. 429.19, F.S.; clarifying that a monitoring fee may be
213 assessed in addition to an administrative fine; amending
214 s. 429.23, F.S.; deleting reporting requirements for
215 assisted living facilities relating to liability claims;
216 amending s. 429.255, F.S.; eliminating provisions
217 authorizing the use of volunteers to provide certain
218 health-care-related services in assisted living
219 facilities; authorizing assisted living facilities to
220 provide limited nursing services; requiring an assisted
221 living facility to be responsible for certain
222 recordkeeping and staff to be trained to monitor residents
223 receiving certain health-care-related services; amending
224 s. 429.28, F.S.; deleting a requirement for a biennial

225 survey of an assisted living facility, to conform to
226 changes made by the act; amending s. 429.35, F.S.;
227 authorizing the agency to provide certain information
228 relating to the inspections of assisted living facilities
229 electronically or through the agency's Internet website;
230 amending s. 429.41, F.S., relating to rulemaking;
231 conforming provisions to changes made by the act; amending
232 s. 429.53, F.S.; revising provisions relating to
233 consultation by the agency; revising a definition;
234 amending s. 429.54, F.S.; requiring licensed assisted
235 living facilities to electronically report certain data
236 semiannually to the agency in accordance with rules
237 adopted by the department; amending s. 429.71, F.S.;
238 revising schedule of inspection violations for adult
239 family-care homes; amending s. 429.911, F.S.; deleting a
240 ground for agency action against an adult day care center;
241 amending s. 429.915, F.S.; revising agency
242 responsibilities regarding the issuance of conditional
243 licenses; amending s. 483.294, F.S.; revising frequency of
244 agency inspections of multiphasic health testing centers;
245 amending s. 499.003, F.S.; defining the term "medical
246 convenience kit" for purposes of pt. I of ch. 499, F.S.;
247 providing an exception to applicability of the term;
248 removing a requirement that certain prescription drug
249 purchasers maintain a separate inventory of certain
250 prescription drugs; amending s. 499.01212, F.S.; providing
251 an exception to the requirement that a wholesale
252 distributor of prescription drugs provide a pedigree paper

253 to the person who receives the drug for wholesale
254 distribution of prescription drugs contained within a
255 medical convenience kit under specified conditions;
256 providing that the exception does not apply to any kit
257 that contains certain controlled substances; amending s.
258 626.9541, F.S.; authorizing an insurer offering a group or
259 individual health benefit plan to offer a wellness
260 program; authorizing rewards or incentives; providing that
261 such rewards or incentives are not insurance benefits;
262 providing for verification of a member's inability to
263 participate for medical reasons; amending s. 633.081,
264 F.S.; limiting Fire Marshal inspections of nursing homes
265 to once a year; providing for additional inspections based
266 on complaints and violations identified in the course of
267 orientation or training activities; amending s. 766.202,
268 F.S.; adding persons licensed under part XIV of ch. 468,
269 F.S., to the definition of "health care provider";
270 amending ss. 394.4787, 400.0239, 408.07, 430.80, and
271 651.118, F.S.; conforming terminology and cross-
272 references; revising a reference; providing an effective
273 date.
274
275 Be It Enacted by the Legislature of the State of Florida:
276
277 Section 1. Present paragraph (e) of subsection (10) and
278 paragraph (e) of subsection (14) of section 112.0455, Florida
279 Statutes, are amended, and paragraphs (f) through (k) of
280 subsection (10) of that section are redesignated as paragraphs

281 (e) through (j), respectively, to read:
282 112.0455 Drug-Free Workplace Act.—
283 (10) EMPLOYER PROTECTION.—
284 ~~(e) Nothing in this section shall be construed to operate~~
285 ~~retroactively, and nothing in this section shall abrogate the~~
286 ~~right of an employer under state law to conduct drug tests prior~~
287 ~~to January 1, 1990. A drug test conducted by an employer prior~~
288 ~~to January 1, 1990, is not subject to this section.~~
289 (14) DISCIPLINE REMEDIES.—
290 (e) Upon resolving an appeal filed pursuant to paragraph
291 (c), and finding a violation of this section, the commission may
292 order the following relief:
293 1. Rescind the disciplinary action, expunge related
294 records from the personnel file of the employee or job applicant
295 and reinstate the employee.
296 2. Order compliance with paragraph (10)<u>(f)</u>~~(g)~~.
297 3. Award back pay and benefits.
298 4. Award the prevailing employee or job applicant the
299 necessary costs of the appeal, reasonable attorney's fees, and
300 expert witness fees.
301 Section 2. Paragraph (n) of subsection (1) of section
302 154.11, Florida Statutes, is amended to read:
303 154.11 Powers of board of trustees.—
304 (1) The board of trustees of each public health trust
305 shall be deemed to exercise a public and essential governmental
306 function of both the state and the county and in furtherance
307 thereof it shall, subject to limitation by the governing body of
308 the county in which such board is located, have all of the

309 powers necessary or convenient to carry out the operation and
310 governance of designated health care facilities, including, but
311 without limiting the generality of, the foregoing:
312 (n) To appoint originally the staff of physicians to
313 practice in any designated facility owned or operated by the
314 board and to approve the bylaws and rules to be adopted by the
315 medical staff of any designated facility owned and operated by
316 the board, such governing regulations to be in accordance with
317 the standards of The Joint Commission ~~on the Accreditation of~~
318 ~~Hospitals~~ which provide, among other things, for the method of
319 appointing additional staff members and for the removal of staff
320 members.
321 Section 3. Subsection (15) of section 318.21, Florida
322 Statutes, is amended to read:
323 318.21 Disposition of civil penalties by county courts.—
324 All civil penalties received by a county court pursuant to the
325 provisions of this chapter shall be distributed and paid monthly
326 as follows:
327 (15) Of the additional fine assessed under s. 318.18(3)(e)
328 for a violation of s. 316.1893, 50 percent of the moneys
329 received from the fines shall be remitted to the Department of
330 Revenue and deposited into the Brain and Spinal Cord Injury
331 Trust Fund of Department of Health and shall be appropriated to
332 the Department of Health ~~Agency for Health Care Administration~~
333 as general revenue to ~~provide an enhanced Medicaid payment to~~
334 ~~nursing homes that~~ serve Medicaid recipients with spinal cord
335 injuries that are medically complex and who are technologically
336 and respiratory dependent ~~with brain and spinal cord injuries~~.

337 The remaining 50 percent of the moneys received from the
338 enhanced fine imposed under s. 318.18(3)(e) shall be remitted to
339 the Department of Revenue and deposited into the Department of
340 Health Administrative Trust Fund to provide financial support to
341 certified trauma centers in the counties where enhanced penalty
342 zones are established to ensure the availability and
343 accessibility of trauma services. Funds deposited into the
344 Administrative Trust Fund under this subsection shall be
345 allocated as follows:
346 (a) Fifty percent shall be allocated equally among all
347 Level I, Level II, and pediatric trauma centers in recognition
348 of readiness costs for maintaining trauma services.
349 (b) Fifty percent shall be allocated among Level I, Level
350 II, and pediatric trauma centers based on each center's relative
351 volume of trauma cases as reported in the Department of Health
352 Trauma Registry.
353 Section 4. Subsection (3) is added to section 381.00315,
354 Florida Statutes, to read:
355 381.00315 Public health advisories; public health
356 emergencies.—The State Health Officer is responsible for
357 declaring public health emergencies and issuing public health
358 advisories.
359 (3) To facilitate effective emergency management, when the
360 United States Department of Health and Human Services contracts
361 for the manufacture and delivery of licensable products in
362 response to a public health emergency and the terms of those
363 contracts are made available to the states, the department shall
364 accept funds provided by counties, municipalities, and other

365 entities designated in the state emergency management plan
366 required under s. 252.35(2)(a) for the purpose of participation
367 in such contracts. The department shall deposit the funds into
368 the Grants and Donations Trust Fund and expend the funds on
369 behalf of the donor county, municipality, or other entity for
370 the purchase the licensable products made available under the
371 contract.
372 Section 5. Paragraph (e) is added to subsection (2) of
373 section 381.0072, Florida Statutes, to read:
374 381.0072 Food service protection.—It shall be the duty of
375 the Department of Health to adopt and enforce sanitation rules
376 consistent with law to ensure the protection of the public from
377 food-borne illness. These rules shall provide the standards and
378 requirements for the storage, preparation, serving, or display
379 of food in food service establishments as defined in this
380 section and which are not permitted or licensed under chapter
381 500 or chapter 509.
382 (2) DUTIES.—
383 (e) The department shall inspect food service
384 establishments in nursing homes licensed under part II of
385 chapter 400 twice each year. The department may make additional
386 inspections only in response to complaints. The department shall
387 coordinate inspections with the Agency for Health Care
388 Administration, such that the department's inspection is at
389 least 60 days after a recertification visit by the Agency for
390 Health Care Administration.
391 Section 6. Section 383.325, Florida Statutes, is repealed.

392 Section 7. Subsection (7) of section 394.4787, Florida
393 Statutes, is amended to read:
394 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788,
395 and 394.4789.—As used in this section and ss. 394.4786,
396 394.4788, and 394.4789:
397 (7) "Specialty psychiatric hospital" means a hospital
398 licensed by the agency pursuant to s. 395.002(26) ~~(28)~~ and part
399 II of chapter 408 as a specialty psychiatric hospital.
400 Section 8. Subsection (2) of section 394.741, Florida
401 Statutes, is amended to read:
402 394.741 Accreditation requirements for providers of
403 behavioral health care services.—
404 (2) Notwithstanding any provision of law to the contrary,
405 accreditation shall be accepted by the agency and department in
406 lieu of the agency's and department's facility licensure onsite
407 review requirements and shall be accepted as a substitute for
408 the department's administrative and program monitoring
409 requirements, except as required by subsections (3) and (4),
410 for:
411 (a) Any organization from which the department purchases
412 behavioral health care services that is accredited by The Joint
413 Commission ~~on Accreditation of Healthcare Organizations~~ or the
414 Council on Accreditation ~~for Children and Family Services~~, or
415 has those services that are being purchased by the department
416 accredited by the Commission on Accreditation of Rehabilitation
417 Facilities ~~CARF—the Rehabilitation Accreditation Commission~~.
418 (b) Any mental health facility licensed by the agency or
419 any substance abuse component licensed by the department that is

420 accredited by The Joint Commission ~~on Accreditation of~~
421 ~~Healthcare Organizations~~, the Commission on Accreditation of
422 Rehabilitation Facilities ~~CARF—the Rehabilitation Accreditation~~
423 ~~Commission~~, or the Council on Accreditation ~~of Children and~~
424 ~~Family Services~~.
425 (c) Any network of providers from which the department or
426 the agency purchases behavioral health care services accredited
427 by The Joint Commission ~~on Accreditation of Healthcare~~
428 ~~Organizations~~, the Commission on Accreditation of Rehabilitation
429 Facilities ~~CARF—the Rehabilitation Accreditation Commission~~, the
430 Council on Accreditation ~~of Children and Family Services~~, or the
431 National Committee for Quality Assurance. A provider
432 organization, which is part of an accredited network, is
433 afforded the same rights under this part.
434 Section 9. Present subsections (15) through (32) of
435 section 395.002, Florida Statutes, are renumbered as subsections
436 (14) through (28), respectively, and present subsections (1),
437 (14), (24), (30), and (31), and paragraph (c) of present
438 subsection (28) of that section are amended to read:
439 395.002 Definitions.—As used in this chapter:
440 (1) "Accrediting organizations" means nationally
441 recognized or approved accrediting organizations whose standards
442 incorporate comparable licensure requirements as determined by
443 the agency ~~the Joint Commission on Accreditation of Healthcare~~
444 ~~Organizations, the American Osteopathic Association, the~~
445 ~~Commission on Accreditation of Rehabilitation Facilities, and~~
446 ~~the Accreditation Association for Ambulatory Health Care, Inc~~.

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

447 ~~(14) "Initial denial determination" means a determination~~
448 ~~by a private review agent that the health care services~~
449 ~~furnished or proposed to be furnished to a patient are~~
450 ~~inappropriate, not medically necessary, or not reasonable.~~
451 ~~(24) "Private review agent" means any person or entity~~
452 ~~which performs utilization review services for third-party~~
453 ~~payors on a contractual basis for outpatient or inpatient~~
454 ~~services. However, the term shall not include full-time~~
455 ~~employees, personnel, or staff of health insurers, health~~
456 ~~maintenance organizations, or hospitals, or wholly owned~~
457 ~~subsidiaries thereof or affiliates under common ownership, when~~
458 ~~performing utilization review for their respective hospitals,~~
459 ~~health maintenance organizations, or insureds of the same~~
460 ~~insurance group. For this purpose, health insurers, health~~
461 ~~maintenance organizations, and hospitals, or wholly owned~~
462 ~~subsidiaries thereof or affiliates under common ownership,~~
463 ~~include such entities engaged as administrators of self-~~
464 ~~insurance as defined in s. 624.031.~~
465 (26) ~~(28)~~ "Specialty hospital" means any facility which
466 meets the provisions of subsection (12), and which regularly
467 makes available either:
468 (c) Intensive residential treatment programs for children
469 and adolescents as defined in subsection (14) ~~(15)~~.
470 ~~(30) "Utilization review" means a system for reviewing the~~
471 ~~medical necessity or appropriateness in the allocation of health~~
472 ~~care resources of hospital services given or proposed to be~~
473 ~~given to a patient or group of patients.~~

474 ~~(31) "Utilization review plan" means a description of the~~
475 ~~policies and procedures governing utilization review activities~~
476 ~~performed by a private review agent.~~
477 Section 10. Paragraph (c) of subsection (1) and paragraph
478 (b) of subsection (2) of section 395.003, Florida Statutes, are
479 amended to read:
480 395.003 Licensure; denial, suspension, and revocation.—
481 (1)
482 ~~(c) Until July 1, 2006, additional emergency departments~~
483 ~~located off the premises of licensed hospitals may not be~~
484 ~~authorized by the agency.~~
485 (2)
486 (b) The agency shall, at the request of a licensee that is
487 a teaching hospital as defined in s. 408.07(45), issue a single
488 license to a licensee for facilities that have been previously
489 licensed as separate premises, provided such separately licensed
490 facilities, taken together, constitute the same premises as
491 defined in s. 395.002(22) ~~(23)~~. Such license for the single
492 premises shall include all of the beds, services, and programs
493 that were previously included on the licenses for the separate
494 premises. The granting of a single license under this paragraph
495 shall not in any manner reduce the number of beds, services, or
496 programs operated by the licensee.
497 Section 11. Paragraph (e) of subsection (2) and subsection
498 (4) of section 395.0193, Florida Statutes, are amended to read:
499 395.0193 Licensed facilities; peer review; disciplinary
500 powers; agency or partnership with physicians.—

501 (2) Each licensed facility, as a condition of licensure,
502 shall provide for peer review of physicians who deliver health
503 care services at the facility. Each licensed facility shall
504 develop written, binding procedures by which such peer review
505 shall be conducted. Such procedures shall include:
506 (e) Recording of agendas and minutes which do not contain
507 confidential material, for review by the Division of <u>Medical</u>
508 <u>Quality Assurance of the department</u> ~~Health Quality Assurance of~~
509 ~~the agency~~.
510 (4) Pursuant to ss. 458.337 and 459.016, any disciplinary
511 actions taken under subsection (3) shall be reported in writing
512 to the Division of <u>Medical Quality Assurance of the department</u>
513 ~~Health Quality Assurance of the agency~~ within 30 working days
514 after its initial occurrence, regardless of the pendency of
515 appeals to the governing board of the hospital. The notification
516 shall identify the disciplined practitioner, the action taken,
517 and the reason for such action. All final disciplinary actions
518 taken under subsection (3), if different from those which were
519 reported to the <u>department</u> ~~agency~~ within 30 days after the
520 initial occurrence, shall be reported within 10 working days to
521 the Division of <u>Medical Quality Assurance of the department</u>
522 ~~Health Quality Assurance of the agency~~ in writing and shall
523 specify the disciplinary action taken and the specific grounds
524 therefor. The division shall review each report and determine
525 whether it potentially involved conduct by the licensee that is
526 subject to disciplinary action, in which case s. 456.073 shall
527 apply. The reports are not subject to inspection under s.

528 119.07(1) even if the division's investigation results in a
529 finding of probable cause.
530 Section 12. Section 395.1023, Florida Statutes, is amended
531 to read:
532 395.1023 Child abuse and neglect cases; duties.—Each
533 licensed facility shall adopt a protocol that, at a minimum,
534 requires the facility to:
535 (1) Incorporate a facility policy that every staff member
536 has an affirmative duty to report, pursuant to chapter 39, any
537 actual or suspected case of child abuse, abandonment, or
538 neglect; and
539 (2) In any case involving suspected child abuse,
540 abandonment, or neglect, designate, at the request of the
541 Department of Children and Family Services, a staff physician to
542 act as a liaison between the hospital and the Department of
543 Children and Family Services office which is investigating the
544 suspected abuse, abandonment, or neglect, and the child
545 protection team, as defined in s. 39.01, when the case is
546 referred to such a team.
547
548 Each general hospital and appropriate specialty hospital shall
549 comply with the provisions of this section and shall notify the
550 agency and the Department of Children and Family Services of its
551 compliance by sending a copy of its policy to the agency and the
552 Department of Children and Family Services as required by rule.
553 The failure by a general hospital or appropriate specialty
554 hospital to comply shall be punished by a fine not exceeding

555 $1,000, to be fixed, imposed, and collected by the agency. Each
556 day in violation is considered a separate offense.
557 Section 13. Subsection (2) and paragraph (d) of subsection
558 (3) of section 395.1041, Florida Statutes, are amended to read:
559 395.1041 Access to emergency services and care.—
560 (2) INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The agency
561 shall establish and maintain an inventory of hospitals with
562 emergency services. The inventory shall list all services within
563 the service capability of the hospital, and such services shall
564 appear on the face of the hospital license. Each hospital having
565 emergency services shall notify the agency of its service
566 capability in the manner and form prescribed by the agency. The
567 agency shall use the inventory to assist emergency medical
568 services providers and others in locating appropriate emergency
569 medical care. The inventory shall also be made available to the
570 general public. ~~On or before August 1, 1992, the agency shall~~
571 ~~request that each hospital identify the services which are~~
572 ~~within its service capability. On or before November 1, 1992,~~
573 ~~the agency shall notify each hospital of the service capability~~
574 ~~to be included in the inventory. The hospital has 15 days from~~
575 ~~the date of receipt to respond to the notice. By December 1,~~
576 ~~1992, the agency shall publish a final inventory.~~ Each hospital
577 shall reaffirm its service capability when its license is
578 renewed and shall notify the agency of the addition of a new
579 service or the termination of a service prior to a change in its
580 service capability.
581 (3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF
582 FACILITY OR HEALTH CARE PERSONNEL.—

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583 (d)1. Every hospital shall ensure the provision of
584 services within the service capability of the hospital, at all
585 times, either directly or indirectly through an arrangement with
586 another hospital, through an arrangement with one or more
587 physicians, or as otherwise made through prior arrangements. A
588 hospital may enter into an agreement with another hospital for
589 purposes of meeting its service capability requirement, and
590 appropriate compensation or other reasonable conditions may be
591 negotiated for these backup services.
592 2. If any arrangement requires the provision of emergency
593 medical transportation, such arrangement must be made in
594 consultation with the applicable provider and may not require
595 the emergency medical service provider to provide transportation
596 that is outside the routine service area of that provider or in
597 a manner that impairs the ability of the emergency medical
598 service provider to timely respond to prehospital emergency
599 calls.
600 3. A hospital shall not be required to ensure service
601 capability at all times as required in subparagraph 1. if, prior
602 to the receiving of any patient needing such service capability,
603 such hospital has demonstrated to the agency that it lacks the
604 ability to ensure such capability and it has exhausted all
605 reasonable efforts to ensure such capability through backup
606 arrangements. In reviewing a hospital's demonstration of lack of
607 ability to ensure service capability, the agency shall consider
608 factors relevant to the particular case, including the
609 following:

610 a. Number and proximity of hospitals with the same service
611 capability.
612 b. Number, type, credentials, and privileges of
613 specialists.
614 c. Frequency of procedures.
615 d. Size of hospital.
616 4. The agency shall publish ~~proposed~~ rules implementing a
617 reasonable exemption procedure ~~by November 1, 1992~~. ~~Subparagraph~~
618 ~~1. shall become effective upon the effective date of said rules~~
619 ~~or January 31, 1993, whichever is earlier. For a period not to~~
620 ~~exceed 1 year from the effective date of subparagraph 1., a~~
621 ~~hospital requesting an exemption shall be deemed to be exempt~~
622 ~~from offering the service until the agency initially acts to~~
623 ~~deny or grant the original request.~~ The agency has 45 days from
624 the date of receipt of the request to approve or deny the
625 request. ~~After the first year from the effective date of~~
626 ~~subparagraph 1.,~~ If the agency fails to initially act within the
627 time period, the hospital is deemed to be exempt from offering
628 the service until the agency initially acts to deny the request.
629 Section 14. Section 395.1046, Florida Statutes, is
630 repealed.
631 Section 15. Paragraph (e) of subsection (1) of section
632 395.1055, Florida Statutes, is amended to read:
633 395.1055 Rules and enforcement.—
634 (1) The agency shall adopt rules pursuant to ss.
635 120.536(1) and 120.54 to implement the provisions of this part,
636 which shall include reasonable and fair minimum standards for
637 ensuring that:

638 (e) Licensed facility beds conform to minimum space,
639 equipment, and furnishings standards as specified by the agency,
640 the Florida Building Code, and the Florida Fire Prevention Code
641 ~~department~~.
642 Section 16. Subsection (1) of section 395.10972, Florida
643 Statutes, is amended to read:
644 395.10972 Health Care Risk Manager Advisory Council.—The
645 Secretary of Health Care Administration may appoint a seven-
646 member advisory council to advise the agency on matters
647 pertaining to health care risk managers. The members of the
648 council shall serve at the pleasure of the secretary. The
649 council shall designate a chair. The council shall meet at the
650 call of the secretary or at those times as may be required by
651 rule of the agency. The members of the advisory council shall
652 receive no compensation for their services, but shall be
653 reimbursed for travel expenses as provided in s. 112.061. The
654 council shall consist of individuals representing the following
655 areas:
656 (1) Two shall be active health care risk managers,
657 including one risk manager who is recommended by and a member of
658 the Florida Society for ~~of~~ Healthcare Risk Management and
659 Patient Safety.
660 Section 17. Subsection (3) of section 395.2050, Florida
661 Statutes, is amended to read:
662 395.2050 Routine inquiry for organ and tissue donation;
663 certification for procurement activities; death records review.—
664 (3) Each organ procurement organization designated by the
665 federal Centers for Medicare and Medicaid Services ~~Health Care~~

666 ~~Financing Administration~~ and licensed by the state shall conduct
667 an annual death records review in the organ procurement
668 organization's affiliated donor hospitals. The organ procurement
669 organization shall enlist the services of every Florida licensed
670 tissue bank and eye bank affiliated with or providing service to
671 the donor hospital and operating in the same service area to
672 participate in the death records review.
673 Section 18. Subsection (2) of section 395.3036, Florida
674 Statutes, is amended to read:
675 395.3036 Confidentiality of records and meetings of
676 corporations that lease public hospitals or other public health
677 care facilities.—The records of a private corporation that
678 leases a public hospital or other public health care facility
679 are confidential and exempt from the provisions of s. 119.07(1)
680 and s. 24(a), Art. I of the State Constitution, and the meetings
681 of the governing board of a private corporation are exempt from
682 s. 286.011 and s. 24(b), Art. I of the State Constitution when
683 the public lessor complies with the public finance
684 accountability provisions of s. 155.40(5) with respect to the
685 transfer of any public funds to the private lessee and when the
686 private lessee meets at least three of the five following
687 criteria:
688 (2) The public lessor and the private lessee do not
689 commingle any of their funds in any account maintained by either
690 of them, other than the payment of the rent and administrative
691 fees or the transfer of funds pursuant to s. 155.40 (2)
692 ~~subsection (2)~~.

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693 Section 19. Section 395.3037, Florida Statutes, is
694 repealed.
695 Section 20. Subsections (1), (4), and (5) of section
696 395.3038, Florida Statutes, are amended to read:
697 395.3038 State-listed primary stroke centers and
698 comprehensive stroke centers; notification of hospitals.—
699 (1) The agency shall make available on its website and to
700 the department a list of the name and address of each hospital
701 that meets the criteria for a primary stroke center and the name
702 and address of each hospital that meets the criteria for a
703 comprehensive stroke center. The list of primary and
704 comprehensive stroke centers shall include only those hospitals
705 that attest in an affidavit submitted to the agency that the
706 hospital meets the named criteria, or those hospitals that
707 attest in an affidavit submitted to the agency that the hospital
708 is certified as a primary or a comprehensive stroke center by
709 The Joint Commission on Accreditation of Healthcare
710 Organizations.
711 (4) The agency shall adopt by rule criteria for a primary
712 stroke center which are substantially similar to the
713 certification standards for primary stroke centers of The Joint
714 Commission on Accreditation of Healthcare Organizations.
715 (5) The agency shall adopt by rule criteria for a
716 comprehensive stroke center. However, if The Joint Commission on
717 Accreditation of Healthcare Organizations establishes criteria
718 for a comprehensive stroke center, the agency shall establish
719 criteria for a comprehensive stroke center which are

720 substantially similar to those criteria established by The Joint
721 Commission ~~on Accreditation of Healthcare Organizations~~.
722 Section 21. Paragraph (e) of subsection (2) of section
723 395.602, Florida Statutes, is amended to read:
724 395.602 Rural hospitals.—
725 (2) DEFINITIONS.—As used in this part:
726 (e) "Rural hospital" means an acute care hospital licensed
727 under this chapter, having 100 or fewer licensed beds and an
728 emergency room, which is:
729 1. The sole provider within a county with a population
730 density of no greater than 100 persons per square mile;
731 2. An acute care hospital, in a county with a population
732 density of no greater than 100 persons per square mile, which is
733 at least 30 minutes of travel time, on normally traveled roads
734 under normal traffic conditions, from any other acute care
735 hospital within the same county;
736 3. A hospital supported by a tax district or subdistrict
737 whose boundaries encompass a population of 100 persons or fewer
738 per square mile;
739 ~~4. A hospital in a constitutional charter county with a~~
740 ~~population of over 1 million persons that has imposed a local~~
741 ~~option health service tax pursuant to law and in an area that~~
742 ~~was directly impacted by a catastrophic event on August 24,~~
743 ~~1992, for which the Governor of Florida declared a state of~~
744 ~~emergency pursuant to chapter 125, and has 120 beds or less that~~
745 ~~serves an agricultural community with an emergency room~~
746 ~~utilization of no less than 20,000 visits and a Medicaid~~
747 ~~inpatient utilization rate greater than 15 percent;~~

748 4.~~5.~~ A hospital with a service area that has a population
749 of 100 persons or fewer per square mile. As used in this
750 subparagraph, the term "service area" means the fewest number of
751 zip codes that account for 75 percent of the hospital's
752 discharges for the most recent 5-year period, based on
753 information available from the hospital inpatient discharge
754 database in the Florida Center for Health Information and Policy
755 Analysis at the Agency for Health Care Administration; or
756 5.~~6.~~ A hospital designated as a critical access hospital,
757 as defined in s. 408.07(15).
758
759 Population densities used in this paragraph must be based upon
760 the most recently completed United States census. A hospital
761 that received funds under s. 409.9116 for a quarter beginning no
762 later than July 1, 2002, is deemed to have been and shall
763 continue to be a rural hospital from that date through June 30,
764 2015, if the hospital continues to have 100 or fewer licensed
765 beds and an emergency room~~, or meets the criteria of~~
766 ~~subparagraph 4~~. An acute care hospital that has not previously
767 been designated as a rural hospital and that meets the criteria
768 of this paragraph shall be granted such designation upon
769 application, including supporting documentation to the Agency
770 for Health Care Administration.
771 Section 22. Subsection (8) of section 400.021, Florida
772 Statutes, is amended to read:
773 400.021 Definitions.—When used in this part, unless the
774 context otherwise requires, the term:

775 (8) "Geriatric outpatient clinic" means a site for
776 providing outpatient health care to persons 60 years of age or
777 older, which is staffed by a registered nurse or a physician
778 assistant, or a licensed practical nurse under the direct
779 supervision of a registered nurse, advanced registered nurse
780 practitioner, or physician.
781 Section 23. Paragraph (g) of subsection (2) of section
782 400.0239, Florida Statutes, is amended to read:
783 400.0239 Quality of Long-Term Care Facility Improvement
784 Trust Fund.—
785 (2) Expenditures from the trust fund shall be allowable
786 for direct support of the following:
787 (g) Other initiatives authorized by the Centers for
788 Medicare and Medicaid Services for the use of federal civil
789 monetary penalties~~, including projects recommended through the~~
790 ~~Medicaid "Up-or-Out" Quality of Care Contract Management Program~~
791 ~~pursuant to s. 400.148~~.
792 Section 24. Subsection (15) of section 400.0255, Florida
793 Statutes, is amended to read
794 400.0255 Resident transfer or discharge; requirements and
795 procedures; hearings.—
796 (15)(a) The department's Office of Appeals Hearings shall
797 conduct hearings under this section. The office shall notify the
798 facility of a resident's request for a hearing.
799 (b) The department shall, by rule, establish procedures to
800 be used for fair hearings requested by residents. These
801 procedures shall be equivalent to the procedures used for fair
802 hearings for other Medicaid cases appearing in s. 409.285 and

803 applicable rules~~, chapter 10-2, part VI, Florida Administrative~~
804 ~~Code~~. The burden of proof must be clear and convincing evidence.
805 A hearing decision must be rendered within 90 days after receipt
806 of the request for hearing.
807 (c) If the hearing decision is favorable to the resident
808 who has been transferred or discharged, the resident must be
809 readmitted to the facility's first available bed.
810 (d) The decision of the hearing officer shall be final.
811 Any aggrieved party may appeal the decision to the district
812 court of appeal in the appellate district where the facility is
813 located. Review procedures shall be conducted in accordance with
814 the Florida Rules of Appellate Procedure.
815 Section 25. Subsection (2) of section 400.063, Florida
816 Statutes, is amended to read:
817 400.063 Resident protection.—
818 (2) The agency is authorized to establish for each
819 facility, subject to intervention by the agency, a separate bank
820 account for the deposit to the credit of the agency of any
821 moneys received from the Health Care Trust Fund or any other
822 moneys received for the maintenance and care of residents in the
823 facility, and the agency is authorized to disburse moneys from
824 such account to pay obligations incurred for the purposes of
825 this section. The agency is authorized to requisition moneys
826 from the Health Care Trust Fund in advance of an actual need for
827 cash on the basis of an estimate by the agency of moneys to be
828 spent under the authority of this section. Any bank account
829 established under this section need not be approved in advance
830 of its creation as required by s. 17.58, but shall be secured by

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831 depository insurance equal to or greater than the balance of
832 such account or by the pledge of collateral security ~~in~~
833 ~~conformance with criteria established in s. 18.11~~. The agency
834 shall notify the Chief Financial Officer of any such account so
835 established and shall make a quarterly accounting to the Chief
836 Financial Officer for all moneys deposited in such account.
837 Section 26. Subsections (1) and (5) of section 400.071,
838 Florida Statutes, are amended to read:
839 400.071 Application for license.—
840 (1) In addition to the requirements of part II of chapter
841 408, the application for a license shall be under oath and must
842 contain the following:
843 (a) The location of the facility for which a license is
844 sought and an indication, as in the original application, that
845 such location conforms to the local zoning ordinances.
846 ~~(b) A signed affidavit disclosing any financial or~~
847 ~~ownership interest that a controlling interest as defined in~~
848 ~~part II of chapter 408 has held in the last 5 years in any~~
849 ~~entity licensed by this state or any other state to provide~~
850 ~~health or residential care which has closed voluntarily or~~
851 ~~involuntarily; has filed for bankruptcy; has had a receiver~~
852 ~~appointed; has had a license denied, suspended, or revoked; or~~
853 ~~has had an injunction issued against it which was initiated by a~~
854 ~~regulatory agency. The affidavit must disclose the reason any~~
855 ~~such entity was closed, whether voluntarily or involuntarily.~~
856 ~~(c) The total number of beds and the total number of~~
857 ~~Medicare and Medicaid certified beds.~~

858 (b) ~~(d)~~ Information relating to the applicant and employees
859 which the agency requires by rule. The applicant must
860 demonstrate that sufficient numbers of qualified staff, by
861 training or experience, will be employed to properly care for
862 the type and number of residents who will reside in the
863 facility.
864 (c) ~~(e)~~ Copies of any civil verdict or judgment involving
865 the applicant rendered within the 10 years preceding the
866 application, relating to medical negligence, violation of
867 residents' rights, or wrongful death. As a condition of
868 licensure, the licensee agrees to provide to the agency copies
869 of any new verdict or judgment involving the applicant, relating
870 to such matters, within 30 days after filing with the clerk of
871 the court. The information required in this paragraph shall be
872 maintained in the facility's licensure file and in an agency
873 database which is available as a public record.
874 (5) As a condition of licensure, each facility must
875 establish ~~and submit with its application~~ a plan for quality
876 assurance and for conducting risk management.
877 Section 27. Section 400.0712, Florida Statutes, is amended
878 to read:
879 400.0712 Application for inactive license.—
880 ~~(1) As specified in this section, the agency may issue an~~
881 ~~inactive license to a nursing home facility for all or a portion~~
882 ~~of its beds. Any request by a licensee that a nursing home or~~
883 ~~portion of a nursing home become inactive must be submitted to~~
884 ~~the agency in the approved format. The facility may not initiate~~
885 ~~any suspension of services, notify residents, or initiate~~

886 ~~inactivity before receiving approval from the agency; and a~~
887 ~~licensee that violates this provision may not be issued an~~
888 ~~inactive license.~~
889 (1)~~(2)~~ In addition to the powers granted under part II of
890 chapter 408, the agency may issue an inactive license to a
891 nursing home that chooses to use an unoccupied contiguous
892 portion of the facility for an alternative use to meet the needs
893 of elderly persons through the use of less restrictive, less
894 institutional services.
895 (a) An inactive license issued under this subsection may
896 be granted for a period not to exceed the current licensure
897 expiration date but may be renewed by the agency at the time of
898 licensure renewal.
899 (b) A request to extend the inactive license must be
900 submitted to the agency in the approved format and approved by
901 the agency in writing.
902 (c) Nursing homes that receive an inactive license to
903 provide alternative services shall not receive preference for
904 participation in the Assisted Living for the Elderly Medicaid
905 waiver.
906 (2)~~(3)~~ The agency shall adopt rules pursuant to ss.
907 120.536(1) and 120.54 necessary to implement this section.
908 Section 28. Section 400.111, Florida Statutes, is amended
909 to read:
910 400.111 Disclosure of controlling interest.—In addition to
911 the requirements of part II of chapter 408, when requested by
912 the agency, the licensee shall submit a signed affidavit
913 disclosing any financial or ownership interest that a

914 controlling interest has held within the last 5 years in any
915 entity licensed by the state or any other state to provide
916 health or residential care which entity has closed voluntarily
917 or involuntarily; has filed for bankruptcy; has had a receiver
918 appointed; has had a license denied, suspended, or revoked; or
919 has had an injunction issued against it which was initiated by a
920 regulatory agency. The affidavit must disclose the reason such
921 entity was closed, whether voluntarily or involuntarily.
922 Section 29. Subsection (2) of section 400.1183, Florida
923 Statutes, is amended to read:
924 400.1183 Resident grievance procedures.—
925 (2) Each facility shall maintain records of all grievances
926 for agency inspection ~~and shall report to the agency at the time~~
927 ~~of relicensure the total number of grievances handled during the~~
928 ~~prior licensure period, a categorization of the cases underlying~~
929 ~~the grievances, and the final disposition of the grievances~~.
930 Section 30. Paragraphs (o) through (w) of subsection (1)
931 of section 400.141, Florida Statutes, are redesignated as
932 paragraphs (n) through (u), respectively, and present paragraphs
933 (f), (g), (j), (n), (o), and (r) of that subsection are amended,
934 to read:
935 400.141 Administration and management of nursing home
936 facilities.—
937 (1) Every licensed facility shall comply with all
938 applicable standards and rules of the agency and shall:
939 (f) Be allowed and encouraged by the agency to provide
940 other needed services under certain conditions. If the facility
941 has a standard licensure status~~, and has had no class I or class~~

942 ~~II deficiencies during the past 2 years~~ or has been awarded a
943 Gold Seal under the program established in s. 400.235, it may ~~be~~
944 ~~encouraged by the agency to~~ provide services, including, but not
945 limited to, respite and adult day services, which enable
946 individuals to move in and out of the facility. A facility is
947 not subject to any additional licensure requirements for
948 providing these services.
949 1. Respite care may be offered to persons in need of
950 short-term or temporary nursing home services. For each person
951 admitted under the respite care program, the facility licensee
952 must:
953 a. Have a written abbreviated plan of care that, at a
954 minimum, includes nutritional requirements, medication orders,
955 physician orders, nursing assessments, and dietary preferences.
956 The nursing or physician assessments may take the place of all
957 other assessments required for full-time residents.
958 b. Have a contract that, at a minimum, specifies the
959 services to be provided to the respite resident, including
960 charges for services, activities, equipment, emergency medical
961 services, and the administration of medications. If multiple
962 respite admissions for a single person are anticipated, the
963 original contract is valid for 1 year after the date of
964 execution.
965 c. Ensure that each resident is released to his or her
966 caregiver or an individual designated in writing by the
967 caregiver.
968 2. A person admitted under the respite care program is:

969 a. Exempt from requirements in rule related to discharge
970 planning.
971 b. Covered by the resident's rights set forth in s.
972 400.022(1)(a)-(o) and (r)-(t). Funds or property of the resident
973 shall not be considered trust funds subject to the requirements
974 of s. 400.022(1)(h) until the resident has been in the facility
975 for more than 14 consecutive days.
976 c. Allowed to use his or her personal medications for the
977 respite stay if permitted by facility policy. The facility must
978 obtain a physician's orders for the medications. The caregiver
979 may provide information regarding the medications as part of the
980 nursing assessment, which must agree with the physician's
981 orders. Medications shall be released with the resident upon
982 discharge in accordance with current orders.
983 3. A person receiving respite care is entitled to a total
984 of 60 days in the facility within a contract year or a calendar
985 year if the contract is for less than 12 months. However, each
986 single stay may not exceed 14 days. If a stay exceeds 14
987 consecutive days, the facility must comply with all assessment
988 and care planning requirements applicable to nursing home
989 residents.
990 4. A person receiving respite care must reside in a
991 licensed nursing home bed.
992 5. A prospective respite resident must provide medical
993 information from a physician, a physician assistant, or a nurse
994 practitioner and other information from the primary caregiver as
995 may be required by the facility prior to or at the time of
996 admission to receive respite care. The medical information must

997 include a physician's order for respite care and proof of a
998 physical examination by a licensed physician, physician
999 assistant, or nurse practitioner. The physician's order and
1000 physical examination may be used to provide intermittent respite
1001 care for up to 12 months after the date the order is written.
1002 6. The facility must assume the duties of the primary
1003 caregiver. To ensure continuity of care and services, the
1004 resident is entitled to retain his or her personal physician and
1005 must have access to medically necessary services such as
1006 physical therapy, occupational therapy, or speech therapy, as
1007 needed. The facility must arrange for transportation to these
1008 services if necessary. ~~Respite care must be provided in~~
1009 ~~accordance with this part and rules adopted by the agency.~~
1010 ~~However, the agency shall, by rule, adopt modified requirements~~
1011 ~~for resident assessment, resident care plans, resident~~
1012 ~~contracts, physician orders, and other provisions, as~~
1013 ~~appropriate, for short-term or temporary nursing home services.~~
1014 7. The agency shall allow for shared programming and staff
1015 in a facility which meets minimum standards and offers services
1016 pursuant to this paragraph, but, if the facility is cited for
1017 deficiencies in patient care, may require additional staff and
1018 programs appropriate to the needs of service recipients. A
1019 person who receives respite care may not be counted as a
1020 resident of the facility for purposes of the facility's licensed
1021 capacity unless that person receives 24-hour respite care. A
1022 person receiving either respite care for 24 hours or longer or
1023 adult day services must be included when calculating minimum
1024 staffing for the facility. Any costs and revenues generated by a

1025 nursing home facility from nonresidential programs or services
1026 shall be excluded from the calculations of Medicaid per diems
1027 for nursing home institutional care reimbursement.
1028 (g) If the facility has a standard license or is a Gold
1029 Seal facility, exceeds the minimum required hours of licensed
1030 nursing and certified nursing assistant direct care per resident
1031 per day, and is part of a continuing care facility licensed
1032 under chapter 651 or a retirement community that offers other
1033 services pursuant to part III of this chapter or part I or part
1034 III of chapter 429 on a single campus, be allowed to share
1035 programming and staff. At the time of inspection and in the
1036 semiannual report required pursuant to paragraph (n) ~~(o)~~, a
1037 continuing care facility or retirement community that uses this
1038 option must demonstrate through staffing records that minimum
1039 staffing requirements for the facility were met. Licensed nurses
1040 and certified nursing assistants who work in the nursing home
1041 facility may be used to provide services elsewhere on campus if
1042 the facility exceeds the minimum number of direct care hours
1043 required per resident per day and the total number of residents
1044 receiving direct care services from a licensed nurse or a
1045 certified nursing assistant does not cause the facility to
1046 violate the staffing ratios required under s. 400.23(3)(a).
1047 Compliance with the minimum staffing ratios shall be based on
1048 total number of residents receiving direct care services,
1049 regardless of where they reside on campus. If the facility
1050 receives a conditional license, it may not share staff until the
1051 conditional license status ends. This paragraph does not
1052 restrict the agency's authority under federal or state law to

1053 require additional staff if a facility is cited for deficiencies
1054 in care which are caused by an insufficient number of certified
1055 nursing assistants or licensed nurses. The agency may adopt
1056 rules for the documentation necessary to determine compliance
1057 with this provision.
1058 (j) Keep full records of resident admissions and
1059 discharges; medical and general health status, including medical
1060 records, personal and social history, and identity and address
1061 of next of kin or other persons who may have responsibility for
1062 the affairs of the residents; and individual resident care plans
1063 including, but not limited to, prescribed services, service
1064 frequency and duration, and service goals. The records shall be
1065 open to inspection by the agency. <u>The facility must maintain</u>
1066 <u>clinical records on each resident in accordance with accepted</u>
1067 <u>professional standards and practices that are complete,</u>
1068 <u>accurately documented, readily accessible, and systematically</u>
1069 <u>organized.</u>
1070 ~~(n) Submit to the agency the information specified in s.~~
1071 ~~400.071(1)(b) for a management company within 30 days after the~~
1072 ~~effective date of the management agreement.~~
1073 <u>(n)</u>~~(o)~~1. Submit semiannually to the agency, or more
1074 frequently if requested by the agency, information regarding
1075 facility staff-to-resident ratios, staff turnover, and staff
1076 stability, including information regarding certified nursing
1077 assistants, licensed nurses, the director of nursing, and the
1078 facility administrator. For purposes of this reporting:
1079 a. Staff-to-resident ratios must be reported in the
1080 categories specified in s. 400.23(3)(a) and applicable rules.

1081 The ratio must be reported as an average for the most recent
1082 calendar quarter.
1083 b. Staff turnover must be reported for the most recent 12-
1084 month period ending on the last workday of the most recent
1085 calendar quarter prior to the date the information is submitted.
1086 The turnover rate must be computed quarterly, with the annual
1087 rate being the cumulative sum of the quarterly rates. The
1088 turnover rate is the total number of terminations or separations
1089 experienced during the quarter, excluding any employee
1090 terminated during a probationary period of 3 months or less,
1091 divided by the total number of staff employed at the end of the
1092 period for which the rate is computed, and expressed as a
1093 percentage.
1094 c. The formula for determining staff stability is the
1095 total number of employees that have been employed for more than
1096 12 months, divided by the total number of employees employed at
1097 the end of the most recent calendar quarter, and expressed as a
1098 percentage.
1099 d. A nursing facility that has failed to comply with state
1100 minimum-staffing requirements for 2 consecutive days is
1101 prohibited from accepting new admissions until the facility has
1102 achieved the minimum-staffing requirements for a period of 6
1103 consecutive days. For the purposes of this sub-subparagraph, any
1104 person who was a resident of the facility and was absent from
1105 the facility for the purpose of receiving medical care at a
1106 separate location or was on a leave of absence is not considered
1107 a new admission. Failure to impose such an admissions moratorium
1108 is subject to a $1,000 fine ~~constitutes a class II deficiency~~.

1109 e. A nursing facility which does not have a conditional
1110 license may be cited for failure to comply with the standards in
1111 s. 400.23(3)(a)1.a. only if it has failed to meet those
1112 standards on 2 consecutive days or if it has failed to meet at
1113 least 97 percent of those standards on any one day.
1114 f. A facility which has a conditional license must be in
1115 compliance with the standards in s. 400.23(3)(a) at all times.
1116 2. This paragraph does not limit the agency's ability to
1117 impose a deficiency or take other actions if a facility does not
1118 have enough staff to meet the residents' needs.
1119 ~~(r) Report to the agency any filing for bankruptcy~~
1120 ~~protection by the facility or its parent corporation,~~
1121 ~~divestiture or spin-off of its assets, or corporate~~
1122 ~~reorganization within 30 days after the completion of such~~
1123 ~~activity.~~
1124 Section 31. Subsection (3) of section 400.142, Florida
1125 Statutes, is amended to read:
1126 400.142 Emergency medication kits; orders not to
1127 resuscitate.—
1128 (3) Facility staff may withhold or withdraw
1129 cardiopulmonary resuscitation if presented with an order not to
1130 resuscitate executed pursuant to s. 401.45. ~~The agency shall~~
1131 ~~adopt rules providing for the implementation of such orders.~~
1132 Facility staff and facilities shall not be subject to criminal
1133 prosecution or civil liability, nor be considered to have
1134 engaged in negligent or unprofessional conduct, for withholding
1135 or withdrawing cardiopulmonary resuscitation pursuant to such an
1136 order and rules adopted by the agency. The absence of an order

1137 not to resuscitate executed pursuant to s. 401.45 does not
1138 preclude a physician from withholding or withdrawing
1139 cardiopulmonary resuscitation as otherwise permitted by law.
1140 Section 32. Subsections (11) through (15) of section
1141 400.147, Florida Statutes, are renumbered as subsections (10)
1142 through (14), respectively, and present subsection (10) is
1143 amended to read:
1144 400.147 Internal risk management and quality assurance
1145 program.—
1146 ~~(10) By the 10th of each month, each facility subject to~~
1147 ~~this section shall report any notice received pursuant to s.~~
1148 ~~400.0233(2) and each initial complaint that was filed with the~~
1149 ~~clerk of the court and served on the facility during the~~
1150 ~~previous month by a resident or a resident's family member,~~
1151 ~~guardian, conservator, or personal legal representative. The~~
1152 ~~report must include the name of the resident, the resident's~~
1153 ~~date of birth and social security number, the Medicaid~~
1154 ~~identification number for Medicaid-eligible persons, the date or~~
1155 ~~dates of the incident leading to the claim or dates of~~
1156 ~~residency, if applicable, and the type of injury or violation of~~
1157 ~~rights alleged to have occurred. Each facility shall also submit~~
1158 ~~a copy of the notices received pursuant to s. 400.0233(2) and~~
1159 ~~complaints filed with the clerk of the court. This report is~~
1160 ~~confidential as provided by law and is not discoverable or~~
1161 ~~admissible in any civil or administrative action, except in such~~
1162 ~~actions brought by the agency to enforce the provisions of this~~
1163 ~~part.~~

1164 Section 33. Section 400.148, Florida Statutes, is
1165 repealed.
1166 Section 34. Paragraph (f) of subsection (5) of section
1167 400.162, Florida Statutes, is amended to read:
1168 400.162 Property and personal affairs of residents.—
1169 (5)
1170 (f) At least every 3 months, the licensee shall furnish
1171 the resident and the guardian, trustee, or conservator, if any,
1172 for the resident a complete and verified statement of all funds
1173 ~~and other property~~ to which this subsection applies, detailing
1174 the amounts ~~and items~~ received, together with their sources and
1175 disposition. For resident property, the licensee shall furnish
1176 such a statement annually and within 7 calendar days after a
1177 request for a statement. In any event, the licensee shall
1178 furnish such statements ~~a statement~~ annually and upon the
1179 discharge or transfer of a resident. Any governmental agency or
1180 private charitable agency contributing funds or other property
1181 on account of a resident also shall be entitled to receive such
1182 statements ~~statement~~ annually and upon discharge or transfer and
1183 such other report as it may require pursuant to law.
1184 Section 35. Paragraphs (d) and (e) of subsection (2) of
1185 section 400.179, Florida Statutes, are amended to read:
1186 400.179 Liability for Medicaid underpayments and
1187 overpayments.—
1188 (2) Because any transfer of a nursing facility may expose
1189 the fact that Medicaid may have underpaid or overpaid the
1190 transferor, and because in most instances, any such underpayment
1191 or overpayment can only be determined following a formal field

1192 audit, the liabilities for any such underpayments or
1193 overpayments shall be as follows:
1194 (d) Where the transfer involves a facility that has been
1195 leased by the transferor:
1196 1. The transferee shall, as a condition to being issued a
1197 license by the agency, acquire, maintain, and provide proof to
1198 the agency of a bond with a term of 30 months, renewable
1199 annually, in an amount not less than the total of 3 months'
1200 Medicaid payments to the facility computed on the basis of the
1201 preceding 12-month average Medicaid payments to the facility.
1202 2. A leasehold licensee may meet the requirements of
1203 subparagraph 1. by payment of a nonrefundable fee, paid at
1204 initial licensure, paid at the time of any subsequent change of
1205 ownership, and paid annually thereafter, in the amount of 1
1206 percent of the total of 3 months' Medicaid payments to the
1207 facility computed on the basis of the preceding 12-month average
1208 Medicaid payments to the facility. If a preceding 12-month
1209 average is not available, projected Medicaid payments may be
1210 used. The fee shall be deposited into the Grants and Donations
1211 Trust Fund and shall be accounted for separately as a Medicaid
1212 nursing home overpayment account. These fees shall be used at
1213 the sole discretion of the agency to repay nursing home Medicaid
1214 overpayments. Payment of this fee shall not release the licensee
1215 from any liability for any Medicaid overpayments, nor shall
1216 payment bar the agency from seeking to recoup overpayments from
1217 the licensee and any other liable party. As a condition of
1218 exercising this lease bond alternative, licensees paying this
1219 fee must maintain an existing lease bond through the end of the

1220 30-month term period of that bond. The agency is herein granted
1221 specific authority to promulgate all rules pertaining to the
1222 administration and management of this account, including
1223 withdrawals from the account, subject to federal review and
1224 approval. This provision shall take effect upon becoming law and
1225 shall apply to any leasehold license application. The financial
1226 viability of the Medicaid nursing home overpayment account shall
1227 be determined by the agency through annual review of the account
1228 balance and the amount of total outstanding, unpaid Medicaid
1229 overpayments owing from leasehold licensees to the agency as
1230 determined by final agency audits. By March 31 of each year, the
1231 agency shall assess the cumulative fees collected under this
1232 subparagraph, minus any amounts used to repay nursing home
1233 Medicaid overpayments and amounts transferred to contribute to
1234 the General Revenue Fund pursuant to s. 215.20. If the net
1235 cumulative collections, minus amounts utilized to repay nursing
1236 home Medicaid overpayments, exceed $25 million, the provisions
1237 of this paragraph shall not apply for the subsequent fiscal
1238 year.
1239 3. The leasehold licensee may meet the bond requirement
1240 through other arrangements acceptable to the agency. The agency
1241 is herein granted specific authority to promulgate rules
1242 pertaining to lease bond arrangements.
1243 4. All existing nursing facility licensees, operating the
1244 facility as a leasehold, shall acquire, maintain, and provide
1245 proof to the agency of the 30-month bond required in
1246 subparagraph 1., above, on and after July 1, 1993, for each
1247 license renewal.

1248 5. It shall be the responsibility of all nursing facility
1249 operators, operating the facility as a leasehold, to renew the
1250 30-month bond and to provide proof of such renewal to the agency
1251 annually.
1252 6. Any failure of the nursing facility operator to
1253 acquire, maintain, renew annually, or provide proof to the
1254 agency shall be grounds for the agency to deny, revoke, and
1255 suspend the facility license to operate such facility and to
1256 take any further action, including, but not limited to,
1257 enjoining the facility, asserting a moratorium pursuant to part
1258 II of chapter 408, or applying for a receiver, deemed necessary
1259 to ensure compliance with this section and to safeguard and
1260 protect the health, safety, and welfare of the facility's
1261 residents. A lease agreement required as a condition of bond
1262 financing or refinancing under s. 154.213 by a health facilities
1263 authority or required under s. 159.30 by a county or
1264 municipality is not a leasehold for purposes of this paragraph
1265 and is not subject to the bond requirement of this paragraph.
1266 ~~(e) For the 2009-2010 fiscal year only, the provisions of~~
1267 ~~paragraph (d) shall not apply. This paragraph expires July 1,~~
1268 ~~2010.~~
1269 Section 36. Subsection (3) of section 400.19, Florida
1270 Statutes, is amended to read:
1271 400.19 Right of entry and inspection.—
1272 (3) The agency shall every 15 months conduct at least one
1273 unannounced inspection to determine compliance by the licensee
1274 with statutes, and with rules promulgated under the provisions
1275 of those statutes, governing minimum standards of construction,

1276 quality and adequacy of care, and rights of residents. The
1277 survey shall be conducted every 6 months for the next 2-year
1278 period if the facility has been cited for a class I deficiency,
1279 has been cited for two or more class II deficiencies arising
1280 from separate surveys or investigations within a 60-day period,
1281 or has had three or more substantiated complaints within a 6-
1282 month period, each resulting in at least one class I or class II
1283 deficiency. In addition to any other fees or fines in this part,
1284 the agency shall assess a fine for each facility that is subject
1285 to the 6-month survey cycle. The fine for the 2-year period
1286 shall be $6,000, one-half to be paid at the completion of each
1287 survey. The agency may adjust this fine by the change in the
1288 Consumer Price Index, based on the 12 months immediately
1289 preceding the increase, to cover the cost of the additional
1290 surveys. The agency shall verify through subsequent inspection
1291 that any deficiency identified during inspection is corrected.
1292 However, the agency may verify the correction of a class III or
1293 class IV deficiency ~~unrelated to resident rights or resident~~
1294 ~~care~~ without reinspecting the facility if adequate written
1295 documentation has been received from the facility, which
1296 provides assurance that the deficiency has been corrected. The
1297 giving or causing to be given of advance notice of such
1298 unannounced inspections by an employee of the agency to any
1299 unauthorized person shall constitute cause for suspension of not
1300 fewer than 5 working days according to the provisions of chapter
1301 110.
1302 Section 37. Section 400.195, Florida Statutes, is
1303 repealed.

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

1304 Section 38. Subsection (5) of section 400.23, Florida
1305 Statutes, is amended to read:
1306 400.23 Rules; evaluation and deficiencies; licensure
1307 status.—
1308 (5)<u>(a)</u> The agency, in collaboration with the Division of
1309 Children's Medical Services <u>Network</u> of the Department of Health,
1310 must~~, no later than December 31, 1993,~~ adopt rules for minimum
1311 standards of care for persons under 21 years of age who reside
1312 in nursing home facilities. The rules must include a methodology
1313 for reviewing a nursing home facility under ss. 408.031-408.045
1314 which serves only persons under 21 years of age. A facility may
1315 be exempt from these standards for specific persons between 18
1316 and 21 years of age, if the person's physician agrees that
1317 minimum standards of care based on age are not necessary.
1318 <u>(b) The agency, in collaboration with the Division of</u>
1319 <u>Children's Medical Services Network, shall adopt rules for</u>
1320 <u>minimum staffing requirements for nursing home facilities that</u>
1321 <u>serve persons under 21 years of age, which shall apply in lieu</u>
1322 <u>of the standards contained in subsection (3).</u>
1323 <u>1. For persons under 21 years of age who require skilled</u>
1324 <u>care, the requirements shall include a minimum combined average</u>
1325 <u>of licensed nurses, respiratory therapists, respiratory care</u>
1326 <u>practitioners, and certified nursing assistants of 3.9 hours of</u>
1327 <u>direct care per resident per day for each nursing home facility.</u>
1328 <u>2. For persons under 21 years of age who are fragile, the</u>
1329 <u>requirements shall include a minimum combined average of</u>
1330 <u>licensed nurses, respiratory therapists, respiratory care</u>

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1331 practitioners, and certified nursing assistants of 5 hours of
1332 direct care per resident per day for each nursing home facility.
1333 Section 39. Subsection (1) of section 400.275, Florida
1334 Statutes, is amended to read:
1335 400.275 Agency duties.—
1336 (1) ~~The agency shall ensure that each newly hired nursing~~
1337 ~~home surveyor, as a part of basic training, is assigned full-~~
1338 ~~time to a licensed nursing home for at least 2 days within a 7-~~
1339 ~~day period to observe facility operations outside of the survey~~
1340 ~~process before the surveyor begins survey responsibilities. Such~~
1341 ~~observations may not be the sole basis of a deficiency citation~~
1342 ~~against the facility.~~ The agency may not assign an individual to
1343 be a member of a survey team for purposes of a survey,
1344 evaluation, or consultation visit at a nursing home facility in
1345 which the surveyor was an employee within the preceding 2 ~~5~~
1346 years.
1347 Section 40. Subsection (2) of section 400.484, Florida
1348 Statutes, is amended to read:
1349 400.484 Right of inspection; violations ~~deficiencies~~;
1350 fines.—
1351 (2) The agency shall impose fines for various classes of
1352 violations ~~deficiencies~~ in accordance with the following
1353 schedule:
1354 (a) Class I violations are defined in s. 408.813. ~~A class~~
1355 ~~I deficiency is any act, omission, or practice that results in a~~
1356 ~~patient's death, disablement, or permanent injury, or places a~~
1357 ~~patient at imminent risk of death, disablement, or permanent~~
1358 ~~injury.~~ Upon finding a class I violation ~~deficiency~~, the agency

1359 shall impose an administrative fine in the amount of $15,000 for
1360 each occurrence and each day that the violation ~~deficiency~~
1361 exists.
1362 (b) Class II violations are defined in s. 408.813. ~~A class~~
1363 ~~II deficiency is any act, omission, or practice that has a~~
1364 ~~direct adverse effect on the health, safety, or security of a~~
1365 ~~patient.~~ Upon finding a class II violation ~~deficiency~~, the
1366 agency shall impose an administrative fine in the amount of
1367 $5,000 for each occurrence and each day that the violation
1368 ~~deficiency~~ exists.
1369 (c) Class III violations are defined in s. 408.813. ~~A~~
1370 ~~class III deficiency is any act, omission, or practice that has~~
1371 ~~an indirect, adverse effect on the health, safety, or security~~
1372 ~~of a patient.~~ Upon finding an uncorrected or repeated class III
1373 violation ~~deficiency~~, the agency shall impose an administrative
1374 fine not to exceed $1,000 for each occurrence and each day that
1375 the uncorrected or repeated violation ~~deficiency~~ exists.
1376 (d) Class IV violations are defined in s. 408.813. ~~A class~~
1377 ~~IV deficiency is any act, omission, or practice related to~~
1378 ~~required reports, forms, or documents which does not have the~~
1379 ~~potential of negatively affecting patients. These violations are~~
1380 ~~of a type that the agency determines do not threaten the health,~~
1381 ~~safety, or security of patients.~~ Upon finding an uncorrected or
1382 repeated class IV violation ~~deficiency~~, the agency shall impose
1383 an administrative fine not to exceed $500 for each occurrence
1384 and each day that the uncorrected or repeated violation
1385 ~~deficiency~~ exists.

1386 Section 41. Paragraph (i) of subsection (1) and subsection
1387 (4) of section 400.606, Florida Statutes, are amended to read:
1388 400.606 License; application; renewal; conditional license
1389 or permit; certificate of need.—
1390 (1) In addition to the requirements of part II of chapter
1391 408, the initial application and change of ownership application
1392 must be accompanied by a plan for the delivery of home,
1393 residential, and homelike inpatient hospice services to
1394 terminally ill persons and their families. Such plan must
1395 contain, but need not be limited to:
1396 ~~(i) The projected annual operating cost of the hospice.~~
1397
1398 If the applicant is an existing licensed health care provider,
1399 the application must be accompanied by a copy of the most recent
1400 profit-loss statement and, if applicable, the most recent
1401 licensure inspection report.
1402 (4) A freestanding hospice facility that is ~~primarily~~
1403 engaged in providing inpatient and related services and that is
1404 not otherwise licensed as a health care facility shall be
1405 required to obtain a certificate of need. However, a
1406 freestanding hospice facility with six or fewer beds shall not
1407 be required to comply with institutional standards such as, but
1408 not limited to, standards requiring sprinkler systems, emergency
1409 electrical systems, or special lavatory devices.
1410 Section 42. Subsection (2) of section 400.607, Florida
1411 Statutes, is amended to read:
1412 400.607 Denial, suspension, revocation of license;
1413 emergency actions; imposition of administrative fine; grounds.—

1414 (2) A violation of this part, part II of chapter 408, or
1415 applicable rules ~~Any of the following actions~~ by a licensed
1416 hospice or any of its employees shall be grounds for
1417 administrative action by the agency against a hospice.~~:~~
1418 ~~(a) A violation of the provisions of this part, part II of~~
1419 ~~chapter 408, or applicable rules.~~
1420 ~~(b) An intentional or negligent act materially affecting~~
1421 ~~the health or safety of a patient.~~
1422 Section 43. Section 400.915, Florida Statutes, is amended
1423 to read:
1424 400.915 Construction and renovation; requirements.—The
1425 requirements for the construction or renovation of a PPEC center
1426 shall comply with:
1427 (1) The provisions of chapter 553, which pertain to
1428 building construction standards, including plumbing, electrical
1429 code, glass, manufactured buildings, accessibility for the
1430 physically disabled;
1431 (2) The provisions of s. 633.022 and applicable rules
1432 pertaining to physical ~~minimum~~ standards for nonresidential
1433 child care ~~physical~~ facilities ~~in rule 10M-12.003, Florida~~
1434 ~~Administrative Code, Child Care Standards~~; and
1435 (3) The standards or rules adopted pursuant to this part
1436 and part II of chapter 408.
1437 Section 44. Subsection (1) of section 400.925, Florida
1438 Statutes, is amended to read:
1439 400.925 Definitions.—As used in this part, the term:
1440 (1) "Accrediting organizations" means The Joint Commission
1441 ~~on Accreditation of Healthcare Organizations~~ or other national

1442 accreditation agencies whose standards for accreditation are
1443 comparable to those required by this part for licensure.
1444 Section 45. Subsections (3) through (6) of section
1445 400.931, Florida Statutes, are renumbered as subsections (2)
1446 through (5), respectively, and present subsection (2) of that
1447 section is amended to read:
1448 400.931 Application for license; fee~~; provisional license;~~
1449 ~~temporary permit~~.—
1450 ~~(2) As an alternative to submitting proof of financial~~
1451 ~~ability to operate as required in s. 408.810(8), the applicant~~
1452 ~~may submit a $50,000 surety bond to the agency.~~
1453 Section 46. Subsection (2) of section 400.932, Florida
1454 Statutes, is amended to read:
1455 400.932 Administrative penalties.—
1456 (2) A violation of this part, part II of chapter 408, or
1457 applicable rules ~~Any of the following actions~~ by an employee of
1458 a home medical equipment provider shall be ~~are~~ grounds for
1459 administrative action or penalties by the agency.~~:~~
1460 ~~(a) Violation of this part, part II of chapter 408, or~~
1461 ~~applicable rules.~~
1462 ~~(b) An intentional, reckless, or negligent act that~~
1463 ~~materially affects the health or safety of a patient.~~
1464 Section 47. Subsection (3) of section 400.967, Florida
1465 Statutes, is amended to read:
1466 400.967 Rules and classification of violations
1467 ~~deficiencies~~.—
1468 (3) The agency shall adopt rules to provide that, when the
1469 criteria established under this part and part II of chapter 408

1470 are not met, such violations ~~deficiencies~~ shall be classified
1471 according to the nature of the violation ~~deficiency~~. The agency
1472 shall indicate the classification on the face of the notice of
1473 deficiencies as follows:
1474 (a) Class I violations ~~deficiencies~~ are defined in s.
1475 408.813 ~~those which the agency determines present an imminent~~
1476 ~~danger to the residents or guests of the facility or a~~
1477 ~~substantial probability that death or serious physical harm~~
1478 ~~would result therefrom~~. ~~The condition or practice constituting a~~
1479 ~~class I violation must be abated or eliminated immediately,~~
1480 ~~unless a fixed period of time, as determined by the agency, is~~
1481 ~~required for correction.~~ A class I violation ~~deficiency~~ is
1482 subject to a civil penalty in an amount not less than $5,000 and
1483 not exceeding $10,000 for each violation ~~deficiency~~. A fine may
1484 be levied notwithstanding the correction of the violation
1485 ~~deficiency~~.
1486 (b) Class II violations ~~deficiencies~~ are defined in s.
1487 408.813 ~~those which the agency determines have a direct or~~
1488 ~~immediate relationship to the health, safety, or security of the~~
1489 ~~facility residents, other than class I deficiencies~~. A class II
1490 violation ~~deficiency~~ is subject to a civil penalty in an amount
1491 not less than $1,000 and not exceeding $5,000 for each violation
1492 ~~deficiency~~. A citation for a class II violation ~~deficiency~~ shall
1493 specify the time within which the violation ~~deficiency~~ must be
1494 corrected. If a class II violation ~~deficiency~~ is corrected
1495 within the time specified, no civil penalty shall be imposed,
1496 unless it is a repeated offense.

1497 (c) Class III violations ~~deficiencies~~ are defined in s.
1498 408.813 ~~those which the agency determines to have an indirect or~~
1499 ~~potential relationship to the health, safety, or security of the~~
1500 ~~facility residents, other than class I or class II deficiencies~~.
1501 A class III violation ~~deficiency~~ is subject to a civil penalty
1502 of not less than $500 and not exceeding $1,000 for each
1503 deficiency. A citation for a class III violation ~~deficiency~~
1504 shall specify the time within which the violation ~~deficiency~~
1505 must be corrected. If a class III violation ~~deficiency~~ is
1506 corrected within the time specified, no civil penalty shall be
1507 imposed, unless it is a repeated offense.
1508 (d) Class IV violations are defined in s. 408.813. Upon
1509 finding an uncorrected or repeated class IV violation, the
1510 agency shall impose an administrative fine not to exceed $500
1511 for each occurrence and each day that the uncorrected or
1512 repeated violation exists.
1513 Section 48. Subsections (4) and (7) of section 400.9905,
1514 Florida Statutes, are amended to read:
1515 400.9905 Definitions.—
1516 (4) "Clinic" means an entity at which health care services
1517 are provided to individuals and which tenders charges for
1518 reimbursement for such services, including a mobile clinic and a
1519 portable health service or equipment provider. For purposes of
1520 this part, the term does not include and the licensure
1521 requirements of this part do not apply to:
1522 (a) Entities licensed or registered by the state under
1523 chapter 395; or entities licensed or registered by the state and
1524 providing only health care services within the scope of services

1525 authorized under their respective licenses granted under ss.
1526 383.30-383.335, chapter 390, chapter 394, chapter 397, this
1527 chapter except part X, chapter 429, chapter 463, chapter 465,
1528 chapter 466, chapter 478, part I of chapter 483, chapter 484, or
1529 chapter 651; end-stage renal disease providers authorized under
1530 42 C.F.R. part 405, subpart U; or providers certified under 42
1531 C.F.R. part 485, subpart B or subpart H; or any entity that
1532 provides neonatal or pediatric hospital-based health care
1533 services or other health care services by licensed practitioners
1534 solely within a hospital licensed under chapter 395.
1535 (b) Entities that own, directly or indirectly, entities
1536 licensed or registered by the state pursuant to chapter 395; or
1537 entities that own, directly or indirectly, entities licensed or
1538 registered by the state and providing only health care services
1539 within the scope of services authorized pursuant to their
1540 respective licenses granted under ss. 383.30-383.335, chapter
1541 390, chapter 394, chapter 397, this chapter except part X,
1542 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
1543 part I of chapter 483, chapter 484, chapter 651; end-stage renal
1544 disease providers authorized under 42 C.F.R. part 405, subpart
1545 U; or providers certified under 42 C.F.R. part 485, subpart B or
1546 subpart H; or any entity that provides neonatal or pediatric
1547 hospital-based health care services by licensed practitioners
1548 solely within a hospital licensed under chapter 395.
1549 (c) Entities that are owned, directly or indirectly, by an
1550 entity licensed or registered by the state pursuant to chapter
1551 395; or entities that are owned, directly or indirectly, by an
1552 entity licensed or registered by the state and providing only

1553 health care services within the scope of services authorized
1554 pursuant to their respective licenses granted under ss. 383.30-
1555 383.335, chapter 390, chapter 394, chapter 397, this chapter
1556 except part X, chapter 429, chapter 463, chapter 465, chapter
1557 466, chapter 478, part I of chapter 483, chapter 484, or chapter
1558 651; end-stage renal disease providers authorized under 42
1559 C.F.R. part 405, subpart U; or providers certified under 42
1560 C.F.R. part 485, subpart B or subpart H; or any entity that
1561 provides neonatal or pediatric hospital-based health care
1562 services by licensed practitioners solely within a hospital
1563 under chapter 395.
1564 (d) Entities that are under common ownership, directly or
1565 indirectly, with an entity licensed or registered by the state
1566 pursuant to chapter 395; or entities that are under common
1567 ownership, directly or indirectly, with an entity licensed or
1568 registered by the state and providing only health care services
1569 within the scope of services authorized pursuant to their
1570 respective licenses granted under ss. 383.30-383.335, chapter
1571 390, chapter 394, chapter 397, this chapter except part X,
1572 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
1573 part I of chapter 483, chapter 484, or chapter 651; end-stage
1574 renal disease providers authorized under 42 C.F.R. part 405,
1575 subpart U; or providers certified under 42 C.F.R. part 485,
1576 subpart B or subpart H; or any entity that provides neonatal or
1577 pediatric hospital-based health care services by licensed
1578 practitioners solely within a hospital licensed under chapter
1579 395.

1580 (e) An entity that is exempt from federal taxation under
1581 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
1582 under 26 U.S.C. s. 409 that has a board of trustees not less
1583 than two-thirds of which are Florida-licensed health care
1584 practitioners and provides only physical therapy services under
1585 physician orders, any community college or university clinic,
1586 and any entity owned or operated by the federal or state
1587 government, including agencies, subdivisions, or municipalities
1588 thereof.
1589 (f) A sole proprietorship, group practice, partnership, or
1590 corporation that provides health care services by physicians
1591 covered by s. 627.419, that is directly supervised by one or
1592 more of such physicians, and that is wholly owned by one or more
1593 of those physicians or by a physician and the spouse, parent,
1594 child, or sibling of that physician.
1595 (g) A sole proprietorship, group practice, partnership, or
1596 corporation that provides health care services by licensed
1597 health care practitioners under chapter 457, chapter 458,
1598 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
1599 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
1600 chapter 490, chapter 491, or part I, part III, part X, part
1601 XIII, or part XIV of chapter 468, or s. 464.012, which are
1602 wholly owned by one or more licensed health care practitioners,
1603 or the licensed health care practitioners set forth in this
1604 paragraph and the spouse, parent, child, or sibling of a
1605 licensed health care practitioner, so long as one of the owners
1606 who is a licensed health care practitioner is supervising the
1607 business activities and is legally responsible for the entity's

1608 compliance with all federal and state laws. However, a health
1609 care practitioner may not supervise services beyond the scope of
1610 the practitioner's license, except that, for the purposes of
1611 this part, a clinic owned by a licensee in s. 456.053(3)(b) that
1612 provides only services authorized pursuant to s. 456.053(3)(b)
1613 may be supervised by a licensee specified in s. 456.053(3)(b).
1614 (h) Clinical facilities affiliated with an accredited
1615 medical school at which training is provided for medical
1616 students, residents, or fellows.
1617 (i) Entities that provide only oncology or radiation
1618 therapy services by physicians licensed under chapter 458 or
1619 chapter 459 or entities that provide oncology or radiation
1620 therapy services by physicians licensed under chapter 458 or
1621 chapter 459 which are owned by a corporation whose shares are
1622 publicly traded on a recognized stock exchange.
1623 (j) Clinical facilities affiliated with a college of
1624 chiropractic accredited by the Council on Chiropractic Education
1625 at which training is provided for chiropractic students.
1626 (k) Entities that provide licensed practitioners to staff
1627 emergency departments or to deliver anesthesia services in
1628 facilities licensed under chapter 395 and that derive at least
1629 90 percent of their gross annual revenues from the provision of
1630 such services. Entities claiming an exemption from licensure
1631 under this paragraph must provide documentation demonstrating
1632 compliance.
1633 (l) Orthotic, ~~or~~ prosthetic, pediatric cardiology, or
1634 perinatology clinical facilities that are a publicly traded
1635 corporation or that are wholly owned, directly or indirectly, by

1636 a publicly traded corporation. As used in this paragraph, a
1637 publicly traded corporation is a corporation that issues
1638 securities traded on an exchange registered with the United
1639 States Securities and Exchange Commission as a national
1640 securities exchange.
1641 (m) Entities that are owned by a corporation that has $250
1642 million or more in total annual sales of health care services
1643 provided by licensed health care practitioners if one or more of
1644 the owners of the entity is a health care practitioner who is
1645 licensed in this state, is responsible for supervising the
1646 business activities of the entity, and is legally responsible
1647 for the entity's compliance with state law for purposes of this
1648 section.
1649 (n) Entities that are owned or controlled, directly or
1650 indirectly, by a publicly traded entity with $100 million or
1651 more, in the aggregate, in total annual revenues derived from
1652 providing health care services by licensed health care
1653 practitioners that are employed or contracted by an entity
1654 described in this paragraph.
1655 (7) "Portable health service or equipment provider" means
1656 an entity that contracts with or employs persons to provide
1657 portable health care services or equipment to multiple locations
1658 ~~performing treatment or diagnostic testing of individuals~~, that
1659 bills third-party payors for those services, and that otherwise
1660 meets the definition of a clinic in subsection (4).
1661 Section 49. Paragraph (b) of subsection (1) and paragraph
1662 (c) of subsection (4) of section 400.991, Florida Statutes, are
1663 amended to read:

1664 400.991 License requirements; background screenings;
1665 prohibitions.—
1666 (1)
1667 (b) Each mobile clinic must obtain a separate health care
1668 clinic license and must provide to the agency, at least
1669 quarterly, its projected street location to enable the agency to
1670 locate and inspect such clinic. A portable health service or
1671 equipment provider must obtain a health care clinic license for
1672 a single administrative office and is not required to submit
1673 quarterly projected street locations.
1674 (4) In addition to the requirements of part II of chapter
1675 408, the applicant must file with the application satisfactory
1676 proof that the clinic is in compliance with this part and
1677 applicable rules, including:
1678 (c) Proof of financial ability to operate as required
1679 under ss. ~~s.~~ 408.810(8) and 408.8065. ~~As an alternative to~~
1680 ~~submitting proof of financial ability to operate as required~~
1681 ~~under s. 408.810(8), the applicant may file a surety bond of at~~
1682 ~~least $500,000 which guarantees that the clinic will act in full~~
1683 ~~conformity with all legal requirements for operating a clinic,~~
1684 ~~payable to the agency. The agency may adopt rules to specify~~
1685 ~~related requirements for such surety bond.~~
1686 Section 50. Paragraph (g) of subsection (1) and paragraph
1687 (a) of subsection (7) of section 400.9935, Florida Statutes, are
1688 amended to read:
1689 400.9935 Clinic responsibilities.—
1690 (1) Each clinic shall appoint a medical director or clinic
1691 director who shall agree in writing to accept legal

1692 responsibility for the following activities on behalf of the
1693 clinic. The medical director or the clinic director shall:
1694 (g) Conduct systematic reviews of clinic billings to
1695 ensure that the billings are not fraudulent or unlawful. Upon
1696 discovery of an unlawful charge, the medical director or clinic
1697 director shall take immediate corrective action. If the clinic
1698 performs only the technical component of magnetic resonance
1699 imaging, static radiographs, computed tomography, or positron
1700 emission tomography, and provides the professional
1701 interpretation of such services, in a fixed facility that is
1702 accredited by The Joint Commission ~~on Accreditation of~~
1703 ~~Healthcare Organizations~~ or the Accreditation Association for
1704 Ambulatory Health Care, and the American College of Radiology;
1705 and if, in the preceding quarter, the percentage of scans
1706 performed by that clinic which was billed to all personal injury
1707 protection insurance carriers was less than 15 percent, the
1708 chief financial officer of the clinic may, in a written
1709 acknowledgment provided to the agency, assume the responsibility
1710 for the conduct of the systematic reviews of clinic billings to
1711 ensure that the billings are not fraudulent or unlawful.
1712 (7)(a) Each clinic engaged in magnetic resonance imaging
1713 services must be accredited by The Joint Commission ~~on~~
1714 ~~Accreditation of Healthcare Organizations~~, the American College
1715 of Radiology, or the Accreditation Association for Ambulatory
1716 Health Care, within 1 year after licensure. A clinic that is
1717 accredited by the American College of Radiology or is within the
1718 original 1-year period after licensure and replaces its core
1719 magnetic resonance imaging equipment shall be given 1 year after

1720 the date on which the equipment is replaced to attain
1721 accreditation. However, a clinic may request a single, 6-month
1722 extension if it provides evidence to the agency establishing
1723 that, for good cause shown, such clinic cannot be accredited
1724 within 1 year after licensure, and that such accreditation will
1725 be completed within the 6-month extension. After obtaining
1726 accreditation as required by this subsection, each such clinic
1727 must maintain accreditation as a condition of renewal of its
1728 license. A clinic that files a change of ownership application
1729 must comply with the original accreditation timeframe
1730 requirements of the transferor. The agency shall deny a change
1731 of ownership application if the clinic is not in compliance with
1732 the accreditation requirements. When a clinic adds, replaces, or
1733 modifies magnetic resonance imaging equipment and the
1734 accreditation agency requires new accreditation, the clinic must
1735 be accredited within 1 year after the date of the addition,
1736 replacement, or modification but may request a single, 6-month
1737 extension if the clinic provides evidence of good cause to the
1738 agency.
1739 Section 51. Subsection (2) of section 408.034, Florida
1740 Statutes, is amended to read:
1741 408.034 Duties and responsibilities of agency; rules.—
1742 (2) In the exercise of its authority to issue licenses to
1743 health care facilities and health service providers, as provided
1744 under chapters 393 and 395 and parts II, ~~and~~ IV, and VIII of
1745 chapter 400, the agency may not issue a license to any health
1746 care facility or health service provider that fails to receive a

1747 certificate of need or an exemption for the licensed facility or
1748 service.
1749 Section 52. Paragraph (d) of subsection (1) of section
1750 408.036, Florida Statutes, is amended to read:
1751 408.036 Projects subject to review; exemptions.—
1752 (1) APPLICABILITY.—Unless exempt under subsection (3), all
1753 health-care-related projects, as described in paragraphs (a)-
1754 (g), are subject to review and must file an application for a
1755 certificate of need with the agency. The agency is exclusively
1756 responsible for determining whether a health-care-related
1757 project is subject to review under ss. 408.031-408.045.
1758 (d) The establishment of a hospice or hospice inpatient
1759 facility~~, except as provided in s. 408.043~~.
1760 Section 53. Subsection (2) of section 408.043, Florida
1761 Statutes, is amended to read:
1762 408.043 Special provisions.—
1763 (2) HOSPICES.—When an application is made for a
1764 certificate of need to establish or to expand a hospice, the
1765 need for such hospice shall be determined on the basis of the
1766 need for and availability of hospice services in the community.
1767 The formula on which the certificate of need is based shall
1768 discourage regional monopolies and promote competition. The
1769 inpatient hospice care component of a hospice which is a
1770 freestanding facility, or a part of a facility, ~~which is~~
1771 ~~primarily engaged in providing inpatient care and related~~
1772 ~~services~~ and is not licensed as a health care facility shall
1773 also be required to obtain a certificate of need. Provision of
1774 hospice care by any current provider of health care is a

1775 significant change in service and therefore requires a
1776 certificate of need for such services.
1777 Section 54. Paragraph (k) of subsection (3) of section
1778 408.05, Florida Statutes, is amended to read:
1779 408.05 Florida Center for Health Information and Policy
1780 Analysis.—
1781 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to
1782 produce comparable and uniform health information and statistics
1783 for the development of policy recommendations, the agency shall
1784 perform the following functions:
1785 (k) Develop, in conjunction with the State Consumer Health
1786 Information and Policy Advisory Council, and implement a long-
1787 range plan for making available health care quality measures and
1788 financial data that will allow consumers to compare health care
1789 services. The health care quality measures and financial data
1790 the agency must make available shall include, but is not limited
1791 to, pharmaceuticals, physicians, health care facilities, and
1792 health plans and managed care entities. The agency shall submit
1793 the initial plan to the Governor, the President of the Senate,
1794 and the Speaker of the House of Representatives by January 1,
1795 2006, and shall update the plan and report on the status of its
1796 implementation annually thereafter. The agency shall also make
1797 the plan and status report available to the public on its
1798 Internet website. As part of the plan, the agency shall identify
1799 the process and timeframes for implementation, any barriers to
1800 implementation, and recommendations of changes in the law that
1801 may be enacted by the Legislature to eliminate the barriers. As
1802 preliminary elements of the plan, the agency shall:

1803 1. Make available patient-safety indicators, inpatient
1804 quality indicators, and performance outcome and patient charge
1805 data collected from health care facilities pursuant to s.
1806 408.061(1)(a) and (2). The terms "patient-safety indicators" and
1807 "inpatient quality indicators" shall be as defined by the
1808 Centers for Medicare and Medicaid Services, the National Quality
1809 Forum, The Joint Commission ~~on Accreditation of Healthcare~~
1810 ~~Organizations~~, the Agency for Healthcare Research and Quality,
1811 the Centers for Disease Control and Prevention, or a similar
1812 national entity that establishes standards to measure the
1813 performance of health care providers, or by other states. The
1814 agency shall determine which conditions, procedures, health care
1815 quality measures, and patient charge data to disclose based upon
1816 input from the council. When determining which conditions and
1817 procedures are to be disclosed, the council and the agency shall
1818 consider variation in costs, variation in outcomes, and
1819 magnitude of variations and other relevant information. When
1820 determining which health care quality measures to disclose, the
1821 agency:
1822 a. Shall consider such factors as volume of cases; average
1823 patient charges; average length of stay; complication rates;
1824 mortality rates; and infection rates, among others, which shall
1825 be adjusted for case mix and severity, if applicable.
1826 b. May consider such additional measures that are adopted
1827 by the Centers for Medicare and Medicaid Studies, National
1828 Quality Forum, The Joint Commission ~~on Accreditation of~~
1829 ~~Healthcare Organizations~~, the Agency for Healthcare Research and
1830 Quality, Centers for Disease Control and Prevention, or a

1831 similar national entity that establishes standards to measure
1832 the performance of health care providers, or by other states.
1833
1834 When determining which patient charge data to disclose, the
1835 agency shall include such measures as the average of
1836 undiscounted charges on frequently performed procedures and
1837 preventive diagnostic procedures, the range of procedure charges
1838 from highest to lowest, average net revenue per adjusted patient
1839 day, average cost per adjusted patient day, and average cost per
1840 admission, among others.
1841 2. Make available performance measures, benefit design,
1842 and premium cost data from health plans licensed pursuant to
1843 chapter 627 or chapter 641. The agency shall determine which
1844 health care quality measures and member and subscriber cost data
1845 to disclose, based upon input from the council. When determining
1846 which data to disclose, the agency shall consider information
1847 that may be required by either individual or group purchasers to
1848 assess the value of the product, which may include membership
1849 satisfaction, quality of care, current enrollment or membership,
1850 coverage areas, accreditation status, premium costs, plan costs,
1851 premium increases, range of benefits, copayments and
1852 deductibles, accuracy and speed of claims payment, credentials
1853 of physicians, number of providers, names of network providers,
1854 and hospitals in the network. Health plans shall make available
1855 to the agency any such data or information that is not currently
1856 reported to the agency or the office.
1857 3. Determine the method and format for public disclosure
1858 of data reported pursuant to this paragraph. The agency shall

1859 make its determination based upon input from the State Consumer
1860 Health Information and Policy Advisory Council. At a minimum,
1861 the data shall be made available on the agency's Internet
1862 website in a manner that allows consumers to conduct an
1863 interactive search that allows them to view and compare the
1864 information for specific providers. The website must include
1865 such additional information as is determined necessary to ensure
1866 that the website enhances informed decisionmaking among
1867 consumers and health care purchasers, which shall include, at a
1868 minimum, appropriate guidance on how to use the data and an
1869 explanation of why the data may vary from provider to provider.
1870 The data specified in subparagraph 1. shall be released no later
1871 than January 1, 2006, for the reporting of infection rates, and
1872 no later than October 1, 2005, for mortality rates and
1873 complication rates. The data specified in subparagraph 2. shall
1874 be released no later than October 1, 2006.
1875 4. Publish on its website undiscounted charges for no
1876 fewer than 150 of the most commonly performed adult and
1877 pediatric procedures, including outpatient, inpatient,
1878 diagnostic, and preventative procedures.
1879 Section 55. Paragraph (a) of subsection (1) of section
1880 408.061, Florida Statutes, is amended to read:
1881 408.061 Data collection; uniform systems of financial
1882 reporting; information relating to physician charges;
1883 confidential information; immunity.—
1884 (1) The agency shall require the submission by health care
1885 facilities, health care providers, and health insurers of data
1886 necessary to carry out the agency's duties. Specifications for

1887 data to be collected under this section shall be developed by
1888 the agency with the assistance of technical advisory panels
1889 including representatives of affected entities, consumers,
1890 purchasers, and such other interested parties as may be
1891 determined by the agency.
1892 (a) Data submitted by health care facilities, including
1893 the facilities as defined in chapter 395, shall include, but are
1894 not limited to: case-mix data, patient admission and discharge
1895 data, hospital emergency department data which shall include the
1896 number of patients treated in the emergency department of a
1897 licensed hospital reported by patient acuity level, data on
1898 hospital-acquired infections as specified by rule, data on
1899 complications as specified by rule, data on readmissions as
1900 specified by rule, with patient and provider-specific
1901 identifiers included, actual charge data by diagnostic groups,
1902 financial data, accounting data, operating expenses, expenses
1903 incurred for rendering services to patients who cannot or do not
1904 pay, interest charges, depreciation expenses based on the
1905 expected useful life of the property and equipment involved, and
1906 demographic data. The agency shall adopt nationally recognized
1907 risk adjustment methodologies or software consistent with the
1908 standards of the Agency for Healthcare Research and Quality and
1909 as selected by the agency for all data submitted as required by
1910 this section. Data may be obtained from documents such as, but
1911 not limited to: leases, contracts, debt instruments, itemized
1912 patient bills, medical record abstracts, and related diagnostic
1913 information. Reported data elements shall be reported
1914 electronically and ~~in accordance with rule 59E-7.012, Florida~~

1915 ~~Administrative Code. Data submitted shall be~~ certified by the
1916 chief executive officer or an appropriate and duly authorized
1917 representative or employee of the licensed facility that the
1918 information submitted is true and accurate.
1919 Section 56. Subsection (43) of section 408.07, Florida
1920 Statutes, is amended to read:
1921 408.07 Definitions.—As used in this chapter, with the
1922 exception of ss. 408.031-408.045, the term:
1923 (43) "Rural hospital" means an acute care hospital
1924 licensed under chapter 395, having 100 or fewer licensed beds
1925 and an emergency room, and which is:
1926 (a) The sole provider within a county with a population
1927 density of no greater than 100 persons per square mile;
1928 (b) An acute care hospital, in a county with a population
1929 density of no greater than 100 persons per square mile, which is
1930 at least 30 minutes of travel time, on normally traveled roads
1931 under normal traffic conditions, from another acute care
1932 hospital within the same county;
1933 (c) A hospital supported by a tax district or subdistrict
1934 whose boundaries encompass a population of 100 persons or fewer
1935 per square mile;
1936 (d) A hospital with a service area that has a population
1937 of 100 persons or fewer per square mile. As used in this
1938 paragraph, the term "service area" means the fewest number of
1939 zip codes that account for 75 percent of the hospital's
1940 discharges for the most recent 5-year period, based on
1941 information available from the hospital inpatient discharge

1942 database in the Florida Center for Health Information and Policy
1943 Analysis at the Agency for Health Care Administration; or
1944 (e) A critical access hospital.
1945
1946 Population densities used in this subsection must be based upon
1947 the most recently completed United States census. A hospital
1948 that received funds under s. 409.9116 for a quarter beginning no
1949 later than July 1, 2002, is deemed to have been and shall
1950 continue to be a rural hospital from that date through June 30,
1951 2015, if the hospital continues to have 100 or fewer licensed
1952 beds and an emergency room~~, or meets the criteria of s.~~
1953 ~~395.602(2)(e)4~~. An acute care hospital that has not previously
1954 been designated as a rural hospital and that meets the criteria
1955 of this subsection shall be granted such designation upon
1956 application, including supporting documentation, to the Agency
1957 for Health Care Administration.
1958 Section 57. Section 408.10, Florida Statutes, is amended
1959 to read:
1960 408.10 Consumer complaints.—The agency shall~~:~~
1961 ~~(1)~~ publish and make available to the public a toll-free
1962 telephone number for the purpose of handling consumer complaints
1963 and shall serve as a liaison between consumer entities and other
1964 private entities and governmental entities for the disposition
1965 of problems identified by consumers of health care.
1966 ~~(2) Be empowered to investigate consumer complaints~~
1967 ~~relating to problems with health care facilities' billing~~
1968 ~~practices and issue reports to be made public in any cases where~~
1969 ~~the agency determines the health care facility has engaged in~~

1970 ~~billing practices which are unreasonable and unfair to the~~
1971 ~~consumer.~~
1972 Section 58. Subsections (12) through (30) of section
1973 408.802, Florida Statutes, are renumbered as subsections (11)
1974 through (29), respectively, and present subsection (11) of that
1975 section is amended to read:
1976 408.802 Applicability.—The provisions of this part apply
1977 to the provision of services that require licensure as defined
1978 in this part and to the following entities licensed, registered,
1979 or certified by the agency, as described in chapters 112, 383,
1980 390, 394, 395, 400, 429, 440, 483, and 765:
1981 ~~(11) Private review agents, as provided under part I of~~
1982 ~~chapter 395.~~
1983 Section 59. Subsection (3) is added to section 408.804,
1984 Florida Statutes, to read:
1985 408.804 License required; display.—
1986 (3) Any person who knowingly alters, defaces, or falsifies
1987 a license certificate issued by the agency, or causes or
1988 procures any person to commit such an offense, commits a
1989 misdemeanor of the second degree, punishable as provided in s.
1990 775.082 or s 775.083. Any licensee or provider who displays an
1991 altered, defaced, or falsified license certificate is subject to
1992 the penalties set forth in s. 408.815 and an administrative fine
1993 of $1,000 for each day of illegal display.
1994 Section 60. Paragraph (d) of subsection (2) of section
1995 408.806, Florida Statutes, is amended, present subsections (3)
1996 through (8) are renumbered as subsections (4) through (9),

1997 respectively, and a new subsection (3) is added to that section,
1998 to read:
1999 408.806 License application process.—
2000 (2)
2001 (d) ~~The agency shall notify the licensee by mail or~~
2002 ~~electronically at least 90 days before the expiration of a~~
2003 ~~license that a renewal license is necessary to continue~~
2004 ~~operation.~~ The licensee's failure to timely file ~~submit~~ a
2005 renewal application and license application fee with the agency
2006 shall result in a $50 per day late fee charged to the licensee
2007 by the agency; however, the aggregate amount of the late fee may
2008 not exceed 50 percent of the licensure fee or $500, whichever is
2009 less. The agency shall provide a courtesy notice to the licensee
2010 by United States mail, electronically, or by any other manner at
2011 its address of record or mailing address, if provided, at least
2012 90 days prior to the expiration of a license informing the
2013 licensee of the expiration of the license. If the agency does
2014 not provide the courtesy notice or the licensee does not receive
2015 the courtesy notice, the licensee continues to be legally
2016 obligated to timely file the renewal application and license
2017 application fee with the agency and is not excused from the
2018 payment of a late fee. If an application is received after the
2019 required filing date and exhibits a hand-canceled postmark
2020 obtained from a United States post office dated on or before the
2021 required filing date, no fine will be levied.
2022 (3) Payment of the late fee is required to consider any
2023 late application complete, and failure to pay the late fee is
2024 considered an omission from the application.

2025 Section 61. Subsections (6) and (9) of section 408.810,
2026 Florida Statutes, are amended to read:
2027 408.810 Minimum licensure requirements.—In addition to the
2028 licensure requirements specified in this part, authorizing
2029 statutes, and applicable rules, each applicant and licensee must
2030 comply with the requirements of this section in order to obtain
2031 and maintain a license.
2032 (6)(a) An applicant must provide the agency with proof of
2033 the applicant's legal right to occupy the property before a
2034 license may be issued. Proof may include, but need not be
2035 limited to, copies of warranty deeds, lease or rental
2036 agreements, contracts for deeds, quitclaim deeds, or other such
2037 documentation.
2038 (b) In the event the property is encumbered by a mortgage
2039 or is leased, an applicant must provide the agency with proof
2040 that the mortgagor or landlord has been provided written notice
2041 of the applicant's intent as mortgagee or tenant to provide
2042 services that require licensure and instruct the mortgagor or
2043 landlord to serve the agency by certified mail with copies of
2044 any foreclosure or eviction actions initiated by the mortgagor
2045 or landlord against the applicant.
2046 (9) A controlling interest may not withhold from the
2047 agency any evidence of financial instability, including, but not
2048 limited to, checks returned due to insufficient funds,
2049 delinquent accounts, nonpayment of withholding taxes, unpaid
2050 utility expenses, nonpayment for essential services, or adverse
2051 court action concerning the financial viability of the provider
2052 or any other provider licensed under this part that is under the

2053 control of the controlling interest. A controlling interest
2054 shall notify the agency within 10 days after a court action to
2055 initiate bankruptcy, foreclosure, or eviction proceedings
2056 concerning the provider, in which the controlling interest is a
2057 petitioner or defendant. Any person who violates this subsection
2058 commits a misdemeanor of the second degree, punishable as
2059 provided in s. 775.082 or s. 775.083. Each day of continuing
2060 violation is a separate offense.
2061 Section 62. Subsection (3) is added to section 408.813,
2062 Florida Statutes, to read:
2063 408.813 Administrative fines; violations.—As a penalty for
2064 any violation of this part, authorizing statutes, or applicable
2065 rules, the agency may impose an administrative fine.
2066 (3) The agency may impose an administrative fine for a
2067 violation that does not qualify as a class I, class II, class
2068 III, or class IV violation. Unless otherwise specified by law,
2069 the amount of the fine shall not exceed $500 for each violation.
2070 Unclassified violations may include:
2071 (a) Violating any term or condition of a license.
2072 (b) Violating any provision of this part, authorizing
2073 statutes, or applicable rules.
2074 (c) Exceeding licensed capacity.
2075 (d) Providing services beyond the scope of the license.
2076 (e) Violating a moratorium imposed pursuant to s. 408.814.
2077 Section 63. Subsection (5) is added to section 408.815,
2078 Florida Statutes, to read:
2079 408.815 License or application denial; revocation.—

2080 (5) In order to ensure the health, safety, and welfare of
2081 clients when a license has been denied, revoked, or is set to
2082 terminate, the agency may extend the license expiration date for
2083 a period of up to 30 days for the sole purpose of allowing the
2084 safe and orderly discharge of clients. The agency may impose
2085 conditions on the extension, including, but not limited to,
2086 prohibiting or limiting admissions, expedited discharge
2087 planning, required status reports, and mandatory monitoring by
2088 the agency or third parties. In imposing these conditions, the
2089 agency shall take into consideration the nature and number of
2090 clients, the availability and location of acceptable alternative
2091 placements, and the ability of the licensee to continue
2092 providing care to the clients. The agency may terminate the
2093 extension or modify the conditions at any time. This authority
2094 is in addition to any other authority granted to the agency
2095 under chapter 120, this part, and authorizing statutes but
2096 creates no right or entitlement to an extension of a license
2097 expiration date.
2098 Section 64. Paragraph (k) of subsection (4) of section
2099 409.221, Florida Statutes, is amended to read:
2100 409.221 Consumer-directed care program.—
2101 (4) CONSUMER-DIRECTED CARE.—
2102 ~~(k) *Reviews and reports.*—The agency and the Departments of~~
2103 ~~Elderly Affairs, Health, and Children and Family Services and~~
2104 ~~the Agency for Persons with Disabilities shall each, on an~~
2105 ~~ongoing basis, review and assess the implementation of the~~
2106 ~~consumer-directed care program. By January 15 of each year, the~~
2107 ~~agency shall submit a written report to the Legislature that~~

2108 ~~includes each department's review of the program and contains~~
2109 ~~recommendations for improvements to the program.~~
2110 Section 65. Subsection (1) of section 409.91196, Florida
2111 Statutes, is amended to read:
2112 409.91196 Supplemental rebate agreements; public records
2113 and public meetings exemption.—
2114 (1) The rebate amount, percent of rebate, manufacturer's
2115 pricing, and supplemental rebate, and other trade secrets as
2116 defined in s. 688.002 that the agency has identified for use in
2117 negotiations, held by the Agency for Health Care Administration
2118 under s. 409.912(39)(a)8.~~7.~~ are confidential and exempt from s.
2119 119.07(1) and s. 24(a), Art. I of the State Constitution.
2120 Section 66. Paragraph (a) of subsection (39) of section
2121 409.912, Florida Statutes, is amended to read:
2122 409.912 Cost-effective purchasing of health care.—The
2123 agency shall purchase goods and services for Medicaid recipients
2124 in the most cost-effective manner consistent with the delivery
2125 of quality medical care. To ensure that medical services are
2126 effectively utilized, the agency may, in any case, require a
2127 confirmation or second physician's opinion of the correct
2128 diagnosis for purposes of authorizing future services under the
2129 Medicaid program. This section does not restrict access to
2130 emergency services or poststabilization care services as defined
2131 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2132 shall be rendered in a manner approved by the agency. The agency
2133 shall maximize the use of prepaid per capita and prepaid
2134 aggregate fixed-sum basis services when appropriate and other
2135 alternative service delivery and reimbursement methodologies,

2136 including competitive bidding pursuant to s. 287.057, designed
2137 to facilitate the cost-effective purchase of a case-managed
2138 continuum of care. The agency shall also require providers to
2139 minimize the exposure of recipients to the need for acute
2140 inpatient, custodial, and other institutional care and the
2141 inappropriate or unnecessary use of high-cost services. The
2142 agency shall contract with a vendor to monitor and evaluate the
2143 clinical practice patterns of providers in order to identify
2144 trends that are outside the normal practice patterns of a
2145 provider's professional peers or the national guidelines of a
2146 provider's professional association. The vendor must be able to
2147 provide information and counseling to a provider whose practice
2148 patterns are outside the norms, in consultation with the agency,
2149 to improve patient care and reduce inappropriate utilization.
2150 The agency may mandate prior authorization, drug therapy
2151 management, or disease management participation for certain
2152 populations of Medicaid beneficiaries, certain drug classes, or
2153 particular drugs to prevent fraud, abuse, overuse, and possible
2154 dangerous drug interactions. The Pharmaceutical and Therapeutics
2155 Committee shall make recommendations to the agency on drugs for
2156 which prior authorization is required. The agency shall inform
2157 the Pharmaceutical and Therapeutics Committee of its decisions
2158 regarding drugs subject to prior authorization. The agency is
2159 authorized to limit the entities it contracts with or enrolls as
2160 Medicaid providers by developing a provider network through
2161 provider credentialing. The agency may competitively bid single-
2162 source-provider contracts if procurement of goods or services
2163 results in demonstrated cost savings to the state without

2164 limiting access to care. The agency may limit its network based
2165 on the assessment of beneficiary access to care, provider
2166 availability, provider quality standards, time and distance
2167 standards for access to care, the cultural competence of the
2168 provider network, demographic characteristics of Medicaid
2169 beneficiaries, practice and provider-to-beneficiary standards,
2170 appointment wait times, beneficiary use of services, provider
2171 turnover, provider profiling, provider licensure history,
2172 previous program integrity investigations and findings, peer
2173 review, provider Medicaid policy and billing compliance records,
2174 clinical and medical record audits, and other factors. Providers
2175 shall not be entitled to enrollment in the Medicaid provider
2176 network. The agency shall determine instances in which allowing
2177 Medicaid beneficiaries to purchase durable medical equipment and
2178 other goods is less expensive to the Medicaid program than long-
2179 term rental of the equipment or goods. The agency may establish
2180 rules to facilitate purchases in lieu of long-term rentals in
2181 order to protect against fraud and abuse in the Medicaid program
2182 as defined in s. 409.913. The agency may seek federal waivers
2183 necessary to administer these policies.
2184 (39)(a) The agency shall implement a Medicaid prescribed-
2185 drug spending-control program that includes the following
2186 components:
2187 1. A Medicaid preferred drug list, which shall be a
2188 listing of cost-effective therapeutic options recommended by the
2189 Medicaid Pharmacy and Therapeutics Committee established
2190 pursuant to s. 409.91195 and adopted by the agency for each
2191 therapeutic class on the preferred drug list. At the discretion

2192 of the committee, and when feasible, the preferred drug list
2193 should include at least two products in a therapeutic class. The
2194 agency may post the preferred drug list and updates to the
2195 preferred drug list on an Internet website without following the
2196 rulemaking procedures of chapter 120. Antiretroviral agents are
2197 excluded from the preferred drug list. The agency shall also
2198 limit the amount of a prescribed drug dispensed to no more than
2199 a 34-day supply unless the drug products' smallest marketed
2200 package is greater than a 34-day supply, or the drug is
2201 determined by the agency to be a maintenance drug in which case
2202 a 100-day maximum supply may be authorized. The agency is
2203 authorized to seek any federal waivers necessary to implement
2204 these cost-control programs and to continue participation in the
2205 federal Medicaid rebate program, or alternatively to negotiate
2206 state-only manufacturer rebates. The agency may adopt rules to
2207 implement this subparagraph. The agency shall continue to
2208 provide unlimited contraceptive drugs and items. The agency must
2209 establish procedures to ensure that:

2210 a. There is a response to a request for prior consultation
2211 by telephone or other telecommunication device within 24 hours
2212 after receipt of a request for prior consultation; and

2213 b. A 72-hour supply of the drug prescribed is provided in
2214 an emergency or when the agency does not provide a response
2215 within 24 hours as required by sub-subparagraph a.

2216 2. Reimbursement to pharmacies for Medicaid prescribed
2217 drugs shall be set at the lesser of: the average wholesale price
2218 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
2219 plus 4.75 percent, the federal upper limit (FUL), the state

2220 maximum allowable cost (SMAC), or the usual and customary (UAC)
2221 charge billed by the provider.
2222 3. For a prescribed drug billed as a 340B prescribed
2223 medication, the claim must meet the requirements of the Deficit
2224 Reduction Act of 2005 and the federal 340B program, contain a
2225 national drug code, and be billed at the actual acquisition cost
2226 or payment shall be denied.
2227 4.~~3.~~ The agency shall develop and implement a process for
2228 managing the drug therapies of Medicaid recipients who are using
2229 significant numbers of prescribed drugs each month. The
2230 management process may include, but is not limited to,
2231 comprehensive, physician-directed medical-record reviews, claims
2232 analyses, and case evaluations to determine the medical
2233 necessity and appropriateness of a patient's treatment plan and
2234 drug therapies. The agency may contract with a private
2235 organization to provide drug-program-management services. The
2236 Medicaid drug benefit management program shall include
2237 initiatives to manage drug therapies for HIV/AIDS patients,
2238 patients using 20 or more unique prescriptions in a 180-day
2239 period, and the top 1,000 patients in annual spending. The
2240 agency shall enroll any Medicaid recipient in the drug benefit
2241 management program if he or she meets the specifications of this
2242 provision and is not enrolled in a Medicaid health maintenance
2243 organization.
2244 5.~~4.~~ The agency may limit the size of its pharmacy network
2245 based on need, competitive bidding, price negotiations,
2246 credentialing, or similar criteria. The agency shall give
2247 special consideration to rural areas in determining the size and

2248 location of pharmacies included in the Medicaid pharmacy
2249 network. A pharmacy credentialing process may include criteria
2250 such as a pharmacy's full-service status, location, size,
2251 patient educational programs, patient consultation, disease
2252 management services, and other characteristics. The agency may
2253 impose a moratorium on Medicaid pharmacy enrollment when it is
2254 determined that it has a sufficient number of Medicaid-
2255 participating providers. The agency must allow dispensing
2256 practitioners to participate as a part of the Medicaid pharmacy
2257 network regardless of the practitioner's proximity to any other
2258 entity that is dispensing prescription drugs under the Medicaid
2259 program. A dispensing practitioner must meet all credentialing
2260 requirements applicable to his or her practice, as determined by
2261 the agency.
2262 6.~~5.~~ The agency shall develop and implement a program that
2263 requires Medicaid practitioners who prescribe drugs to use a
2264 counterfeit-proof prescription pad for Medicaid prescriptions.
2265 The agency shall require the use of standardized counterfeit-
2266 proof prescription pads by Medicaid-participating prescribers or
2267 prescribers who write prescriptions for Medicaid recipients. The
2268 agency may implement the program in targeted geographic areas or
2269 statewide.
2270 7.~~6.~~ The agency may enter into arrangements that require
2271 manufacturers of generic drugs prescribed to Medicaid recipients
2272 to provide rebates of at least 15.1 percent of the average
2273 manufacturer price for the manufacturer's generic products.
2274 These arrangements shall require that if a generic-drug
2275 manufacturer pays federal rebates for Medicaid-reimbursed drugs

2276 at a level below 15.1 percent, the manufacturer must provide a
2277 supplemental rebate to the state in an amount necessary to
2278 achieve a 15.1-percent rebate level.
2279 8.~~7.~~ The agency may establish a preferred drug list as
2280 described in this subsection, and, pursuant to the establishment
2281 of such preferred drug list, it is authorized to negotiate
2282 supplemental rebates from manufacturers that are in addition to
2283 those required by Title XIX of the Social Security Act and at no
2284 less than 14 percent of the average manufacturer price as
2285 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
2286 the federal or supplemental rebate, or both, equals or exceeds
2287 29 percent. There is no upper limit on the supplemental rebates
2288 the agency may negotiate. The agency may determine that specific
2289 products, brand-name or generic, are competitive at lower rebate
2290 percentages. Agreement to pay the minimum supplemental rebate
2291 percentage will guarantee a manufacturer that the Medicaid
2292 Pharmaceutical and Therapeutics Committee will consider a
2293 product for inclusion on the preferred drug list. However, a
2294 pharmaceutical manufacturer is not guaranteed placement on the
2295 preferred drug list by simply paying the minimum supplemental
2296 rebate. Agency decisions will be made on the clinical efficacy
2297 of a drug and recommendations of the Medicaid Pharmaceutical and
2298 Therapeutics Committee, as well as the price of competing
2299 products minus federal and state rebates. The agency is
2300 authorized to contract with an outside agency or contractor to
2301 conduct negotiations for supplemental rebates. For the purposes
2302 of this section, the term "supplemental rebates" means cash
2303 rebates. Effective July 1, 2004, value-added programs as a

2304 substitution for supplemental rebates are prohibited. The agency
2305 is authorized to seek any federal waivers to implement this
2306 initiative.
2307 9.~~8.~~ The Agency for Health Care Administration shall
2308 expand home delivery of pharmacy products. To assist Medicaid
2309 patients in securing their prescriptions and reduce program
2310 costs, the agency shall expand its current mail-order-pharmacy
2311 diabetes-supply program to include all generic and brand-name
2312 drugs used by Medicaid patients with diabetes. Medicaid
2313 recipients in the current program may obtain nondiabetes drugs
2314 on a voluntary basis. This initiative is limited to the
2315 geographic area covered by the current contract. The agency may
2316 seek and implement any federal waivers necessary to implement
2317 this subparagraph.
2318 10.~~9.~~ The agency shall limit to one dose per month any
2319 drug prescribed to treat erectile dysfunction.
2320 11.~~10.~~a. The agency may implement a Medicaid behavioral
2321 drug management system. The agency may contract with a vendor
2322 that has experience in operating behavioral drug management
2323 systems to implement this program. The agency is authorized to
2324 seek federal waivers to implement this program.
2325 b. The agency, in conjunction with the Department of
2326 Children and Family Services, may implement the Medicaid
2327 behavioral drug management system that is designed to improve
2328 the quality of care and behavioral health prescribing practices
2329 based on best practice guidelines, improve patient adherence to
2330 medication plans, reduce clinical risk, and lower prescribed
2331 drug costs and the rate of inappropriate spending on Medicaid

2332 behavioral drugs. The program may include the following
2333 elements:
2334 (I) Provide for the development and adoption of best
2335 practice guidelines for behavioral health-related drugs such as
2336 antipsychotics, antidepressants, and medications for treating
2337 bipolar disorders and other behavioral conditions; translate
2338 them into practice; review behavioral health prescribers and
2339 compare their prescribing patterns to a number of indicators
2340 that are based on national standards; and determine deviations
2341 from best practice guidelines.
2342 (II) Implement processes for providing feedback to and
2343 educating prescribers using best practice educational materials
2344 and peer-to-peer consultation.
2345 (III) Assess Medicaid beneficiaries who are outliers in
2346 their use of behavioral health drugs with regard to the numbers
2347 and types of drugs taken, drug dosages, combination drug
2348 therapies, and other indicators of improper use of behavioral
2349 health drugs.
2350 (IV) Alert prescribers to patients who fail to refill
2351 prescriptions in a timely fashion, are prescribed multiple same-
2352 class behavioral health drugs, and may have other potential
2353 medication problems.
2354 (V) Track spending trends for behavioral health drugs and
2355 deviation from best practice guidelines.
2356 (VI) Use educational and technological approaches to
2357 promote best practices, educate consumers, and train prescribers
2358 in the use of practice guidelines.
2359 (VII) Disseminate electronic and published materials.

2360 (VIII) Hold statewide and regional conferences.
2361 (IX) Implement a disease management program with a model
2362 quality-based medication component for severely mentally ill
2363 individuals and emotionally disturbed children who are high
2364 users of care.
2365 12.~~11.~~a. The agency shall implement a Medicaid
2366 prescription drug management system. The agency may contract
2367 with a vendor that has experience in operating prescription drug
2368 management systems in order to implement this system. Any
2369 management system that is implemented in accordance with this
2370 subparagraph must rely on cooperation between physicians and
2371 pharmacists to determine appropriate practice patterns and
2372 clinical guidelines to improve the prescribing, dispensing, and
2373 use of drugs in the Medicaid program. The agency may seek
2374 federal waivers to implement this program.
2375 b. The drug management system must be designed to improve
2376 the quality of care and prescribing practices based on best
2377 practice guidelines, improve patient adherence to medication
2378 plans, reduce clinical risk, and lower prescribed drug costs and
2379 the rate of inappropriate spending on Medicaid prescription
2380 drugs. The program must:
2381 (I) Provide for the development and adoption of best
2382 practice guidelines for the prescribing and use of drugs in the
2383 Medicaid program, including translating best practice guidelines
2384 into practice; reviewing prescriber patterns and comparing them
2385 to indicators that are based on national standards and practice
2386 patterns of clinical peers in their community, statewide, and

2387 nationally; and determine deviations from best practice
2388 guidelines.
2389 (II) Implement processes for providing feedback to and
2390 educating prescribers using best practice educational materials
2391 and peer-to-peer consultation.
2392 (III) Assess Medicaid recipients who are outliers in their
2393 use of a single or multiple prescription drugs with regard to
2394 the numbers and types of drugs taken, drug dosages, combination
2395 drug therapies, and other indicators of improper use of
2396 prescription drugs.
2397 (IV) Alert prescribers to patients who fail to refill
2398 prescriptions in a timely fashion, are prescribed multiple drugs
2399 that may be redundant or contraindicated, or may have other
2400 potential medication problems.
2401 (V) Track spending trends for prescription drugs and
2402 deviation from best practice guidelines.
2403 (VI) Use educational and technological approaches to
2404 promote best practices, educate consumers, and train prescribers
2405 in the use of practice guidelines.
2406 (VII) Disseminate electronic and published materials.
2407 (VIII) Hold statewide and regional conferences.
2408 (IX) Implement disease management programs in cooperation
2409 with physicians and pharmacists, along with a model quality-
2410 based medication component for individuals having chronic
2411 medical conditions.
2412 13.~~12.~~ The agency is authorized to contract for drug
2413 rebate administration, including, but not limited to,
2414 calculating rebate amounts, invoicing manufacturers, negotiating

2415 disputes with manufacturers, and maintaining a database of
2416 rebate collections.
2417 14.~~13.~~ The agency may specify the preferred daily dosing
2418 form or strength for the purpose of promoting best practices
2419 with regard to the prescribing of certain drugs as specified in
2420 the General Appropriations Act and ensuring cost-effective
2421 prescribing practices.
2422 15.~~14.~~ The agency may require prior authorization for
2423 Medicaid-covered prescribed drugs. The agency may, but is not
2424 required to, prior-authorize the use of a product:
2425 a. For an indication not approved in labeling;
2426 b. To comply with certain clinical guidelines; or
2427 c. If the product has the potential for overuse, misuse,
2428 or abuse.
2429
2430 The agency may require the prescribing professional to provide
2431 information about the rationale and supporting medical evidence
2432 for the use of a drug. The agency may post prior authorization
2433 criteria and protocol and updates to the list of drugs that are
2434 subject to prior authorization on an Internet website without
2435 amending its rule or engaging in additional rulemaking.
2436 16.~~15.~~ The agency, in conjunction with the Pharmaceutical
2437 and Therapeutics Committee, may require age-related prior
2438 authorizations for certain prescribed drugs. The agency may
2439 preauthorize the use of a drug for a recipient who may not meet
2440 the age requirement or may exceed the length of therapy for use
2441 of this product as recommended by the manufacturer and approved
2442 by the Food and Drug Administration. Prior authorization may

2443 require the prescribing professional to provide information
2444 about the rationale and supporting medical evidence for the use
2445 of a drug.
2446 17.~~16.~~ The agency shall implement a step-therapy prior
2447 authorization approval process for medications excluded from the
2448 preferred drug list. Medications listed on the preferred drug
2449 list must be used within the previous 12 months prior to the
2450 alternative medications that are not listed. The step-therapy
2451 prior authorization may require the prescriber to use the
2452 medications of a similar drug class or for a similar medical
2453 indication unless contraindicated in the Food and Drug
2454 Administration labeling. The trial period between the specified
2455 steps may vary according to the medical indication. The step-
2456 therapy approval process shall be developed in accordance with
2457 the committee as stated in s. 409.91195(7) and (8). A drug
2458 product may be approved without meeting the step-therapy prior
2459 authorization criteria if the prescribing physician provides the
2460 agency with additional written medical or clinical documentation
2461 that the product is medically necessary because:
2462 a. There is not a drug on the preferred drug list to treat
2463 the disease or medical condition which is an acceptable clinical
2464 alternative;
2465 b. The alternatives have been ineffective in the treatment
2466 of the beneficiary's disease; or
2467 c. Based on historic evidence and known characteristics of
2468 the patient and the drug, the drug is likely to be ineffective,
2469 or the number of doses have been ineffective.
2470

2471 The agency shall work with the physician to determine the best
2472 alternative for the patient. The agency may adopt rules waiving
2473 the requirements for written clinical documentation for specific
2474 drugs in limited clinical situations.
2475 18.~~17.~~ The agency shall implement a return and reuse
2476 program for drugs dispensed by pharmacies to institutional
2477 recipients, which includes payment of a $5 restocking fee for
2478 the implementation and operation of the program. The return and
2479 reuse program shall be implemented electronically and in a
2480 manner that promotes efficiency. The program must permit a
2481 pharmacy to exclude drugs from the program if it is not
2482 practical or cost-effective for the drug to be included and must
2483 provide for the return to inventory of drugs that cannot be
2484 credited or returned in a cost-effective manner. The agency
2485 shall determine if the program has reduced the amount of
2486 Medicaid prescription drugs which are destroyed on an annual
2487 basis and if there are additional ways to ensure more
2488 prescription drugs are not destroyed which could safely be
2489 reused. The agency's conclusion and recommendations shall be
2490 reported to the Legislature by December 1, 2005.
2491 Section 67. Subsections (3) and (4) of section 429.07,
2492 Florida Statutes, are amended, and subsections (6) and (7) are
2493 added to that section, to read:
2494 429.07 License required; fee; inspections.—
2495 (3) In addition to the requirements of s. 408.806, each
2496 license granted by the agency must state the type of care for
2497 which the license is granted. Licenses shall be issued for one
2498 or more of the following categories of care: standard, extended

2499 congregate care, ~~limited nursing services,~~ or limited mental
2500 health.
2501 (a) A standard license shall be issued to a facility
2502 ~~facilities~~ providing one or more of the personal services
2503 identified in s. 429.02. Such licensee ~~facilities~~ may also
2504 employ or contract with a person ~~licensed under part I of~~
2505 ~~chapter 464~~ to ~~administer medications and~~ perform other tasks as
2506 specified in s. 429.255.
2507 (b) An extended congregate care license shall be issued to
2508 a licensee ~~facilities~~ providing, directly or through contract,
2509 services beyond those authorized in paragraph (a), including
2510 acts performed pursuant to part I of chapter 464 by persons
2511 licensed thereunder, and supportive services defined by rule to
2512 persons who otherwise would be disqualified from continued
2513 residence in a facility licensed under this part.
2514 1. In order for extended congregate care services to be
2515 provided in a facility licensed under this part, the agency must
2516 first determine that all requirements established in law and
2517 rule are met and must specifically designate, on the ~~facility's~~
2518 license, that such services may be provided and whether the
2519 designation applies to all or part of a facility. Such
2520 designation may be made at the time of initial licensure or
2521 relicensure, or upon request in writing by a licensee under this
2522 part and part II of chapter 408. Notification of approval or
2523 denial of such request shall be made in accordance with part II
2524 of chapter 408. An existing licensee ~~facilities~~ qualifying to
2525 provide extended congregate care services must have maintained a
2526 standard license and ~~may~~ not ~~have~~ been subject to administrative

2527 sanctions during the previous 2 years, or since initial
2528 licensure if ~~the facility has been~~ licensed for less than 2
2529 years, for any of the following reasons:
2530 a. A class I or class II violation;
2531 b. Three or more repeat or recurring class III violations
2532 of identical or similar resident care standards as specified in
2533 rule from which a pattern of noncompliance is found by the
2534 agency;
2535 c. Three or more class III violations that were not
2536 corrected in accordance with the corrective action plan approved
2537 by the agency;
2538 d. Violation of resident care standards resulting in a
2539 requirement to employ the services of a consultant pharmacist or
2540 consultant dietitian;
2541 e. Denial, suspension, or revocation of a license for
2542 another facility under this part in which the applicant for an
2543 extended congregate care license has at least 25 percent
2544 ownership interest; or
2545 f. Imposition of a moratorium pursuant to this part or
2546 part II of chapter 408 or initiation of injunctive proceedings.
2547 2. A licensee ~~Facilities~~ that is ~~are~~ licensed to provide
2548 extended congregate care services shall maintain a written
2549 progress report for ~~on~~ each person who receives such services,
2550 and the ~~which~~ report must describe ~~describes~~ the type, amount,
2551 duration, scope, and outcome of services that are rendered and
2552 the general status of the resident's health. ~~A registered nurse,~~
2553 ~~or appropriate designee, representing the agency shall visit~~
2554 ~~such facilities at least quarterly to monitor residents who are~~

2555 ~~receiving extended congregate care services and to determine if~~
2556 ~~the facility is in compliance with this part, part II of chapter~~
2557 ~~408, and rules that relate to extended congregate care. One of~~
2558 ~~these visits may be in conjunction with the regular survey. The~~
2559 ~~monitoring visits may be provided through contractual~~
2560 ~~arrangements with appropriate community agencies. A registered~~
2561 ~~nurse shall serve as part of the team that inspects such~~
2562 ~~facility. The agency may waive one of the required yearly~~
2563 ~~monitoring visits for a facility that has been licensed for at~~
2564 ~~least 24 months to provide extended congregate care services,~~
2565 ~~if, during the inspection, the registered nurse determines that~~
2566 ~~extended congregate care services are being provided~~
2567 ~~appropriately, and if the facility has no class I or class II~~
2568 ~~violations and no uncorrected class III violations. Before such~~
2569 ~~decision is made, the agency shall consult with the long-term~~
2570 ~~care ombudsman council for the area in which the facility is~~
2571 ~~located to determine if any complaints have been made and~~
2572 ~~substantiated about the quality of services or care. The agency~~
2573 ~~may not waive one of the required yearly monitoring visits if~~
2574 ~~complaints have been made and substantiated.~~
2575 3. Licensees ~~Facilities~~ that are licensed to provide
2576 extended congregate care services shall:
2577 a. Demonstrate the capability to meet unanticipated
2578 resident service needs.
2579 b. Offer a physical environment that promotes a homelike
2580 setting, provides for resident privacy, promotes resident
2581 independence, and allows sufficient congregate space as defined
2582 by rule.

2583 c. Have sufficient staff available, taking into account
2584 the physical plant and firesafety features of the building, to
2585 assist with the evacuation of residents in an emergency, as
2586 necessary.
2587 d. Adopt and follow policies and procedures that maximize
2588 resident independence, dignity, choice, and decisionmaking to
2589 permit residents to age in place to the extent possible, so that
2590 moves due to changes in functional status are minimized or
2591 avoided.
2592 e. Allow residents or, if applicable, a resident's
2593 representative, designee, surrogate, guardian, or attorney in
2594 fact to make a variety of personal choices, participate in
2595 developing service plans, and share responsibility in
2596 decisionmaking.
2597 f. Implement the concept of managed risk.
2598 g. Provide, either directly or through contract, the
2599 services of a person licensed pursuant to part I of chapter 464.
2600 h. In addition to the training mandated in s. 429.52,
2601 provide specialized training as defined by rule for facility
2602 staff.
2603 4. Licensees ~~Facilities~~ licensed to provide extended
2604 congregate care services are exempt from the criteria for
2605 continued residency as set forth in rules adopted under s.
2606 429.41. Licensees ~~Facilities so licensed~~ shall adopt their own
2607 requirements within guidelines for continued residency set forth
2608 by rule. However, such licensees ~~facilities~~ may not serve
2609 residents who require 24-hour nursing supervision. Licensees
2610 ~~Facilities~~ licensed to provide extended congregate care services

2611 shall provide each resident with a written copy of facility
2612 policies governing admission and retention.
2613 5. The primary purpose of extended congregate care
2614 services is to allow residents, as they become more impaired,
2615 the option of remaining in a familiar setting from which they
2616 would otherwise be disqualified for continued residency. A
2617 facility licensed to provide extended congregate care services
2618 may also admit an individual who exceeds the admission criteria
2619 for a facility with a standard license, if the individual is
2620 determined appropriate for admission to the extended congregate
2621 care facility.
2622 6. Before admission of an individual to a facility
2623 licensed to provide extended congregate care services, the
2624 individual must undergo a medical examination as provided in s.
2625 429.26(4) and the facility must develop a preliminary service
2626 plan for the individual.
2627 7. When a licensee ~~facility~~ can no longer provide or
2628 arrange for services in accordance with the resident's service
2629 plan and needs and the licensee's ~~facility's~~ policy, the
2630 licensee ~~facility~~ shall make arrangements for relocating the
2631 person in accordance with s. 429.28(1)(k).
2632 8. Failure to provide extended congregate care services
2633 may result in denial of extended congregate care license
2634 renewal.
2635 ~~9. No later than January 1 of each year, the department,~~
2636 ~~in consultation with the agency, shall prepare and submit to the~~
2637 ~~Governor, the President of the Senate, the Speaker of the House~~
2638 ~~of Representatives, and the chairs of appropriate legislative~~

2639 ~~committees, a report on the status of, and recommendations~~
2640 ~~related to, extended congregate care services. The status report~~
2641 ~~must include, but need not be limited to, the following~~
2642 ~~information:~~
2643 ~~a. A description of the facilities licensed to provide~~
2644 ~~such services, including total number of beds licensed under~~
2645 ~~this part.~~
2646 ~~b. The number and characteristics of residents receiving~~
2647 ~~such services.~~
2648 ~~c. The types of services rendered that could not be~~
2649 ~~provided through a standard license.~~
2650 ~~d. An analysis of deficiencies cited during licensure~~
2651 ~~inspections.~~
2652 ~~e. The number of residents who required extended~~
2653 ~~congregate care services at admission and the source of~~
2654 ~~admission.~~
2655 ~~f. Recommendations for statutory or regulatory changes.~~
2656 ~~g. The availability of extended congregate care to state~~
2657 ~~clients residing in facilities licensed under this part and in~~
2658 ~~need of additional services, and recommendations for~~
2659 ~~appropriations to subsidize extended congregate care services~~
2660 ~~for such persons.~~
2661 ~~h. Such other information as the department considers~~
2662 ~~appropriate.~~
2663 ~~(c) A limited nursing services license shall be issued to~~
2664 ~~a facility that provides services beyond those authorized in~~
2665 ~~paragraph (a) and as specified in this paragraph.~~

2666 ~~1. In order for limited nursing services to be provided in~~
2667 ~~a facility licensed under this part, the agency must first~~
2668 ~~determine that all requirements established in law and rule are~~
2669 ~~met and must specifically designate, on the facility's license,~~
2670 ~~that such services may be provided. Such designation may be made~~
2671 ~~at the time of initial licensure or relicensure, or upon request~~
2672 ~~in writing by a licensee under this part and part II of chapter~~
2673 ~~408. Notification of approval or denial of such request shall be~~
2674 ~~made in accordance with part II of chapter 408. Existing~~
2675 ~~facilities qualifying to provide limited nursing services shall~~
2676 ~~have maintained a standard license and may not have been subject~~
2677 ~~to administrative sanctions that affect the health, safety, and~~
2678 ~~welfare of residents for the previous 2 years or since initial~~
2679 ~~licensure if the facility has been licensed for less than 2~~
2680 ~~years.~~
2681 ~~2. Facilities that are licensed to provide limited nursing~~
2682 ~~services shall maintain a written progress report on each person~~
2683 ~~who receives such nursing services, which report describes the~~
2684 ~~type, amount, duration, scope, and outcome of services that are~~
2685 ~~rendered and the general status of the resident's health. A~~
2686 ~~registered nurse representing the agency shall visit such~~
2687 ~~facilities at least twice a year to monitor residents who are~~
2688 ~~receiving limited nursing services and to determine if the~~
2689 ~~facility is in compliance with applicable provisions of this~~
2690 ~~part, part II of chapter 408, and related rules. The monitoring~~
2691 ~~visits may be provided through contractual arrangements with~~
2692 ~~appropriate community agencies. A registered nurse shall also~~
2693 ~~serve as part of the team that inspects such facility.~~

2694 ~~3. A person who receives limited nursing services under~~
2695 ~~this part must meet the admission criteria established by the~~
2696 ~~agency for assisted living facilities. When a resident no longer~~
2697 ~~meets the admission criteria for a facility licensed under this~~
2698 ~~part, arrangements for relocating the person shall be made in~~
2699 ~~accordance with s. 429.28(1)(k), unless the facility is licensed~~
2700 ~~to provide extended congregate care services.~~
2701 (4) In accordance with s. 408.805, an applicant or
2702 licensee shall pay a fee for each license application submitted
2703 under this part, part II of chapter 408, and applicable rules.
2704 The amount of the fee shall be established by rule.
2705 (a) The biennial license fee required of a facility is
2706 $356 ~~$300~~ per license, with an additional fee of $67.50 ~~$50~~ per
2707 resident based on the total licensed resident capacity of the
2708 facility, except that no additional fee will be assessed for
2709 beds designated for recipients of optional state supplementation
2710 payments provided for in s. 409.212. The total fee may not
2711 exceed $18,000 ~~$10,000~~.
2712 (b) In addition to the total fee assessed under paragraph
2713 (a), the agency shall require facilities that are licensed to
2714 provide extended congregate care services under this part to pay
2715 an additional fee per licensed facility. The amount of the
2716 biennial fee shall be $501 ~~$400~~ per license, with an additional
2717 fee of $10 per resident based on the total licensed resident
2718 capacity of the facility.
2719 ~~(c) In addition to the total fee assessed under paragraph~~
2720 ~~(a), the agency shall require facilities that are licensed to~~
2721 ~~provide limited nursing services under this part to pay an~~

2722 ~~additional fee per licensed facility. The amount of the biennial~~
2723 ~~fee shall be $250 per license, with an additional fee of $10 per~~
2724 ~~resident based on the total licensed resident capacity of the~~
2725 ~~facility.~~
2726 (6) In order to determine whether the facility is
2727 adequately protecting residents' rights as provided in s.
2728 429.28, the biennial survey shall include private informal
2729 conversations with a sample of residents and consultation with
2730 the ombudsman council in the planning and service area in which
2731 the facility is located to discuss residents' experiences within
2732 the facility.
2733 (7) An assisted living facility that has been cited within
2734 the previous 24-month period for a class I or class II
2735 violation, regardless of the status of any enforcement or
2736 disciplinary action, is subject to periodic unannounced
2737 monitoring to determine if the facility is in compliance with
2738 this part, part II of chapter 408, and applicable rules.
2739 Monitoring may occur through a desk review or an onsite
2740 assessment. If the class I or class II violation relates to
2741 providing or failing to provide nursing care, a registered nurse
2742 must participate in at least two onsite monitoring visits within
2743 a 12-month period.
2744 Section 68. Subsection (7) of section 429.11, Florida
2745 Statutes, is renumbered as subsection (6), and present
2746 subsection (6) of that section is amended to read:
2747 429.11 Initial application for license~~; provisional~~
2748 ~~license~~.—

2749 ~~(6) In addition to the license categories available in s.~~
2750 ~~408.808, a provisional license may be issued to an applicant~~
2751 ~~making initial application for licensure or making application~~
2752 ~~for a change of ownership. A provisional license shall be~~
2753 ~~limited in duration to a specific period of time not to exceed 6~~
2754 ~~months, as determined by the agency.~~
2755 Section 69. Section 429.12, Florida Statutes, is amended
2756 to read:
2757 429.12 Sale or transfer of ownership of a facility.—It is
2758 the intent of the Legislature to protect the rights of the
2759 residents of an assisted living facility when the facility is
2760 sold or the ownership thereof is transferred. Therefore, in
2761 addition to the requirements of part II of chapter 408, whenever
2762 a facility is sold or the ownership thereof is transferred,
2763 including leasing~~:~~.
2764 ~~(1)~~ The transferee shall notify the residents, in writing,
2765 of the change of ownership within 7 days after receipt of the
2766 new license.
2767 ~~(2) The transferor of a facility the license of which is~~
2768 ~~denied pending an administrative hearing shall, as a part of the~~
2769 ~~written change-of-ownership contract, advise the transferee that~~
2770 ~~a plan of correction must be submitted by the transferee and~~
2771 ~~approved by the agency at least 7 days before the change of~~
2772 ~~ownership and that failure to correct the condition which~~
2773 ~~resulted in the moratorium pursuant to part II of chapter 408 or~~
2774 ~~denial of licensure is grounds for denial of the transferee's~~
2775 ~~license.~~

2776 Section 70. Paragraphs (b) through (l) of subsection (1)
2777 of section 429.14, Florida Statutes, are redesignated as
2778 paragraphs (a) through (k), respectively, and present paragraph
2779 (a) of subsection (1) and subsections (5) and (6) of that
2780 section are amended to read:

2781 429.14 Administrative penalties.—

2782 (1) In addition to the requirements of part II of chapter
2783 408, the agency may deny, revoke, and suspend any license issued
2784 under this part and impose an administrative fine in the manner
2785 provided in chapter 120 against a licensee of an assisted living
2786 facility for a violation of any provision of this part, part II
2787 of chapter 408, or applicable rules, or for any of the following
2788 actions by a licensee of an assisted living facility, for the
2789 actions of any person subject to level 2 background screening
2790 under s. 408.809, or for the actions of any facility employee:

2791 ~~(a) An intentional or negligent act seriously affecting~~
2792 ~~the health, safety, or welfare of a resident of the facility.~~

2793 (5) An action taken by the agency to suspend, deny, or
2794 revoke a facility's license under this part or part II of
2795 chapter 408, in which the agency claims that the facility owner
2796 or an employee of the facility has threatened the health,
2797 safety, or welfare of a resident of the facility <u>shall</u> be heard
2798 by the Division of Administrative Hearings of the Department of
2799 Management Services within 120 days after receipt of the
2800 facility's request for a hearing, unless that time limitation is
2801 waived by both parties. The administrative law judge must render
2802 a decision within 30 days after receipt of a proposed
2803 recommended order.

2804 (6) The agency shall provide to the Division of Hotels and
2805 Restaurants of the Department of Business and Professional
2806 Regulation, on a monthly basis, a list of those assisted living
2807 facilities that have had their licenses denied, suspended, or
2808 revoked or that are involved in an appellate proceeding pursuant
2809 to s. 120.60 related to the denial, suspension, or revocation of
2810 a license. This information may be provided electronically or
2811 through the agency's Internet website.
2812 Section 71. Subsections (1), (4), and (5) of section
2813 429.17, Florida Statutes, are amended to read:
2814 429.17 Expiration of license; renewal; conditional
2815 license.—
2816 (1) ~~Limited nursing,~~ Extended congregate care~~,~~ and limited
2817 mental health licenses shall expire at the same time as the
2818 facility's standard license, regardless of when issued.
2819 (4) In addition to the license categories available in s.
2820 408.808, a conditional license may be issued to an applicant for
2821 license renewal if the applicant fails to meet all standards and
2822 requirements for licensure. A conditional license issued under
2823 this subsection shall be limited in duration to a specific
2824 period of time not to exceed 6 months, as determined by the
2825 agency~~, and shall be accompanied by an agency-approved plan of~~
2826 ~~correction~~.
2827 (5) When an extended congregate care ~~or limited nursing~~
2828 ~~license~~ is requested during a facility's biennial license
2829 period, the fee shall be prorated in order to permit the
2830 additional license to expire at the end of the biennial license

2831 period. The fee shall be calculated as of the date the
2832 additional license application is received by the agency.
2833 Section 72. Subsection (7) of section 429.19, Florida
2834 Statutes, is amended to read:
2835 429.19 Violations; imposition of administrative fines;
2836 grounds.—
2837 (7) In addition to any administrative fines imposed, the
2838 agency may assess a survey or monitoring fee, equal to the
2839 lesser of one half of the facility's biennial license and bed
2840 fee or $500, to cover the cost of conducting initial complaint
2841 investigations that result in the finding of a violation that
2842 was the subject of the complaint or to monitor the health,
2843 safety, or security of residents under s. 429.07 (7) ~~monitoring~~
2844 ~~visits conducted under s. 429.28(3)(c) to verify the correction~~
2845 ~~of the violations~~.
2846 Section 73. Subsections (6) through (10) of section
2847 429.23, Florida Statutes, are renumbered as subsections (5)
2848 through (9), respectively, and present subsection (5) of that
2849 section is amended to read:
2850 429.23 Internal risk management and quality assurance
2851 program; adverse incidents and reporting requirements.—
2852 ~~(5) Each facility shall report monthly to the agency any~~
2853 ~~liability claim filed against it. The report must include the~~
2854 ~~name of the resident, the dates of the incident leading to the~~
2855 ~~claim, if applicable, and the type of injury or violation of~~
2856 ~~rights alleged to have occurred. This report is not discoverable~~
2857 ~~in any civil or administrative action, except in such actions~~
2858 ~~brought by the agency to enforce the provisions of this part.~~

2859 Section 74. Paragraph (a) of subsection (1) and subsection
2860 (2) of section 429.255, Florida Statutes, are amended to read:
2861 429.255 Use of personnel; emergency care.—
2862 (1)(a) Persons under contract to the facility <u>or</u>~~,~~ facility
2863 staff~~, or volunteers,~~ who are licensed according to part I of
2864 chapter 464, or those persons exempt under s. 464.022(1), and
2865 others as defined by rule, may administer medications to
2866 residents, take residents' vital signs, manage individual weekly
2867 pill organizers for residents who self-administer medication,
2868 give prepackaged enemas ordered by a physician, observe
2869 residents, document observations on the appropriate resident's
2870 record, report observations to the resident's physician, and
2871 contract or allow residents or a resident's representative,
2872 designee, surrogate, guardian, or attorney in fact to contract
2873 with a third party, provided residents meet the criteria for
2874 appropriate placement as defined in s. 429.26. <u>Persons under</u>
2875 <u>contract to the facility or facility staff who are licensed</u>
2876 <u>according to part I of chapter 464 may provide limited nursing</u>
2877 <u>services.</u> Nursing assistants certified pursuant to part II of
2878 chapter 464 may take residents' vital signs as directed by a
2879 licensed nurse or physician. <u>The facility is responsible for</u>
2880 <u>maintaining documentation of services provided under this</u>
2881 <u>paragraph as required by rule and ensuring that staff are</u>
2882 <u>adequately trained to monitor residents receiving these</u>
2883 <u>services.</u>
2884 (2) In facilities licensed to provide extended congregate
2885 care, persons under contract to the facility <u>or</u>~~,~~ facility staff~~,~~
2886 ~~or volunteers,~~ who are licensed according to part I of chapter

2887 464, or those persons exempt under s. 464.022(1), or those
2888 persons certified as nursing assistants pursuant to part II of
2889 chapter 464, may also perform all duties within the scope of
2890 their license or certification, as approved by the facility
2891 administrator and pursuant to this part.
2892 Section 75. Subsection (3) of section 429.28, Florida
2893 Statutes, is amended to read:
2894 429.28 Resident bill of rights.—
2895 ~~(3)(a) The agency shall conduct a survey to determine~~
2896 ~~general compliance with facility standards and compliance with~~
2897 ~~residents' rights as a prerequisite to initial licensure or~~
2898 ~~licensure renewal.~~
2899 ~~(b) In order to determine whether the facility is~~
2900 ~~adequately protecting residents' rights, the biennial survey~~
2901 ~~shall include private informal conversations with a sample of~~
2902 ~~residents and consultation with the ombudsman council in the~~
2903 ~~planning and service area in which the facility is located to~~
2904 ~~discuss residents' experiences within the facility.~~
2905 ~~(c) During any calendar year in which no survey is~~
2906 ~~conducted, the agency shall conduct at least one monitoring~~
2907 ~~visit of each facility cited in the previous year for a class I~~
2908 ~~or class II violation, or more than three uncorrected class III~~
2909 ~~violations.~~
2910 ~~(d) The agency may conduct periodic followup inspections~~
2911 ~~as necessary to monitor the compliance of facilities with a~~
2912 ~~history of any class I, class II, or class III violations that~~
2913 ~~threaten the health, safety, or security of residents.~~

2914 ~~(c) The agency may conduct complaint investigations as~~
2915 ~~warranted to investigate any allegations of noncompliance with~~
2916 ~~requirements required under this part or rules adopted under~~
2917 ~~this part.~~
2918 Section 76. Subsection (2) of section 429.35, Florida
2919 Statutes, is amended to read:
2920 429.35 Maintenance of records; reports.—
2921 (2) Within 60 days after the date of the biennial
2922 inspection visit required under s. 408.811 or within 30 days
2923 after the date of any interim visit, the agency shall forward
2924 the results of the inspection to the local ombudsman council in
2925 whose planning and service area, as defined in part II of
2926 chapter 400, the facility is located; to at least one public
2927 library or, in the absence of a public library, the county seat
2928 in the county in which the inspected assisted living facility is
2929 located; and, when appropriate, to the district Adult Services
2930 and Mental Health Program Offices. <u>This information may be</u>
2931 <u>provided electronically or through the agency's Internet</u>
2932 <u>website.</u>
2933 Section 77. Paragraphs (i) and (j) of subsection (1) of
2934 section 429.41, Florida Statutes, are amended to read:
2935 429.41 Rules establishing standards.—
2936 (1) It is the intent of the Legislature that rules
2937 published and enforced pursuant to this section shall include
2938 criteria by which a reasonable and consistent quality of
2939 resident care and quality of life may be ensured and the results
2940 of such resident care may be demonstrated. Such rules shall also
2941 ensure a safe and sanitary environment that is residential and

2942 noninstitutional in design or nature. It is further intended
2943 that reasonable efforts be made to accommodate the needs and
2944 preferences of residents to enhance the quality of life in a
2945 facility. The agency, in consultation with the department, may
2946 adopt rules to administer the requirements of part II of chapter
2947 408. In order to provide safe and sanitary facilities and the
2948 highest quality of resident care accommodating the needs and
2949 preferences of residents, the department, in consultation with
2950 the agency, the Department of Children and Family Services, and
2951 the Department of Health, shall adopt rules, policies, and
2952 procedures to administer this part, which must include
2953 reasonable and fair minimum standards in relation to:
2954 (i) Facilities holding an ~~a limited nursing,~~ extended
2955 congregate care~~,~~ or limited mental health license.
2956 (j) The establishment of specific criteria to define
2957 appropriateness of resident admission and continued residency in
2958 a facility holding a standard, ~~limited nursing,~~ extended
2959 congregate care, and limited mental health license.
2960 Section 78. Subsections (1) and (2) of section 429.53,
2961 Florida Statutes, are amended to read:
2962 429.53 Consultation by the agency.—
2963 (1) The ~~area offices of licensure and certification of the~~
2964 agency shall provide consultation to the following upon request:
2965 (a) A licensee of a facility.
2966 (b) A person interested in obtaining a license to operate
2967 a facility under this part.
2968 (2) As used in this section, "consultation" includes:

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2969 (a) An explanation of the requirements of this part and
2970 rules adopted pursuant thereto;
2971 (b) An explanation of the license application and renewal
2972 procedures;
2973 ~~(c) The provision of a checklist of general local and~~
2974 ~~state approvals required prior to constructing or developing a~~
2975 ~~facility and a listing of the types of agencies responsible for~~
2976 ~~such approvals;~~
2977 ~~(d) An explanation of benefits and financial assistance~~
2978 ~~available to a recipient of supplemental security income~~
2979 ~~residing in a facility;~~
2980 <u>(c)</u>~~(e)~~ Any other information which the agency deems
2981 necessary to promote compliance with the requirements of this
2982 part; and
2983 ~~(f) A preconstruction review of a facility to ensure~~
2984 ~~compliance with agency rules and this part.~~
2985 Section 79. Subsections (1) and (2) of section 429.54,
2986 Florida Statutes, are renumbered as subsections (2) and (3),
2987 respectively, and a new subsection (1) is added to that section
2988 to read:
2989 429.54 Collection of information; local subsidy.—
2990 <u>(1) A facility that is licensed under this part must</u>
2991 <u>report electronically to the agency semiannually data related to</u>
2992 <u>the facility, including, but not limited to, the total number of</u>
2993 <u>residents, the number of residents who are receiving limited</u>
2994 <u>mental health services, the number of residents who are</u>
2995 <u>receiving extended congregate care services, the number of</u>
2996 <u>residents who are receiving limited nursing services, and</u>

2997 <u>professional staffing employed by or under contract with the</u>
2998 <u>licensee to provide resident services. The department, in</u>
2999 <u>consultation with the agency, shall adopt rules to administer</u>
3000 <u>this subsection.</u>
3001 Section 80. Subsections (1) and (5) of section 429.71,
3002 Florida Statutes, are amended to read:
3003 429.71 Classification of <u>violations</u> ~~deficiencies~~;
3004 administrative fines.—
3005 (1) In addition to the requirements of part II of chapter
3006 408 and in addition to any other liability or penalty provided
3007 by law, the agency may impose an administrative fine on a
3008 provider according to the following classification:
3009 (a) Class I violations are <u>defined in s. 408.813</u> ~~those~~
3010 ~~conditions or practices related to the operation and maintenance~~
3011 ~~of an adult family-care home or to the care of residents which~~
3012 ~~the agency determines present an imminent danger to the~~
3013 ~~residents or guests of the facility or a substantial probability~~
3014 ~~that death or serious physical or emotional harm would result~~
3015 ~~therefrom. The condition or practice that constitutes a class I~~
3016 ~~violation must be abated or eliminated within 24 hours, unless a~~
3017 ~~fixed period, as determined by the agency, is required for~~
3018 ~~correction~~. A class I <u>violation</u> ~~deficiency~~ is subject to an
3019 administrative fine in an amount not less than $500 and not
3020 exceeding $1,000 for each violation. ~~A fine may be levied~~
3021 ~~notwithstanding the correction of the deficiency.~~
3022 (b) Class II violations are <u>defined in s. 408.813</u> ~~those~~
3023 ~~conditions or practices related to the operation and maintenance~~
3024 ~~of an adult family-care home or to the care of residents which~~

3025 ~~the agency determines directly threaten the physical or~~
3026 ~~emotional health, safety, or security of the residents, other~~
3027 ~~than class I violations~~. A class II violation is subject to an
3028 administrative fine in an amount not less than $250 and not
3029 exceeding $500 for each violation. ~~A citation for a class II~~
3030 ~~violation must specify the time within which the violation is~~
3031 ~~required to be corrected. If a class II violation is corrected~~
3032 ~~within the time specified, no civil penalty shall be imposed,~~
3033 ~~unless it is a repeated offense.~~
3034 (c) Class III violations are <u>defined in s. 408.813</u> ~~those~~
3035 ~~conditions or practices related to the operation and maintenance~~
3036 ~~of an adult family-care home or to the care of residents which~~
3037 ~~the agency determines indirectly or potentially threaten the~~
3038 ~~physical or emotional health, safety, or security of residents,~~
3039 ~~other than class I or class II violations~~. A class III violation
3040 is subject to an administrative fine in an amount not less than
3041 $100 and not exceeding $250 for each violation. ~~A citation for a~~
3042 ~~class III violation shall specify the time within which the~~
3043 ~~violation is required to be corrected.~~ If a class III violation
3044 is corrected within the time specified, no civil penalty shall
3045 be imposed, unless it is a repeated <u>violation</u> ~~offense~~.
3046 (d) Class IV violations are <u>defined in s. 408.813</u> ~~those~~
3047 ~~conditions or occurrences related to the operation and~~
3048 ~~maintenance of an adult family-care home, or related to the~~
3049 ~~required reports, forms, or documents, which do not have the~~
3050 ~~potential of negatively affecting the residents~~. ~~A provider that~~
3051 ~~does not correct~~ A class IV violation ~~within the time limit~~
3052 ~~specified by the agency~~ is subject to an administrative fine in

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3053 an amount not less than $50 and not exceeding $100 for each
3054 violation. Any class IV violation that is corrected during the
3055 time the agency survey is conducted will be identified as an
3056 agency finding and not as a violation, unless it is a repeat
3057 violation.
3058 ~~(5) As an alternative to or in conjunction with an~~
3059 ~~administrative action against a provider, the agency may request~~
3060 ~~a plan of corrective action that demonstrates a good faith~~
3061 ~~effort to remedy each violation by a specific date, subject to~~
3062 ~~the approval of the agency.~~
3063 Section 81. Paragraphs (b) through (e) of subsection (2)
3064 of section 429.911, Florida Statutes, are redesignated as
3065 paragraphs (a) through (d), respectively, and present paragraph
3066 (a) of that subsection is amended to read:
3067 429.911 Denial, suspension, revocation of license;
3068 emergency action; administrative fines; investigations and
3069 inspections.—
3070 (2) Each of the following actions by the owner of an adult
3071 day care center or by its operator or employee is a ground for
3072 action by the agency against the owner of the center or its
3073 operator or employee:
3074 ~~(a) An intentional or negligent act materially affecting~~
3075 ~~the health or safety of center participants.~~
3076 Section 82. Section 429.915, Florida Statutes, is amended
3077 to read:
3078 429.915 Conditional license.—In addition to the license
3079 categories available in part II of chapter 408, the agency may
3080 issue a conditional license to an applicant for license renewal

3081 or change of ownership if the applicant fails to meet all
3082 standards and requirements for licensure. A conditional license
3083 issued under this subsection must be limited to a specific
3084 period not exceeding 6 months, as determined by the agency~~, and~~
3085 ~~must be accompanied by an approved plan of correction~~.
3086 Section 83. Paragraphs (b) and (h) of subsection (3) of
3087 section 430.80, Florida Statutes, are amended to read:
3088 430.80 Implementation of a teaching nursing home pilot
3089 project.—
3090 (3) To be designated as a teaching nursing home, a nursing
3091 home licensee must, at a minimum:
3092 (b) Participate in a nationally recognized accreditation
3093 program and hold a valid accreditation, such as the
3094 accreditation awarded by The Joint Commission ~~on Accreditation~~
3095 ~~of Healthcare Organizations~~;
3096 (h) Maintain insurance coverage pursuant to s.
3097 400.141(1)(q) ~~(s)~~ or proof of financial responsibility in a
3098 minimum amount of $750,000. Such proof of financial
3099 responsibility may include:
3100 1. Maintaining an escrow account consisting of cash or
3101 assets eligible for deposit in accordance with s. 625.52; or
3102 2. Obtaining and maintaining pursuant to chapter 675 an
3103 unexpired, irrevocable, nontransferable and nonassignable letter
3104 of credit issued by any bank or savings association organized
3105 and existing under the laws of this state or any bank or savings
3106 association organized under the laws of the United States that
3107 has its principal place of business in this state or has a
3108 branch office which is authorized to receive deposits in this

3109 state. The letter of credit shall be used to satisfy the
3110 obligation of the facility to the claimant upon presentment of a
3111 final judgment indicating liability and awarding damages to be
3112 paid by the facility or upon presentment of a settlement
3113 agreement signed by all parties to the agreement when such final
3114 judgment or settlement is a result of a liability claim against
3115 the facility.
3116 Section 84. Paragraph (a) of subsection (2) of section
3117 440.13, Florida Statutes, is amended to read:
3118 440.13 Medical services and supplies; penalty for
3119 violations; limitations.—
3120 (2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—
3121 (a) Subject to the limitations specified elsewhere in this
3122 chapter, the employer shall furnish to the employee such
3123 medically necessary remedial treatment, care, and attendance for
3124 such period as the nature of the injury or the process of
3125 recovery may require, which is in accordance with established
3126 practice parameters and protocols of treatment as provided for
3127 in this chapter, including medicines, medical supplies, durable
3128 medical equipment, orthoses, prostheses, and other medically
3129 necessary apparatus. Remedial treatment, care, and attendance,
3130 including work-hardening programs or pain-management programs
3131 accredited by the Commission on Accreditation of Rehabilitation
3132 Facilities or The Joint Commission ~~on the Accreditation of~~
3133 ~~Health Organizations~~ or pain-management programs affiliated with
3134 medical schools, shall be considered as covered treatment only
3135 when such care is given based on a referral by a physician as
3136 defined in this chapter. Medically necessary treatment, care,

3137 and attendance does not include chiropractic services in excess
3138 of 24 treatments or rendered 12 weeks beyond the date of the
3139 initial chiropractic treatment, whichever comes first, unless
3140 the carrier authorizes additional treatment or the employee is
3141 catastrophically injured.
3142
3143 Failure of the carrier to timely comply with this subsection
3144 shall be a violation of this chapter and the carrier shall be
3145 subject to penalties as provided for in s. 440.525.
3146 Section 85. Section 483.294, Florida Statutes, is amended
3147 to read:
3148 483.294 Inspection of centers.—In accordance with s.
3149 408.811, the agency shall biennially~~, at least once annually,~~
3150 inspect the premises and operations of all centers subject to
3151 licensure under this part.
3152 Section 86. Subsections (32) through (54) of section
3153 499.003, Florida Statutes, are renumbered as subsections (33)
3154 through (55), respectively, present subsection (42) and
3155 paragraph (a) of present subsection (53) are amended, and a new
3156 subsection (32) is added to that subsection, to read:
3157 499.003 Definitions of terms used in this part.—As used in
3158 this part, the term:
3159 (32) "Medical convenience kit" means packages or units
3160 that contain combination products as defined in 21 C.F.R. s.
3161 3.2(e)(2).
3162 (43)~~(42)~~ "Prescription drug" means a prescription,
3163 medicinal, or legend drug, including, but not limited to,
3164 finished dosage forms or active ingredients subject to, defined

3165 by, or described by s. 503(b) of the Federal Food, Drug, and
3166 Cosmetic Act or s. 465.003(8), s. 499.007(13), or subsection
3167 (11), subsection (46) ~~(45)~~, or subsection (53) ~~(52)~~.
3168 (54) ~~(53)~~ "Wholesale distribution" means distribution of
3169 prescription drugs to persons other than a consumer or patient,
3170 but does not include:
3171 (a) Any of the following activities, which is not a
3172 violation of s. 499.005(21) if such activity is conducted in
3173 accordance with s. 499.01(2)(g):
3174 1. The purchase or other acquisition by a hospital or
3175 other health care entity that is a member of a group purchasing
3176 organization of a prescription drug for its own use from the
3177 group purchasing organization or from other hospitals or health
3178 care entities that are members of that organization.
3179 2. The sale, purchase, or trade of a prescription drug or
3180 an offer to sell, purchase, or trade a prescription drug by a
3181 charitable organization described in s. 501(c)(3) of the
3182 Internal Revenue Code of 1986, as amended and revised, to a
3183 nonprofit affiliate of the organization to the extent otherwise
3184 permitted by law.
3185 3. The sale, purchase, or trade of a prescription drug or
3186 an offer to sell, purchase, or trade a prescription drug among
3187 hospitals or other health care entities that are under common
3188 control. For purposes of this subparagraph, "common control"
3189 means the power to direct or cause the direction of the
3190 management and policies of a person or an organization, whether
3191 by ownership of stock, by voting rights, by contract, or
3192 otherwise.

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

3193 4. The sale, purchase, trade, or other transfer of a
3194 prescription drug from or for any federal, state, or local
3195 government agency or any entity eligible to purchase
3196 prescription drugs at public health services prices pursuant to
3197 Pub. L. No. 102-585, s. 602 to a contract provider or its
3198 subcontractor for eligible patients of the agency or entity
3199 under the following conditions:
3200 a. The agency or entity must obtain written authorization
3201 for the sale, purchase, trade, or other transfer of a
3202 prescription drug under this subparagraph from the State Surgeon
3203 General or his or her designee.
3204 b. The contract provider or subcontractor must be
3205 authorized by law to administer or dispense prescription drugs.
3206 c. In the case of a subcontractor, the agency or entity
3207 must be a party to and execute the subcontract.
3208 ~~d. A contract provider or subcontractor must maintain~~
3209 ~~separate and apart from other prescription drug inventory any~~
3210 ~~prescription drugs of the agency or entity in its possession.~~
3211 d.~~e.~~ The contract provider and subcontractor must maintain
3212 and produce immediately for inspection all records of movement
3213 or transfer of all the prescription drugs belonging to the
3214 agency or entity, including, but not limited to, the records of
3215 receipt and disposition of prescription drugs. Each contractor
3216 and subcontractor dispensing or administering these drugs must
3217 maintain and produce records documenting the dispensing or
3218 administration. Records that are required to be maintained
3219 include, but are not limited to, a perpetual inventory itemizing
3220 drugs received and drugs dispensed by prescription number or

3221 administered by patient identifier, which must be submitted to
3222 the agency or entity quarterly.
3223 e.~~f.~~ The contract provider or subcontractor may administer
3224 or dispense the prescription drugs only to the eligible patients
3225 of the agency or entity or must return the prescription drugs
3226 for or to the agency or entity. The contract provider or
3227 subcontractor must require proof from each person seeking to
3228 fill a prescription or obtain treatment that the person is an
3229 eligible patient of the agency or entity and must, at a minimum,
3230 maintain a copy of this proof as part of the records of the
3231 contractor or subcontractor required under sub-subparagraph d.
3232 ~~e.~~
3233 f.~~g.~~ In addition to the departmental inspection authority
3234 set forth in s. 499.051, the establishment of the contract
3235 provider and subcontractor and all records pertaining to
3236 prescription drugs subject to this subparagraph shall be subject
3237 to inspection by the agency or entity. All records relating to
3238 prescription drugs of a manufacturer under this subparagraph
3239 shall be subject to audit by the manufacturer of those drugs,
3240 without identifying individual patient information.
3241 Section 87. Paragraph (i) is added to subsection (3) of
3242 section 499.01212, Florida Statutes, to read:
3243 499.01212 Pedigree paper.—
3244 (3) EXCEPTIONS.—A pedigree paper is not required for:
3245 (i) The wholesale distribution of prescription drugs
3246 contained within a medical convenience kit if:
3247 1. The medical convenience kit is assembled in an
3248 establishment that is registered as a medical device

3249 manufacturer with the United States Food and Drug
3250 Administration;
3251 2. The medical convenience kit manufacturer purchased the
3252 prescription drug directly from the manufacturer or from a
3253 wholesaler that purchased the prescription drug directly from
3254 the manufacturer;
3255 3. The medical convenience kit manufacturer complies with
3256 federal law for the distribution of the prescription drugs
3257 within the kit; and
3258 4. The drugs contained in the medical convenience kit are:
3259 a. Intravenous solutions intended for the replenishment of
3260 fluids and electrolytes;
3261 b. Products intended to maintain the equilibrium of water
3262 and minerals in the body;
3263 c. Products intended for irrigation or reconstitution;
3264 d. Anesthetics; or
3265 e. Anticoagulants.
3266
3267 This exemption does not apply to a convenience kit containing
3268 any controlled substance that appears in a schedule contained in
3269 or subject to chapter 893 or the federal Comprehensive Drug
3270 Abuse Prevention and Control Act of 1970.
3271 Section 88. Subsection (3) is added to section 626.9541,
3272 Florida Statutes, to read:
3273 626.9541 Unfair methods of competition and unfair or
3274 deceptive acts or practices defined; alternative rates of
3275 payment; wellness programs.—
3276 (3) WELLNESS PROGRAMS.—An insurer issuing a group or

3277 individual health benefit plan may offer a voluntary wellness or
3278 health-improvement program that allows for rewards or
3279 incentives, including, but not limited to, merchandise, gift
3280 cards, debit cards, premium discounts or rebates, contributions
3281 towards a member's health savings account, modifications to
3282 copayment, deductible, or coinsurance amounts, or any
3283 combination of these incentives, to encourage or reward
3284 participation in the program. The health plan member may be
3285 required to provide verification, such as a statement from his
3286 or her physician, that a medical condition makes it unreasonably
3287 difficult or medically inadvisable for the individual to
3288 participate in the wellness program. Any reward or incentive
3289 established under this subsection is not an insurance benefit
3290 and does not violate this section. This subsection does not
3291 prohibit an insurer from offering incentives or rewards to
3292 members for adherence to wellness or health improvement programs
3293 if otherwise allowed by state or federal law. Notwithstanding
3294 any provision of this subsection, no insurer, nor its agent, may
3295 use any incentive authorized by this subsection for the purpose
3296 of redirecting patients from one health care insurance plan to
3297 another.
3298 Section 89. Subsection (1) of section 627.645, Florida
3299 Statutes, is amended to read:
3300 627.645 Denial of health insurance claims restricted.—
3301 (1) No claim for payment under a health insurance policy
3302 or self-insured program of health benefits for treatment, care,
3303 or services in a licensed hospital which is accredited by The
3304 Joint Commission ~~on the Accreditation of Hospitals~~, the American

3305 Osteopathic Association, or the Commission on the Accreditation
3306 of Rehabilitative Facilities shall be denied because such
3307 hospital lacks major surgical facilities and is primarily of a
3308 rehabilitative nature, if such rehabilitation is specifically
3309 for treatment of physical disability.
3310 Section 90. Paragraph (c) of subsection (2) of section
3311 627.668, Florida Statutes, is amended to read:
3312 627.668 Optional coverage for mental and nervous disorders
3313 required; exception.—
3314 (2) Under group policies or contracts, inpatient hospital
3315 benefits, partial hospitalization benefits, and outpatient
3316 benefits consisting of durational limits, dollar amounts,
3317 deductibles, and coinsurance factors shall not be less favorable
3318 than for physical illness generally, except that:
3319 (c) Partial hospitalization benefits shall be provided
3320 under the direction of a licensed physician. For purposes of
3321 this part, the term "partial hospitalization services" is
3322 defined as those services offered by a program accredited by The
3323 Joint Commission ~~on Accreditation of Hospitals (JCAH)~~ or in
3324 compliance with equivalent standards. Alcohol rehabilitation
3325 programs accredited by The Joint Commission ~~on Accreditation of~~
3326 ~~Hospitals~~ or approved by the state and licensed drug abuse
3327 rehabilitation programs shall also be qualified providers under
3328 this section. In any benefit year, if partial hospitalization
3329 services or a combination of inpatient and partial
3330 hospitalization are utilized, the total benefits paid for all
3331 such services shall not exceed the cost of 30 days of inpatient
3332 hospitalization for psychiatric services, including physician

3333 fees, which prevail in the community in which the partial
3334 hospitalization services are rendered. If partial
3335 hospitalization services benefits are provided beyond the limits
3336 set forth in this paragraph, the durational limits, dollar
3337 amounts, and coinsurance factors thereof need not be the same as
3338 those applicable to physical illness generally.
3339 Section 91. Subsection (3) of section 627.669, Florida
3340 Statutes, is amended to read:
3341 627.669 Optional coverage required for substance abuse
3342 impaired persons; exception.—
3343 (3) The benefits provided under this section shall be
3344 applicable only if treatment is provided by, or under the
3345 supervision of, or is prescribed by, a licensed physician or
3346 licensed psychologist and if services are provided in a program
3347 accredited by The Joint Commission ~~on Accreditation of Hospitals~~
3348 or approved by the state.
3349 Section 92. Paragraph (a) of subsection (1) of section
3350 627.736, Florida Statutes, is amended to read:
3351 627.736 Required personal injury protection benefits;
3352 exclusions; priority; claims.—
3353 (1) REQUIRED BENEFITS.—Every insurance policy complying
3354 with the security requirements of s. 627.733 shall provide
3355 personal injury protection to the named insured, relatives
3356 residing in the same household, persons operating the insured
3357 motor vehicle, passengers in such motor vehicle, and other
3358 persons struck by such motor vehicle and suffering bodily injury
3359 while not an occupant of a self-propelled vehicle, subject to
3360 the provisions of subsection (2) and paragraph (4)(e), to a

3361 limit of $10,000 for loss sustained by any such person as a
3362 result of bodily injury, sickness, disease, or death arising out
3363 of the ownership, maintenance, or use of a motor vehicle as
3364 follows:
3365 (a) *Medical benefits.*—Eighty percent of all reasonable
3366 expenses for medically necessary medical, surgical, X-ray,
3367 dental, and rehabilitative services, including prosthetic
3368 devices, and medically necessary ambulance, hospital, and
3369 nursing services. However, the medical benefits shall provide
3370 reimbursement only for such services and care that are lawfully
3371 provided, supervised, ordered, or prescribed by a physician
3372 licensed under chapter 458 or chapter 459, a dentist licensed
3373 under chapter 466, or a chiropractic physician licensed under
3374 chapter 460 or that are provided by any of the following persons
3375 or entities:
3376 1. A hospital or ambulatory surgical center licensed under
3377 chapter 395.
3378 2. A person or entity licensed under ss. 401.2101-401.45
3379 that provides emergency transportation and treatment.
3380 3. An entity wholly owned by one or more physicians
3381 licensed under chapter 458 or chapter 459, chiropractic
3382 physicians licensed under chapter 460, or dentists licensed
3383 under chapter 466 or by such practitioner or practitioners and
3384 the spouse, parent, child, or sibling of that practitioner or
3385 those practitioners.
3386 4. An entity wholly owned, directly or indirectly, by a
3387 hospital or hospitals.

3388 5. A health care clinic licensed under ss. 400.990-400.995
3389 that is:
3390 a. Accredited by The Joint Commission ~~on Accreditation of~~
3391 ~~Healthcare Organizations~~, the American Osteopathic Association,
3392 the Commission on Accreditation of Rehabilitation Facilities, or
3393 the Accreditation Association for Ambulatory Health Care, Inc.;
3394 or
3395 b. A health care clinic that:
3396 (I) Has a medical director licensed under chapter 458,
3397 chapter 459, or chapter 460;
3398 (II) Has been continuously licensed for more than 3 years
3399 or is a publicly traded corporation that issues securities
3400 traded on an exchange registered with the United States
3401 Securities and Exchange Commission as a national securities
3402 exchange; and
3403 (III) Provides at least four of the following medical
3404 specialties:
3405 (A) General medicine.
3406 (B) Radiography.
3407 (C) Orthopedic medicine.
3408 (D) Physical medicine.
3409 (E) Physical therapy.
3410 (F) Physical rehabilitation.
3411 (G) Prescribing or dispensing outpatient prescription
3412 medication.
3413 (H) Laboratory services.
3414

3415 The Financial Services Commission shall adopt by rule the form
3416 that must be used by an insurer and a health care provider
3417 specified in subparagraph 3., subparagraph 4., or subparagraph
3418 5. to document that the health care provider meets the criteria
3419 of this paragraph, which rule must include a requirement for a
3420 sworn statement or affidavit.
3421
3422 Only insurers writing motor vehicle liability insurance in this
3423 state may provide the required benefits of this section, and no
3424 such insurer shall require the purchase of any other motor
3425 vehicle coverage other than the purchase of property damage
3426 liability coverage as required by s. 627.7275 as a condition for
3427 providing such required benefits. Insurers may not require that
3428 property damage liability insurance in an amount greater than
3429 $10,000 be purchased in conjunction with personal injury
3430 protection. Such insurers shall make benefits and required
3431 property damage liability insurance coverage available through
3432 normal marketing channels. Any insurer writing motor vehicle
3433 liability insurance in this state who fails to comply with such
3434 availability requirement as a general business practice shall be
3435 deemed to have violated part IX of chapter 626, and such
3436 violation shall constitute an unfair method of competition or an
3437 unfair or deceptive act or practice involving the business of
3438 insurance; and any such insurer committing such violation shall
3439 be subject to the penalties afforded in such part, as well as
3440 those which may be afforded elsewhere in the insurance code.
3441 Section 93. Section 633.081, Florida Statutes, is amended
3442 to read:

3443 633.081 Inspection of buildings and equipment; orders;
3444 firesafety inspection training requirements; certification;
3445 disciplinary action.—The State Fire Marshal and her or his
3446 agents shall, at any reasonable hour, when the department has
3447 reasonable cause to believe that a violation of this chapter or
3448 s. 509.215, or a rule promulgated thereunder, or a minimum
3449 firesafety code adopted by a local authority, may exist, inspect
3450 any and all buildings and structures which are subject to the
3451 requirements of this chapter or s. 509.215 and rules promulgated
3452 thereunder. The authority to inspect shall extend to all
3453 equipment, vehicles, and chemicals which are located within the
3454 premises of any such building or structure. The State Fire
3455 Marshal and her or his agents shall inspect nursing homes
3456 licensed under part II of chapter 400 only once every calendar
3457 year and upon receiving a complaint forming the basis of a
3458 reasonable cause to believe that a violation of this chapter or
3459 s. 509.215, or a rule promulgated thereunder, or a minimum
3460 firesafety code adopted by a local authority may exist and upon
3461 identifying such a violation in the course of conducting
3462 orientation or training activities within a nursing home.
3463 (1) Each county, municipality, and special district that
3464 has firesafety enforcement responsibilities shall employ or
3465 contract with a firesafety inspector. The firesafety inspector
3466 must conduct all firesafety inspections that are required by
3467 law. The governing body of a county, municipality, or special
3468 district that has firesafety enforcement responsibilities may
3469 provide a schedule of fees to pay only the costs of inspections
3470 conducted pursuant to this subsection and related administrative

3471 expenses. Two or more counties, municipalities, or special
3472 districts that have firesafety enforcement responsibilities may
3473 jointly employ or contract with a firesafety inspector.
3474 (2) Every firesafety inspection conducted pursuant to
3475 state or local firesafety requirements shall be by a person
3476 certified as having met the inspection training requirements set
3477 by the State Fire Marshal. Such person shall:
3478 (a) Be a high school graduate or the equivalent as
3479 determined by the department;
3480 (b) Not have been found guilty of, or having pleaded
3481 guilty or nolo contendere to, a felony or a crime punishable by
3482 imprisonment of 1 year or more under the law of the United
3483 States, or of any state thereof, which involves moral turpitude,
3484 without regard to whether a judgment of conviction has been
3485 entered by the court having jurisdiction of such cases;
3486 (c) Have her or his fingerprints on file with the
3487 department or with an agency designated by the department;
3488 (d) Have good moral character as determined by the
3489 department;
3490 (e) Be at least 18 years of age;
3491 (f) Have satisfactorily completed the firesafety inspector
3492 certification examination as prescribed by the department; and
3493 (g)1. Have satisfactorily completed, as determined by the
3494 department, a firesafety inspector training program of not less
3495 than 200 hours established by the department and administered by
3496 agencies and institutions approved by the department for the
3497 purpose of providing basic certification training for firesafety
3498 inspectors; or

3499 2. Have received in another state training which is
3500 determined by the department to be at least equivalent to that
3501 required by the department for approved firesafety inspector
3502 education and training programs in this state.
3503 (3) Each special state firesafety inspection which is
3504 required by law and is conducted by or on behalf of an agency of
3505 the state must be performed by an individual who has met the
3506 provision of subsection (2), except that the duration of the
3507 training program shall not exceed 120 hours of specific training
3508 for the type of property that such special state firesafety
3509 inspectors are assigned to inspect.
3510 (4) A firefighter certified pursuant to s. 633.35 may
3511 conduct firesafety inspections, under the supervision of a
3512 certified firesafety inspector, while on duty as a member of a
3513 fire department company conducting inservice firesafety
3514 inspections without being certified as a firesafety inspector,
3515 if such firefighter has satisfactorily completed an inservice
3516 fire department company inspector training program of at least
3517 24 hours' duration as provided by rule of the department.
3518 (5) Every firesafety inspector or special state firesafety
3519 inspector certificate is valid for a period of 3 years from the
3520 date of issuance. Renewal of certification shall be subject to
3521 the affected person's completing proper application for renewal
3522 and meeting all of the requirements for renewal as established
3523 under this chapter or by rule promulgated thereunder, which
3524 shall include completion of at least 40 hours during the
3525 preceding 3-year period of continuing education as required by

3526 the rule of the department or, in lieu thereof, successful
3527 passage of an examination as established by the department.
3528 (6) The State Fire Marshal may deny, refuse to renew,
3529 suspend, or revoke the certificate of a firesafety inspector or
3530 special state firesafety inspector if it finds that any of the
3531 following grounds exist:
3532 (a) Any cause for which issuance of a certificate could
3533 have been refused had it then existed and been known to the
3534 State Fire Marshal.
3535 (b) Violation of this chapter or any rule or order of the
3536 State Fire Marshal.
3537 (c) Falsification of records relating to the certificate.
3538 (d) Having been found guilty of or having pleaded guilty
3539 or nolo contendere to a felony, whether or not a judgment of
3540 conviction has been entered.
3541 (e) Failure to meet any of the renewal requirements.
3542 (f) Having been convicted of a crime in any jurisdiction
3543 which directly relates to the practice of fire code inspection,
3544 plan review, or administration.
3545 (g) Making or filing a report or record that the
3546 certificateholder knows to be false, or knowingly inducing
3547 another to file a false report or record, or knowingly failing
3548 to file a report or record required by state or local law, or
3549 knowingly impeding or obstructing such filing, or knowingly
3550 inducing another person to impede or obstruct such filing.
3551 (h) Failing to properly enforce applicable fire codes or
3552 permit requirements within this state which the
3553 certificateholder knows are applicable by committing willful

3554 misconduct, gross negligence, gross misconduct, repeated
3555 negligence, or negligence resulting in a significant danger to
3556 life or property.
3557 (i) Accepting labor, services, or materials at no charge
3558 or at a noncompetitive rate from any person who performs work
3559 that is under the enforcement authority of the certificateholder
3560 and who is not an immediate family member of the
3561 certificateholder. For the purpose of this paragraph, the term
3562 "immediate family member" means a spouse, child, parent,
3563 sibling, grandparent, aunt, uncle, or first cousin of the person
3564 or the person's spouse or any person who resides in the primary
3565 residence of the certificateholder.
3566 (7) The department shall provide by rule for the
3567 certification of firesafety inspectors.
3568 Section 94. Subsection (12) of section 641.495, Florida
3569 Statutes, is amended to read:
3570 641.495 Requirements for issuance and maintenance of
3571 certificate.—
3572 (12) The provisions of part I of chapter 395 do not apply
3573 to a health maintenance organization that, on or before January
3574 1, 1991, provides not more than 10 outpatient holding beds for
3575 short-term and hospice-type patients in an ambulatory care
3576 facility for its members, provided that such health maintenance
3577 organization maintains current accreditation by The Joint
3578 Commission ~~on Accreditation of Health Care Organizations~~, the
3579 Accreditation Association for Ambulatory Health Care, or the
3580 National Committee for Quality Assurance.

3581 Section 95. Subsection (13) of section 651.118, Florida
3582 Statutes, is amended to read:
3583 651.118 Agency for Health Care Administration;
3584 certificates of need; sheltered beds; community beds.—
3585 (13) Residents, as defined in this chapter, are not
3586 considered new admissions for the purpose of s.
3587 400.141(1)(n)~~(o)~~1.d.
3588 Section 96. Subsection (2) of section 766.1015, Florida
3589 Statutes, is amended to read:
3590 766.1015 Civil immunity for members of or consultants to
3591 certain boards, committees, or other entities.—
3592 (2) Such committee, board, group, commission, or other
3593 entity must be established in accordance with state law or in
3594 accordance with requirements of The Joint Commission ~~on~~
3595 ~~Accreditation of Healthcare Organizations~~, established and duly
3596 constituted by one or more public or licensed private hospitals
3597 or behavioral health agencies, or established by a governmental
3598 agency. To be protected by this section, the act, decision,
3599 omission, or utterance may not be made or done in bad faith or
3600 with malicious intent.
3601 Section 97. Subsection (4) of section 766.202, Florida
3602 Statutes, is amended to read:
3603 766.202 Definitions; ss. 766.201-766.212.—As used in ss.
3604 766.201-766.212, the term:
3605 (4) "Health care provider" means any hospital, ambulatory
3606 surgical center, or mobile surgical facility as defined and
3607 licensed under chapter 395; a birth center licensed under
3608 chapter 383; any person licensed under chapter 458, chapter 459,

3609 chapter 460, chapter 461, chapter 462, chapter 463, part I of
3610 chapter 464, chapter 466, chapter 467, part XIV of chapter 468,
3611 or chapter 486; a clinical lab licensed under chapter 483; a
3612 health maintenance organization certificated under part I of
3613 chapter 641; a blood bank; a plasma center; an industrial
3614 clinic; a renal dialysis facility; or a professional association
3615 partnership, corporation, joint venture, or other association
3616 for professional activity by health care providers.
3617 Section 98. This act shall take effect July 1, 2010.