1 A bill to be entitled
2 An act relating to health care; amending s. 83.42, F.S.,
3 establishing that s. 400.0255, F.S., provides exclusive
4 procedures for resident transfer and discharge; amending
5 s. 112.0455, F.S., relating to the Drug-Free Workplace
6 Act; deleting an obsolete provision; deleting a
7 requirement that a laboratory that conducts drug tests
8 submit certain reports to the Agency for Health Care
9 Administration; amending s. 318.21, F.S.; revising
10 distribution of funds from civil penalties imposed for
11 traffic infractions by county courts; repealing s.
12 383.325, F.S., relating to confidentiality of inspection
13 reports of licensed birth center facilities; amending s.
14 395.002, F.S.; revising and deleting definitions
15 applicable to regulation of hospitals and other licensed
16 facilities; conforming a cross-reference; amending s.
17 395.003, F.S.; deleting an obsolete provision; conforming
18 a cross-reference; amending s. 395.0161, F.S.; deleting a
19 provision requiring licensure inspection fees for
20 hospitals, ambulatory surgical centers, and mobile
21 surgical facilities to be paid at the time of the
22 inspection; amending s. 395.0193, F.S.; requiring a
23 licensed facility to report certain peer review
24 information and final disciplinary actions to the Division
25 of Medical Quality Assurance of the Department of Health
26 rather than the Division of Health Quality Assurance of
27 the Agency for Health Care Administration; amending s.
28 395.1023, F.S.; providing for the Department of Children

29 and Family Services rather than the Department of Health
30 to perform certain functions with respect to child
31 protection cases; requiring certain hospitals to notify
32 the Department of Children and Family Services of
33 compliance; amending s. 395.1041, F.S., relating to
34 hospital emergency services and care; deleting obsolete
35 provisions; repealing s. 395.1046, F.S., relating to
36 complaint investigation procedures; amending s. 395.1055,
37 F.S.; requiring additional housekeeping and sanitation
38 procedures in licensed facilities for infection control
39 purposes; requiring licensed facility beds to conform to
40 standards specified by the Agency for Health Care
41 Administration, the Florida Building Code, and the Florida
42 Fire Prevention Code; amending s. 395.10972, F.S.;
43 revising a reference to the Florida Society of Healthcare
44 Risk Management to conform to the current designation;
45 amending s. 395.2050, F.S.; revising a reference to the
46 federal Health Care Financing Administration to conform to
47 the current designation; amending s. 395.3036, F.S.;
48 correcting a reference; repealing s. 395.3037, F.S.,
49 relating to redundant definitions; amending ss. 154.11,
50 394.741, 395.3038, 400.925, 400.9935, 408.05, 440.13,
51 627.645, 627.668, 627.669, 627.736, 641.495, and 766.1015,
52 F.S.; revising references to the Joint Commission on
53 Accreditation of Healthcare Organizations, the Commission
54 on Accreditation of Rehabilitation Facilities, and the
55 Council on Accreditation to conform to their current
56 designations; amending s. 395.4025, F.S.; authorizing the

57 Department of Health to grant additional extensions for
58 trauma center applicants under certain circumstances;
59 amending s. 395.602, F.S.; revising the definition of the
60 term "rural hospital" to delete an obsolete provision;
61 amending s. 400.021, F.S.; revising the definition of the
62 term "geriatric outpatient clinic" to include additional
63 staff; revising the term "resident care plan"; removing a
64 provision that requires certain signatures on the plan;
65 amending s. 400.0255, F.S.; correcting an obsolete cross-
66 reference to administrative rules; amending s. 400.063,
67 F.S.; deleting an obsolete provision; amending ss. 400.071
68 and 400.0712, F.S.; revising applicability of general
69 licensure requirements under part II of ch. 408, F.S., the
70 Health Care Licensing Procedures Act, to applications for
71 nursing home licensure; revising provisions governing
72 inactive licenses; amending s. 400.111, F.S.; providing
73 for disclosure of controlling interest of a nursing home
74 facility upon request by the Agency for Health Care
75 Administration; amending s. 400.1183, F.S.; revising
76 grievance record maintenance and reporting requirements
77 for nursing homes; amending s. 400.141, F.S.; providing
78 criteria for the provision of respite services by nursing
79 homes; requiring a written plan of care; requiring a
80 contract for services; requiring resident release to
81 caregivers to be designated in writing; providing an
82 exemption to the application of discharge planning rules;
83 providing for residents' rights; providing for use of
84 personal medications; providing terms of respite stay;

85 providing for communication of patient information;
86 requiring a physician's order for care and proof of a
87 physical examination; providing for services for respite
88 patients and duties of facilities with respect to such
89 patients; conforming a cross-reference; requiring
90 facilities to maintain clinical records that meet
91 specified standards; providing a fine relating to an
92 admissions moratorium; deleting requirement for facilities
93 to submit certain information related to management
94 companies to the agency; deleting a requirement for
95 facilities to notify the agency of certain bankruptcy
96 filings to conform to changes made by the act; providing a
97 limit on fees charged by a facility for copies of patient
98 records; amending s. 400.142, F.S.; deleting language
99 relating to agency adoption of rules; repealing s.
100 400.145, F.S., relating to records of care and treatment
101 of residents; repealing ss. 400.0234 and 429.294, F.S.,
102 relating to availability of facility records for
103 investigation of resident's rights violations and
104 defenses; amending 400.147, F.S.; removing a requirement
105 for nursing homes and related health care facilities to
106 notify the agency within a specified period of time after
107 receipt of an adverse incident report; revising reporting
108 requirements for licensed nursing home facilities relating
109 to adverse incidents; repealing s. 400.148, F.S., relating
110 to the Medicaid "Up-or-Out" Quality of Care Contract
111 Management Program; amending s. 400.179, F.S.; deleting an
112 obsolete provision; amending s. 400.19, F.S.; revising

113 inspection requirements; amending s. 400.23, F.S.;
114 deleting an obsolete provision; correcting a reference;
115 directing the agency to adopt rules for minimum staffing
116 standards in nursing homes that serve persons under 21
117 years of age; providing minimum staffing standards;
118 amending s. 400.275, F.S.; revising agency duties with
119 regard to training nursing home surveyor teams; revising
120 requirements for team members; amending s. 400.462, F.S.;
121 revising the definition of the term "remuneration" as it
122 applies to home health agencies; amending s. 400.484,
123 F.S.; revising the schedule of home health agency
124 inspection violations; amending s. 400.506, F.S.; deleting
125 language relating to exemptions from penalties imposed on
126 nurse registries if a nurse registry does not bill the
127 Florida Medicaid Program; providing criteria for an
128 administrator to manage a nurse registry; amending s.
129 400.509, F.S.; revising the service providers exempt from
130 licensure registration to include organizations that
131 provide companion services only for persons with
132 developmental disabilities; amending s. 400.606, F.S.;
133 revising the content requirements of the plan accompanying
134 an initial or change-of-ownership application for
135 licensure of a hospice; revising requirements relating to
136 certificates of need for certain hospice facilities;
137 amending s. 400.607, F.S.; revising grounds for agency
138 action against a hospice; amending s. 400.915, F.S.;
139 correcting an obsolete cross-reference to administrative
140 rules; amending s. 400.931, F.S.; deleting a requirement

141 that an applicant for a home medical equipment provider
142 license submit a surety bond to the agency; requiring
143 applicants to submit documentation of accreditation within
144 a specified period of time; amending s. 400.932, F.S.;
145 revising grounds for the imposition of administrative
146 penalties for certain violations by an employee of a home
147 medical equipment provider; amending s. 400.967, F.S.;
148 revising the schedule of inspection violations for
149 intermediate care facilities for the developmentally
150 disabled; providing a penalty for certain violations;
151 amending s. 400.9905, F.S.; revising the definitions of
152 the terms "clinic" and "portable equipment provider";
153 providing that part X of ch. 400, F.S., the Health Care
154 Clinic Act, does not apply to certain clinical facilities,
155 an entity owned by a corporation with a specified amount
156 of annual sales of health care services under certain
157 circumstances, an entity owned or controlled by a publicly
158 traded entity with a specified amount of annual revenues,
159 or an entity that employs a specified number of licensed
160 health care practitioners under certain conditions;
161 amending s. 400.991, F.S.; conforming terminology;
162 revising application requirements relating to
163 documentation of financial ability to operate a mobile
164 clinic; amending s. 408.033, F.S.; permitting fees
165 assessed on certain health care facilities to be collected
166 prospectively at the time of licensure renewal and
167 prorated for the licensure period; amending s. 408.034,
168 F.S.; revising agency authority relating to licensing of

169 intermediate care facilities for the developmentally
170 disabled; amending s. 408.036, F.S.; deleting an exemption
171 from certain certificate-of-need review requirements for a
172 hospice or a hospice inpatient facility; deleting a
173 requirement that the agency submit a report regarding
174 requests for exemption; amending s. 408.037, F.S.;
175 revising certificate-of-need requirements for general
176 hospital applicants to evaluate the applicant's parent
177 corporation if audited financial statements of the
178 applicant do not exist; amending s. 408.043, F.S.;
179 revising requirements for certain freestanding inpatient
180 hospice care facilities to obtain a certificate of need;
181 amending s. 408.061, F.S.; revising health care facility
182 data reporting requirements; amending s. 408.10, F.S.;
183 removing agency authority to investigate certain consumer
184 complaints; amending s. 408.802, F.S.; removing
185 applicability of part II of ch. 408, F.S., relating to
186 general licensure requirements, to private review agents;
187 amending s. 408.804, F.S.; providing penalties for
188 altering, defacing, or falsifying a license certificate
189 issued by the agency or displaying such an altered,
190 defaced, or falsified certificate; amending s. 408.806,
191 F.S.; revising agency responsibilities for notification of
192 licensees of impending expiration of a license; requiring
193 payment of a late fee for a license application to be
194 considered complete under certain circumstances; amending
195 s. 408.8065, F.S.; requiring home health agencies, home
196 medical equipment providers, and health care clinics to

197 submit projected financial statements; amending s.
198 408.809, F.S., relating to background screening of
199 specified employees of health care providers; revising
200 provisions for required rescreening; removing provisions
201 authorizing the agency to adopt rules establishing a
202 rescreening schedule; establishing a rescreening schedule;
203 amending s. 408.810, F.S.; requiring disclosure of
204 information by a controlling interest of certain court
205 actions relating to financial instability within a
206 specified time period; amending s. 408.813, F.S.;
207 authorizing the agency to impose fines for unclassified
208 violations of part II of ch. 408, F.S.; amending s.
209 408.815, F.S.; providing for certain mitigating
210 circumstances to be considered for any application subject
211 to denial; authorizing the agency to extend a license
212 expiration date under certain circumstances; amending s.
213 s. 409.212, F.S.; increasing the limit on the amount of
214 additional supplementation provided by a third party under
215 the optional state supplementation program; amending s.
216 409.91196, F.S.; revising components of a Medicaid
217 prescribed-drug spending-control program; conforming a
218 cross-reference; amending s. 409.912, F.S.; revising
219 procedures for implementation of a Medicaid prescribed-
220 drug spending-control program; amending s. 429.07, F.S.;
221 deleting the requirement for an assisted living facility
222 to obtain an additional license in order to provide
223 limited nursing services; deleting the requirement for the
224 agency to conduct quarterly monitoring visits of

225 facilities that hold a license to provide extended
226 congregate care services; deleting the requirement for the
227 department to report annually on the status of and
228 recommendations related to extended congregate care;
229 deleting the requirement for the agency to conduct
230 monitoring visits at least twice a year to facilities
231 providing limited nursing services; eliminating the
232 license fee for the limited nursing services license;
233 transferring from another provision of law the requirement
234 that the standard survey of an assisted living facility
235 include specific actions to determine whether the facility
236 is adequately protecting residents' rights; providing that
237 under specified conditions an assisted living facility
238 that has a class I or class II violation is subject to
239 periodic unannounced monitoring; requiring a registered
240 nurse to participate in certain monitoring visits;
241 amending s. 429.11, F.S.; revising licensure application
242 requirements for assisted living facilities to eliminate
243 provisional licenses; amending s. 429.12, F.S.; deleting a
244 requirement that a transferor of an assisted living
245 facility advise the transferee to submit a plan for
246 correction of certain deficiencies to the Agency for
247 Health Care Administration before ownership of the
248 facility is transferred; amending s. 429.14, F.S.;
249 clarifying provisions relating to a facility's request for
250 a hearing under certain circumstances; amending s. 429.17,
251 F.S.; deleting provisions relating to the limited nursing
252 services license; revising agency responsibilities

253 regarding the issuance of conditional licenses; amending
254 s. 429.195, F.S.; revising the list of entities prohibited
255 from providing rebates; providing exceptions to prohibited
256 patient brokering for assisted living facilities; amending
257 s. 429.23, F.S.; deleting reporting requirements for
258 assisted living facilities relating to liability claims;
259 amending s. 429.255, F.S.; eliminating provisions
260 authorizing the use of volunteers to provide certain
261 health-care-related services in assisted living
262 facilities; authorizing assisted living facilities to
263 provide limited nursing services; requiring an assisted
264 living facility to be responsible for certain
265 recordkeeping and staff to be trained to monitor residents
266 receiving certain health-care-related services; amending
267 s. 429.28, F.S.; deleting a requirement for a biennial
268 survey of an assisted living facility, to conform to
269 changes made by the act; conforming a cross-reference;
270 amending s. 429.41, F.S., relating to rulemaking;
271 conforming provisions to changes made by the act; deleting
272 the requirement for the Department of Elderly Affairs to
273 submit a copy of proposed rules to the Legislature;
274 amending s. 429.53, F.S.; revising provisions relating to
275 consultation by the agency; revising a definition;
276 amending s. 429.71, F.S.; revising schedule of inspection
277 violations for adult family-care homes; amending s.
278 429.915, F.S.; revising agency responsibilities regarding
279 the issuance of conditional licenses; amending s. 440.102,
280 F.S.; deleting the requirement for laboratories to submit

281 a monthly report to the agency with statistical
282 information regarding the testing of employees and job
283 applicants; amending s. 456.053, F.S.; revising the
284 definition of the term "group practice" as it relates to
285 financial arrangements of referring health care providers
286 and providers of health care services to include group
287 practices that provide radiation therapy services under
288 certain circumstances; amending s. 483.035, F.S.;
289 requiring certain clinical laboratories operated by one or
290 more practitioners licensed under part I of ch. 464, F.S.,
291 the Nurse Practice Act, to be licensed under part I of ch.
292 483, F.S., the Florida Clinical Laboratory Law; amending
293 s. 483.051, F.S.; establishing qualifications necessary
294 for clinical laboratory licensure; amending s. 483.294,
295 F.S.; revising frequency of agency inspections of
296 multiphasic health testing centers; amending s. 499.003,
297 F.S.; removing the requirement for certain prescription
298 drug purchasers to maintain a separate inventory of
299 certain prescription drugs; amending s. 633.081, F.S.;
300 limiting State Fire Marshal inspections of nursing homes
301 to once a year; providing for additional inspections based
302 on complaints and violations identified in the course of
303 orientation or training activities; amending s. 766.202,
304 F.S.; adding persons licensed under part XIV of ch. 468,
305 F.S., relating to orthotics, prosthetics, and pedorthics,
306 to the definition of "health care provider"; amending s.
307 817.505, F.S.; creating an exception to the patient
308 brokering prohibition for assisted living facilities;

309 amending ss. 394.4787, 400.0239, 408.07, 430.80, and
310 651.118, F.S.; conforming terminology and references to
311 changes made by the act; revising a reference;
312 establishing that assisted living facility licensure fees
313 have been adjusted by Consumer Price Index since 1998 and
314 are not intended to be reset by this act; providing an
315 effective date.
316
317 Be It Enacted by the Legislature of the State of Florida:
318
319 Section 1. Subsection (1) of section 83.42, Florida
320 Statutes, is amended to read:
321 83.42 Exclusions from application of part.—This part does
322 not apply to:
323 (1) Residency or detention in a facility, whether public
324 or private, when residence or detention is incidental to the
325 provision of medical, geriatric, educational, counseling,
326 religious, or similar services. For residents of a facility
327 licensed under part II of chapter 400, the provisions of s.
328 400.0255 are the exclusive procedures for all transfers and
329 discharges.
330 Section 2. Paragraphs (f) through (k) of subsection (10)
331 of section 112.0455, Florida Statutes, are redesignated as
332 paragraphs (e) through (j), respectively, paragraph (e) of
333 subsection (12) is redesignated as paragraph (d), and present
334 paragraph (e) of subsection (10), present paragraph (d) of
335 subsection (12), and paragraph (e) of subsection (14) of that
336 section are amended to read:

337 112.0455 Drug-Free Workplace Act.—
338 (10) EMPLOYER PROTECTION.—
339 ~~(c) Nothing in this section shall be construed to operate~~
340 ~~retroactively, and nothing in this section shall abrogate the~~
341 ~~right of an employer under state law to conduct drug tests prior~~
342 ~~to January 1, 1990. A drug test conducted by an employer prior~~
343 ~~to January 1, 1990, is not subject to this section.~~
344 (12) DRUG-TESTING STANDARDS; LABORATORIES.—
345 ~~(d) The laboratory shall submit to the Agency for Health~~
346 ~~Care Administration a monthly report with statistical~~
347 ~~information regarding the testing of employees and job~~
348 ~~applicants. The reports shall include information on the methods~~
349 ~~of analyses conducted, the drugs tested for, the number of~~
350 ~~positive and negative results for both initial and confirmation~~
351 ~~tests, and any other information deemed appropriate by the~~
352 ~~Agency for Health Care Administration. No monthly report shall~~
353 ~~identify specific employees or job applicants.~~
354 (14) DISCIPLINE REMEDIES.—
355 (e) Upon resolving an appeal filed pursuant to paragraph
356 (c), and finding a violation of this section, the commission may
357 order the following relief:
358 1. Rescind the disciplinary action, expunge related
359 records from the personnel file of the employee or job applicant
360 and reinstate the employee.
361 2. Order compliance with paragraph (10)(f)~~(g)~~.
362 3. Award back pay and benefits.
363 4. Award the prevailing employee or job applicant the
364 necessary costs of the appeal, reasonable attorney's fees, and

365 expert witness fees.
366 Section 3. Paragraph (n) of subsection (1) of section
367 154.11, Florida Statutes, is amended to read:
368 154.11 Powers of board of trustees.—
369 (1) The board of trustees of each public health trust
370 shall be deemed to exercise a public and essential governmental
371 function of both the state and the county and in furtherance
372 thereof it shall, subject to limitation by the governing body of
373 the county in which such board is located, have all of the
374 powers necessary or convenient to carry out the operation and
375 governance of designated health care facilities, including, but
376 without limiting the generality of, the foregoing:
377 (n) To appoint originally the staff of physicians to
378 practice in any designated facility owned or operated by the
379 board and to approve the bylaws and rules to be adopted by the
380 medical staff of any designated facility owned and operated by
381 the board, such governing regulations to be in accordance with
382 the standards of the Joint Commission ~~on the Accreditation of~~
383 ~~Hospitals~~ which provide, among other things, for the method of
384 appointing additional staff members and for the removal of staff
385 members.
386 Section 4. Subsection (15) of section 318.21, Florida
387 Statutes, is amended to read:
388 318.21 Disposition of civil penalties by county courts.—
389 All civil penalties received by a county court pursuant to the
390 provisions of this chapter shall be distributed and paid monthly
391 as follows:
392 (15) Of the additional fine assessed under s. 318.18(3)(e)

393 for a violation of s. 316.1893, 50 percent of the moneys
394 received from the fines <u>shall be remitted to the Department of</u>
395 <u>Revenue and deposited into the Brain and Spinal Cord Injury</u>
396 <u>Trust Fund of Department of Health and</u> shall be appropriated to
397 the <u>Department of Health</u> ~~Agency for Health Care Administration~~
398 as general revenue to ~~provide an enhanced Medicaid payment to~~
399 ~~nursing homes that~~ serve Medicaid recipients with brain and
400 spinal cord injuries <u>that are medically complex and who are</u>
401 <u>technologically and respiratory dependent</u>. The remaining 50
402 percent of the moneys received from the enhanced fine imposed
403 under s. 318.18(3)(e) shall be remitted to the Department of
404 Revenue and deposited into the Department of Health Emergency
405 Medical Services Trust Fund to provide financial support to
406 certified trauma centers in the counties where enhanced penalty
407 zones are established to ensure the availability and
408 accessibility of trauma services. Funds deposited into the
409 Emergency Medical Services Trust Fund under this subsection
410 shall be allocated as follows:
411 (a) Fifty percent shall be allocated equally among all
412 Level I, Level II, and pediatric trauma centers in recognition
413 of readiness costs for maintaining trauma services.
414 (b) Fifty percent shall be allocated among Level I, Level
415 II, and pediatric trauma centers based on each center's relative
416 volume of trauma cases as reported in the Department of Health
417 Trauma Registry.
418 Section 5. <u>Section 383.325, Florida Statutes, is repealed.</u>
419 Section 6. Subsection (7) of section 394.4787, Florida
420 Statutes, is amended to read:

421 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788,
422 and 394.4789.—As used in this section and ss. 394.4786,
423 394.4788, and 394.4789:
424 (7) "Specialty psychiatric hospital" means a hospital
425 licensed by the agency pursuant to s. 395.002(26) ~~(28)~~ and part
426 II of chapter 408 as a specialty psychiatric hospital.
427 Section 7. Subsection (2) of section 394.741, Florida
428 Statutes, is amended to read:
429 394.741 Accreditation requirements for providers of
430 behavioral health care services.—
431 (2) Notwithstanding any provision of law to the contrary,
432 accreditation shall be accepted by the agency and department in
433 lieu of the agency's and department's facility licensure onsite
434 review requirements and shall be accepted as a substitute for
435 the department's administrative and program monitoring
436 requirements, except as required by subsections (3) and (4),
437 for:
438 (a) Any organization from which the department purchases
439 behavioral health care services that is accredited by the Joint
440 Commission ~~on Accreditation of Healthcare Organizations~~ or the
441 Council on Accreditation ~~for Children and Family Services~~, or
442 has those services that are being purchased by the department
443 accredited by the Commission on Accreditation of Rehabilitation
444 Facilities ~~CARF—the Rehabilitation Accreditation Commission~~.
445 (b) Any mental health facility licensed by the agency or
446 any substance abuse component licensed by the department that is
447 accredited by the Joint Commission ~~on Accreditation of~~
448 ~~Healthcare Organizations~~, the Commission on Accreditation of

449 Rehabilitation Facilities ~~CARF—the Rehabilitation Accreditation~~
450 ~~Commission~~, or the Council on Accreditation ~~of Children and~~
451 ~~Family Services~~.
452 (c) Any network of providers from which the department or
453 the agency purchases behavioral health care services accredited
454 by the Joint Commission ~~on Accreditation of Healthcare~~
455 ~~Organizations~~, the Commission on Accreditation of Rehabilitation
456 Facilities ~~CARF—the Rehabilitation Accreditation Commission~~, the
457 Council on Accreditation ~~of Children and Family Services~~, or the
458 National Committee for Quality Assurance. A provider
459 organization, which is part of an accredited network, is
460 afforded the same rights under this part.
461 Section 8. Present subsections (15) through (32) of
462 section 395.002, Florida Statutes, are renumbered as subsections
463 (14) through (28), respectively, and present subsections (1),
464 (14), (24), (30), and (31) and paragraph (c) of present
465 subsection (28) of that section are amended to read:
466 395.002 Definitions.—As used in this chapter:
467 (1) "Accrediting organizations" means nationally
468 recognized or approved accrediting organizations whose standards
469 incorporate comparable licensure requirements as determined by
470 the agency ~~the Joint Commission on Accreditation of Healthcare~~
471 ~~Organizations, the American Osteopathic Association, the~~
472 ~~Commission on Accreditation of Rehabilitation Facilities, and~~
473 ~~the Accreditation Association for Ambulatory Health Care, Inc~~.
474 ~~(14) "Initial denial determination" means a determination~~
475 ~~by a private review agent that the health care services~~
476 ~~furnished or proposed to be furnished to a patient are~~

477 ~~inappropriate, not medically necessary, or not reasonable.~~
478 ~~(24) "Private review agent" means any person or entity~~
479 ~~which performs utilization review services for third-party~~
480 ~~payors on a contractual basis for outpatient or inpatient~~
481 ~~services. However, the term shall not include full-time~~
482 ~~employees, personnel, or staff of health insurers, health~~
483 ~~maintenance organizations, or hospitals, or wholly owned~~
484 ~~subsidiaries thereof or affiliates under common ownership, when~~
485 ~~performing utilization review for their respective hospitals,~~
486 ~~health maintenance organizations, or insureds of the same~~
487 ~~insurance group. For this purpose, health insurers, health~~
488 ~~maintenance organizations, and hospitals, or wholly owned~~
489 ~~subsidiaries thereof or affiliates under common ownership,~~
490 ~~include such entities engaged as administrators of self-~~
491 ~~insurance as defined in s. 624.031.~~
492 (26) ~~(28)~~ "Specialty hospital" means any facility which
493 meets the provisions of subsection (12), and which regularly
494 makes available either:
495 (c) Intensive residential treatment programs for children
496 and adolescents as defined in subsection (14) ~~(15)~~.
497 ~~(30) "Utilization review" means a system for reviewing the~~
498 ~~medical necessity or appropriateness in the allocation of health~~
499 ~~care resources of hospital services given or proposed to be~~
500 ~~given to a patient or group of patients.~~
501 ~~(31) "Utilization review plan" means a description of the~~
502 ~~policies and procedures governing utilization review activities~~
503 ~~performed by a private review agent.~~
504 Section 9. Paragraph (c) of subsection (1) and paragraph

505 (b) of subsection (2) of section 395.003, Florida Statutes, are
506 amended to read:
507 395.003 Licensure; denial, suspension, and revocation.—
508 (1)
509 ~~(c) Until July 1, 2006, additional emergency departments~~
510 ~~located off the premises of licensed hospitals may not be~~
511 ~~authorized by the agency.~~
512 (2)
513 (b) The agency shall, at the request of a licensee that is
514 a teaching hospital as defined in s. 408.07(45), issue a single
515 license to a licensee for facilities that have been previously
516 licensed as separate premises, provided such separately licensed
517 facilities, taken together, constitute the same premises as
518 defined in s. 395.002<u>(22)</u>~~(23)~~. Such license for the single
519 premises shall include all of the beds, services, and programs
520 that were previously included on the licenses for the separate
521 premises. The granting of a single license under this paragraph
522 shall not in any manner reduce the number of beds, services, or
523 programs operated by the licensee.
524 Section 10. Subsection (3) of section 395.0161, Florida
525 Statutes, is amended to read:
526 395.0161 Licensure inspection.—
527 (3) In accordance with s. 408.805, an applicant or
528 licensee shall pay a fee for each license application submitted
529 under this part, part II of chapter 408, and applicable rules.
530 With the exception of state-operated licensed facilities, each
531 facility licensed under this part shall pay to the agency~~, at~~
532 ~~the time of inspection,~~ the following fees:

533 (a) Inspection for licensure.—A fee shall be paid which is
534 not less than $8 per hospital bed, nor more than $12 per
535 hospital bed, except that the minimum fee shall be $400 per
536 facility.
537 (b) Inspection for lifesafety only.—A fee shall be paid
538 which is not less than 75 cents per hospital bed, nor more than
539 $1.50 per hospital bed, except that the minimum fee shall be $40
540 per facility.
541 Section 11. Paragraph (e) of subsection (2) and subsection
542 (4) of section 395.0193, Florida Statutes, are amended to read:
543 395.0193 Licensed facilities; peer review; disciplinary
544 powers; agency or partnership with physicians.—
545 (2) Each licensed facility, as a condition of licensure,
546 shall provide for peer review of physicians who deliver health
547 care services at the facility. Each licensed facility shall
548 develop written, binding procedures by which such peer review
549 shall be conducted. Such procedures shall include:
550 (e) Recording of agendas and minutes which do not contain
551 confidential material, for review by the Division of Medical
552 Quality Assurance of the department ~~Health Quality Assurance of~~
553 ~~the agency~~.
554 (4) Pursuant to ss. 458.337 and 459.016, any disciplinary
555 actions taken under subsection (3) shall be reported in writing
556 to the Division of Medical Quality Assurance of the department
557 ~~Health Quality Assurance of the agency~~ within 30 working days
558 after its initial occurrence, regardless of the pendency of
559 appeals to the governing board of the hospital. The notification
560 shall identify the disciplined practitioner, the action taken,

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

561 and the reason for such action. All final disciplinary actions
562 taken under subsection (3), if different from those which were
563 reported to the department ~~agency~~ within 30 days after the
564 initial occurrence, shall be reported within 10 working days to
565 the Division of Medical Quality Assurance of the department
566 ~~Health Quality Assurance of the agency~~ in writing and shall
567 specify the disciplinary action taken and the specific grounds
568 therefor. The division shall review each report and determine
569 whether it potentially involved conduct by the licensee that is
570 subject to disciplinary action, in which case s. 456.073 shall
571 apply. The reports are not subject to inspection under s.
572 119.07(1) even if the division's investigation results in a
573 finding of probable cause.
574 Section 12. Section 395.1023, Florida Statutes, is amended
575 to read:
576 395.1023 Child abuse and neglect cases; duties.—Each
577 licensed facility shall adopt a protocol that, at a minimum,
578 requires the facility to:
579 (1) Incorporate a facility policy that every staff member
580 has an affirmative duty to report, pursuant to chapter 39, any
581 actual or suspected case of child abuse, abandonment, or
582 neglect; and
583 (2) In any case involving suspected child abuse,
584 abandonment, or neglect, designate, at the request of the
585 Department of Children and Family Services, a staff physician to
586 act as a liaison between the hospital and the Department of
587 Children and Family Services office which is investigating the
588 suspected abuse, abandonment, or neglect, and the child

589 protection team, as defined in s. 39.01, when the case is
590 referred to such a team.
591
592 Each general hospital and appropriate specialty hospital shall
593 comply with the provisions of this section and shall notify the
594 agency and the Department of Children and Family Services of its
595 compliance by sending a copy of its policy to the agency and the
596 Department of Children and Family Services as required by rule.
597 The failure by a general hospital or appropriate specialty
598 hospital to comply shall be punished by a fine not exceeding
599 $1,000, to be fixed, imposed, and collected by the agency. Each
600 day in violation is considered a separate offense.
601 Section 13. Subsection (2) and paragraph (d) of subsection
602 (3) of section 395.1041, Florida Statutes, are amended to read:
603 395.1041 Access to emergency services and care.—
604 (2) INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The agency
605 shall establish and maintain an inventory of hospitals with
606 emergency services. The inventory shall list all services within
607 the service capability of the hospital, and such services shall
608 appear on the face of the hospital license. Each hospital having
609 emergency services shall notify the agency of its service
610 capability in the manner and form prescribed by the agency. The
611 agency shall use the inventory to assist emergency medical
612 services providers and others in locating appropriate emergency
613 medical care. The inventory shall also be made available to the
614 general public. ~~On or before August 1, 1992, the agency shall~~
615 ~~request that each hospital identify the services which are~~
616 ~~within its service capability. On or before November 1, 1992,~~

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

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

673 request.
674 Section 14. Section 395.1046, Florida Statutes, is
675 repealed.
676 Section 15. Paragraphs (b) and (e) of subsection (1) of
677 section 395.1055, Florida Statutes, are amended to read:
678 395.1055 Rules and enforcement.—
679 (1) The agency shall adopt rules pursuant to ss.
680 120.536(1) and 120.54 to implement the provisions of this part,
681 which shall include reasonable and fair minimum standards for
682 ensuring that:
683 (b) Infection control, housekeeping, sanitary conditions,
684 and medical record procedures that will adequately protect
685 patient care and safety are established and implemented. These
686 procedures shall require housekeeping and sanitation staff to
687 wear masks and gloves when cleaning patient rooms and
688 disinfecting environmental surfaces in patient rooms in
689 accordance with the time instructions on the label of the
690 disinfectant used by the hospital. The agency may impose an
691 administrative fine for each day that a violation of this
692 paragraph occurs.
693 (e) Licensed facility beds conform to minimum space,
694 equipment, and furnishings standards as specified by the agency,
695 the Florida Building Code, and the Florida Fire Prevention Code
696 ~~department~~.
697 Section 16. Subsection (1) of section 395.10972, Florida
698 Statutes, is amended to read:
699 395.10972 Health Care Risk Manager Advisory Council.—The
700 Secretary of Health Care Administration may appoint a seven-

701 member advisory council to advise the agency on matters
702 pertaining to health care risk managers. The members of the
703 council shall serve at the pleasure of the secretary. The
704 council shall designate a chair. The council shall meet at the
705 call of the secretary or at those times as may be required by
706 rule of the agency. The members of the advisory council shall
707 receive no compensation for their services, but shall be
708 reimbursed for travel expenses as provided in s. 112.061. The
709 council shall consist of individuals representing the following
710 areas:
711 (1) Two shall be active health care risk managers,
712 including one risk manager who is recommended by and a member of
713 the Florida Society for ~~of~~ Healthcare Risk Management and
714 Patient Safety.
715 Section 17. Subsection (3) of section 395.2050, Florida
716 Statutes, is amended to read:
717 395.2050 Routine inquiry for organ and tissue donation;
718 certification for procurement activities; death records review.—
719 (3) Each organ procurement organization designated by the
720 federal Centers for Medicare and Medicaid Services ~~Health Care~~
721 ~~Financing Administration~~ and licensed by the state shall conduct
722 an annual death records review in the organ procurement
723 organization's affiliated donor hospitals. The organ procurement
724 organization shall enlist the services of every Florida licensed
725 tissue bank and eye bank affiliated with or providing service to
726 the donor hospital and operating in the same service area to
727 participate in the death records review.
728 Section 18. Subsection (2) of section 395.3036, Florida

729 Statutes, is amended to read:
730 395.3036 Confidentiality of records and meetings of
731 corporations that lease public hospitals or other public health
732 care facilities.—The records of a private corporation that
733 leases a public hospital or other public health care facility
734 are confidential and exempt from the provisions of s. 119.07(1)
735 and s. 24(a), Art. I of the State Constitution, and the meetings
736 of the governing board of a private corporation are exempt from
737 s. 286.011 and s. 24(b), Art. I of the State Constitution when
738 the public lessor complies with the public finance
739 accountability provisions of s. 155.40(5) with respect to the
740 transfer of any public funds to the private lessee and when the
741 private lessee meets at least three of the five following
742 criteria:
743 (2) The public lessor and the private lessee do not
744 commingle any of their funds in any account maintained by either
745 of them, other than the payment of the rent and administrative
746 fees or the transfer of funds pursuant to s. 155.40 ~~subsection~~
747 ~~(2)~~.
748 Section 19. Section 395.3037, Florida Statutes, is
749 repealed.
750 Section 20. Subsections (1), (4), and (5) of section
751 395.3038, Florida Statutes, are amended to read:
752 395.3038 State-listed primary stroke centers and
753 comprehensive stroke centers; notification of hospitals.—
754 (1) The agency shall make available on its website and to
755 the department a list of the name and address of each hospital
756 that meets the criteria for a primary stroke center and the name

757 and address of each hospital that meets the criteria for a
758 comprehensive stroke center. The list of primary and
759 comprehensive stroke centers shall include only those hospitals
760 that attest in an affidavit submitted to the agency that the
761 hospital meets the named criteria, or those hospitals that
762 attest in an affidavit submitted to the agency that the hospital
763 is certified as a primary or a comprehensive stroke center by
764 the Joint Commission ~~on Accreditation of Healthcare~~
765 ~~Organizations~~.
766 (4) The agency shall adopt by rule criteria for a primary
767 stroke center which are substantially similar to the
768 certification standards for primary stroke centers of the Joint
769 Commission ~~on Accreditation of Healthcare Organizations~~.
770 (5) The agency shall adopt by rule criteria for a
771 comprehensive stroke center. However, if the Joint Commission ~~on~~
772 ~~Accreditation of Healthcare Organizations~~ establishes criteria
773 for a comprehensive stroke center, the agency shall establish
774 criteria for a comprehensive stroke center which are
775 substantially similar to those criteria established by the Joint
776 Commission ~~on Accreditation of Healthcare Organizations~~.
777 Section 21. Paragraph (d) of subsection (2) of section
778 395.4025, Florida Statutes, is amended to read:
779 395.4025 Trauma centers; selection; quality assurance;
780 records.—
781 (2)
782 (d)1. Notwithstanding other provisions in this section,
783 the department may grant up to an additional 18 months to a
784 hospital applicant that is unable to meet all requirements as

785 provided in paragraph (c) at the time of application if the
786 number of applicants in the service area in which the applicant
787 is located is equal to or less than the service area allocation,
788 as provided by rule of the department. An applicant that is
789 granted additional time pursuant to this paragraph shall submit
790 a plan for departmental approval which includes timelines and
791 activities that the applicant proposes to complete in order to
792 meet application requirements. Any applicant that demonstrates
793 an ongoing effort to complete the activities within the
794 timelines outlined in the plan shall be included in the number
795 of trauma centers at such time that the department has conducted
796 a provisional review of the application and has determined that
797 the application is complete and that the hospital has the
798 critical elements required for a trauma center. An applicant
799 that has received an additional 18 months pursuant to this
800 paragraph shall be granted up to two additional 6-month
801 extensions to meet all requirements as provided in paragraph
802 (c), if construction related to a critical element is delayed as
803 a result of governmental action or inaction with respect to
804 regulations or permitting, and the applicant has made a good
805 faith effort to comply with the applicable regulations or obtain
806 the required permits.
807 2. Timeframes provided in subsections (1)-(8) shall be
808 stayed until the department determines that the application is
809 complete and that the hospital has the critical elements
810 required for a trauma center.
811 Section 22. Paragraph (e) of subsection (2) of section
812 395.602, Florida Statutes, is amended to read:

813 395.602 Rural hospitals.—
814 (2) DEFINITIONS.—As used in this part:
815 (e) "Rural hospital" means an acute care hospital licensed
816 under this chapter, having 100 or fewer licensed beds and an
817 emergency room, which is:
818 1. The sole provider within a county with a population
819 density of no greater than 100 persons per square mile;
820 2. An acute care hospital, in a county with a population
821 density of no greater than 100 persons per square mile, which is
822 at least 30 minutes of travel time, on normally traveled roads
823 under normal traffic conditions, from any other acute care
824 hospital within the same county;
825 3. A hospital supported by a tax district or subdistrict
826 whose boundaries encompass a population of 100 persons or fewer
827 per square mile;
828 ~~4. A hospital in a constitutional charter county with a~~
829 ~~population of over 1 million persons that has imposed a local~~
830 ~~option health service tax pursuant to law and in an area that~~
831 ~~was directly impacted by a catastrophic event on August 24,~~
832 ~~1992, for which the Governor of Florida declared a state of~~
833 ~~emergency pursuant to chapter 125, and has 120 beds or less that~~
834 ~~serves an agricultural community with an emergency room~~
835 ~~utilization of no less than 20,000 visits and a Medicaid~~
836 ~~inpatient utilization rate greater than 15 percent;~~
837 4.~~5.~~ A hospital with a service area that has a population
838 of 100 persons or fewer per square mile. As used in this
839 subparagraph, the term "service area" means the fewest number of
840 zip codes that account for 75 percent of the hospital's

841 discharges for the most recent 5-year period, based on
842 information available from the hospital inpatient discharge
843 database in the Florida Center for Health Information and Policy
844 Analysis at the Agency for Health Care Administration; or
845 5.~~6.~~ A hospital designated as a critical access hospital,
846 as defined in s. 408.07(15).
847
848 Population densities used in this paragraph must be based upon
849 the most recently completed United States census. A hospital
850 that received funds under s. 409.9116 for a quarter beginning no
851 later than July 1, 2002, is deemed to have been and shall
852 continue to be a rural hospital from that date through June 30,
853 2015, if the hospital continues to have 100 or fewer licensed
854 beds and an emergency room~~, or meets the criteria of~~
855 ~~subparagraph 4~~. An acute care hospital that has not previously
856 been designated as a rural hospital and that meets the criteria
857 of this paragraph shall be granted such designation upon
858 application, including supporting documentation to the Agency
859 for Health Care Administration.
860 Section 23. Subsections (8) and (16) of section 400.021,
861 Florida Statutes, are amended to read:
862 400.021 Definitions.—When used in this part, unless the
863 context otherwise requires, the term:
864 (8) "Geriatric outpatient clinic" means a site for
865 providing outpatient health care to persons 60 years of age or
866 older, which is staffed by a registered nurse or a physician
867 assistant, or a licensed practical nurse under the direct
868 supervision of a registered nurse, advanced registered nurse

869 practitioner, physician assistant, or physician.
870 (16) "Resident care plan" means a written plan developed,
871 maintained, and reviewed not less than quarterly by a registered
872 nurse, with participation from other facility staff and the
873 resident or his or her designee or legal representative, which
874 includes a comprehensive assessment of the needs of an
875 individual resident; the type and frequency of services required
876 to provide the necessary care for the resident to attain or
877 maintain the highest practicable physical, mental, and
878 psychosocial well-being; a listing of services provided within
879 or outside the facility to meet those needs; and an explanation
880 of service goals. ~~The resident care plan must be signed by the~~
881 ~~director of nursing or another registered nurse employed by the~~
882 ~~facility to whom institutional responsibilities have been~~
883 ~~delegated and by the resident, the resident's designee, or the~~
884 ~~resident's legal representative. The facility may not use an~~
885 ~~agency or temporary registered nurse to satisfy the foregoing~~
886 ~~requirement and must document the institutional responsibilities~~
887 ~~that have been delegated to the registered nurse.~~
888 Section 24. Paragraph (g) of subsection (2) of section
889 400.0239, Florida Statutes, is amended to read:
890 400.0239 Quality of Long-Term Care Facility Improvement
891 Trust Fund.—
892 (2) Expenditures from the trust fund shall be allowable
893 for direct support of the following:
894 (g) Other initiatives authorized by the Centers for
895 Medicare and Medicaid Services for the use of federal civil
896 monetary penalties~~, including projects recommended through the~~

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

897 ~~Medicaid "Up-or-Out" Quality of Care Contract Management Program~~
898 ~~pursuant to s. 400.148~~.
899 Section 25. Subsection (15) of section 400.0255, Florida
900 Statutes, is amended to read
901 400.0255 Resident transfer or discharge; requirements and
902 procedures; hearings.—
903 (15)(a) The department's Office of Appeals Hearings shall
904 conduct hearings under this section. The office shall notify the
905 facility of a resident's request for a hearing.
906 (b) The department shall, by rule, establish procedures to
907 be used for fair hearings requested by residents. These
908 procedures shall be equivalent to the procedures used for fair
909 hearings for other Medicaid cases appearing in s. 409.285 and
910 applicable rules~~, chapter 10-2, part VI, Florida Administrative~~
911 ~~Code~~. The burden of proof must be clear and convincing evidence.
912 A hearing decision must be rendered within 90 days after receipt
913 of the request for hearing.
914 (c) If the hearing decision is favorable to the resident
915 who has been transferred or discharged, the resident must be
916 readmitted to the facility's first available bed.
917 (d) The decision of the hearing officer shall be final.
918 Any aggrieved party may appeal the decision to the district
919 court of appeal in the appellate district where the facility is
920 located. Review procedures shall be conducted in accordance with
921 the Florida Rules of Appellate Procedure.
922 Section 26. Subsection (2) of section 400.063, Florida
923 Statutes, is amended to read:
924 400.063 Resident protection.—

925 (2) The agency is authorized to establish for each
926 facility, subject to intervention by the agency, a separate bank
927 account for the deposit to the credit of the agency of any
928 moneys received from the Health Care Trust Fund or any other
929 moneys received for the maintenance and care of residents in the
930 facility, and the agency is authorized to disburse moneys from
931 such account to pay obligations incurred for the purposes of
932 this section. The agency is authorized to requisition moneys
933 from the Health Care Trust Fund in advance of an actual need for
934 cash on the basis of an estimate by the agency of moneys to be
935 spent under the authority of this section. Any bank account
936 established under this section need not be approved in advance
937 of its creation as required by s. 17.58, but shall be secured by
938 depository insurance equal to or greater than the balance of
939 such account or by the pledge of collateral security ~~in~~
940 ~~conformance with criteria established in s. 18.11~~. The agency
941 shall notify the Chief Financial Officer of any such account so
942 established and shall make a quarterly accounting to the Chief
943 Financial Officer for all moneys deposited in such account.
944 Section 27. Subsections (1) and (5) of section 400.071,
945 Florida Statutes, are amended to read:
946 400.071 Application for license.—
947 (1) In addition to the requirements of part II of chapter
948 408, the application for a license shall be under oath and must
949 contain the following:
950 (a) The location of the facility for which a license is
951 sought and an indication, as in the original application, that
952 such location conforms to the local zoning ordinances.

953 ~~(b) A signed affidavit disclosing any financial or~~
954 ~~ownership interest that a controlling interest as defined in~~
955 ~~part II of chapter 408 has held in the last 5 years in any~~
956 ~~entity licensed by this state or any other state to provide~~
957 ~~health or residential care which has closed voluntarily or~~
958 ~~involuntarily; has filed for bankruptcy; has had a receiver~~
959 ~~appointed; has had a license denied, suspended, or revoked; or~~
960 ~~has had an injunction issued against it which was initiated by a~~
961 ~~regulatory agency. The affidavit must disclose the reason any~~
962 ~~such entity was closed, whether voluntarily or involuntarily.~~
963 ~~(c) The total number of beds and the total number of~~
964 ~~Medicare and Medicaid certified beds.~~
965 <u>(b)</u>~~(d)~~ Information relating to the applicant and employees
966 which the agency requires by rule. The applicant must
967 demonstrate that sufficient numbers of qualified staff, by
968 training or experience, will be employed to properly care for
969 the type and number of residents who will reside in the
970 facility.
971 ~~(e) Copies of any civil verdict or judgment involving the~~
972 ~~applicant rendered within the 10 years preceding the~~
973 ~~application, relating to medical negligence, violation of~~
974 ~~residents' rights, or wrongful death. As a condition of~~
975 ~~licensure, the licensee agrees to provide to the agency copies~~
976 ~~of any new verdict or judgment involving the applicant, relating~~
977 ~~to such matters, within 30 days after filing with the clerk of~~
978 ~~the court. The information required in this paragraph shall be~~
979 ~~maintained in the facility's licensure file and in an agency~~
980 ~~database which is available as a public record.~~

981 (5) As a condition of licensure, each facility must
982 establish ~~and submit with its application~~ a plan for quality
983 assurance and for conducting risk management.
984 Section 28. Section 400.0712, Florida Statutes, is amended
985 to read:
986 400.0712 Application for inactive license.—
987 ~~(1) As specified in this section, the agency may issue an~~
988 ~~inactive license to a nursing home facility for all or a portion~~
989 ~~of its beds. Any request by a licensee that a nursing home or~~
990 ~~portion of a nursing home become inactive must be submitted to~~
991 ~~the agency in the approved format. The facility may not initiate~~
992 ~~any suspension of services, notify residents, or initiate~~
993 ~~inactivity before receiving approval from the agency; and a~~
994 ~~licensee that violates this provision may not be issued an~~
995 ~~inactive license.~~
996 (1) ~~(2)~~ In addition to the powers granted under part II of
997 chapter 408, the agency may issue an inactive license for a
998 portion of the total beds to a nursing home that chooses to use
999 an unoccupied contiguous portion of the facility for an
1000 alternative use to meet the needs of elderly persons through the
1001 use of less restrictive, less institutional services.
1002 (a) An inactive license issued under this subsection may
1003 be granted for a period not to exceed the current licensure
1004 expiration date but may be renewed by the agency at the time of
1005 licensure renewal.
1006 (b) A request to extend the inactive license must be
1007 submitted to the agency in the approved format and approved by
1008 the agency in writing.

1009 (c) Nursing homes that receive an inactive license to
1010 provide alternative services shall not receive preference for
1011 participation in the Assisted Living for the Elderly Medicaid
1012 waiver.
1013 (2) ~~(3)~~ The agency shall adopt rules pursuant to ss.
1014 120.536(1) and 120.54 necessary to implement this section.
1015 Section 29. Section 400.111, Florida Statutes, is amended
1016 to read:
1017 400.111 Disclosure of controlling interest.—In addition to
1018 the requirements of part II of chapter 408, when requested by
1019 the agency, the licensee shall submit a signed affidavit
1020 disclosing any financial or ownership interest that a
1021 controlling interest has held within the last 5 years in any
1022 entity licensed by the state or any other state to provide
1023 health or residential care which entity has closed voluntarily
1024 or involuntarily; has filed for bankruptcy; has had a receiver
1025 appointed; has had a license denied, suspended, or revoked; or
1026 has had an injunction issued against it which was initiated by a
1027 regulatory agency. The affidavit must disclose the reason such
1028 entity was closed, whether voluntarily or involuntarily.
1029 Section 30. Subsection (2) of section 400.1183, Florida
1030 Statutes, is amended to read:
1031 400.1183 Resident grievance procedures.—
1032 (2) Each facility shall maintain records of all grievances
1033 and shall retain a log for agency inspection of ~~report to the~~
1034 ~~agency at the time of relicensure~~ the total number of grievances
1035 handled ~~during the prior licensure period~~, a categorization of
1036 the cases underlying the grievances, and the final disposition

1037 of the grievances.
1038 Section 31. Section 400.141, Florida Statutes, is amended
1039 to read:
1040 400.141 Administration and management of nursing home
1041 facilities.—
1042 (1) Every licensed facility shall comply with all
1043 applicable standards and rules of the agency and shall:
1044 (a) Be under the administrative direction and charge of a
1045 licensed administrator.
1046 (b) Appoint a medical director licensed pursuant to
1047 chapter 458 or chapter 459. The agency may establish by rule
1048 more specific criteria for the appointment of a medical
1049 director.
1050 (c) Have available the regular, consultative, and
1051 emergency services of physicians licensed by the state.
1052 (d) Provide for resident use of a community pharmacy as
1053 specified in s. 400.022(1)(q). Any other law to the contrary
1054 notwithstanding, a registered pharmacist licensed in Florida,
1055 that is under contract with a facility licensed under this
1056 chapter or chapter 429, shall repackage a nursing facility
1057 resident's bulk prescription medication which has been packaged
1058 by another pharmacist licensed in any state in the United States
1059 into a unit dose system compatible with the system used by the
1060 nursing facility, if the pharmacist is requested to offer such
1061 service. In order to be eligible for the repackaging, a resident
1062 or the resident's spouse must receive prescription medication
1063 benefits provided through a former employer as part of his or
1064 her retirement benefits, a qualified pension plan as specified

1065 in s. 4972 of the Internal Revenue Code, a federal retirement
1066 program as specified under 5 C.F.R. s. 831, or a long-term care
1067 policy as defined in s. 627.9404(1). A pharmacist who correctly
1068 repackages and relabels the medication and the nursing facility
1069 which correctly administers such repackaged medication under
1070 this paragraph may not be held liable in any civil or
1071 administrative action arising from the repackaging. In order to
1072 be eligible for the repackaging, a nursing facility resident for
1073 whom the medication is to be repackaged shall sign an informed
1074 consent form provided by the facility which includes an
1075 explanation of the repackaging process and which notifies the
1076 resident of the immunities from liability provided in this
1077 paragraph. A pharmacist who repackages and relabels prescription
1078 medications, as authorized under this paragraph, may charge a
1079 reasonable fee for costs resulting from the implementation of
1080 this provision.
1081 (e) Provide for the access of the facility residents to
1082 dental and other health-related services, recreational services,
1083 rehabilitative services, and social work services appropriate to
1084 their needs and conditions and not directly furnished by the
1085 licensee. When a geriatric outpatient nurse clinic is conducted
1086 in accordance with rules adopted by the agency, outpatients
1087 attending such clinic shall not be counted as part of the
1088 general resident population of the nursing home facility, nor
1089 shall the nursing staff of the geriatric outpatient clinic be
1090 counted as part of the nursing staff of the facility, until the
1091 outpatient clinic load exceeds 15 a day.
1092 (f) Be allowed and encouraged by the agency to provide

1093 other needed services under certain conditions. If the facility
1094 has a standard licensure status, ~~and has had no class I or class~~
1095 ~~II deficiencies during the past 2 years or has been awarded a~~
1096 ~~Gold Seal under the program established in s. 400.235,~~ it may ~~be~~
1097 ~~encouraged by the agency to~~ provide services, including, but not
1098 limited to, respite and adult day services, which enable
1099 individuals to move in and out of the facility. A facility is
1100 not subject to any additional licensure requirements for
1101 providing these services<u>, under the following conditions:</u>~~.~~
1102 <u>1.</u> Respite care may be offered to persons in need of
1103 short-term or temporary nursing home services. <u>For each person</u>
1104 <u>admitted under the respite care program, the facility licensee</u>
1105 <u>must:</u>
1106 <u>a. Have a written abbreviated plan of care that, at a</u>
1107 <u>minimum, includes nutritional requirements, medication orders,</u>
1108 <u>physician orders, nursing assessments, and dietary preferences.</u>
1109 <u>The nursing or physician assessments may take the place of all</u>
1110 <u>other assessments required for full-time residents.</u>
1111 <u>b. Have a contract that, at a minimum, specifies the</u>
1112 <u>services to be provided to the respite resident, including</u>
1113 <u>charges for services, activities, equipment, emergency medical</u>
1114 <u>services, and the administration of medications. If multiple</u>
1115 <u>respite admissions for a single person are anticipated, the</u>
1116 <u>original contract is valid for 1 year after the date of</u>
1117 <u>execution.</u>
1118 <u>c. Ensure that each resident is released to his or her</u>
1119 <u>caregiver or an individual designated in writing by the</u>
1120 <u>caregiver.</u>

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

1121 2. A person admitted under the respite care program is:
1122 a. Exempt from requirements in rule related to discharge
1123 planning.
1124 b. Covered by the residents' rights set forth in s.
1125 400.022(1)(a)-(o) and (r)-(t). Funds or property of the resident
1126 shall not be considered trust funds subject to the requirements
1127 of s. 400.022(1)(h) until the resident has been in the facility
1128 for more than 14 consecutive days.
1129 c. Allowed to use his or her personal medications for the
1130 respite stay if permitted by facility policy. The facility must
1131 obtain a physician's order for the medications. The caregiver
1132 may provide information regarding the medications as part of the
1133 nursing assessment and that information must agree with the
1134 physician's order. Medications shall be released with the
1135 resident upon discharge in accordance with current physician's
1136 orders.
1137 3. A person receiving respite care is entitled to reside
1138 in the facility for a total of 60 days within a contract year or
1139 within a calendar year if the contract is for less than 12
1140 months. However, each single stay may not exceed 14 days. If a
1141 stay exceeds 14 consecutive days, the facility must comply with
1142 all assessment and care planning requirements applicable to
1143 nursing home residents.
1144 4. A person receiving respite care must reside in a
1145 licensed nursing home bed.
1146 5. A prospective respite resident must provide medical
1147 information from a physician, physician assistant, or nurse
1148 practitioner and other information from the primary caregiver as

1149 may be required by the facility before or at the time of
1150 admission to receive respite care. The medical information must
1151 include a physician's order for respite care and proof of a
1152 physical examination by a licensed physician, physician
1153 assistant, or nurse practitioner. The physician's order and
1154 physical examination may be used to provide intermittent respite
1155 care for up to 12 months after the date the order is written.
1156 6. The facility must assume the duties of the primary
1157 caregiver. To ensure continuity of care and services, the
1158 resident is entitled to retain his or her personal physician and
1159 must have access to medically necessary services such as
1160 physical therapy, occupational therapy, or speech therapy, as
1161 needed. The facility must arrange for transportation to these
1162 services if necessary. ~~Respite care must be provided in~~
1163 ~~accordance with this part and rules adopted by the agency.~~
1164 ~~However, the agency shall, by rule, adopt modified requirements~~
1165 ~~for resident assessment, resident care plans, resident~~
1166 ~~contracts, physician orders, and other provisions, as~~
1167 ~~appropriate, for short-term or temporary nursing home services.~~
1168 7. The agency shall allow for shared programming and staff
1169 in a facility which meets minimum standards and offers services
1170 pursuant to this paragraph, but, if the facility is cited for
1171 deficiencies in patient care, may require additional staff and
1172 programs appropriate to the needs of service recipients. A
1173 person who receives respite care may not be counted as a
1174 resident of the facility for purposes of the facility's licensed
1175 capacity unless that person receives 24-hour respite care. A
1176 person receiving either respite care for 24 hours or longer or

1177 adult day services must be included when calculating minimum
1178 staffing for the facility. Any costs and revenues generated by a
1179 nursing home facility from nonresidential programs or services
1180 shall be excluded from the calculations of Medicaid per diems
1181 for nursing home institutional care reimbursement.
1182 (g) If the facility has a standard license ~~or is a Gold~~
1183 ~~Seal facility~~, exceeds the minimum required hours of licensed
1184 nursing and certified nursing assistant direct care per resident
1185 per day, and is part of a continuing care facility licensed
1186 under chapter 651 or a retirement community that offers other
1187 services pursuant to part III of this chapter or part I or part
1188 III of chapter 429 on a single campus, be allowed to share
1189 programming and staff. At the time of inspection ~~and in the~~
1190 ~~semiannual report required pursuant to paragraph (o)~~, a
1191 continuing care facility or retirement community that uses this
1192 option must demonstrate through staffing records that minimum
1193 staffing requirements for the facility were met. Licensed nurses
1194 and certified nursing assistants who work in the nursing home
1195 facility may be used to provide services elsewhere on campus if
1196 the facility exceeds the minimum number of direct care hours
1197 required per resident per day and the total number of residents
1198 receiving direct care services from a licensed nurse or a
1199 certified nursing assistant does not cause the facility to
1200 violate the staffing ratios required under s. 400.23(3)(a).
1201 Compliance with the minimum staffing ratios shall be based on
1202 total number of residents receiving direct care services,
1203 regardless of where they reside on campus. If the facility
1204 receives a conditional license, it may not share staff until the

1205 conditional license status ends. This paragraph does not
1206 restrict the agency's authority under federal or state law to
1207 require additional staff if a facility is cited for deficiencies
1208 in care which are caused by an insufficient number of certified
1209 nursing assistants or licensed nurses. The agency may adopt
1210 rules for the documentation necessary to determine compliance
1211 with this provision.
1212 (h) Maintain the facility premises and equipment and
1213 conduct its operations in a safe and sanitary manner.
1214 (i) If the licensee furnishes food service, provide a
1215 wholesome and nourishing diet sufficient to meet generally
1216 accepted standards of proper nutrition for its residents and
1217 provide such therapeutic diets as may be prescribed by attending
1218 physicians. In making rules to implement this paragraph, the
1219 agency shall be guided by standards recommended by nationally
1220 recognized professional groups and associations with knowledge
1221 of dietetics.
1222 (j) Keep full records of resident admissions and
1223 discharges; medical and general health status, including medical
1224 records, personal and social history, and identity and address
1225 of next of kin or other persons who may have responsibility for
1226 the affairs of the residents; and individual resident care plans
1227 including, but not limited to, prescribed services, service
1228 frequency and duration, and service goals. The records shall be
1229 open to inspection by the agency. The facility must maintain
1230 clinical records on each resident in accordance with accepted
1231 professional standards and practices that are complete,
1232 accurately documented, readily accessible, and systematically

1233 organized.
1234 (k) Keep such fiscal records of its operations and
1235 conditions as may be necessary to provide information pursuant
1236 to this part.
1237 (l) Furnish copies of personnel records for employees
1238 affiliated with such facility, to any other facility licensed by
1239 this state requesting this information pursuant to this part.
1240 Such information contained in the records may include, but is
1241 not limited to, disciplinary matters and any reason for
1242 termination. Any facility releasing such records pursuant to
1243 this part shall be considered to be acting in good faith and may
1244 not be held liable for information contained in such records,
1245 absent a showing that the facility maliciously falsified such
1246 records.
1247 (m) Publicly display a poster provided by the agency
1248 containing the names, addresses, and telephone numbers for the
1249 state's abuse hotline, the State Long-Term Care Ombudsman, the
1250 Agency for Health Care Administration consumer hotline, the
1251 Advocacy Center for Persons with Disabilities, the Florida
1252 Statewide Advocacy Council, and the Medicaid Fraud Control Unit,
1253 with a clear description of the assistance to be expected from
1254 each.
1255 ~~(n) Submit to the agency the information specified in s.~~
1256 ~~400.071(1)(b) for a management company within 30 days after the~~
1257 ~~effective date of the management agreement.~~
1258 (n)~~(o)~~1. ~~Submit semiannually to the agency, or more~~
1259 ~~frequently if requested by the agency, information regarding~~
1260 ~~facility staff-to-resident ratios, staff turnover, and staff~~

1261 ~~stability, including information regarding certified nursing~~
1262 ~~assistants, licensed nurses, the director of nursing, and the~~
1263 ~~facility administrator. For purposes of this reporting:~~
1264 ~~a. Staff-to-resident ratios must be reported in the~~
1265 ~~categories specified in s. 400.23(3)(a) and applicable rules.~~
1266 ~~The ratio must be reported as an average for the most recent~~
1267 ~~calendar quarter.~~
1268 ~~b. Staff turnover must be reported for the most recent 12-~~
1269 ~~month period ending on the last workday of the most recent~~
1270 ~~calendar quarter prior to the date the information is submitted.~~
1271 ~~The turnover rate must be computed quarterly, with the annual~~
1272 ~~rate being the cumulative sum of the quarterly rates. The~~
1273 ~~turnover rate is the total number of terminations or separations~~
1274 ~~experienced during the quarter, excluding any employee~~
1275 ~~terminated during a probationary period of 3 months or less,~~
1276 ~~divided by the total number of staff employed at the end of the~~
1277 ~~period for which the rate is computed, and expressed as a~~
1278 ~~percentage.~~
1279 ~~c. The formula for determining staff stability is the~~
1280 ~~total number of employees that have been employed for more than~~
1281 ~~12 months, divided by the total number of employees employed at~~
1282 ~~the end of the most recent calendar quarter, and expressed as a~~
1283 ~~percentage.~~
1284 ~~d.~~ A nursing facility that has failed to comply with state
1285 minimum-staffing requirements for 2 consecutive days is
1286 prohibited from accepting new admissions until the facility has
1287 achieved the minimum-staffing requirements for a period of 6
1288 consecutive days. For the purposes of this sub-subparagraph, any

1289 person who was a resident of the facility and was absent from
1290 the facility for the purpose of receiving medical care at a
1291 separate location or was on a leave of absence is not considered
1292 a new admission. Failure to impose such an admissions moratorium
1293 is subject to a $1,000 fine ~~constitutes a class II deficiency~~.
1294 2.~~e.~~ A nursing facility which does not have a conditional
1295 license may be cited for failure to comply with the standards in
1296 s. 400.23(3)(a)1.b. and c. only if it has failed to meet those
1297 standards on 2 consecutive days or if it has failed to meet at
1298 least 97 percent of those standards on any one day.
1299 3.~~f.~~ A facility which has a conditional license must be in
1300 compliance with the standards in s. 400.23(3)(a) at all times.
1301 ~~2. This paragraph does not limit the agency's ability to~~
1302 ~~impose a deficiency or take other actions if a facility does not~~
1303 ~~have enough staff to meet the residents' needs.~~
1304 (o)~~(p)~~ Notify a licensed physician when a resident
1305 exhibits signs of dementia or cognitive impairment or has a
1306 change of condition in order to rule out the presence of an
1307 underlying physiological condition that may be contributing to
1308 such dementia or impairment. The notification must occur within
1309 30 days after the acknowledgment of such signs by facility
1310 staff. If an underlying condition is determined to exist, the
1311 facility shall arrange, with the appropriate health care
1312 provider, the necessary care and services to treat the
1313 condition.
1314 (p)~~(q)~~ If the facility implements a dining and hospitality
1315 attendant program, ensure that the program is developed and
1316 implemented under the supervision of the facility director of

1317 nursing. A licensed nurse, licensed speech or occupational
1318 therapist, or a registered dietitian must conduct training of
1319 dining and hospitality attendants. A person employed by a
1320 facility as a dining and hospitality attendant must perform
1321 tasks under the direct supervision of a licensed nurse.
1322 ~~(r) Report to the agency any filing for bankruptcy~~
1323 ~~protection by the facility or its parent corporation,~~
1324 ~~divestiture or spin-off of its assets, or corporate~~
1325 ~~reorganization within 30 days after the completion of such~~
1326 ~~activity.~~
1327 (q)~~(s)~~ Maintain general and professional liability
1328 insurance coverage that is in force at all times. In lieu of
1329 general and professional liability insurance coverage, a state-
1330 designated teaching nursing home and its affiliated assisted
1331 living facilities created under s. 430.80 may demonstrate proof
1332 of financial responsibility as provided in s. 430.80(3)(g).
1333 (r)~~(t)~~ Maintain in the medical record for each resident a
1334 daily chart of certified nursing assistant services provided to
1335 the resident. The certified nursing assistant who is caring for
1336 the resident must complete this record by the end of his or her
1337 shift. This record must indicate assistance with activities of
1338 daily living, assistance with eating, and assistance with
1339 drinking, and must record each offering of nutrition and
1340 hydration for those residents whose plan of care or assessment
1341 indicates a risk for malnutrition or dehydration.
1342 (s)~~(u)~~ Before November 30 of each year, subject to the
1343 availability of an adequate supply of the necessary vaccine,
1344 provide for immunizations against influenza viruses to all its

1345 consenting residents in accordance with the recommendations of
1346 the United States Centers for Disease Control and Prevention,
1347 subject to exemptions for medical contraindications and
1348 religious or personal beliefs. Subject to these exemptions, any
1349 consenting person who becomes a resident of the facility after
1350 November 30 but before March 31 of the following year must be
1351 immunized within 5 working days after becoming a resident.
1352 Immunization shall not be provided to any resident who provides
1353 documentation that he or she has been immunized as required by
1354 this paragraph. This paragraph does not prohibit a resident from
1355 receiving the immunization from his or her personal physician if
1356 he or she so chooses. A resident who chooses to receive the
1357 immunization from his or her personal physician shall provide
1358 proof of immunization to the facility. The agency may adopt and
1359 enforce any rules necessary to comply with or implement this
1360 paragraph.
1361 (t) ~~(v)~~ Assess all residents for eligibility for
1362 pneumococcal polysaccharide vaccination (PPV) and vaccinate
1363 residents when indicated within 60 days after the effective date
1364 of this act in accordance with the recommendations of the United
1365 States Centers for Disease Control and Prevention, subject to
1366 exemptions for medical contraindications and religious or
1367 personal beliefs. Residents admitted after the effective date of
1368 this act shall be assessed within 5 working days of admission
1369 and, when indicated, vaccinated within 60 days in accordance
1370 with the recommendations of the United States Centers for
1371 Disease Control and Prevention, subject to exemptions for
1372 medical contraindications and religious or personal beliefs.

1373 Immunization shall not be provided to any resident who provides
1374 documentation that he or she has been immunized as required by
1375 this paragraph. This paragraph does not prohibit a resident from
1376 receiving the immunization from his or her personal physician if
1377 he or she so chooses. A resident who chooses to receive the
1378 immunization from his or her personal physician shall provide
1379 proof of immunization to the facility. The agency may adopt and
1380 enforce any rules necessary to comply with or implement this
1381 paragraph.
1382 (u) ~~(w)~~ Annually encourage and promote to its employees the
1383 benefits associated with immunizations against influenza viruses
1384 in accordance with the recommendations of the United States
1385 Centers for Disease Control and Prevention. The agency may adopt
1386 and enforce any rules necessary to comply with or implement this
1387 paragraph.
1388
1389 This subsection does not limit the agency's ability to impose a
1390 deficiency or take other actions if a facility does not have
1391 enough staff to meet the residents' needs.
1392 (2) Facilities that have been awarded a Gold Seal under
1393 the program established in s. 400.235 may develop a plan to
1394 provide certified nursing assistant training as prescribed by
1395 federal regulations and state rules and may apply to the agency
1396 for approval of their program.
1397 (3) A facility may charge a reasonable fee for the copying
1398 of resident records. The fee may not exceed $1 per page for the
1399 first 25 pages and 25 cents per page for each page in excess of
1400 25 pages.

1401 Section 32. Subsection (3) of section 400.142, Florida
1402 Statutes, is amended to read:
1403 400.142 Emergency medication kits; orders not to
1404 resuscitate.—
1405 (3) Facility staff may withhold or withdraw
1406 cardiopulmonary resuscitation if presented with an order not to
1407 resuscitate executed pursuant to s. 401.45. ~~The agency shall~~
1408 ~~adopt rules providing for the implementation of such orders.~~
1409 Facility staff and facilities shall not be subject to criminal
1410 prosecution or civil liability, nor be considered to have
1411 engaged in negligent or unprofessional conduct, for withholding
1412 or withdrawing cardiopulmonary resuscitation pursuant to such an
1413 order and rules adopted by the agency. The absence of an order
1414 not to resuscitate executed pursuant to s. 401.45 does not
1415 preclude a physician from withholding or withdrawing
1416 cardiopulmonary resuscitation as otherwise permitted by law.
1417 Section 33. Sections 400.0234, 400.145, and 429.294,
1418 Florida Statutes, are repealed.
1419 Section 34. Subsection (9) and subsections (11) through
1420 (15) of section 400.147, Florida Statutes, are renumbered as
1421 subsections (8) through (13), respectively, and present
1422 subsections (7), (8), and (10) of that section are amended to
1423 read:
1424 400.147 Internal risk management and quality assurance
1425 program.—
1426 (7) The facility shall initiate an investigation ~~and shall~~
1427 ~~notify the agency~~ within 1 business day after the risk manager
1428 or his or her designee has received a report pursuant to

1429 paragraph (1)(d). Each facility shall complete the investigation
1430 and submit a report to the agency within 15 calendar days after
1431 an incident is determined to be an adverse incident. The
1432 notification must be made in writing and be provided
1433 electronically, by facsimile device or overnight mail delivery.
1434 The agency shall develop a form for reporting this information
1435 and the notification must include the name of the risk manager
1436 of the facility, information regarding the identity of the
1437 affected resident, the type of adverse incident, the initiation
1438 of an investigation by the facility, and whether the events
1439 causing or resulting in the adverse incident represent a
1440 potential risk to any other resident. The notification is
1441 confidential as provided by law and is not discoverable or
1442 admissible in any civil or administrative action, except in
1443 disciplinary proceedings by the agency or the appropriate
1444 regulatory board. The agency may investigate, as it deems
1445 appropriate, any such incident and prescribe measures that must
1446 or may be taken in response to the incident. The agency shall
1447 review each report incident and determine whether it potentially
1448 involved conduct by the health care professional who is subject
1449 to disciplinary action, in which case the provisions of s.
1450 456.073 shall apply.
1451 (8)(a) Each facility shall complete the investigation and
1452 submit an adverse incident report to the agency for each adverse
1453 incident within 15 calendar days after its occurrence. If, after
1454 a complete investigation, the risk manager determines that the
1455 incident was not an adverse incident as defined in subsection
1456 (5), the facility shall include this information in the report.

1457 ~~The agency shall develop a form for reporting this information.~~
1458 ~~(b) The information reported to the agency pursuant to~~
1459 ~~paragraph (a) which relates to persons licensed under chapter~~
1460 ~~458, chapter 459, chapter 461, or chapter 466 shall be reviewed~~
1461 ~~by the agency. The agency shall determine whether any of the~~
1462 ~~incidents potentially involved conduct by a health care~~
1463 ~~professional who is subject to disciplinary action, in which~~
1464 ~~case the provisions of s. 456.073 shall apply.~~
1465 ~~(c) The report submitted to the agency must also contain~~
1466 ~~the name of the risk manager of the facility.~~
1467 ~~(d) The adverse incident report is confidential as~~
1468 ~~provided by law and is not discoverable or admissible in any~~
1469 ~~civil or administrative action, except in disciplinary~~
1470 ~~proceedings by the agency or the appropriate regulatory board.~~
1471 ~~(10) By the 10th of each month, each facility subject to~~
1472 ~~this section shall report any notice received pursuant to s.~~
1473 ~~400.0233(2) and each initial complaint that was filed with the~~
1474 ~~clerk of the court and served on the facility during the~~
1475 ~~previous month by a resident or a resident's family member,~~
1476 ~~guardian, conservator, or personal legal representative. The~~
1477 ~~report must include the name of the resident, the resident's~~
1478 ~~date of birth and social security number, the Medicaid~~
1479 ~~identification number for Medicaid-eligible persons, the date or~~
1480 ~~dates of the incident leading to the claim or dates of~~
1481 ~~residency, if applicable, and the type of injury or violation of~~
1482 ~~rights alleged to have occurred. Each facility shall also submit~~
1483 ~~a copy of the notices received pursuant to s. 400.0233(2) and~~
1484 ~~complaints filed with the clerk of the court. This report is~~

1485 ~~confidential as provided by law and is not discoverable or~~
1486 ~~admissible in any civil or administrative action, except in such~~
1487 ~~actions brought by the agency to enforce the provisions of this~~
1488 ~~part.~~
1489 Section 35. Section 400.148, Florida Statutes, is
1490 repealed.
1491 Section 36. Paragraph (e) of subsection (2) of section
1492 400.179, Florida Statutes, is amended to read:
1493 400.179 Liability for Medicaid underpayments and
1494 overpayments.—
1495 (2) Because any transfer of a nursing facility may expose
1496 the fact that Medicaid may have underpaid or overpaid the
1497 transferor, and because in most instances, any such underpayment
1498 or overpayment can only be determined following a formal field
1499 audit, the liabilities for any such underpayments or
1500 overpayments shall be as follows:
1501 ~~(e) For the 2009-2010 fiscal year only, the provisions of~~
1502 ~~paragraph (d) shall not apply. This paragraph expires July 1,~~
1503 ~~2010.~~
1504 Section 37. Subsection (3) of section 400.19, Florida
1505 Statutes, is amended to read:
1506 400.19 Right of entry and inspection.—
1507 (3) The agency shall every 15 months conduct at least one
1508 unannounced inspection to determine compliance by the licensee
1509 with statutes, and with rules promulgated under the provisions
1510 of those statutes, governing minimum standards of construction,
1511 quality and adequacy of care, and rights of residents. The
1512 survey shall be conducted every 6 months for the next 2-year

1513 period if the facility has been cited for a class I deficiency,
1514 has been cited for two or more class II deficiencies arising
1515 from separate surveys or investigations within a 60-day period,
1516 or has had three or more substantiated complaints within a 6-
1517 month period, each resulting in at least one class I or class II
1518 deficiency. In addition to any other fees or fines in this part,
1519 the agency shall assess a fine for each facility that is subject
1520 to the 6-month survey cycle. The fine for the 2-year period
1521 shall be $6,000, one-half to be paid at the completion of each
1522 survey. The agency may adjust this fine by the change in the
1523 Consumer Price Index, based on the 12 months immediately
1524 preceding the increase, to cover the cost of the additional
1525 surveys. The agency shall verify through subsequent inspection
1526 that any deficiency identified during inspection is corrected.
1527 However, the agency may verify the correction of a class III or
1528 class IV deficiency ~~unrelated to resident rights or resident~~
1529 ~~care~~ without reinspecting the facility if adequate written
1530 documentation has been received from the facility, which
1531 provides assurance that the deficiency has been corrected. The
1532 giving or causing to be given of advance notice of such
1533 unannounced inspections by an employee of the agency to any
1534 unauthorized person shall constitute cause for suspension of not
1535 fewer than 5 working days according to the provisions of chapter
1536 110.
1537 Section 38. Subsection (5) of section 400.23, Florida
1538 Statutes, is amended to read:
1539 400.23 Rules; evaluation and deficiencies; licensure
1540 status.—

1541 (5) (a) The agency, in collaboration with the Division of
1542 Children's Medical Services Network of the Department of Health,
1543 must, no later than December 31, 1993, adopt rules for minimum
1544 standards of care for persons under 21 years of age who reside
1545 in nursing home facilities. The rules must include a methodology
1546 for reviewing a nursing home facility under ss. 408.031-408.045
1547 which serves only persons under 21 years of age. A facility may
1548 be exempt from these standards for specific persons between 18
1549 and 21 years of age, if the person's physician agrees that
1550 minimum standards of care based on age are not necessary.
1551 (b) The agency, in collaboration with the Division of
1552 Children's Medical Services Network, shall adopt rules for
1553 minimum staffing requirements for nursing home facilities that
1554 serve persons under 21 years of age, which shall apply in lieu
1555 of the standards contained in subsection (3).
1556 1. For persons under 21 years of age who require skilled
1557 care, the requirements shall include a minimum combined average
1558 of licensed nurses, respiratory therapists, respiratory care
1559 practitioners, and certified nursing assistants of 3.9 hours of
1560 direct care per resident per day for each nursing home facility.
1561 2. For persons under 21 years of age who are fragile, the
1562 requirements shall include a minimum combined average of
1563 licensed nurses, respiratory therapists, respiratory care
1564 practitioners, and certified nursing assistants of 5 hours of
1565 direct care per resident per day for each nursing home facility.
1566 Section 39. Subsection (1) of section 400.275, Florida
1567 Statutes, is amended to read:
1568 400.275 Agency duties.—

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

1569 (1) ~~The agency shall ensure that each newly hired nursing~~
1570 ~~home surveyor, as a part of basic training, is assigned full-~~
1571 ~~time to a licensed nursing home for at least 2 days within a 7-~~
1572 ~~day period to observe facility operations outside of the survey~~
1573 ~~process before the surveyor begins survey responsibilities. Such~~
1574 ~~observations may not be the sole basis of a deficiency citation~~
1575 ~~against the facility.~~ The agency may not assign an individual to
1576 be a member of a survey team for purposes of a survey,
1577 evaluation, or consultation visit at a nursing home facility in
1578 which the surveyor was an employee within the preceding <u>2</u> ~~5~~
1579 years.
1580 Section 40. Subsection (27) of section 400.462, Florida
1581 Statutes, is amended to read:
1582 400.462 Definitions.—As used in this part, the term:
1583 (27) "Remuneration" means any payment or other benefit
1584 made directly or indirectly, overtly or covertly, in cash or in
1585 kind. <u>However, when the term is used in any provision of law</u>
1586 <u>relating to a health care provider, such term does not mean an</u>
1587 <u>item with an individual value of up to $15, including, but not</u>
1588 <u>limited to, plaques, certificates, trophies, or novelties that</u>
1589 <u>are intended solely for presentation or are customarily given</u>
1590 <u>away solely for promotional, recognition, or advertising</u>
1591 <u>purposes.</u>
1592 Section 41. Subsection (2) of section 400.484, Florida
1593 Statutes, is amended to read:
1594 400.484 Right of inspection; <u>violations</u> ~~deficiencies~~;
1595 fines.—
1596 (2) The agency shall impose fines for various classes of

1597 violations ~~deficiencies~~ in accordance with the following
1598 schedule:
1599 (a) Class I violations are defined in s. 408.813. ~~A class~~
1600 ~~I deficiency is any act, omission, or practice that results in a~~
1601 ~~patient's death, disablement, or permanent injury, or places a~~
1602 ~~patient at imminent risk of death, disablement, or permanent~~
1603 ~~injury.~~ Upon finding a class I violation ~~deficiency~~, the agency
1604 shall impose an administrative fine in the amount of $15,000 for
1605 each occurrence and each day that the violation ~~deficiency~~
1606 exists.
1607 (b) Class II violations are defined in s. 408.813. ~~A class~~
1608 ~~II deficiency is any act, omission, or practice that has a~~
1609 ~~direct adverse effect on the health, safety, or security of a~~
1610 ~~patient.~~ Upon finding a class II violation ~~deficiency~~, the
1611 agency shall impose an administrative fine in the amount of
1612 $5,000 for each occurrence and each day that the violation
1613 ~~deficiency~~ exists.
1614 (c) Class III violations are defined in s. 408.813. ~~A~~
1615 ~~class III deficiency is any act, omission, or practice that has~~
1616 ~~an indirect, adverse effect on the health, safety, or security~~
1617 ~~of a patient.~~ Upon finding an uncorrected or repeated class III
1618 violation ~~deficiency~~, the agency shall impose an administrative
1619 fine not to exceed $1,000 for each occurrence and each day that
1620 the uncorrected or repeated violation ~~deficiency~~ exists.
1621 (d) Class IV violations are defined in s. 408.813. ~~A class~~
1622 ~~IV deficiency is any act, omission, or practice related to~~
1623 ~~required reports, forms, or documents which does not have the~~
1624 ~~potential of negatively affecting patients. These violations are~~

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

1625 ~~of a type that the agency determines do not threaten the health,~~
1626 ~~safety, or security of patients.~~ Upon finding an uncorrected or
1627 repeated class IV violation ~~deficiency~~, the agency shall impose
1628 an administrative fine not to exceed $500 for each occurrence
1629 and each day that the uncorrected or repeated violation
1630 ~~deficiency~~ exists.
1631 Section 42. Subsections (16) and (17) of section 400.506,
1632 Florida Statutes, are renumbered as subsections (17) and (18),
1633 respectively, paragraph (a) of subsection (15) is amended, and a
1634 new subsection (16) is added to that section, to read:
1635 400.506 Licensure of nurse registries; requirements;
1636 penalties.—
1637 (15)(a) The agency may deny, suspend, or revoke the
1638 license of a nurse registry and shall impose a fine of $5,000
1639 against a nurse registry that:
1640 1. Provides services to residents in an assisted living
1641 facility for which the nurse registry does not receive fair
1642 market value remuneration.
1643 2. Provides staffing to an assisted living facility for
1644 which the nurse registry does not receive fair market value
1645 remuneration.
1646 3. Fails to provide the agency, upon request, with copies
1647 of all contracts with assisted living facilities which were
1648 executed within the last 5 years.
1649 4. Gives remuneration to a case manager, discharge
1650 planner, facility-based staff member, or third-party vendor who
1651 is involved in the discharge planning process of a facility
1652 licensed under chapter 395 or this chapter and from whom the

1653 nurse registry receives referrals. A nurse registry is exempt
1654 from this subparagraph if it does not bill the ~~Florida Medicaid~~
1655 ~~program or the~~ Medicare program or share a controlling interest
1656 with any entity licensed, registered, or certified under part II
1657 of chapter 408 that bills the ~~Florida Medicaid program or the~~
1658 Medicare program.
1659 5. Gives remuneration to a physician, a member of the
1660 physician's office staff, or an immediate family member of the
1661 physician, and the nurse registry received a patient referral in
1662 the last 12 months from that physician or the physician's office
1663 staff. A nurse registry is exempt from this subparagraph if it
1664 does not bill the ~~Florida Medicaid program or the~~ Medicare
1665 program or share a controlling interest with any entity
1666 licensed, registered, or certified under part II of chapter 408
1667 that bills the ~~Florida Medicaid program or the~~ Medicare program.
1668 <u>(16) An administrator may manage only one nurse registry,</u>
1669 <u>except that an administrator may manage up to five registries if</u>
1670 <u>all five registries have identical controlling interests as</u>
1671 <u>defined in s. 408.803 and are located within one agency</u>
1672 <u>geographic service area or within an immediately contiguous</u>
1673 <u>county. An administrator shall designate, in writing, for each</u>
1674 <u>licensed entity, a qualified alternate administrator to serve</u>
1675 <u>during the administrator's absence.</u>
1676 Section 43. Subsection (1) of section 400.509, Florida
1677 Statutes, is amended to read:
1678 400.509 Registration of particular service providers
1679 exempt from licensure; certificate of registration; regulation
1680 of registrants.—

1681 (1) Any organization that provides companion services or
1682 homemaker services and does not provide a home health service to
1683 a person is exempt from licensure under this part. However, any
1684 organization that provides companion services or homemaker
1685 services must register with the agency. An organization under
1686 contract with the Agency for Persons with Disabilities that
1687 provides companion services only for persons with a
1688 developmental disability, as defined in s. 393.063, are exempt
1689 from registration.
1690 Section 44. Paragraph (i) of subsection (1) and subsection
1691 (4) of section 400.606, Florida Statutes, are amended to read:
1692 400.606 License; application; renewal; conditional license
1693 or permit; certificate of need.—
1694 (1) In addition to the requirements of part II of chapter
1695 408, the initial application and change of ownership application
1696 must be accompanied by a plan for the delivery of home,
1697 residential, and homelike inpatient hospice services to
1698 terminally ill persons and their families. Such plan must
1699 contain, but need not be limited to:
1700 ~~(i) The projected annual operating cost of the hospice.~~
1701 If the applicant is an existing licensed health care provider,
1702 the application must be accompanied by a copy of the most recent
1703 profit-loss statement and, if applicable, the most recent
1704 licensure inspection report.
1705 (4) A freestanding hospice facility that is ~~primarily~~
1706 engaged in providing inpatient and related services and that is
1707 not otherwise licensed as a health care facility shall be
1708 required to obtain a certificate of need. However, a

1709 freestanding hospice facility with six or fewer beds shall not
1710 be required to comply with institutional standards such as, but
1711 not limited to, standards requiring sprinkler systems, emergency
1712 electrical systems, or special lavatory devices.
1713 Section 45. Subsection (2) of section 400.607, Florida
1714 Statutes, is amended to read:
1715 400.607 Denial, suspension, revocation of license;
1716 emergency actions; imposition of administrative fine; grounds.—
1717 (2) A violation of this part, part II of chapter 408, or
1718 applicable rules ~~Any of the following actions~~ by a licensed
1719 hospice or any of its employees shall be grounds for
1720 administrative action by the agency against a hospice.~~:~~
1721 ~~(a) A violation of the provisions of this part, part II of~~
1722 ~~chapter 408, or applicable rules.~~
1723 ~~(b) An intentional or negligent act materially affecting~~
1724 ~~the health or safety of a patient.~~
1725 Section 46. Section 400.915, Florida Statutes, is amended
1726 to read:
1727 400.915 Construction and renovation; requirements.—The
1728 requirements for the construction or renovation of a PPEC center
1729 shall comply with:
1730 (1) The provisions of chapter 553, which pertain to
1731 building construction standards, including plumbing, electrical
1732 code, glass, manufactured buildings, accessibility for the
1733 physically disabled;
1734 (2) The provisions of s. 633.022 and applicable rules
1735 pertaining to physical ~~minimum~~ standards for nonresidential
1736 child care ~~physical~~ facilities ~~in rule 10M-12.003, Florida~~

1737 ~~Administrative Code, Child Care Standards~~; and
1738 (3) The standards or rules adopted pursuant to this part
1739 and part II of chapter 408.
1740 Section 47. Subsection (1) of section 400.925, Florida
1741 Statutes, is amended to read:
1742 400.925 Definitions.—As used in this part, the term:
1743 (1) "Accrediting organizations" means the Joint Commission
1744 ~~on Accreditation of Healthcare Organizations~~ or other national
1745 accreditation agencies whose standards for accreditation are
1746 comparable to those required by this part for licensure.
1747 Section 48. Subsection (2) of section 400.931, Florida
1748 Statutes, is amended to read:
1749 400.931 Application for license; fee~~; provisional license;~~
1750 ~~temporary permit~~.—
1751 (2) An applicant for initial licensure, change of
1752 ownership, or renewal to operate a licensed home medical
1753 equipment provider at a location outside the state must submit
1754 documentation of accreditation or an application for
1755 accreditation from an accrediting organization that is
1756 recognized by the agency. An applicant that has applied for
1757 accreditation must provide proof of accreditation that is not
1758 conditional or provisional within 120 days after the date the
1759 agency receives the application for licensure or the application
1760 shall be withdrawn from further consideration. Such
1761 accreditation must be maintained by the home medical equipment
1762 provider to maintain licensure. ~~As an alternative to submitting~~
1763 ~~proof of financial ability to operate as required in s.~~
1764 ~~408.810(8), the applicant may submit a $50,000 surety bond to~~

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

1765 ~~the agency.~~
1766 Section 49. Subsection (2) of section 400.932, Florida
1767 Statutes, is amended to read:
1768 400.932 Administrative penalties.—
1769 (2) A violation of this part, part II of chapter 408, or
1770 applicable rules ~~Any of the following actions~~ by an employee of
1771 a home medical equipment provider shall be ~~are~~ grounds for
1772 administrative action or penalties by the agency.~~:~~
1773 ~~(a) Violation of this part, part II of chapter 408, or~~
1774 ~~applicable rules.~~
1775 ~~(b) An intentional, reckless, or negligent act that~~
1776 ~~materially affects the health or safety of a patient.~~
1777 Section 50. Subsection (3) of section 400.967, Florida
1778 Statutes, is amended to read:
1779 400.967 Rules and classification of violations
1780 ~~deficiencies~~.—
1781 (3) The agency shall adopt rules to provide that, when the
1782 criteria established under this part and part II of chapter 408
1783 are not met, such violations ~~deficiencies~~ shall be classified
1784 according to the nature of the violation ~~deficiency~~. The agency
1785 shall indicate the classification on the face of the notice of
1786 deficiencies as follows:
1787 (a) Class I violations ~~deficiencies~~ are defined in s.
1788 408.813 ~~those which the agency determines present an imminent~~
1789 ~~danger to the residents or guests of the facility or a~~
1790 ~~substantial probability that death or serious physical harm~~
1791 ~~would result therefrom~~. ~~The condition or practice constituting a~~
1792 ~~class I violation must be abated or eliminated immediately,~~

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

1793 ~~unless a fixed period of time, as determined by the agency, is~~
1794 ~~required for correction.~~ A class I violation ~~deficiency~~ is
1795 subject to a civil penalty in an amount not less than $5,000 and
1796 not exceeding $10,000 for each violation ~~deficiency~~. A fine may
1797 be levied notwithstanding the correction of the violation
1798 ~~deficiency~~.
1799 (b) Class II violations ~~deficiencies~~ are defined in s.
1800 408.813 ~~those which the agency determines have a direct or~~
1801 ~~immediate relationship to the health, safety, or security of the~~
1802 ~~facility residents, other than class I deficiencies~~. A class II
1803 violation ~~deficiency~~ is subject to a civil penalty in an amount
1804 not less than $1,000 and not exceeding $5,000 for each violation
1805 ~~deficiency~~. A citation for a class II violation ~~deficiency~~ shall
1806 specify the time within which the violation ~~deficiency~~ must be
1807 corrected. If a class II violation ~~deficiency~~ is corrected
1808 within the time specified, no civil penalty shall be imposed,
1809 unless it is a repeated offense.
1810 (c) Class III violations ~~deficiencies~~ are defined in s.
1811 408.813 ~~those which the agency determines to have an indirect or~~
1812 ~~potential relationship to the health, safety, or security of the~~
1813 ~~facility residents, other than class I or class II deficiencies~~.
1814 A class III violation ~~deficiency~~ is subject to a civil penalty
1815 of not less than $500 and not exceeding $1,000 for each
1816 deficiency. A citation for a class III violation ~~deficiency~~
1817 shall specify the time within which the violation ~~deficiency~~
1818 must be corrected. If a class III violation ~~deficiency~~ is
1819 corrected within the time specified, no civil penalty shall be
1820 imposed, unless it is a repeated offense.

1821 (d) Class IV violations are defined in s. 408.813. Upon
1822 finding an uncorrected or repeated class IV violation, the
1823 agency shall impose an administrative fine not to exceed $500
1824 for each occurrence and each day that the uncorrected or
1825 repeated violation exists.
1826 Section 51. Subsections (4) and (7) of section 400.9905,
1827 Florida Statutes, are amended to read:
1828 400.9905 Definitions.—
1829 (4) "Clinic" means an entity at which health care services
1830 are provided to individuals and which tenders charges for
1831 reimbursement for such services, including a mobile clinic and a
1832 portable health service or equipment provider. For purposes of
1833 this part, the term does not include and the licensure
1834 requirements of this part do not apply to:
1835 (a) Entities licensed or registered by the state under
1836 chapter 395; or entities licensed or registered by the state and
1837 providing only health care services within the scope of services
1838 authorized under their respective licenses granted under ss.
1839 383.30-383.335, chapter 390, chapter 394, chapter 397, this
1840 chapter except part X, chapter 429, chapter 463, chapter 465,
1841 chapter 466, chapter 478, part I of chapter 483, chapter 484, or
1842 chapter 651; end-stage renal disease providers authorized under
1843 42 C.F.R. part 405, subpart U; or providers certified under 42
1844 C.F.R. part 485, subpart B or subpart H; or any entity that
1845 provides neonatal or pediatric hospital-based health care
1846 services or other health care services by licensed practitioners
1847 solely within a hospital licensed under chapter 395.
1848 (b) Entities that own, directly or indirectly, entities

1849 licensed or registered by the state pursuant to chapter 395; or
1850 entities that own, directly or indirectly, entities licensed or
1851 registered by the state and providing only health care services
1852 within the scope of services authorized pursuant to their
1853 respective licenses granted under ss. 383.30-383.335, chapter
1854 390, chapter 394, chapter 397, this chapter except part X,
1855 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
1856 part I of chapter 483, chapter 484, chapter 651; end-stage renal
1857 disease providers authorized under 42 C.F.R. part 405, subpart
1858 U; or providers certified under 42 C.F.R. part 485, subpart B or
1859 subpart H; or any entity that provides neonatal or pediatric
1860 hospital-based health care services by licensed practitioners
1861 solely within a hospital licensed under chapter 395.
1862 (c) Entities that are owned, directly or indirectly, by an
1863 entity licensed or registered by the state pursuant to chapter
1864 395; or entities that are owned, directly or indirectly, by an
1865 entity licensed or registered by the state and providing only
1866 health care services within the scope of services authorized
1867 pursuant to their respective licenses granted under ss. 383.30-
1868 383.335, chapter 390, chapter 394, chapter 397, this chapter
1869 except part X, chapter 429, chapter 463, chapter 465, chapter
1870 466, chapter 478, part I of chapter 483, chapter 484, or chapter
1871 651; end-stage renal disease providers authorized under 42
1872 C.F.R. part 405, subpart U; or providers certified under 42
1873 C.F.R. part 485, subpart B or subpart H; or any entity that
1874 provides neonatal or pediatric hospital-based health care
1875 services by licensed practitioners solely within a hospital
1876 under chapter 395.

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

1877 (d) Entities that are under common ownership, directly or
1878 indirectly, with an entity licensed or registered by the state
1879 pursuant to chapter 395; or entities that are under common
1880 ownership, directly or indirectly, with an entity licensed or
1881 registered by the state and providing only health care services
1882 within the scope of services authorized pursuant to their
1883 respective licenses granted under ss. 383.30-383.335, chapter
1884 390, chapter 394, chapter 397, this chapter except part X,
1885 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
1886 part I of chapter 483, chapter 484, or chapter 651; end-stage
1887 renal disease providers authorized under 42 C.F.R. part 405,
1888 subpart U; or providers certified under 42 C.F.R. part 485,
1889 subpart B or subpart H; or any entity that provides neonatal or
1890 pediatric hospital-based health care services by licensed
1891 practitioners solely within a hospital licensed under chapter
1892 395.
1893 (e) An entity that is exempt from federal taxation under
1894 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
1895 under 26 U.S.C. s. 409 that has a board of trustees not less
1896 than two-thirds of which are Florida-licensed health care
1897 practitioners and provides only physical therapy services under
1898 physician orders, any community college or university clinic,
1899 and any entity owned or operated by the federal or state
1900 government, including agencies, subdivisions, or municipalities
1901 thereof.
1902 (f) A sole proprietorship, group practice, partnership, or
1903 corporation that provides health care services by physicians
1904 covered by s. 627.419, that is directly supervised by one or

1905 more of such physicians, and that is wholly owned by one or more
1906 of those physicians or by a physician and the spouse, parent,
1907 child, or sibling of that physician.
1908 (g) A sole proprietorship, group practice, partnership, or
1909 corporation that provides health care services by licensed
1910 health care practitioners under chapter 457, chapter 458,
1911 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
1912 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
1913 chapter 490, chapter 491, or part I, part III, part X, part
1914 XIII, or part XIV of chapter 468, or s. 464.012, which are
1915 wholly owned by one or more licensed health care practitioners,
1916 or the licensed health care practitioners set forth in this
1917 paragraph and the spouse, parent, child, or sibling of a
1918 licensed health care practitioner, so long as one of the owners
1919 who is a licensed health care practitioner is supervising the
1920 business activities and is legally responsible for the entity's
1921 compliance with all federal and state laws. However, a health
1922 care practitioner may not supervise services beyond the scope of
1923 the practitioner's license, except that, for the purposes of
1924 this part, a clinic owned by a licensee in s. 456.053(3)(b) that
1925 provides only services authorized pursuant to s. 456.053(3)(b)
1926 may be supervised by a licensee specified in s. 456.053(3)(b).
1927 (h) Clinical facilities affiliated with an accredited
1928 medical school at which training is provided for medical
1929 students, residents, or fellows.
1930 (i) Entities that provide only oncology or radiation
1931 therapy services by physicians licensed under chapter 458 or
1932 chapter 459 or entities that provide oncology or radiation

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

1933 therapy services by physicians licensed under chapter 458 or
1934 chapter 459 which are owned by a corporation whose shares are
1935 publicly traded on a recognized stock exchange.
1936 (j) Clinical facilities affiliated with a college of
1937 chiropractic accredited by the Council on Chiropractic Education
1938 at which training is provided for chiropractic students.
1939 (k) Entities that provide licensed practitioners to staff
1940 emergency departments or to deliver anesthesia services in
1941 facilities licensed under chapter 395 and that derive at least
1942 90 percent of their gross annual revenues from the provision of
1943 such services. Entities claiming an exemption from licensure
1944 under this paragraph must provide documentation demonstrating
1945 compliance.
1946 (l) Orthotic, ~~or~~ prosthetic, pediatric cardiology, or
1947 perinatology clinical facilities that are a publicly traded
1948 corporation or that are wholly owned, directly or indirectly, by
1949 a publicly traded corporation. As used in this paragraph, a
1950 publicly traded corporation is a corporation that issues
1951 securities traded on an exchange registered with the United
1952 States Securities and Exchange Commission as a national
1953 securities exchange.
1954 (m) Entities that are owned by a corporation that has $250
1955 million or more in total annual sales of health care services
1956 provided by licensed health care practitioners if one or more of
1957 the owners of the entity is a health care practitioner who is
1958 licensed in this state, is responsible for supervising the
1959 business activities of the entity, and is legally responsible
1960 for the entity's compliance with state law for purposes of this

1961 section.
1962 (n) Entities that are owned or controlled, directly or
1963 indirectly, by a publicly traded entity with $100 million or
1964 more, in the aggregate, in total annual revenues derived from
1965 providing health care services by licensed health care
1966 practitioners that are employed or contracted by an entity
1967 described in this paragraph.
1968 (o) Entities that employ 50 or more health care
1969 practitioners licensed under chapter 458 or chapter 459 when the
1970 billing for medical services is under a single tax
1971 identification number. The application for exemption under this
1972 paragraph shall contain information that includes the name,
1973 residence address, business address, and phone number of the
1974 entity that owns the practice; a complete list of the names and
1975 contact information of all the officers and directors of the
1976 entity; the name, residence address, business address, and
1977 medical license number of each licensed Florida health care
1978 practitioner employed by the entity; the corporate tax
1979 identification number of the entity seeking an exemption; a
1980 listing of health care services to be provided by the entity at
1981 the health care clinics owned or operated by the entity and a
1982 certified statement prepared by an independent certified public
1983 accountant which states that the entity and the health care
1984 clinics owned or operated by the entity have not received
1985 payment for health care services under personal injury
1986 protection insurance coverage for the previous year. If the
1987 agency determines that an entity that is exempt under this
1988 paragraph has received payments for medical services under

1989 personal injury protection insurance coverage the agency may
1990 deny or revoke the exemption from licensure under this
1991 paragraph.
1992 (7) "Portable health service or equipment provider" means
1993 an entity that contracts with or employs persons to provide
1994 portable health services or equipment to multiple locations
1995 ~~performing treatment or diagnostic testing of individuals~~, that
1996 bills third-party payors for those services, and that otherwise
1997 meets the definition of a clinic in subsection (4).
1998 Section 52. Paragraph (b) of subsection (1) and paragraph
1999 (c) of subsection (4) of section 400.991, Florida Statutes, are
2000 amended to read:
2001 400.991 License requirements; background screenings;
2002 prohibitions.—
2003 (1)
2004 (b) Each mobile clinic must obtain a separate health care
2005 clinic license and must provide to the agency, at least
2006 quarterly, its projected street location to enable the agency to
2007 locate and inspect such clinic. A portable health service or
2008 equipment provider must obtain a health care clinic license for
2009 a single administrative office and is not required to submit
2010 quarterly projected street locations.
2011 (4) In addition to the requirements of part II of chapter
2012 408, the applicant must file with the application satisfactory
2013 proof that the clinic is in compliance with this part and
2014 applicable rules, including:
2015 (c) Proof of financial ability to operate as required
2016 under ss. ~~s.~~ 408.810(8) and 408.8065. ~~As an alternative to~~

2017 ~~submitting proof of financial ability to operate as required~~
2018 ~~under s. 408.810(8), the applicant may file a surety bond of at~~
2019 ~~least $500,000 which guarantees that the clinic will act in full~~
2020 ~~conformity with all legal requirements for operating a clinic,~~
2021 ~~payable to the agency. The agency may adopt rules to specify~~
2022 ~~related requirements for such surety bond.~~
2023 Section 53. Paragraph (g) of subsection (1) and paragraph
2024 (a) of subsection (7) of section 400.9935, Florida Statutes, are
2025 amended to read:
2026 400.9935 Clinic responsibilities.—
2027 (1) Each clinic shall appoint a medical director or clinic
2028 director who shall agree in writing to accept legal
2029 responsibility for the following activities on behalf of the
2030 clinic. The medical director or the clinic director shall:
2031 (g) Conduct systematic reviews of clinic billings to
2032 ensure that the billings are not fraudulent or unlawful. Upon
2033 discovery of an unlawful charge, the medical director or clinic
2034 director shall take immediate corrective action. If the clinic
2035 performs only the technical component of magnetic resonance
2036 imaging, static radiographs, computed tomography, or positron
2037 emission tomography, and provides the professional
2038 interpretation of such services, in a fixed facility that is
2039 accredited by the Joint Commission ~~on Accreditation of~~
2040 ~~Healthcare Organizations~~ or the Accreditation Association for
2041 Ambulatory Health Care, and the American College of Radiology;
2042 and if, in the preceding quarter, the percentage of scans
2043 performed by that clinic which was billed to all personal injury
2044 protection insurance carriers was less than 15 percent, the

2045 chief financial officer of the clinic may, in a written
2046 acknowledgment provided to the agency, assume the responsibility
2047 for the conduct of the systematic reviews of clinic billings to
2048 ensure that the billings are not fraudulent or unlawful.
2049 (7)(a) Each clinic engaged in magnetic resonance imaging
2050 services must be accredited by the Joint Commission ~~on~~
2051 ~~Accreditation of Healthcare Organizations~~, the American College
2052 of Radiology, or the Accreditation Association for Ambulatory
2053 Health Care, within 1 year after licensure. A clinic that is
2054 accredited by the American College of Radiology or is within the
2055 original 1-year period after licensure and replaces its core
2056 magnetic resonance imaging equipment shall be given 1 year after
2057 the date on which the equipment is replaced to attain
2058 accreditation. However, a clinic may request a single, 6-month
2059 extension if it provides evidence to the agency establishing
2060 that, for good cause shown, such clinic cannot be accredited
2061 within 1 year after licensure, and that such accreditation will
2062 be completed within the 6-month extension. After obtaining
2063 accreditation as required by this subsection, each such clinic
2064 must maintain accreditation as a condition of renewal of its
2065 license. A clinic that files a change of ownership application
2066 must comply with the original accreditation timeframe
2067 requirements of the transferor. The agency shall deny a change
2068 of ownership application if the clinic is not in compliance with
2069 the accreditation requirements. When a clinic adds, replaces, or
2070 modifies magnetic resonance imaging equipment and the
2071 accreditation agency requires new accreditation, the clinic must
2072 be accredited within 1 year after the date of the addition,

2073 replacement, or modification but may request a single, 6-month
2074 extension if the clinic provides evidence of good cause to the
2075 agency.
2076 Section 54. Paragraph (a) of subsection (2) of section
2077 408.033, Florida Statutes, is amended to read:
2078 408.033 Local and state health planning.—
2079 (2) FUNDING.—
2080 (a) The Legislature intends that the cost of local health
2081 councils be borne by assessments on selected health care
2082 facilities subject to facility licensure by the Agency for
2083 Health Care Administration, including abortion clinics, assisted
2084 living facilities, ambulatory surgical centers, birthing
2085 centers, clinical laboratories except community nonprofit blood
2086 banks and clinical laboratories operated by practitioners for
2087 exclusive use regulated under s. 483.035, home health agencies,
2088 hospices, hospitals, intermediate care facilities for the
2089 developmentally disabled, nursing homes, health care clinics,
2090 and multiphasic testing centers and by assessments on
2091 organizations subject to certification by the agency pursuant to
2092 chapter 641, part III, including health maintenance
2093 organizations and prepaid health clinics. Fees assessed may be
2094 collected prospectively at the time of licensure renewal and
2095 prorated for the licensure period.
2096 Section 55. Subsection (2) of section 408.034, Florida
2097 Statutes, is amended to read:
2098 408.034 Duties and responsibilities of agency; rules.—
2099 (2) In the exercise of its authority to issue licenses to
2100 health care facilities and health service providers, as provided

2101 under chapters 393 and 395 and parts II, ~~and~~ IV, and VIII of
2102 chapter 400, the agency may not issue a license to any health
2103 care facility or health service provider that fails to receive a
2104 certificate of need or an exemption for the licensed facility or
2105 service.
2106 Section 56. Paragraph (d) of subsection (1) and paragraph
2107 (m) of subsection (3) of section 408.036, Florida Statutes, are
2108 amended to read:
2109 408.036 Projects subject to review; exemptions.—
2110 (1) APPLICABILITY.—Unless exempt under subsection (3), all
2111 health-care-related projects, as described in paragraphs (a)-
2112 (g), are subject to review and must file an application for a
2113 certificate of need with the agency. The agency is exclusively
2114 responsible for determining whether a health-care-related
2115 project is subject to review under ss. 408.031-408.045.
2116 (d) The establishment of a hospice or hospice inpatient
2117 facility~~, except as provided in s. 408.043~~.
2118 (3) EXEMPTIONS.—Upon request, the following projects are
2119 subject to exemption from the provisions of subsection (1):
2120 (m)1. For the provision of adult open-heart services in a
2121 hospital located within the boundaries of a health service
2122 planning district, as defined in s. 408.032(5), which has
2123 experienced an annual net out-migration of at least 600 open-
2124 heart-surgery cases for 3 consecutive years according to the
2125 most recent data reported to the agency, and the district's
2126 population per licensed and operational open-heart programs
2127 exceeds the state average of population per licensed and
2128 operational open-heart programs by at least 25 percent. All

2129 hospitals within a health service planning district which meet
2130 the criteria reference in sub-subparagraphs 2.a.-h. shall be
2131 eligible for this exemption on July 1, 2004, and shall receive
2132 the exemption upon filing for it and subject to the following:
2133 a. A hospital that has received a notice of intent to
2134 grant a certificate of need or a final order of the agency
2135 granting a certificate of need for the establishment of an open-
2136 heart-surgery program is entitled to receive a letter of
2137 exemption for the establishment of an adult open-heart-surgery
2138 program upon filing a request for exemption and complying with
2139 the criteria enumerated in sub-subparagraphs 2.a.-h., and is
2140 entitled to immediately commence operation of the program.
2141 b. An otherwise eligible hospital that has not received a
2142 notice of intent to grant a certificate of need or a final order
2143 of the agency granting a certificate of need for the
2144 establishment of an open-heart-surgery program is entitled to
2145 immediately receive a letter of exemption for the establishment
2146 of an adult open-heart-surgery program upon filing a request for
2147 exemption and complying with the criteria enumerated in sub-
2148 subparagraphs 2.a.-h., but is not entitled to commence operation
2149 of its program until December 31, 2006.
2150 2. A hospital shall be exempt from the certificate-of-need
2151 review for the establishment of an open-heart-surgery program
2152 when the application for exemption submitted under this
2153 paragraph complies with the following criteria:
2154 a. The applicant must certify that it will meet and
2155 continuously maintain the minimum licensure requirements adopted
2156 by the agency governing adult open-heart programs, including the

2157 most current guidelines of the American College of Cardiology
2158 and American Heart Association Guidelines for Adult Open Heart
2159 Programs.
2160 b. The applicant must certify that it will maintain
2161 sufficient appropriate equipment and health personnel to ensure
2162 quality and safety.
2163 c. The applicant must certify that it will maintain
2164 appropriate times of operation and protocols to ensure
2165 availability and appropriate referrals in the event of
2166 emergencies.
2167 d. The applicant can demonstrate that it has discharged at
2168 least 300 inpatients with a principal diagnosis of ischemic
2169 heart disease for the most recent 12-month period as reported to
2170 the agency.
2171 e. The applicant is a general acute care hospital that is
2172 in operation for 3 years or more.
2173 f. The applicant is performing more than 300 diagnostic
2174 cardiac catheterization procedures per year, combined inpatient
2175 and outpatient.
2176 g. The applicant's payor mix at a minimum reflects the
2177 community average for Medicaid, charity care, and self-pay
2178 patients or the applicant must certify that it will provide a
2179 minimum of 5 percent of Medicaid, charity care, and self-pay to
2180 open-heart-surgery patients.
2181 h. If the applicant fails to meet the established criteria
2182 for open-heart programs or fails to reach 300 surgeries per year
2183 by the end of its third year of operation, it must show cause
2184 why its exemption should not be revoked.

2185 ~~3. By December 31, 2004, and annually thereafter, the~~
2186 ~~agency shall submit a report to the Legislature providing~~
2187 ~~information concerning the number of requests for exemption it~~
2188 ~~has received under this paragraph during the calendar year and~~
2189 ~~the number of exemptions it has granted or denied during the~~
2190 ~~calendar year.~~
2191 Section 57. Paragraph (c) of subsection (1) of section
2192 408.037, Florida Statutes, is amended to read:
2193 408.037 Application content.—
2194 (1) Except as provided in subsection (2) for a general
2195 hospital, an application for a certificate of need must contain:
2196 (c) An audited financial statement of the applicant or the
2197 applicant's parent corporation if audited financial statements
2198 of the applicant do not exist. In an application submitted by an
2199 existing health care facility, health maintenance organization,
2200 or hospice, financial condition documentation must include, but
2201 need not be limited to, a balance sheet and a profit-and-loss
2202 statement of the 2 previous fiscal years' operation.
2203 Section 58. Subsection (2) of section 408.043, Florida
2204 Statutes, is amended to read:
2205 408.043 Special provisions.—
2206 (2) HOSPICES.—When an application is made for a
2207 certificate of need to establish or to expand a hospice, the
2208 need for such hospice shall be determined on the basis of the
2209 need for and availability of hospice services in the community.
2210 The formula on which the certificate of need is based shall
2211 discourage regional monopolies and promote competition. The
2212 inpatient hospice care component of a hospice which is a

2213 freestanding facility, or a part of a facility, ~~which is~~
2214 ~~primarily engaged in providing inpatient care and related~~
2215 ~~services~~ and is not licensed as a health care facility shall
2216 also be required to obtain a certificate of need. Provision of
2217 hospice care by any current provider of health care is a
2218 significant change in service and therefore requires a
2219 certificate of need for such services.
2220 Section 59. Paragraph (k) of subsection (3) of section
2221 408.05, Florida Statutes, is amended to read:
2222 408.05 Florida Center for Health Information and Policy
2223 Analysis.—
2224 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to
2225 produce comparable and uniform health information and statistics
2226 for the development of policy recommendations, the agency shall
2227 perform the following functions:
2228 (k) Develop, in conjunction with the State Consumer Health
2229 Information and Policy Advisory Council, and implement a long-
2230 range plan for making available health care quality measures and
2231 financial data that will allow consumers to compare health care
2232 services. The health care quality measures and financial data
2233 the agency must make available shall include, but is not limited
2234 to, pharmaceuticals, physicians, health care facilities, and
2235 health plans and managed care entities. The agency shall update
2236 the plan and report on the status of its implementation
2237 annually. The agency shall also make the plan and status report
2238 available to the public on its Internet website. As part of the
2239 plan, the agency shall identify the process and timeframes for
2240 implementation, any barriers to implementation, and

2241 recommendations of changes in the law that may be enacted by the
2242 Legislature to eliminate the barriers. As preliminary elements
2243 of the plan, the agency shall:
2244 1. Make available patient-safety indicators, inpatient
2245 quality indicators, and performance outcome and patient charge
2246 data collected from health care facilities pursuant to s.
2247 408.061(1)(a) and (2). The terms "patient-safety indicators" and
2248 "inpatient quality indicators" shall be as defined by the
2249 Centers for Medicare and Medicaid Services, the National Quality
2250 Forum, the Joint Commission ~~on Accreditation of Healthcare~~
2251 ~~Organizations~~, the Agency for Healthcare Research and Quality,
2252 the Centers for Disease Control and Prevention, or a similar
2253 national entity that establishes standards to measure the
2254 performance of health care providers, or by other states. The
2255 agency shall determine which conditions, procedures, health care
2256 quality measures, and patient charge data to disclose based upon
2257 input from the council. When determining which conditions and
2258 procedures are to be disclosed, the council and the agency shall
2259 consider variation in costs, variation in outcomes, and
2260 magnitude of variations and other relevant information. When
2261 determining which health care quality measures to disclose, the
2262 agency:
2263 a. Shall consider such factors as volume of cases; average
2264 patient charges; average length of stay; complication rates;
2265 mortality rates; and infection rates, among others, which shall
2266 be adjusted for case mix and severity, if applicable.
2267 b. May consider such additional measures that are adopted
2268 by the Centers for Medicare and Medicaid Studies, National

2269 Quality Forum, the Joint Commission ~~on Accreditation of~~
2270 ~~Healthcare Organizations~~, the Agency for Healthcare Research and
2271 Quality, Centers for Disease Control and Prevention, or a
2272 similar national entity that establishes standards to measure
2273 the performance of health care providers, or by other states.
2274
2275 When determining which patient charge data to disclose, the
2276 agency shall include such measures as the average of
2277 undiscounted charges on frequently performed procedures and
2278 preventive diagnostic procedures, the range of procedure charges
2279 from highest to lowest, average net revenue per adjusted patient
2280 day, average cost per adjusted patient day, and average cost per
2281 admission, among others.
2282 2. Make available performance measures, benefit design,
2283 and premium cost data from health plans licensed pursuant to
2284 chapter 627 or chapter 641. The agency shall determine which
2285 health care quality measures and member and subscriber cost data
2286 to disclose, based upon input from the council. When determining
2287 which data to disclose, the agency shall consider information
2288 that may be required by either individual or group purchasers to
2289 assess the value of the product, which may include membership
2290 satisfaction, quality of care, current enrollment or membership,
2291 coverage areas, accreditation status, premium costs, plan costs,
2292 premium increases, range of benefits, copayments and
2293 deductibles, accuracy and speed of claims payment, credentials
2294 of physicians, number of providers, names of network providers,
2295 and hospitals in the network. Health plans shall make available
2296 to the agency any such data or information that is not currently

2297 reported to the agency or the office.
2298 3. Determine the method and format for public disclosure
2299 of data reported pursuant to this paragraph. The agency shall
2300 make its determination based upon input from the State Consumer
2301 Health Information and Policy Advisory Council. At a minimum,
2302 the data shall be made available on the agency's Internet
2303 website in a manner that allows consumers to conduct an
2304 interactive search that allows them to view and compare the
2305 information for specific providers. The website must include
2306 such additional information as is determined necessary to ensure
2307 that the website enhances informed decisionmaking among
2308 consumers and health care purchasers, which shall include, at a
2309 minimum, appropriate guidance on how to use the data and an
2310 explanation of why the data may vary from provider to provider.
2311 4. Publish on its website undiscounted charges for no
2312 fewer than 150 of the most commonly performed adult and
2313 pediatric procedures, including outpatient, inpatient,
2314 diagnostic, and preventative procedures.
2315 Section 60. Paragraph (a) of subsection (1) of section
2316 408.061, Florida Statutes, is amended to read:
2317 408.061 Data collection; uniform systems of financial
2318 reporting; information relating to physician charges;
2319 confidential information; immunity.—
2320 (1) The agency shall require the submission by health care
2321 facilities, health care providers, and health insurers of data
2322 necessary to carry out the agency's duties. Specifications for
2323 data to be collected under this section shall be developed by
2324 the agency with the assistance of technical advisory panels

2325 including representatives of affected entities, consumers,
2326 purchasers, and such other interested parties as may be
2327 determined by the agency.
2328 (a) Data submitted by health care facilities, including
2329 the facilities as defined in chapter 395, shall include, but are
2330 not limited to: case-mix data, patient admission and discharge
2331 data, hospital emergency department data which shall include the
2332 number of patients treated in the emergency department of a
2333 licensed hospital reported by patient acuity level, data on
2334 hospital-acquired infections as specified by rule, data on
2335 complications as specified by rule, data on readmissions as
2336 specified by rule, with patient and provider-specific
2337 identifiers included, actual charge data by diagnostic groups,
2338 financial data, accounting data, operating expenses, expenses
2339 incurred for rendering services to patients who cannot or do not
2340 pay, interest charges, depreciation expenses based on the
2341 expected useful life of the property and equipment involved, and
2342 demographic data. The agency shall adopt nationally recognized
2343 risk adjustment methodologies or software consistent with the
2344 standards of the Agency for Healthcare Research and Quality and
2345 as selected by the agency for all data submitted as required by
2346 this section. Data may be obtained from documents such as, but
2347 not limited to: leases, contracts, debt instruments, itemized
2348 patient bills, medical record abstracts, and related diagnostic
2349 information. Reported data elements shall be reported
2350 electronically and ~~in accordance with rule 59E-7.012, Florida~~
2351 ~~Administrative Code. Data submitted shall be~~ certified by the
2352 chief executive officer or an appropriate and duly authorized

2353 representative or employee of the licensed facility that the
2354 information submitted is true and accurate.
2355 Section 61. Subsection (43) of section 408.07, Florida
2356 Statutes, is amended to read:
2357 408.07 Definitions.—As used in this chapter, with the
2358 exception of ss. 408.031-408.045, the term:
2359 (43) "Rural hospital" means an acute care hospital
2360 licensed under chapter 395, having 100 or fewer licensed beds
2361 and an emergency room, and which is:
2362 (a) The sole provider within a county with a population
2363 density of no greater than 100 persons per square mile;
2364 (b) An acute care hospital, in a county with a population
2365 density of no greater than 100 persons per square mile, which is
2366 at least 30 minutes of travel time, on normally traveled roads
2367 under normal traffic conditions, from another acute care
2368 hospital within the same county;
2369 (c) A hospital supported by a tax district or subdistrict
2370 whose boundaries encompass a population of 100 persons or fewer
2371 per square mile;
2372 (d) A hospital with a service area that has a population
2373 of 100 persons or fewer per square mile. As used in this
2374 paragraph, the term "service area" means the fewest number of
2375 zip codes that account for 75 percent of the hospital's
2376 discharges for the most recent 5-year period, based on
2377 information available from the hospital inpatient discharge
2378 database in the Florida Center for Health Information and Policy
2379 Analysis at the Agency for Health Care Administration; or
2380 (e) A critical access hospital.

2381

2382 Population densities used in this subsection must be based upon
2383 the most recently completed United States census. A hospital
2384 that received funds under s. 409.9116 for a quarter beginning no
2385 later than July 1, 2002, is deemed to have been and shall
2386 continue to be a rural hospital from that date through June 30,
2387 2015, if the hospital continues to have 100 or fewer licensed
2388 beds and an emergency room~~, or meets the criteria of s.~~
2389 ~~395.602(2)(e)4~~. An acute care hospital that has not previously
2390 been designated as a rural hospital and that meets the criteria
2391 of this subsection shall be granted such designation upon
2392 application, including supporting documentation, to the Agency
2393 for Health Care Administration.

2394 Section 62. Section 408.10, Florida Statutes, is amended
2395 to read:

2396 408.10 Consumer complaints.—The agency shall~~:~~

2397 ~~(1)~~ publish and make available to the public a toll-free
2398 telephone number for the purpose of handling consumer complaints
2399 and shall serve as a liaison between consumer entities and other
2400 private entities and governmental entities for the disposition
2401 of problems identified by consumers of health care.

2402 ~~(2) Be empowered to investigate consumer complaints~~
2403 ~~relating to problems with health care facilities' billing~~
2404 ~~practices and issue reports to be made public in any cases where~~
2405 ~~the agency determines the health care facility has engaged in~~
2406 ~~billing practices which are unreasonable and unfair to the~~
2407 ~~consumer.~~

2408 Section 63. Subsections (12) through (30) of section

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

2409 408.802, Florida Statutes, are renumbered as subsections (11)
2410 through (29), respectively, and present subsection (11) of that
2411 section is amended to read:
2412 408.802 Applicability.—The provisions of this part apply
2413 to the provision of services that require licensure as defined
2414 in this part and to the following entities licensed, registered,
2415 or certified by the agency, as described in chapters 112, 383,
2416 390, 394, 395, 400, 429, 440, 483, and 765:
2417 ~~(11) Private review agents, as provided under part I of~~
2418 ~~chapter 395.~~
2419 Section 64. Subsection (3) is added to section 408.804,
2420 Florida Statutes, to read:
2421 408.804 License required; display.—
2422 (3) Any person who knowingly alters, defaces, or falsifies
2423 a license certificate issued by the agency, or causes or
2424 procures any person to commit such an offense, commits a
2425 misdemeanor of the second degree, punishable as provided in s.
2426 775.082 or s 775.083. Any licensee or provider who displays an
2427 altered, defaced, or falsified license certificate is subject to
2428 the penalties set forth in s. 408.815 and an administrative fine
2429 of $1,000 for each day of illegal display.
2430 Section 65. Paragraph (d) of subsection (2) of section
2431 408.806, Florida Statutes, is amended, and paragraph (e) is
2432 added to that subsection, to read:
2433 408.806 License application process.—
2434 (2)
2435 (d) ~~The agency shall notify the licensee by mail or~~
2436 ~~electronically at least 90 days before the expiration of a~~

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

2437 ~~license that a renewal license is necessary to continue~~
2438 ~~operation.~~ The licensee's failure to timely file ~~submit~~ a
2439 renewal application and license application fee with the agency
2440 shall result in a $50 per day late fee charged to the licensee
2441 by the agency; however, the aggregate amount of the late fee may
2442 not exceed 50 percent of the licensure fee or $500, whichever is
2443 less. The agency shall provide a courtesy notice to the licensee
2444 by United States mail, electronically, or by any other manner at
2445 its address of record or mailing address, if provided, at least
2446 90 days prior to the expiration of a license informing the
2447 licensee of the expiration of the license. If the licensee does
2448 not receive the courtesy notice, the licensee continues to be
2449 legally obligated to timely file the renewal application and
2450 license application fee with the agency and is not excused from
2451 the payment of a late fee. If an application is received after
2452 the required filing date and exhibits a hand-canceled postmark
2453 obtained from a United States post office dated on or before the
2454 required filing date, no fine will be levied.
2455 (e) The applicant must pay the late fee before a late
2456 application is considered complete and failure to pay the late
2457 fee is considered an omission from the application for licensure
2458 pursuant to paragraph (3)(b).
2459 Section 66. Paragraph (b) of subsection (1) of section
2460 408.8065, Florida Statutes, is amended to read:
2461 408.8065 Additional licensure requirements for home health
2462 agencies, home medical equipment providers, and health care
2463 clinics.—
2464 (1) An applicant for initial licensure, or initial

2465 licensure due to a change of ownership, as a home health agency,
2466 home medical equipment provider, or health care clinic shall:
2467 (b) Submit projected ~~pro forma~~ financial statements,
2468 including a balance sheet, income and expense statement, and a
2469 statement of cash flows for the first 2 years of operation which
2470 provide evidence that the applicant has sufficient assets,
2471 credit, and projected revenues to cover liabilities and
2472 expenses.
2473
2474 All documents required under this subsection must be prepared in
2475 accordance with generally accepted accounting principles and may
2476 be in a compilation form. The financial statements must be
2477 signed by a certified public accountant.
2478 Section 67. Subsections (5) through (8) of section
2479 408.809, Florida Statutes are renumbered as subsections (6)
2480 through (9), respectively, and subsection (4) of that section is
2481 amended to read:
2482 408.809 Background screening; prohibited offenses.—
2483 (4) In addition to the offenses listed in s. 435.04, all
2484 persons required to undergo background screening pursuant to
2485 this part or authorizing statutes must not have an arrest
2486 awaiting final disposition for, must not have been found guilty
2487 of, regardless of adjudication, or entered a plea of nolo
2488 contendere or guilty to, and must not have been adjudicated
2489 delinquent and the record not have been sealed or expunged for
2490 any of the following offenses or any similar offense of another
2491 jurisdiction:
2492 (a) Any authorizing statutes, if the offense was a felony.

2493 (b) This chapter, if the offense was a felony.
2494 (c) Section 409.920, relating to Medicaid provider fraud.
2495 (d) Section 409.9201, relating to Medicaid fraud.
2496 (e) Section 741.28, relating to domestic violence.
2497 (f) Section 817.034, relating to fraudulent acts through
2498 mail, wire, radio, electromagnetic, photoelectronic, or
2499 photooptical systems.
2500 (g) Section 817.234, relating to false and fraudulent
2501 insurance claims.
2502 (h) Section 817.505, relating to patient brokering.
2503 (i) Section 817.568, relating to criminal use of personal
2504 identification information.
2505 (j) Section 817.60, relating to obtaining a credit card
2506 through fraudulent means.
2507 (k) Section 817.61, relating to fraudulent use of credit
2508 cards, if the offense was a felony.
2509 (l) Section 831.01, relating to forgery.
2510 (m) Section 831.02, relating to uttering forged
2511 instruments.
2512 (n) Section 831.07, relating to forging bank bills,
2513 checks, drafts, or promissory notes.
2514 (o) Section 831.09, relating to uttering forged bank
2515 bills, checks, drafts, or promissory notes.
2516 (p) Section 831.30, relating to fraud in obtaining
2517 medicinal drugs.
2518 (q) Section 831.31, relating to the sale, manufacture,
2519 delivery, or possession with the intent to sell, manufacture, or
2520 deliver any counterfeit controlled substance, if the offense was

2521 a felony.
2522 (5) A person who serves as a controlling interest of, is
2523 employed by, or contracts with a licensee on July 31, 2010, who
2524 has been screened and qualified according to standards specified
2525 in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,
2526 in accordance with the schedule provided in paragraphs (a)-(c).
2527 The agency may adopt rules to establish a schedule to stagger
2528 the implementation of the required rescreening over the 5-year
2529 period, beginning July 31, 2010, through July 31, 2015. If, upon
2530 rescreening, such person has a disqualifying offense that was
2531 not a disqualifying offense at the time of the last screening,
2532 but is a current disqualifying offense and was committed before
2533 the last screening, he or she may apply for an exemption from
2534 the appropriate licensing agency and, if agreed to by the
2535 employer, may continue to perform his or her duties until the
2536 licensing agency renders a decision on the application for
2537 exemption if the person is eligible to apply for an exemption
2538 and the exemption request is received by the agency within 30
2539 days after receipt of the rescreening results by the person. The
2540 rescreening schedule shall be:
2541 (a) Individuals whose last screening was conducted before
2542 December 31, 2003, must be rescreened by July 31, 2013.
2543 (b) Individuals whose last screening was conducted between
2544 January 1, 2004, through December 31, 2007, must be rescreened
2545 by July 31, 2014.
2546 (c) Individuals whose last screening was conducted between
2547 January 1, 2008, through July 31, 2010, must be rescreened by
2548 July 31, 2015.

2549 Section 68. Subsection (9) of section 408.810, Florida
2550 Statutes, is amended to read:
2551 408.810 Minimum licensure requirements.—In addition to the
2552 licensure requirements specified in this part, authorizing
2553 statutes, and applicable rules, each applicant and licensee must
2554 comply with the requirements of this section in order to obtain
2555 and maintain a license.
2556 (9) A controlling interest may not withhold from the
2557 agency any evidence of financial instability, including, but not
2558 limited to, checks returned due to insufficient funds,
2559 delinquent accounts, nonpayment of withholding taxes, unpaid
2560 utility expenses, nonpayment for essential services, or adverse
2561 court action concerning the financial viability of the provider
2562 or any other provider licensed under this part that is under the
2563 control of the controlling interest. A controlling interest
2564 shall notify the agency within 10 days after a court action to
2565 initiate bankruptcy, foreclosure, or eviction proceedings
2566 concerning the provider in which the controlling interest is a
2567 petitioner or defendant. Any person who violates this subsection
2568 commits a misdemeanor of the second degree, punishable as
2569 provided in s. 775.082 or s. 775.083. Each day of continuing
2570 violation is a separate offense.
2571 Section 69. Subsection (3) is added to section 408.813,
2572 Florida Statutes, to read:
2573 408.813 Administrative fines; violations.—As a penalty for
2574 any violation of this part, authorizing statutes, or applicable
2575 rules, the agency may impose an administrative fine.
2576 (3) The agency may impose an administrative fine for a

2577 violation that is not designated as a class I, class II, class
2578 III, or class IV violation. Unless otherwise specified by law,
2579 the amount of the fine shall not exceed $500 for each violation.
2580 Unclassified violations may include:
2581 (a) Violating any term or condition of a license.
2582 (b) Violating any provision of this part, authorizing
2583 statutes, or applicable rules.
2584 (c) Exceeding licensed capacity.
2585 (d) Providing services beyond the scope of the license.
2586 (e) Violating a moratorium imposed pursuant to s. 408.814.
2587 Section 70. Subsection (4) of section 408.815, Florida
2588 Statutes, is amended, and subsections (5) and (6) are added to
2589 that section, to read:
2590 408.815 License or application denial; revocation.—
2591 (4) Unless an applicant is determined by the agency to
2592 satisfy the provisions of subsection (5) for the action in
2593 question, the agency shall deny an application for a license or
2594 license renewal based upon any of the following actions of an
2595 applicant, a controlling interest of the applicant, or any
2596 entity in which a controlling interest of the applicant was an
2597 owner or officer when the following actions occurred ~~In addition~~
2598 ~~to the grounds provided in authorizing statutes, the agency~~
2599 ~~shall deny an application for a license or license renewal if~~
2600 ~~the applicant or a person having a controlling interest in an~~
2601 ~~applicant has been~~:
2602 (a) Conviction ~~Convicted~~ of~~,~~ or ~~enters~~ a plea of guilty or
2603 nolo contendere to, regardless of adjudication, a felony under
2604 chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or

2605 42 U.S.C. ss. 1395-1396, Medicare fraud, Medicaid fraud, or
2606 insurance fraud, unless the sentence and any subsequent period
2607 of probation for such convictions or plea ended more than 15
2608 years prior to the date of the application;
2609 (b) Termination ~~Terminated~~ for cause from the Medicare
2610 program or a state ~~Florida~~ Medicaid program ~~pursuant to s.~~
2611 ~~409.913~~, unless the applicant has been in good standing with the
2612 Medicare program or a state ~~Florida~~ Medicaid program for the
2613 most recent 5 years and the termination occurred at least 20
2614 years before the date of the application.~~; or~~
2615 ~~(c) Terminated for cause, pursuant to the appeals~~
2616 ~~procedures established by the state or Federal Government, from~~
2617 ~~the federal Medicare program or from any other state Medicaid~~
2618 ~~program, unless the applicant has been in good standing with a~~
2619 ~~state Medicaid program or the federal Medicare program for the~~
2620 ~~most recent 5 years and the termination occurred at least 20~~
2621 ~~years prior to the date of the application.~~
2622 (5) For any application subject to denial under subsection
2623 (4), the agency may consider mitigating circumstances, as
2624 applicable, including, but not limited to:
2625 (a) Completion or lawful release from confinement,
2626 supervision, or sanction, including any terms of probation, and
2627 full restitution;
2628 (b) Execution of a compliance plan with the agency;
2629 (c) Compliance with any integrity agreement or compliance
2630 plan with any other government agency;
2631 (d) Determination by the Medicare program or a state
2632 Medicaid program that the controlling interest or entity in

2633 which the controlling interest was an owner or officer is
2634 currently allowed to participate in the Medicare program or a
2635 state Medicaid program, either directly as a provider or
2636 indirectly as an owner or officer of a provider entity;
2637 (e) Continuation of licensure by the controlling interest
2638 or entity in which the controlling interest was an owner or
2639 officer, either directly as a licensee or indirectly as an owner
2640 or officer of a licensed entity in the state where the action
2641 occurred;
2642 (f) Overall impact upon the public health, safety, or
2643 welfare; or
2644 (g) Determination that license denial is not commensurate
2645 with the prior action taken by the Medicare program or a state
2646 Medicaid program.
2647
2648 After considering the circumstances set forth in this
2649 subsection, the agency shall grant the license, with or without
2650 conditions, grant a provisional license for a period of no more
2651 than the licensure cycle, with or without conditions, or deny
2652 the license.
2653 (6) In order to ensure the health, safety, and welfare of
2654 clients when a license has been denied, revoked, or is set to
2655 terminate, the agency may extend the license expiration date for
2656 a period of up to 30 days for the sole purpose of allowing the
2657 safe and orderly discharge of clients. The agency may impose
2658 conditions on the extension, including, but not limited to,
2659 prohibiting or limiting admissions, expedited discharge
2660 planning, required status reports, and mandatory monitoring by

2661 <u>the agency or third parties. When imposing these conditions, the</u>
2662 <u>agency shall take into consideration the nature and number of</u>
2663 <u>clients, the availability and location of acceptable alternative</u>
2664 <u>placements, and the ability of the licensee to continue</u>
2665 <u>providing care to the clients. The agency may terminate the</u>
2666 <u>extension or modify the conditions at any time. This authority</u>
2667 <u>is in addition to any other authority granted to the agency</u>
2668 <u>under chapter 120, this part, and authorizing statutes but</u>
2669 <u>creates no right or entitlement to an extension of a license</u>
2670 <u>expiration date.</u>
2671 Section 71. Paragraph (c) of subsection (4) of section
2672 409.212, Florida Statutes, is amended to read:
2673 409.212 Optional supplementation.—
2674 (4) In addition to the amount of optional supplementation
2675 provided by the state, a person may receive additional
2676 supplementation from third parties to contribute to his or her
2677 cost of care. Additional supplementation may be provided under
2678 the following conditions:
2679 (c) The additional supplementation shall not exceed <u>three</u>
2680 ~~two~~ times the provider rate recognized under the optional state
2681 supplementation program.
2682 Section 72. Subsection (1) of section 409.91196, Florida
2683 Statutes, is amended to read:
2684 409.91196 Supplemental rebate agreements; public records
2685 and public meetings exemption.—
2686 (1) The rebate amount, percent of rebate, manufacturer's
2687 pricing, and supplemental rebate, and other trade secrets as
2688 defined in s. 688.002 that the agency has identified for use in

2689 negotiations, held by the Agency for Health Care Administration
2690 under s. 409.912(39)(a)8. ~~7.~~ are confidential and exempt from s.
2691 119.07(1) and s. 24(a), Art. I of the State Constitution.
2692 Section 73. Paragraph (a) of subsection (39) of section
2693 409.912, Florida Statutes, is amended to read:
2694 409.912 Cost-effective purchasing of health care.—The
2695 agency shall purchase goods and services for Medicaid recipients
2696 in the most cost-effective manner consistent with the delivery
2697 of quality medical care. To ensure that medical services are
2698 effectively utilized, the agency may, in any case, require a
2699 confirmation or second physician's opinion of the correct
2700 diagnosis for purposes of authorizing future services under the
2701 Medicaid program. This section does not restrict access to
2702 emergency services or poststabilization care services as defined
2703 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2704 shall be rendered in a manner approved by the agency. The agency
2705 shall maximize the use of prepaid per capita and prepaid
2706 aggregate fixed-sum basis services when appropriate and other
2707 alternative service delivery and reimbursement methodologies,
2708 including competitive bidding pursuant to s. 287.057, designed
2709 to facilitate the cost-effective purchase of a case-managed
2710 continuum of care. The agency shall also require providers to
2711 minimize the exposure of recipients to the need for acute
2712 inpatient, custodial, and other institutional care and the
2713 inappropriate or unnecessary use of high-cost services. The
2714 agency shall contract with a vendor to monitor and evaluate the
2715 clinical practice patterns of providers in order to identify
2716 trends that are outside the normal practice patterns of a

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

2717 provider's professional peers or the national guidelines of a
2718 provider's professional association. The vendor must be able to
2719 provide information and counseling to a provider whose practice
2720 patterns are outside the norms, in consultation with the agency,
2721 to improve patient care and reduce inappropriate utilization.
2722 The agency may mandate prior authorization, drug therapy
2723 management, or disease management participation for certain
2724 populations of Medicaid beneficiaries, certain drug classes, or
2725 particular drugs to prevent fraud, abuse, overuse, and possible
2726 dangerous drug interactions. The Pharmaceutical and Therapeutics
2727 Committee shall make recommendations to the agency on drugs for
2728 which prior authorization is required. The agency shall inform
2729 the Pharmaceutical and Therapeutics Committee of its decisions
2730 regarding drugs subject to prior authorization. The agency is
2731 authorized to limit the entities it contracts with or enrolls as
2732 Medicaid providers by developing a provider network through
2733 provider credentialing. The agency may competitively bid single-
2734 source-provider contracts if procurement of goods or services
2735 results in demonstrated cost savings to the state without
2736 limiting access to care. The agency may limit its network based
2737 on the assessment of beneficiary access to care, provider
2738 availability, provider quality standards, time and distance
2739 standards for access to care, the cultural competence of the
2740 provider network, demographic characteristics of Medicaid
2741 beneficiaries, practice and provider-to-beneficiary standards,
2742 appointment wait times, beneficiary use of services, provider
2743 turnover, provider profiling, provider licensure history,
2744 previous program integrity investigations and findings, peer

2745 review, provider Medicaid policy and billing compliance records,
2746 clinical and medical record audits, and other factors. Providers
2747 shall not be entitled to enrollment in the Medicaid provider
2748 network. The agency shall determine instances in which allowing
2749 Medicaid beneficiaries to purchase durable medical equipment and
2750 other goods is less expensive to the Medicaid program than long-
2751 term rental of the equipment or goods. The agency may establish
2752 rules to facilitate purchases in lieu of long-term rentals in
2753 order to protect against fraud and abuse in the Medicaid program
2754 as defined in s. 409.913. The agency may seek federal waivers
2755 necessary to administer these policies.
2756 (39)(a) The agency shall implement a Medicaid prescribed-
2757 drug spending-control program that includes the following
2758 components:
2759 1. A Medicaid preferred drug list, which shall be a
2760 listing of cost-effective therapeutic options recommended by the
2761 Medicaid Pharmacy and Therapeutics Committee established
2762 pursuant to s. 409.91195 and adopted by the agency for each
2763 therapeutic class on the preferred drug list. At the discretion
2764 of the committee, and when feasible, the preferred drug list
2765 should include at least two products in a therapeutic class. The
2766 agency may post the preferred drug list and updates to the
2767 preferred drug list on an Internet website without following the
2768 rulemaking procedures of chapter 120. Antiretroviral agents are
2769 excluded from the preferred drug list. The agency shall also
2770 limit the amount of a prescribed drug dispensed to no more than
2771 a 34-day supply unless the drug products' smallest marketed
2772 package is greater than a 34-day supply, or the drug is

2773 determined by the agency to be a maintenance drug in which case
2774 a 100-day maximum supply may be authorized. The agency is
2775 authorized to seek any federal waivers necessary to implement
2776 these cost-control programs and to continue participation in the
2777 federal Medicaid rebate program, or alternatively to negotiate
2778 state-only manufacturer rebates. The agency may adopt rules to
2779 implement this subparagraph. The agency shall continue to
2780 provide unlimited contraceptive drugs and items. The agency must
2781 establish procedures to ensure that:
2782 a. There is a response to a request for prior consultation
2783 by telephone or other telecommunication device within 24 hours
2784 after receipt of a request for prior consultation; and
2785 b. A 72-hour supply of the drug prescribed is provided in
2786 an emergency or when the agency does not provide a response
2787 within 24 hours as required by sub-subparagraph a.
2788 2. Reimbursement to pharmacies for Medicaid prescribed
2789 drugs shall be set at the lesser of: the average wholesale price
2790 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
2791 plus 4.75 percent, the federal upper limit (FUL), the state
2792 maximum allowable cost (SMAC), or the usual and customary (UAC)
2793 charge billed by the provider.
2794 3. For a prescribed drug billed as a 340B prescribed
2795 medication rendered to all Medicaid-eligible individuals,
2796 including claims for cost sharing for which the agency is
2797 responsible, the claim must meet the requirements of the Deficit
2798 Reduction Act of 2005 and the federal 340B program and contain a
2799 national drug code.
2800 4.~~3.~~ The agency shall develop and implement a process for

2801 managing the drug therapies of Medicaid recipients who are using
2802 significant numbers of prescribed drugs each month. The
2803 management process may include, but is not limited to,
2804 comprehensive, physician-directed medical-record reviews, claims
2805 analyses, and case evaluations to determine the medical
2806 necessity and appropriateness of a patient's treatment plan and
2807 drug therapies. The agency may contract with a private
2808 organization to provide drug-program-management services. The
2809 Medicaid drug benefit management program shall include
2810 initiatives to manage drug therapies for HIV/AIDS patients,
2811 patients using 20 or more unique prescriptions in a 180-day
2812 period, and the top 1,000 patients in annual spending. The
2813 agency shall enroll any Medicaid recipient in the drug benefit
2814 management program if he or she meets the specifications of this
2815 provision and is not enrolled in a Medicaid health maintenance
2816 organization.

2817 5.~~4.~~ The agency may limit the size of its pharmacy network
2818 based on need, competitive bidding, price negotiations,
2819 credentialing, or similar criteria. The agency shall give
2820 special consideration to rural areas in determining the size and
2821 location of pharmacies included in the Medicaid pharmacy
2822 network. A pharmacy credentialing process may include criteria
2823 such as a pharmacy's full-service status, location, size,
2824 patient educational programs, patient consultation, disease
2825 management services, and other characteristics. The agency may
2826 impose a moratorium on Medicaid pharmacy enrollment when it is
2827 determined that it has a sufficient number of Medicaid-
2828 participating providers. The agency must allow dispensing

2829 practitioners to participate as a part of the Medicaid pharmacy
2830 network regardless of the practitioner's proximity to any other
2831 entity that is dispensing prescription drugs under the Medicaid
2832 program. A dispensing practitioner must meet all credentialing
2833 requirements applicable to his or her practice, as determined by
2834 the agency.
2835 6.~~5.~~ The agency shall develop and implement a program that
2836 requires Medicaid practitioners who prescribe drugs to use a
2837 counterfeit-proof prescription pad for Medicaid prescriptions.
2838 The agency shall require the use of standardized counterfeit-
2839 proof prescription pads by Medicaid-participating prescribers or
2840 prescribers who write prescriptions for Medicaid recipients. The
2841 agency may implement the program in targeted geographic areas or
2842 statewide.
2843 7.~~6.~~ The agency may enter into arrangements that require
2844 manufacturers of generic drugs prescribed to Medicaid recipients
2845 to provide rebates of at least 15.1 percent of the average
2846 manufacturer price for the manufacturer's generic products.
2847 These arrangements shall require that if a generic-drug
2848 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2849 at a level below 15.1 percent, the manufacturer must provide a
2850 supplemental rebate to the state in an amount necessary to
2851 achieve a 15.1-percent rebate level.
2852 8.~~7.~~ The agency may establish a preferred drug list as
2853 described in this subsection, and, pursuant to the establishment
2854 of such preferred drug list, it is authorized to negotiate
2855 supplemental rebates from manufacturers that are in addition to
2856 those required by Title XIX of the Social Security Act and at no

2857 less than 14 percent of the average manufacturer price as
2858 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
2859 the federal or supplemental rebate, or both, equals or exceeds
2860 29 percent. There is no upper limit on the supplemental rebates
2861 the agency may negotiate. The agency may determine that specific
2862 products, brand-name or generic, are competitive at lower rebate
2863 percentages. Agreement to pay the minimum supplemental rebate
2864 percentage will guarantee a manufacturer that the Medicaid
2865 Pharmaceutical and Therapeutics Committee will consider a
2866 product for inclusion on the preferred drug list. However, a
2867 pharmaceutical manufacturer is not guaranteed placement on the
2868 preferred drug list by simply paying the minimum supplemental
2869 rebate. Agency decisions will be made on the clinical efficacy
2870 of a drug and recommendations of the Medicaid Pharmaceutical and
2871 Therapeutics Committee, as well as the price of competing
2872 products minus federal and state rebates. The agency is
2873 authorized to contract with an outside agency or contractor to
2874 conduct negotiations for supplemental rebates. For the purposes
2875 of this section, the term "supplemental rebates" means cash
2876 rebates. Effective July 1, 2004, value-added programs as a
2877 substitution for supplemental rebates are prohibited. The agency
2878 is authorized to seek any federal waivers to implement this
2879 initiative.

2880 9.~~8.~~ The Agency for Health Care Administration shall
2881 expand home delivery of pharmacy products. To assist Medicaid
2882 patients in securing their prescriptions and reduce program
2883 costs, the agency shall expand its current mail-order-pharmacy
2884 diabetes-supply program to include all generic and brand-name

2885 drugs used by Medicaid patients with diabetes. Medicaid
2886 recipients in the current program may obtain nondiabetes drugs
2887 on a voluntary basis. This initiative is limited to the
2888 geographic area covered by the current contract. The agency may
2889 seek and implement any federal waivers necessary to implement
2890 this subparagraph.
2891 10.~~9.~~ The agency shall limit to one dose per month any
2892 drug prescribed to treat erectile dysfunction.
2893 11.~~10.~~a. The agency may implement a Medicaid behavioral
2894 drug management system. The agency may contract with a vendor
2895 that has experience in operating behavioral drug management
2896 systems to implement this program. The agency is authorized to
2897 seek federal waivers to implement this program.
2898 b. The agency, in conjunction with the Department of
2899 Children and Family Services, may implement the Medicaid
2900 behavioral drug management system that is designed to improve
2901 the quality of care and behavioral health prescribing practices
2902 based on best practice guidelines, improve patient adherence to
2903 medication plans, reduce clinical risk, and lower prescribed
2904 drug costs and the rate of inappropriate spending on Medicaid
2905 behavioral drugs. The program may include the following
2906 elements:
2907 (I) Provide for the development and adoption of best
2908 practice guidelines for behavioral health-related drugs such as
2909 antipsychotics, antidepressants, and medications for treating
2910 bipolar disorders and other behavioral conditions; translate
2911 them into practice; review behavioral health prescribers and
2912 compare their prescribing patterns to a number of indicators

2913 that are based on national standards; and determine deviations
2914 from best practice guidelines.
2915 (II) Implement processes for providing feedback to and
2916 educating prescribers using best practice educational materials
2917 and peer-to-peer consultation.
2918 (III) Assess Medicaid beneficiaries who are outliers in
2919 their use of behavioral health drugs with regard to the numbers
2920 and types of drugs taken, drug dosages, combination drug
2921 therapies, and other indicators of improper use of behavioral
2922 health drugs.
2923 (IV) Alert prescribers to patients who fail to refill
2924 prescriptions in a timely fashion, are prescribed multiple same-
2925 class behavioral health drugs, and may have other potential
2926 medication problems.
2927 (V) Track spending trends for behavioral health drugs and
2928 deviation from best practice guidelines.
2929 (VI) Use educational and technological approaches to
2930 promote best practices, educate consumers, and train prescribers
2931 in the use of practice guidelines.
2932 (VII) Disseminate electronic and published materials.
2933 (VIII) Hold statewide and regional conferences.
2934 (IX) Implement a disease management program with a model
2935 quality-based medication component for severely mentally ill
2936 individuals and emotionally disturbed children who are high
2937 users of care.
2938 12.~~11.~~a. The agency shall implement a Medicaid
2939 prescription drug management system. The agency may contract
2940 with a vendor that has experience in operating prescription drug

2941 management systems in order to implement this system. Any
2942 management system that is implemented in accordance with this
2943 subparagraph must rely on cooperation between physicians and
2944 pharmacists to determine appropriate practice patterns and
2945 clinical guidelines to improve the prescribing, dispensing, and
2946 use of drugs in the Medicaid program. The agency may seek
2947 federal waivers to implement this program.
2948 b. The drug management system must be designed to improve
2949 the quality of care and prescribing practices based on best
2950 practice guidelines, improve patient adherence to medication
2951 plans, reduce clinical risk, and lower prescribed drug costs and
2952 the rate of inappropriate spending on Medicaid prescription
2953 drugs. The program must:
2954 (I) Provide for the development and adoption of best
2955 practice guidelines for the prescribing and use of drugs in the
2956 Medicaid program, including translating best practice guidelines
2957 into practice; reviewing prescriber patterns and comparing them
2958 to indicators that are based on national standards and practice
2959 patterns of clinical peers in their community, statewide, and
2960 nationally; and determine deviations from best practice
2961 guidelines.
2962 (II) Implement processes for providing feedback to and
2963 educating prescribers using best practice educational materials
2964 and peer-to-peer consultation.
2965 (III) Assess Medicaid recipients who are outliers in their
2966 use of a single or multiple prescription drugs with regard to
2967 the numbers and types of drugs taken, drug dosages, combination
2968 drug therapies, and other indicators of improper use of

2969 prescription drugs.
2970 (IV) Alert prescribers to patients who fail to refill
2971 prescriptions in a timely fashion, are prescribed multiple drugs
2972 that may be redundant or contraindicated, or may have other
2973 potential medication problems.
2974 (V) Track spending trends for prescription drugs and
2975 deviation from best practice guidelines.
2976 (VI) Use educational and technological approaches to
2977 promote best practices, educate consumers, and train prescribers
2978 in the use of practice guidelines.
2979 (VII) Disseminate electronic and published materials.
2980 (VIII) Hold statewide and regional conferences.
2981 (IX) Implement disease management programs in cooperation
2982 with physicians and pharmacists, along with a model quality-
2983 based medication component for individuals having chronic
2984 medical conditions.
2985 13.~~12.~~ The agency is authorized to contract for drug
2986 rebate administration, including, but not limited to,
2987 calculating rebate amounts, invoicing manufacturers, negotiating
2988 disputes with manufacturers, and maintaining a database of
2989 rebate collections.
2990 14.~~13.~~ The agency may specify the preferred daily dosing
2991 form or strength for the purpose of promoting best practices
2992 with regard to the prescribing of certain drugs as specified in
2993 the General Appropriations Act and ensuring cost-effective
2994 prescribing practices.
2995 15.~~14.~~ The agency may require prior authorization for
2996 Medicaid-covered prescribed drugs. The agency may, but is not

2997 required to, prior-authorize the use of a product:
2998 a. For an indication not approved in labeling;
2999 b. To comply with certain clinical guidelines; or
3000 c. If the product has the potential for overuse, misuse,
3001 or abuse.
3002
3003 The agency may require the prescribing professional to provide
3004 information about the rationale and supporting medical evidence
3005 for the use of a drug. The agency shall accept electronic prior
3006 authorization requests from prescribers or pharmacists for any
3007 drug requiring prior authorization and ~~may~~ post prior
3008 authorization criteria and protocol and updates to the list of
3009 drugs that are subject to prior authorization on an Internet
3010 website without amending its rule or engaging in additional
3011 rulemaking.
3012 16.~~15.~~ The agency, in conjunction with the Pharmaceutical
3013 and Therapeutics Committee, may require age-related prior
3014 authorizations for certain prescribed drugs. The agency may
3015 preauthorize the use of a drug for a recipient who may not meet
3016 the age requirement or may exceed the length of therapy for use
3017 of this product as recommended by the manufacturer and approved
3018 by the Food and Drug Administration. Prior authorization may
3019 require the prescribing professional to provide information
3020 about the rationale and supporting medical evidence for the use
3021 of a drug.
3022 17.~~16.~~ The agency shall implement a step-therapy prior
3023 authorization approval process for medications excluded from the
3024 preferred drug list. Medications listed on the preferred drug

3025 list must be used within the previous 12 months prior to the
3026 alternative medications that are not listed. The step-therapy
3027 prior authorization may require the prescriber to use the
3028 medications of a similar drug class or for a similar medical
3029 indication unless contraindicated in the Food and Drug
3030 Administration labeling. The trial period between the specified
3031 steps may vary according to the medical indication. The step-
3032 therapy approval process shall be developed in accordance with
3033 the committee as stated in s. 409.91195(7) and (8). A drug
3034 product may be approved without meeting the step-therapy prior
3035 authorization criteria if the prescribing physician provides the
3036 agency with additional written medical or clinical documentation
3037 that the product is medically necessary because:
3038 a. There is not a drug on the preferred drug list to treat
3039 the disease or medical condition which is an acceptable clinical
3040 alternative;
3041 b. The alternatives have been ineffective in the treatment
3042 of the beneficiary's disease; or
3043 c. Based on historic evidence and known characteristics of
3044 the patient and the drug, the drug is likely to be ineffective,
3045 or the number of doses have been ineffective.
3046
3047 The agency shall work with the physician to determine the best
3048 alternative for the patient. The agency may adopt rules waiving
3049 the requirements for written clinical documentation for specific
3050 drugs in limited clinical situations.
3051 18.~~17.~~ The agency shall implement a return and reuse
3052 program for drugs dispensed by pharmacies to institutional

3053 recipients, which includes payment of a $5 restocking fee for
3054 the implementation and operation of the program. The return and
3055 reuse program shall be implemented electronically and in a
3056 manner that promotes efficiency. The program must permit a
3057 pharmacy to exclude drugs from the program if it is not
3058 practical or cost-effective for the drug to be included and must
3059 provide for the return to inventory of drugs that cannot be
3060 credited or returned in a cost-effective manner. The agency
3061 shall determine if the program has reduced the amount of
3062 Medicaid prescription drugs which are destroyed on an annual
3063 basis and if there are additional ways to ensure more
3064 prescription drugs are not destroyed which could safely be
3065 reused. The agency's conclusion and recommendations shall be
3066 reported to the Legislature by December 1, 2005.
3067 Section 74. Subsection (3) and paragraph (c) of subsection
3068 (4) of section 429.07, Florida Statutes, are amended, and
3069 subsections (6) and (7) are added to that section, to read:
3070 429.07 License required; fee; inspections.—
3071 (3) In addition to the requirements of s. 408.806, each
3072 license granted by the agency must state the type of care for
3073 which the license is granted. Licenses shall be issued for one
3074 or more of the following categories of care: standard, extended
3075 congregate care, ~~limited nursing services,~~ or limited mental
3076 health.
3077 (a) A standard license shall be issued to a facility
3078 ~~facilities~~ providing one or more of the personal services
3079 identified in s. 429.02. Such licensee ~~facilities~~ may also
3080 employ or contract with a person ~~licensed under part I of~~

3081 ~~chapter 464~~ to ~~administer medications and~~ perform other tasks as
3082 specified in s. 429.255.
3083 (b) An extended congregate care license shall be issued to
3084 a licensee ~~facilities~~ providing, directly or through contract,
3085 services beyond those authorized in paragraph (a), including
3086 services performed by persons licensed under part I of chapter
3087 464 and supportive services, as defined by rule, to persons who
3088 would otherwise be disqualified from continued residence in a
3089 facility licensed under this part.
3090 1. In order for extended congregate care services to be
3091 provided, the agency must first determine that all requirements
3092 established in law and rule are met and must specifically
3093 designate, on the ~~facility's~~ license, that such services may be
3094 provided and whether the designation applies to all or part of
3095 the facility. Such designation may be made at the time of
3096 initial licensure or relicensure, or upon request in writing by
3097 a licensee under this part and part II of chapter 408. The
3098 notification of approval or the denial of the request shall be
3099 made in accordance with part II of chapter 408. An existing
3100 licensee ~~facilities~~ qualifying to provide extended congregate
3101 care services must have maintained a standard license and ~~may~~
3102 not ~~have~~ been subject to administrative sanctions during the
3103 previous 2 years, or since initial licensure if ~~the facility has~~
3104 ~~been~~ licensed for less than 2 years, for any of the following
3105 reasons:
3106 a. A class I or class II violation;
3107 b. Three or more repeat or recurring class III violations
3108 of identical or similar resident care standards from which a

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

3109 pattern of noncompliance is found by the agency;
3110 c. Three or more class III violations that were not
3111 corrected in accordance with the corrective action plan approved
3112 by the agency;
3113 d. Violation of resident care standards which results in
3114 requiring the facility to employ the services of a consultant
3115 pharmacist or consultant dietitian;
3116 e. Denial, suspension, or revocation of a license for
3117 another facility licensed under this part in which the applicant
3118 for an extended congregate care license has at least 25 percent
3119 ownership interest; or
3120 f. Imposition of a moratorium pursuant to this part or
3121 part II of chapter 408 or initiation of injunctive proceedings.
3122 2. A facility that is licensed to provide extended
3123 congregate care services shall maintain a written progress
3124 report for ~~on~~ each person who receives services which describes
3125 the type, amount, duration, scope, and outcome of services that
3126 are rendered and the general status of the resident's health. ~~A~~
3127 ~~registered nurse, or appropriate designee, representing the~~
3128 ~~agency shall visit the facility at least quarterly to monitor~~
3129 ~~residents who are receiving extended congregate care services~~
3130 ~~and to determine if the facility is in compliance with this~~
3131 ~~part, part II of chapter 408, and relevant rules. One of the~~
3132 ~~visits may be in conjunction with the regular survey. The~~
3133 ~~monitoring visits may be provided through contractual~~
3134 ~~arrangements with appropriate community agencies. A registered~~
3135 ~~nurse shall serve as part of the team that inspects the~~
3136 ~~facility. The agency may waive one of the required yearly~~

3137 ~~monitoring visits for a facility that has been licensed for at~~
3138 ~~least 24 months to provide extended congregate care services,~~
3139 ~~if, during the inspection, the registered nurse determines that~~
3140 ~~extended congregate care services are being provided~~
3141 ~~appropriately, and if the facility has no class I or class II~~
3142 ~~violations and no uncorrected class III violations. The agency~~
3143 ~~must first consult with the long-term care ombudsman council for~~
3144 ~~the area in which the facility is located to determine if any~~
3145 ~~complaints have been made and substantiated about the quality of~~
3146 ~~services or care. The agency may not waive one of the required~~
3147 ~~yearly monitoring visits if complaints have been made and~~
3148 ~~substantiated.~~
3149 3. A facility that is licensed to provide extended
3150 congregate care services must:
3151 a. Demonstrate the capability to meet unanticipated
3152 resident service needs.
3153 b. Offer a physical environment that promotes a homelike
3154 setting, provides for resident privacy, promotes resident
3155 independence, and allows sufficient congregate space as defined
3156 by rule.
3157 c. Have sufficient staff available, taking into account
3158 the physical plant and firesafety features of the building, to
3159 assist with the evacuation of residents in an emergency.
3160 d. Adopt and follow policies and procedures that maximize
3161 resident independence, dignity, choice, and decisionmaking to
3162 permit residents to age in place, so that moves due to changes
3163 in functional status are minimized or avoided.
3164 e. Allow residents or, if applicable, a resident's

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

3165 representative, designee, surrogate, guardian, or attorney in
3166 fact to make a variety of personal choices, participate in
3167 developing service plans, and share responsibility in
3168 decisionmaking.
3169 f. Implement the concept of managed risk.
3170 g. Provide, directly or through contract, the services of
3171 a person licensed under part I of chapter 464.
3172 h. In addition to the training mandated in s. 429.52,
3173 provide specialized training as defined by rule for facility
3174 staff.
3175 4. A facility that is licensed to provide extended
3176 congregate care services is exempt from the criteria for
3177 continued residency set forth in rules adopted under s. 429.41.
3178 A licensed facility must adopt its own requirements within
3179 guidelines for continued residency set forth by rule. However,
3180 the facility may not serve residents who require 24-hour nursing
3181 supervision. A licensed facility that provides extended
3182 congregate care services must also provide each resident with a
3183 written copy of facility policies governing admission and
3184 retention.
3185 5. The primary purpose of extended congregate care
3186 services is to allow residents, as they become more impaired,
3187 the option of remaining in a familiar setting from which they
3188 would otherwise be disqualified for continued residency. A
3189 facility licensed to provide extended congregate care services
3190 may also admit an individual who exceeds the admission criteria
3191 for a facility with a standard license, if the individual is
3192 determined appropriate for admission to the extended congregate

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

3193 care facility.
3194 6. Before the admission of an individual to a facility
3195 licensed to provide extended congregate care services, the
3196 individual must undergo a medical examination as provided in s.
3197 429.26(4) and the facility must develop a preliminary service
3198 plan for the individual.
3199 7. When a licensee ~~facility~~ can no longer provide or
3200 arrange for services in accordance with the resident's service
3201 plan and needs and the licensee's ~~facility's~~ policy, the
3202 licensee ~~facility~~ shall make arrangements for relocating the
3203 person in accordance with s. 429.28(1)(k).
3204 8. Failure to provide extended congregate care services
3205 may result in denial of extended congregate care license
3206 renewal.
3207 ~~(c) A limited nursing services license shall be issued to~~
3208 ~~a facility that provides services beyond those authorized in~~
3209 ~~paragraph (a) and as specified in this paragraph.~~
3210 ~~1. In order for limited nursing services to be provided in~~
3211 ~~a facility licensed under this part, the agency must first~~
3212 ~~determine that all requirements established in law and rule are~~
3213 ~~met and must specifically designate, on the facility's license,~~
3214 ~~that such services may be provided. Such designation may be made~~
3215 ~~at the time of initial licensure or relicensure, or upon request~~
3216 ~~in writing by a licensee under this part and part II of chapter~~
3217 ~~408. Notification of approval or denial of such request shall be~~
3218 ~~made in accordance with part II of chapter 408. Existing~~
3219 ~~facilities qualifying to provide limited nursing services shall~~
3220 ~~have maintained a standard license and may not have been subject~~

3221 ~~to administrative sanctions that affect the health, safety, and~~
3222 ~~welfare of residents for the previous 2 years or since initial~~
3223 ~~licensure if the facility has been licensed for less than 2~~
3224 ~~years.~~
3225 ~~2. Facilities that are licensed to provide limited nursing~~
3226 ~~services shall maintain a written progress report on each person~~
3227 ~~who receives such nursing services, which report describes the~~
3228 ~~type, amount, duration, scope, and outcome of services that are~~
3229 ~~rendered and the general status of the resident's health. A~~
3230 ~~registered nurse representing the agency shall visit such~~
3231 ~~facilities at least twice a year to monitor residents who are~~
3232 ~~receiving limited nursing services and to determine if the~~
3233 ~~facility is in compliance with applicable provisions of this~~
3234 ~~part, part II of chapter 408, and related rules. The monitoring~~
3235 ~~visits may be provided through contractual arrangements with~~
3236 ~~appropriate community agencies. A registered nurse shall also~~
3237 ~~serve as part of the team that inspects such facility.~~
3238 ~~3. A person who receives limited nursing services under~~
3239 ~~this part must meet the admission criteria established by the~~
3240 ~~agency for assisted living facilities. When a resident no longer~~
3241 ~~meets the admission criteria for a facility licensed under this~~
3242 ~~part, arrangements for relocating the person shall be made in~~
3243 ~~accordance with s. 429.28(1)(k), unless the facility is licensed~~
3244 ~~to provide extended congregate care services.~~
3245 (4) In accordance with s. 408.805, an applicant or
3246 licensee shall pay a fee for each license application submitted
3247 under this part, part II of chapter 408, and applicable rules.
3248 The amount of the fee shall be established by rule.

3249 ~~(c) In addition to the total fee assessed under paragraph~~
3250 ~~(a), the agency shall require facilities that are licensed to~~
3251 ~~provide limited nursing services under this part to pay an~~
3252 ~~additional fee per licensed facility. The amount of the biennial~~
3253 ~~fee shall be $250 per license, with an additional fee of $10 per~~
3254 ~~resident based on the total licensed resident capacity of the~~
3255 ~~facility.~~
3256 (6) In order to determine whether the facility is
3257 adequately protecting residents' rights as provided in s.
3258 429.28, the agency's standard licensure survey shall include
3259 private informal conversations with a sample of residents and
3260 consultation with the ombudsman council in the planning and
3261 service area in which the facility is located to discuss
3262 residents' experiences within the facility.
3263 (7) An assisted living facility that has been cited within
3264 the previous 24-month period for a class I or class II
3265 violation, regardless of the status of any enforcement or
3266 disciplinary action, is subject to periodic unannounced
3267 monitoring to determine if the facility is in compliance with
3268 this part, part II of chapter 408, and applicable rules.
3269 Monitoring may occur through a desk review or an onsite
3270 assessment. If the class I or class II violation relates to
3271 providing or failing to provide nursing care, a registered nurse
3272 must participate in monitoring activities during the 12-month
3273 period following the violation.
3274 Section 75. Subsection (7) of section 429.11, Florida
3275 Statutes, is renumbered as subsection (6), and present
3276 subsection (6) of that section is amended to read:

3277 429.11 Initial application for license~~; provisional~~
3278 ~~license~~.—
3279 ~~(6) In addition to the license categories available in s.~~
3280 ~~408.808, a provisional license may be issued to an applicant~~
3281 ~~making initial application for licensure or making application~~
3282 ~~for a change of ownership. A provisional license shall be~~
3283 ~~limited in duration to a specific period of time not to exceed 6~~
3284 ~~months, as determined by the agency.~~
3285 Section 76. Section 429.12, Florida Statutes, is amended
3286 to read:
3287 429.12 Sale or transfer of ownership of a facility.—It is
3288 the intent of the Legislature to protect the rights of the
3289 residents of an assisted living facility when the facility is
3290 sold or the ownership thereof is transferred. Therefore, in
3291 addition to the requirements of part II of chapter 408, whenever
3292 a facility is sold or the ownership thereof is transferred,
3293 including leasing,~~:~~
3294 ~~(1)~~ the transferee shall notify the residents, in writing,
3295 of the change of ownership within 7 days after receipt of the
3296 new license.
3297 ~~(2) The transferor of a facility the license of which is~~
3298 ~~denied pending an administrative hearing shall, as a part of the~~
3299 ~~written change-of-ownership contract, advise the transferee that~~
3300 ~~a plan of correction must be submitted by the transferee and~~
3301 ~~approved by the agency at least 7 days before the change of~~
3302 ~~ownership and that failure to correct the condition which~~
3303 ~~resulted in the moratorium pursuant to part II of chapter 408 or~~
3304 ~~denial of licensure is grounds for denial of the transferee's~~

3305 ~~license.~~
3306 Section 77. Subsection (5) of section 429.14, Florida
3307 Statutes, is amended to read:
3308 429.14 Administrative penalties.—
3309 (5) An action taken by the agency to suspend, deny, or
3310 revoke a facility's license under this part or part II of
3311 chapter 408, in which the agency claims that the facility owner
3312 or an employee of the facility has threatened the health,
3313 safety, or welfare of a resident of the facility, shall be heard
3314 by the Division of Administrative Hearings of the Department of
3315 Management Services within 120 days after receipt of the
3316 facility's request for a hearing, unless that time limitation is
3317 waived by both parties. The administrative law judge must render
3318 a decision within 30 days after receipt of a proposed
3319 recommended order.
3320 Section 78. Subsections (1), (4), and (5) of section
3321 429.17, Florida Statutes, are amended to read:
3322 429.17 Expiration of license; renewal; conditional
3323 license.—
3324 (1) ~~Limited nursing,~~ Extended congregate care~~,~~ and limited
3325 mental health licenses shall expire at the same time as the
3326 facility's standard license, regardless of when issued.
3327 (4) In addition to the license categories available in s.
3328 408.808, a conditional license may be issued to an applicant for
3329 license renewal if the applicant fails to meet all standards and
3330 requirements for licensure. A conditional license issued under
3331 this subsection shall be limited in duration to a specific
3332 period of time not to exceed 6 months, as determined by the

3333 agency~~, and shall be accompanied by an agency-approved plan of~~
3334 ~~correction~~.
3335 (5) When an extended congregate care ~~or limited nursing~~
3336 ~~license~~ is requested during a facility's biennial license
3337 period, the fee shall be prorated in order to permit the
3338 additional license to expire at the end of the biennial license
3339 period. The fee shall be calculated as of the date the
3340 additional license application is received by the agency.
3341 Section 79. Section 429.195, Florida Statutes, is amended
3342 to read:
3343 429.195 Rebates prohibited; penalties.—
3344 (1) It is unlawful for any assisted living facility
3345 licensed under this part to contract or promise to pay or
3346 receive any commission, bonus, kickback, or rebate or engage in
3347 any split-fee arrangement in any form whatsoever with any health
3348 care provider or health care facility pursuant to s. 817.505
3349 ~~physician, surgeon, organization, agency, or person, either~~
3350 ~~directly or indirectly, for residents referred to an assisted~~
3351 ~~living facility licensed under this part~~. ~~A facility may employ~~
3352 ~~or contract with persons to market the facility, provided the~~
3353 ~~employee or contract provider clearly indicates that he or she~~
3354 ~~represents the facility. A person or agency independent of the~~
3355 ~~facility may provide placement or referral services for a fee to~~
3356 ~~individuals seeking assistance in finding a suitable facility;~~
3357 ~~however, any fee paid for placement or referral services must be~~
3358 ~~paid by the individual looking for a facility, not by the~~
3359 ~~facility.~~
3360 (2) A violation of this section shall be considered

3361 patient brokering and is punishable as provided in s. 817.505.
3362 (3) This section does not apply to:
3363 (a) An individual employed by the facility, or with whom
3364 the facility contracts to market the facility, if the employee
3365 or contract provider clearly indicates that he or she works with
3366 or for the facility.
3367 (b) A referral service that provides information,
3368 consultation, or referrals to consumers to assist them in
3369 finding appropriate care or housing options for seniors or
3370 disabled adults, provided that such referred consumers are not
3371 Medicaid recipients.
3372 (c) Residents of an assisted living facility who refer
3373 friends, family members, or other individuals with whom they
3374 have a personal relationship to the assisted living facility,
3375 and does not prohibit the assisted living facility from
3376 providing a monetary reward to the resident for making such a
3377 referral.
3378 Section 80. Subsections (6) through (10) of section
3379 429.23, Florida Statutes, are renumbered as subsections (5)
3380 through (9), respectively, and present subsection (5) of that
3381 section is amended to read:
3382 429.23 Internal risk management and quality assurance
3383 program; adverse incidents and reporting requirements.—
3384 (5) Each facility shall report monthly to the agency any
3385 liability claim filed against it. The report must include the
3386 name of the resident, the dates of the incident leading to the
3387 claim, if applicable, and the type of injury or violation of
3388 rights alleged to have occurred. This report is not discoverable

3389 ~~in any civil or administrative action, except in such actions~~
3390 ~~brought by the agency to enforce the provisions of this part.~~
3391 Section 81. Paragraph (a) of subsection (1) and subsection
3392 (2) of section 429.255, Florida Statutes, are amended to read:
3393 429.255 Use of personnel; emergency care.—
3394 (1)(a) Persons under contract to the facility <u>or</u>~~,~~ facility
3395 staff~~, or volunteers,~~ who are licensed according to part I of
3396 chapter 464, or those persons exempt under s. 464.022(1), and
3397 others as defined by rule, may administer medications to
3398 residents, take residents' vital signs, manage individual weekly
3399 pill organizers for residents who self-administer medication,
3400 give prepackaged enemas ordered by a physician, observe
3401 residents, document observations on the appropriate resident's
3402 record, report observations to the resident's physician, and
3403 contract or allow residents or a resident's representative,
3404 designee, surrogate, guardian, or attorney in fact to contract
3405 with a third party, provided residents meet the criteria for
3406 appropriate placement as defined in s. 429.26. <u>Persons under</u>
3407 <u>contract to the facility or facility staff who are licensed</u>
3408 <u>according to part I of chapter 464 may provide limited nursing</u>
3409 <u>services.</u> Nursing assistants certified pursuant to part II of
3410 chapter 464 may take residents' vital signs as directed by a
3411 licensed nurse or physician. <u>The facility is responsible for</u>
3412 <u>maintaining documentation of services provided under this</u>
3413 <u>paragraph and as required by rule and for ensuring that staff</u>
3414 <u>are adequately trained to monitor residents receiving these</u>
3415 <u>services.</u>
3416 (2) In facilities licensed to provide extended congregate

3417 care, persons under contract to the facility or~~,~~ facility staff~~,~~
3418 ~~or volunteers,~~ who are licensed according to part I of chapter
3419 464, or those persons exempt under s. 464.022(1), or those
3420 persons certified as nursing assistants pursuant to part II of
3421 chapter 464, may also perform all duties within the scope of
3422 their license or certification, as approved by the facility
3423 administrator and pursuant to this part.
3424 Section 82. Subsections (4), (5), (6), and (7) of section
3425 429.28, Florida Statutes, are renumbered as subsections (3),
3426 (4), (5), and (6), respectively, and present subsections (3) and
3427 (6) of that section are amended to read:
3428 429.28 Resident bill of rights.—
3429 ~~(3)(a) The agency shall conduct a survey to determine~~
3430 ~~general compliance with facility standards and compliance with~~
3431 ~~residents' rights as a prerequisite to initial licensure or~~
3432 ~~licensure renewal.~~
3433 ~~(b) In order to determine whether the facility is~~
3434 ~~adequately protecting residents' rights, the biennial survey~~
3435 ~~shall include private informal conversations with a sample of~~
3436 ~~residents and consultation with the ombudsman council in the~~
3437 ~~planning and service area in which the facility is located to~~
3438 ~~discuss residents' experiences within the facility.~~
3439 ~~(c) During any calendar year in which no survey is~~
3440 ~~conducted, the agency shall conduct at least one monitoring~~
3441 ~~visit of each facility cited in the previous year for a class I~~
3442 ~~or class II violation, or more than three uncorrected class III~~
3443 ~~violations.~~
3444 ~~(d) The agency may conduct periodic followup inspections~~

3445 ~~as necessary to monitor the compliance of facilities with a~~
3446 ~~history of any class I, class II, or class III violations that~~
3447 ~~threaten the health, safety, or security of residents.~~
3448 ~~(e) The agency may conduct complaint investigations as~~
3449 ~~warranted to investigate any allegations of noncompliance with~~
3450 ~~requirements required under this part or rules adopted under~~
3451 ~~this part.~~
3452 (5)~~(6)~~ Any facility which terminates the residency of an
3453 individual who participated in activities specified in
3454 subsection (4) ~~(5)~~ shall show good cause in a court of competent
3455 jurisdiction.
3456 Section 83. Subsections (4) and (5) of section 429.41,
3457 Florida Statutes, are renumbered as subsections (3) and (4),
3458 respectively, and paragraphs (i) and (j) of subsection (1) and
3459 present subsection (3) of that section are amended to read:
3460 429.41 Rules establishing standards.—
3461 (1) It is the intent of the Legislature that rules
3462 published and enforced pursuant to this section shall include
3463 criteria by which a reasonable and consistent quality of
3464 resident care and quality of life may be ensured and the results
3465 of such resident care may be demonstrated. Such rules shall also
3466 ensure a safe and sanitary environment that is residential and
3467 noninstitutional in design or nature. It is further intended
3468 that reasonable efforts be made to accommodate the needs and
3469 preferences of residents to enhance the quality of life in a
3470 facility. The agency, in consultation with the department, may
3471 adopt rules to administer the requirements of part II of chapter
3472 408. In order to provide safe and sanitary facilities and the

3473 highest quality of resident care accommodating the needs and
3474 preferences of residents, the department, in consultation with
3475 the agency, the Department of Children and Family Services, and
3476 the Department of Health, shall adopt rules, policies, and
3477 procedures to administer this part, which must include
3478 reasonable and fair minimum standards in relation to:
3479 (i) Facilities holding an ~~a limited nursing,~~ extended
3480 congregate care~~,~~ or limited mental health license.
3481 (j) The establishment of specific criteria to define
3482 appropriateness of resident admission and continued residency in
3483 a facility holding a standard, ~~limited nursing,~~ extended
3484 congregate care, and limited mental health license.
3485 ~~(3) The department shall submit a copy of proposed rules~~
3486 ~~to the Speaker of the House of Representatives, the President of~~
3487 ~~the Senate, and appropriate committees of substance for review~~
3488 ~~and comment prior to the promulgation thereof. Rules promulgated~~
3489 ~~by the department shall encourage the development of homelike~~
3490 ~~facilities which promote the dignity, individuality, personal~~
3491 ~~strengths, and decisionmaking ability of residents.~~
3492 Section 84. Subsections (1) and (2) of section 429.53,
3493 Florida Statutes, are amended to read:
3494 429.53 Consultation by the agency.—
3495 (1) The ~~area offices of licensure and certification of the~~
3496 agency shall provide consultation to the following upon request:
3497 (a) A licensee of a facility.
3498 (b) A person interested in obtaining a license to operate
3499 a facility under this part.
3500 (2) As used in this section, "consultation" includes:

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

3501 (a) An explanation of the requirements of this part and
3502 rules adopted pursuant thereto;
3503 (b) An explanation of the license application and renewal
3504 procedures; and
3505 ~~(c) The provision of a checklist of general local and~~
3506 ~~state approvals required prior to constructing or developing a~~
3507 ~~facility and a listing of the types of agencies responsible for~~
3508 ~~such approvals;~~
3509 ~~(d) An explanation of benefits and financial assistance~~
3510 ~~available to a recipient of supplemental security income~~
3511 ~~residing in a facility;~~
3512 (c) ~~(e)~~ Any other information which the agency deems
3513 necessary to promote compliance with the requirements of this
3514 part~~; and~~
3515 ~~(f) A preconstruction review of a facility to ensure~~
3516 ~~compliance with agency rules and this part~~.
3517 Section 85. Subsection (6) of section 429.71, Florida
3518 Statutes, is renumbered as subsection (5), and subsection (1)
3519 and present subsection (5) of that section are amended to read:
3520 429.71 Classification of violations ~~deficiencies~~;
3521 administrative fines.—
3522 (1) In addition to the requirements of part II of chapter
3523 408 and in addition to any other liability or penalty provided
3524 by law, the agency may impose an administrative fine on a
3525 provider according to the following classification:
3526 (a) Class I violations are defined in s. 408.813 ~~those~~
3527 ~~conditions or practices related to the operation and maintenance~~
3528 ~~of an adult family-care home or to the care of residents which~~

3529 ~~the agency determines present an imminent danger to the~~
3530 ~~residents or guests of the facility or a substantial probability~~
3531 ~~that death or serious physical or emotional harm would result~~
3532 ~~therefrom. The condition or practice that constitutes a class I~~
3533 ~~violation must be abated or eliminated within 24 hours, unless a~~
3534 ~~fixed period, as determined by the agency, is required for~~
3535 ~~correction~~. A class I violation ~~deficiency~~ is subject to an
3536 administrative fine in an amount not less than $500 and not
3537 exceeding $1,000 for each violation. ~~A fine may be levied~~
3538 ~~notwithstanding the correction of the deficiency.~~
3539 (b) Class II violations are defined in s. 408.813 ~~those~~
3540 ~~conditions or practices related to the operation and maintenance~~
3541 ~~of an adult family-care home or to the care of residents which~~
3542 ~~the agency determines directly threaten the physical or~~
3543 ~~emotional health, safety, or security of the residents, other~~
3544 ~~than class I violations~~. A class II violation is subject to an
3545 administrative fine in an amount not less than $250 and not
3546 exceeding $500 for each violation. ~~A citation for a class II~~
3547 ~~violation must specify the time within which the violation is~~
3548 ~~required to be corrected. If a class II violation is corrected~~
3549 ~~within the time specified, no civil penalty shall be imposed,~~
3550 ~~unless it is a repeated offense.~~
3551 (c) Class III violations are defined in s. 408.813 ~~those~~
3552 ~~conditions or practices related to the operation and maintenance~~
3553 ~~of an adult family-care home or to the care of residents which~~
3554 ~~the agency determines indirectly or potentially threaten the~~
3555 ~~physical or emotional health, safety, or security of residents,~~
3556 ~~other than class I or class II violations~~. A class III violation

3557 is subject to an administrative fine in an amount not less than
3558 $100 and not exceeding $250 for each violation. ~~A citation for a~~
3559 ~~class III violation shall specify the time within which the~~
3560 ~~violation is required to be corrected.~~ If a class III violation
3561 is corrected within the time specified, no civil penalty shall
3562 be imposed, unless it is a repeated violation ~~offense~~.
3563 (d) Class IV violations are defined in s. 408.813 ~~those~~
3564 ~~conditions or occurrences related to the operation and~~
3565 ~~maintenance of an adult family-care home, or related to the~~
3566 ~~required reports, forms, or documents, which do not have the~~
3567 ~~potential of negatively affecting the residents~~. ~~A provider that~~
3568 ~~does not correct~~ A class IV violation ~~within the time limit~~
3569 ~~specified by the agency~~ is subject to an administrative fine in
3570 an amount not less than $50 and not exceeding $100 for each
3571 violation. Any class IV violation that is corrected during the
3572 time the agency survey is conducted will be identified as an
3573 agency finding and not as a violation, unless it is a repeat
3574 violation.
3575 ~~(5) As an alternative to or in conjunction with an~~
3576 ~~administrative action against a provider, the agency may request~~
3577 ~~a plan of corrective action that demonstrates a good faith~~
3578 ~~effort to remedy each violation by a specific date, subject to~~
3579 ~~the approval of the agency.~~
3580 Section 86. Section 429.915, Florida Statutes, is amended
3581 to read:
3582 429.915 Conditional license.—In addition to the license
3583 categories available in part II of chapter 408, the agency may
3584 issue a conditional license to an applicant for license renewal

3585 or change of ownership if the applicant fails to meet all
3586 standards and requirements for licensure. A conditional license
3587 issued under this subsection must be limited to a specific
3588 period not exceeding 6 months, as determined by the agency~~, and~~
3589 ~~must be accompanied by an approved plan of correction~~.
3590 Section 87. Paragraphs (b) and (g) of subsection (3) of
3591 section 430.80, Florida Statutes, are amended to read:
3592 430.80 Implementation of a teaching nursing home pilot
3593 project.—
3594 (3) To be designated as a teaching nursing home, a nursing
3595 home licensee must, at a minimum:
3596 (b) Participate in a nationally recognized accreditation
3597 program and hold a valid accreditation, such as the
3598 accreditation awarded by the Joint Commission ~~on Accreditation~~
3599 ~~of Healthcare Organizations~~, or, at the time of initial
3600 designation, possess a Gold Seal Award as conferred by the state
3601 on its licensed nursing home;
3602 (g) Maintain insurance coverage pursuant to s.
3603 400.141(1)(q) ~~(s)~~ or proof of financial responsibility in a
3604 minimum amount of $750,000. Such proof of financial
3605 responsibility may include:
3606 1. Maintaining an escrow account consisting of cash or
3607 assets eligible for deposit in accordance with s. 625.52; or
3608 2. Obtaining and maintaining pursuant to chapter 675 an
3609 unexpired, irrevocable, nontransferable and nonassignable letter
3610 of credit issued by any bank or savings association organized
3611 and existing under the laws of this state or any bank or savings
3612 association organized under the laws of the United States that

3613 has its principal place of business in this state or has a
3614 branch office which is authorized to receive deposits in this
3615 state. The letter of credit shall be used to satisfy the
3616 obligation of the facility to the claimant upon presentment of a
3617 final judgment indicating liability and awarding damages to be
3618 paid by the facility or upon presentment of a settlement
3619 agreement signed by all parties to the agreement when such final
3620 judgment or settlement is a result of a liability claim against
3621 the facility.
3622 Section 88. Paragraph (d) of subsection (9) of section
3623 440.102, Florida Statutes, is amended to read:
3624 440.102 Drug-free workplace program requirements.—The
3625 following provisions apply to a drug-free workplace program
3626 implemented pursuant to law or to rules adopted by the Agency
3627 for Health Care Administration:
3628 (9) DRUG-TESTING STANDARDS FOR LABORATORIES.—
3629 ~~(d) The laboratory shall submit to the Agency for Health~~
3630 ~~Care Administration a monthly report with statistical~~
3631 ~~information regarding the testing of employees and job~~
3632 ~~applicants. The report must include information on the methods~~
3633 ~~of analysis conducted, the drugs tested for, the number of~~
3634 ~~positive and negative results for both initial tests and~~
3635 ~~confirmation tests, and any other information deemed appropriate~~
3636 ~~by the Agency for Health Care Administration. A monthly report~~
3637 ~~must not identify specific employees or job applicants.~~
3638 Section 89. Paragraph (a) of subsection (2) of section
3639 440.13, Florida Statutes, is amended to read:
3640 440.13 Medical services and supplies; penalty for

3641 violations; limitations.—
3642 (2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—
3643 (a) Subject to the limitations specified elsewhere in this
3644 chapter, the employer shall furnish to the employee such
3645 medically necessary remedial treatment, care, and attendance for
3646 such period as the nature of the injury or the process of
3647 recovery may require, which is in accordance with established
3648 practice parameters and protocols of treatment as provided for
3649 in this chapter, including medicines, medical supplies, durable
3650 medical equipment, orthoses, prostheses, and other medically
3651 necessary apparatus. Remedial treatment, care, and attendance,
3652 including work-hardening programs or pain-management programs
3653 accredited by the Commission on Accreditation of Rehabilitation
3654 Facilities or <u>the</u> Joint Commission ~~on the Accreditation of~~
3655 ~~Health Organizations~~ or pain-management programs affiliated with
3656 medical schools, shall be considered as covered treatment only
3657 when such care is given based on a referral by a physician as
3658 defined in this chapter. Medically necessary treatment, care,
3659 and attendance does not include chiropractic services in excess
3660 of 24 treatments or rendered 12 weeks beyond the date of the
3661 initial chiropractic treatment, whichever comes first, unless
3662 the carrier authorizes additional treatment or the employee is
3663 catastrophically injured.
3664
3665 Failure of the carrier to timely comply with this subsection
3666 shall be a violation of this chapter and the carrier shall be
3667 subject to penalties as provided for in s. 440.525.
3668 Section 90. Paragraph (h) of subsection (3) of section

3669 456.053, Florida Statutes, is amended to read:
3670 456.053 Financial arrangements between referring health
3671 care providers and providers of health care services.—
3672 (3) DEFINITIONS.—For the purpose of this section, the
3673 word, phrase, or term:
3674 (h) "Group practice" means a group of two or more health
3675 care providers legally organized as a partnership, professional
3676 corporation, or similar association:
3677 1. In which each health care provider who is a member of
3678 the group provides substantially the full range of services
3679 which the health care provider routinely provides, including
3680 medical care, consultation, diagnosis, or treatment, through the
3681 joint use of shared office space, facilities, equipment, and
3682 personnel;
3683 2. For which substantially all of the services of the
3684 health care providers who are members of the group are provided
3685 through the group and are billed in the name of the group and
3686 amounts so received are treated as receipts of the group; ~~and~~
3687 3. In which the overhead expenses of and the income from
3688 the practice are distributed in accordance with methods
3689 previously determined by members of the group; and
3690 4. In which a group practice that provides radiation
3691 therapy services provides the full range of radiation therapy
3692 services such that no single type of cancer, either as a primary
3693 or secondary diagnosis as described by the International
3694 Statistical Classification of Diseases, constitutes 40 percent
3695 or more of the group's cases that require professional and
3696 technical services for radiation therapy, and in which the

3697 health care providers within the group who are referring
3698 patients for radiation therapy services do not own 50 percent or
3699 more of the group practice. For purposes of this subparagraph,
3700 the term "cases" means a patient's radiation treatment course.
3701 Section 91. Subsection (1) of section 483.035, Florida
3702 Statutes, is amended to read:
3703 483.035 Clinical laboratories operated by practitioners
3704 for exclusive use; licensure and regulation.—
3705 (1) A clinical laboratory operated by one or more
3706 practitioners licensed under chapter 458, chapter 459, chapter
3707 460, chapter 461, chapter 462, part I of chapter 464, or chapter
3708 466, exclusively in connection with the diagnosis and treatment
3709 of their own patients, must be licensed under this part and must
3710 comply with the provisions of this part, except that the agency
3711 shall adopt rules for staffing, for personnel, including
3712 education and training of personnel, for proficiency testing,
3713 and for construction standards relating to the licensure and
3714 operation of the laboratory based upon and not exceeding the
3715 same standards contained in the federal Clinical Laboratory
3716 Improvement Amendments of 1988 and the federal regulations
3717 adopted thereunder.
3718 Section 92. Subsections (1) and (9) of section 483.051,
3719 Florida Statutes, are amended to read:
3720 483.051 Powers and duties of the agency.—The agency shall
3721 adopt rules to implement this part, which rules must include,
3722 but are not limited to, the following:
3723 (1) LICENSING; QUALIFICATIONS.—The agency shall provide
3724 for biennial licensure of all nonwaived clinical laboratories

3725 meeting the requirements of this part and shall prescribe the
3726 qualifications necessary for such licensure, including, but not
3727 limited to, application for or proof of a federal Clinical
3728 Laboratory Improvement Amendment (CLIA) certificate. For
3729 purposes of this section, the term "nonwaived clinical
3730 laboratories" means laboratories that perform any test that the
3731 Centers for Medicare and Medicaid Services has determined does
3732 not qualify for a certificate of waiver under the Clinical
3733 Laboratory Improvement Amendments of 1988 and the federal rules
3734 adopted thereunder.
3735 (9) ALTERNATE-SITE TESTING.—The agency, in consultation
3736 with the Board of Clinical Laboratory Personnel, shall adopt, by
3737 rule, the criteria for alternate-site testing to be performed
3738 under the supervision of a clinical laboratory director. The
3739 elements to be addressed in the rule include, but are not
3740 limited to: a hospital internal needs assessment; a protocol of
3741 implementation including tests to be performed and who will
3742 perform the tests; criteria to be used in selecting the method
3743 of testing to be used for alternate-site testing; minimum
3744 training and education requirements for those who will perform
3745 alternate-site testing, such as documented training, licensure,
3746 certification, or other medical professional background not
3747 limited to laboratory professionals; documented inservice
3748 training as well as initial and ongoing competency validation;
3749 an appropriate internal and external quality control protocol;
3750 an internal mechanism for identifying and tracking alternate-
3751 site testing by the central laboratory; and recordkeeping
3752 requirements. ~~Alternate-site testing locations must register~~

3753 ~~when the clinical laboratory applies to renew its license.~~ For
3754 purposes of this subsection, the term "alternate-site testing"
3755 means any laboratory testing done under the administrative
3756 control of a hospital, but performed out of the physical or
3757 administrative confines of the central laboratory.
3758 Section 93. Section 483.294, Florida Statutes, is amended
3759 to read:
3760 483.294 Inspection of centers.—In accordance with s.
3761 408.811, the agency shall biennially~~, at least once annually,~~
3762 inspect the premises and operations of all centers subject to
3763 licensure under this part.
3764 Section 94. Paragraph (a) of subsection (54) of section
3765 499.003, Florida Statutes, is amended to read:
3766 499.003 Definitions of terms used in this part.—As used in
3767 this part, the term:
3768 (54) "Wholesale distribution" means distribution of
3769 prescription drugs to persons other than a consumer or patient,
3770 but does not include:
3771 (a) Any of the following activities, which is not a
3772 violation of s. 499.005(21) if such activity is conducted in
3773 accordance with s. 499.01(2)(g):
3774 1. The purchase or other acquisition by a hospital or
3775 other health care entity that is a member of a group purchasing
3776 organization of a prescription drug for its own use from the
3777 group purchasing organization or from other hospitals or health
3778 care entities that are members of that organization.
3779 2. The sale, purchase, or trade of a prescription drug or
3780 an offer to sell, purchase, or trade a prescription drug by a

3781 charitable organization described in s. 501(c)(3) of the
3782 Internal Revenue Code of 1986, as amended and revised, to a
3783 nonprofit affiliate of the organization to the extent otherwise
3784 permitted by law.
3785 3. The sale, purchase, or trade of a prescription drug or
3786 an offer to sell, purchase, or trade a prescription drug among
3787 hospitals or other health care entities that are under common
3788 control. For purposes of this subparagraph, "common control"
3789 means the power to direct or cause the direction of the
3790 management and policies of a person or an organization, whether
3791 by ownership of stock, by voting rights, by contract, or
3792 otherwise.
3793 4. The sale, purchase, trade, or other transfer of a
3794 prescription drug from or for any federal, state, or local
3795 government agency or any entity eligible to purchase
3796 prescription drugs at public health services prices pursuant to
3797 Pub. L. No. 102-585, s. 602 to a contract provider or its
3798 subcontractor for eligible patients of the agency or entity
3799 under the following conditions:
3800 a. The agency or entity must obtain written authorization
3801 for the sale, purchase, trade, or other transfer of a
3802 prescription drug under this subparagraph from the State Surgeon
3803 General or his or her designee.
3804 b. The contract provider or subcontractor must be
3805 authorized by law to administer or dispense prescription drugs.
3806 c. In the case of a subcontractor, the agency or entity
3807 must be a party to and execute the subcontract.
3808 ~~d. A contract provider or subcontractor must maintain~~

3809 ~~separate and apart from other prescription drug inventory any~~
3810 ~~prescription drugs of the agency or entity in its possession.~~
3811 d.~~e.~~ The contract provider and subcontractor must maintain
3812 and produce immediately for inspection all records of movement
3813 or transfer of all the prescription drugs belonging to the
3814 agency or entity, including, but not limited to, the records of
3815 receipt and disposition of prescription drugs. Each contractor
3816 and subcontractor dispensing or administering these drugs must
3817 maintain and produce records documenting the dispensing or
3818 administration. Records that are required to be maintained
3819 include, but are not limited to, a perpetual inventory itemizing
3820 drugs received and drugs dispensed by prescription number or
3821 administered by patient identifier, which must be submitted to
3822 the agency or entity quarterly.
3823 e.~~f.~~ The contract provider or subcontractor may administer
3824 or dispense the prescription drugs only to the eligible patients
3825 of the agency or entity or must return the prescription drugs
3826 for or to the agency or entity. The contract provider or
3827 subcontractor must require proof from each person seeking to
3828 fill a prescription or obtain treatment that the person is an
3829 eligible patient of the agency or entity and must, at a minimum,
3830 maintain a copy of this proof as part of the records of the
3831 contractor or subcontractor required under sub-subparagraph e.
3832 f.~~g.~~ In addition to the departmental inspection authority
3833 set forth in s. 499.051, the establishment of the contract
3834 provider and subcontractor and all records pertaining to
3835 prescription drugs subject to this subparagraph shall be subject
3836 to inspection by the agency or entity. All records relating to

3837 prescription drugs of a manufacturer under this subparagraph
3838 shall be subject to audit by the manufacturer of those drugs,
3839 without identifying individual patient information.
3840 Section 95. Subsection (1) of section 627.645, Florida
3841 Statutes, is amended to read:
3842 627.645 Denial of health insurance claims restricted.—
3843 (1) No claim for payment under a health insurance policy
3844 or self-insured program of health benefits for treatment, care,
3845 or services in a licensed hospital which is accredited by the
3846 Joint Commission ~~on the Accreditation of Hospitals~~, the American
3847 Osteopathic Association, or the Commission on the Accreditation
3848 of Rehabilitative Facilities shall be denied because such
3849 hospital lacks major surgical facilities and is primarily of a
3850 rehabilitative nature, if such rehabilitation is specifically
3851 for treatment of physical disability.
3852 Section 96. Paragraph (c) of subsection (2) of section
3853 627.668, Florida Statutes, is amended to read:
3854 627.668 Optional coverage for mental and nervous disorders
3855 required; exception.—
3856 (2) Under group policies or contracts, inpatient hospital
3857 benefits, partial hospitalization benefits, and outpatient
3858 benefits consisting of durational limits, dollar amounts,
3859 deductibles, and coinsurance factors shall not be less favorable
3860 than for physical illness generally, except that:
3861 (c) Partial hospitalization benefits shall be provided
3862 under the direction of a licensed physician. For purposes of
3863 this part, the term "partial hospitalization services" is
3864 defined as those services offered by a program accredited by the

3865 Joint Commission ~~on Accreditation of Hospitals (JCAH)~~ or in
3866 compliance with equivalent standards. Alcohol rehabilitation
3867 programs accredited by the Joint Commission ~~on Accreditation of~~
3868 ~~Hospitals~~ or approved by the state and licensed drug abuse
3869 rehabilitation programs shall also be qualified providers under
3870 this section. In any benefit year, if partial hospitalization
3871 services or a combination of inpatient and partial
3872 hospitalization are utilized, the total benefits paid for all
3873 such services shall not exceed the cost of 30 days of inpatient
3874 hospitalization for psychiatric services, including physician
3875 fees, which prevail in the community in which the partial
3876 hospitalization services are rendered. If partial
3877 hospitalization services benefits are provided beyond the limits
3878 set forth in this paragraph, the durational limits, dollar
3879 amounts, and coinsurance factors thereof need not be the same as
3880 those applicable to physical illness generally.
3881 Section 97. Subsection (3) of section 627.669, Florida
3882 Statutes, is amended to read:
3883 627.669 Optional coverage required for substance abuse
3884 impaired persons; exception.—
3885 (3) The benefits provided under this section shall be
3886 applicable only if treatment is provided by, or under the
3887 supervision of, or is prescribed by, a licensed physician or
3888 licensed psychologist and if services are provided in a program
3889 accredited by the Joint Commission ~~on Accreditation of Hospitals~~
3890 or approved by the state.
3891 Section 98. Paragraph (a) of subsection (1) of section
3892 627.736, Florida Statutes, is amended to read:

3893 627.736 Required personal injury protection benefits;
3894 exclusions; priority; claims.—
3895 (1) REQUIRED BENEFITS.—Every insurance policy complying
3896 with the security requirements of s. 627.733 shall provide
3897 personal injury protection to the named insured, relatives
3898 residing in the same household, persons operating the insured
3899 motor vehicle, passengers in such motor vehicle, and other
3900 persons struck by such motor vehicle and suffering bodily injury
3901 while not an occupant of a self-propelled vehicle, subject to
3902 the provisions of subsection (2) and paragraph (4)(e), to a
3903 limit of $10,000 for loss sustained by any such person as a
3904 result of bodily injury, sickness, disease, or death arising out
3905 of the ownership, maintenance, or use of a motor vehicle as
3906 follows:
3907 (a) *Medical benefits.*—Eighty percent of all reasonable
3908 expenses for medically necessary medical, surgical, X-ray,
3909 dental, and rehabilitative services, including prosthetic
3910 devices, and medically necessary ambulance, hospital, and
3911 nursing services. However, the medical benefits shall provide
3912 reimbursement only for such services and care that are lawfully
3913 provided, supervised, ordered, or prescribed by a physician
3914 licensed under chapter 458 or chapter 459, a dentist licensed
3915 under chapter 466, or a chiropractic physician licensed under
3916 chapter 460 or that are provided by any of the following persons
3917 or entities:
3918 1. A hospital or ambulatory surgical center licensed under
3919 chapter 395.
3920 2. A person or entity licensed under ss. 401.2101-401.45

3921 that provides emergency transportation and treatment.
3922 3. An entity wholly owned by one or more physicians
3923 licensed under chapter 458 or chapter 459, chiropractic
3924 physicians licensed under chapter 460, or dentists licensed
3925 under chapter 466 or by such practitioner or practitioners and
3926 the spouse, parent, child, or sibling of that practitioner or
3927 those practitioners.
3928 4. An entity wholly owned, directly or indirectly, by a
3929 hospital or hospitals.
3930 5. A health care clinic licensed under ss. 400.990-400.995
3931 that is:
3932 a. Accredited by the Joint Commission ~~on Accreditation of~~
3933 ~~Healthcare Organizations~~, the American Osteopathic Association,
3934 the Commission on Accreditation of Rehabilitation Facilities, or
3935 the Accreditation Association for Ambulatory Health Care, Inc.;
3936 or
3937 b. A health care clinic that:
3938 (I) Has a medical director licensed under chapter 458,
3939 chapter 459, or chapter 460;
3940 (II) Has been continuously licensed for more than 3 years
3941 or is a publicly traded corporation that issues securities
3942 traded on an exchange registered with the United States
3943 Securities and Exchange Commission as a national securities
3944 exchange; and
3945 (III) Provides at least four of the following medical
3946 specialties:
3947 (A) General medicine.
3948 (B) Radiography.

3949 (C) Orthopedic medicine.
3950 (D) Physical medicine.
3951 (E) Physical therapy.
3952 (F) Physical rehabilitation.
3953 (G) Prescribing or dispensing outpatient prescription
3954 medication.
3955 (H) Laboratory services.
3956
3957 The Financial Services Commission shall adopt by rule the form
3958 that must be used by an insurer and a health care provider
3959 specified in subparagraph 3., subparagraph 4., or subparagraph
3960 5. to document that the health care provider meets the criteria
3961 of this paragraph, which rule must include a requirement for a
3962 sworn statement or affidavit.
3963
3964 Only insurers writing motor vehicle liability insurance in this
3965 state may provide the required benefits of this section, and no
3966 such insurer shall require the purchase of any other motor
3967 vehicle coverage other than the purchase of property damage
3968 liability coverage as required by s. 627.7275 as a condition for
3969 providing such required benefits. Insurers may not require that
3970 property damage liability insurance in an amount greater than
3971 $10,000 be purchased in conjunction with personal injury
3972 protection. Such insurers shall make benefits and required
3973 property damage liability insurance coverage available through
3974 normal marketing channels. Any insurer writing motor vehicle
3975 liability insurance in this state who fails to comply with such
3976 availability requirement as a general business practice shall be

3977 deemed to have violated part IX of chapter 626, and such
3978 violation shall constitute an unfair method of competition or an
3979 unfair or deceptive act or practice involving the business of
3980 insurance; and any such insurer committing such violation shall
3981 be subject to the penalties afforded in such part, as well as
3982 those which may be afforded elsewhere in the insurance code.
3983 Section 99. Section 633.081, Florida Statutes, is amended
3984 to read:
3985 633.081 Inspection of buildings and equipment; orders;
3986 firesafety inspection training requirements; certification;
3987 disciplinary action.—The State Fire Marshal and her or his
3988 agents shall, at any reasonable hour, when the State Fire
3989 Marshal has reasonable cause to believe that a violation of this
3990 chapter or s. 509.215, or a rule promulgated thereunder, or a
3991 minimum firesafety code adopted by a local authority, may exist,
3992 inspect any and all buildings and structures which are subject
3993 to the requirements of this chapter or s. 509.215 and rules
3994 promulgated thereunder. The authority to inspect shall extend to
3995 all equipment, vehicles, and chemicals which are located within
3996 the premises of any such building or structure. The State Fire
3997 Marshal and her or his agents shall inspect nursing homes
3998 licensed under part II of chapter 400 only once every calendar
3999 year and upon receiving a complaint forming the basis of a
4000 reasonable cause to believe that a violation of this chapter or
4001 s. 509.215, or a rule promulgated thereunder, or a minimum
4002 firesafety code adopted by a local authority may exist and upon
4003 identifying such a violation in the course of conducting
4004 orientation or training activities within a nursing home.

4005 (1) Each county, municipality, and special district that
4006 has firesafety enforcement responsibilities shall employ or
4007 contract with a firesafety inspector. Except as provided in s.
4008 633.082(2), the firesafety inspector must conduct all firesafety
4009 inspections that are required by law. The governing body of a
4010 county, municipality, or special district that has firesafety
4011 enforcement responsibilities may provide a schedule of fees to
4012 pay only the costs of inspections conducted pursuant to this
4013 subsection and related administrative expenses. Two or more
4014 counties, municipalities, or special districts that have
4015 firesafety enforcement responsibilities may jointly employ or
4016 contract with a firesafety inspector.
4017 (2) Except as provided in s. 633.082(2), every firesafety
4018 inspection conducted pursuant to state or local firesafety
4019 requirements shall be by a person certified as having met the
4020 inspection training requirements set by the State Fire Marshal.
4021 Such person shall:
4022 (a) Be a high school graduate or the equivalent as
4023 determined by the department;
4024 (b) Not have been found guilty of, or having pleaded
4025 guilty or nolo contendere to, a felony or a crime punishable by
4026 imprisonment of 1 year or more under the law of the United
4027 States, or of any state thereof, which involves moral turpitude,
4028 without regard to whether a judgment of conviction has been
4029 entered by the court having jurisdiction of such cases;
4030 (c) Have her or his fingerprints on file with the
4031 department or with an agency designated by the department;
4032 (d) Have good moral character as determined by the

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

4033 department;
4034 (e) Be at least 18 years of age;
4035 (f) Have satisfactorily completed the firesafety inspector
4036 certification examination as prescribed by the department; and
4037 (g)1. Have satisfactorily completed, as determined by the
4038 department, a firesafety inspector training program of not less
4039 than 200 hours established by the department and administered by
4040 agencies and institutions approved by the department for the
4041 purpose of providing basic certification training for firesafety
4042 inspectors; or
4043 2. Have received in another state training which is
4044 determined by the department to be at least equivalent to that
4045 required by the department for approved firesafety inspector
4046 education and training programs in this state.
4047 (3) Each special state firesafety inspection which is
4048 required by law and is conducted by or on behalf of an agency of
4049 the state must be performed by an individual who has met the
4050 provision of subsection (2), except that the duration of the
4051 training program shall not exceed 120 hours of specific training
4052 for the type of property that such special state firesafety
4053 inspectors are assigned to inspect.
4054 (4) A firefighter certified pursuant to s. 633.35 may
4055 conduct firesafety inspections, under the supervision of a
4056 certified firesafety inspector, while on duty as a member of a
4057 fire department company conducting inservice firesafety
4058 inspections without being certified as a firesafety inspector,
4059 if such firefighter has satisfactorily completed an inservice
4060 fire department company inspector training program of at least

4061 24 hours' duration as provided by rule of the department.
4062 (5) Every firesafety inspector or special state firesafety
4063 inspector certificate is valid for a period of 3 years from the
4064 date of issuance. Renewal of certification shall be subject to
4065 the affected person's completing proper application for renewal
4066 and meeting all of the requirements for renewal as established
4067 under this chapter or by rule promulgated thereunder, which
4068 shall include completion of at least 40 hours during the
4069 preceding 3-year period of continuing education as required by
4070 the rule of the department or, in lieu thereof, successful
4071 passage of an examination as established by the department.
4072 (6) The State Fire Marshal may deny, refuse to renew,
4073 suspend, or revoke the certificate of a firesafety inspector or
4074 special state firesafety inspector if it finds that any of the
4075 following grounds exist:
4076 (a) Any cause for which issuance of a certificate could
4077 have been refused had it then existed and been known to the
4078 State Fire Marshal.
4079 (b) Violation of this chapter or any rule or order of the
4080 State Fire Marshal.
4081 (c) Falsification of records relating to the certificate.
4082 (d) Having been found guilty of or having pleaded guilty
4083 or nolo contendere to a felony, whether or not a judgment of
4084 conviction has been entered.
4085 (e) Failure to meet any of the renewal requirements.
4086 (f) Having been convicted of a crime in any jurisdiction
4087 which directly relates to the practice of fire code inspection,
4088 plan review, or administration.

4089 (g) Making or filing a report or record that the
4090 certificateholder knows to be false, or knowingly inducing
4091 another to file a false report or record, or knowingly failing
4092 to file a report or record required by state or local law, or
4093 knowingly impeding or obstructing such filing, or knowingly
4094 inducing another person to impede or obstruct such filing.
4095 (h) Failing to properly enforce applicable fire codes or
4096 permit requirements within this state which the
4097 certificateholder knows are applicable by committing willful
4098 misconduct, gross negligence, gross misconduct, repeated
4099 negligence, or negligence resulting in a significant danger to
4100 life or property.
4101 (i) Accepting labor, services, or materials at no charge
4102 or at a noncompetitive rate from any person who performs work
4103 that is under the enforcement authority of the certificateholder
4104 and who is not an immediate family member of the
4105 certificateholder. For the purpose of this paragraph, the term
4106 "immediate family member" means a spouse, child, parent,
4107 sibling, grandparent, aunt, uncle, or first cousin of the person
4108 or the person's spouse or any person who resides in the primary
4109 residence of the certificateholder.
4110 (7) The Division of State Fire Marshal and the Florida
4111 Building Code Administrators and Inspectors Board, established
4112 pursuant to s. 468.605, shall enter into a reciprocity agreement
4113 to facilitate joint recognition of continuing education
4114 recertification hours for certificateholders licensed under s.
4115 468.609 and firesafety inspectors certified under subsection
4116 (2).

4117 (8) The State Fire Marshal shall develop by rule an
4118 advanced training and certification program for firesafety
4119 inspectors having fire code management responsibilities. The
4120 program must be consistent with the appropriate provisions of
4121 NFPA 1037, or similar standards adopted by the division, and
4122 establish minimum training, education, and experience levels for
4123 firesafety inspectors having fire code management
4124 responsibilities.
4125 (9) The department shall provide by rule for the
4126 certification of firesafety inspectors.
4127 Section 100. Subsection (12) of section 641.495, Florida
4128 Statutes, is amended to read:
4129 641.495 Requirements for issuance and maintenance of
4130 certificate.—
4131 (12) The provisions of part I of chapter 395 do not apply
4132 to a health maintenance organization that, on or before January
4133 1, 1991, provides not more than 10 outpatient holding beds for
4134 short-term and hospice-type patients in an ambulatory care
4135 facility for its members, provided that such health maintenance
4136 organization maintains current accreditation by the Joint
4137 Commission ~~on Accreditation of Health Care Organizations~~, the
4138 Accreditation Association for Ambulatory Health Care, or the
4139 National Committee for Quality Assurance.
4140 Section 101. Subsection (13) of section 651.118, Florida
4141 Statutes, is amended to read:
4142 651.118 Agency for Health Care Administration;
4143 certificates of need; sheltered beds; community beds.—
4144 (13) Residents, as defined in this chapter, are not

4145 considered new admissions for the purpose of s.
4146 400.141(1)<u>(n)</u>~~(o)~~1.~~d.~~
4147 Section 102. Subsection (2) of section 766.1015, Florida
4148 Statutes, is amended to read:
4149 766.1015 Civil immunity for members of or consultants to
4150 certain boards, committees, or other entities.—
4151 (2) Such committee, board, group, commission, or other
4152 entity must be established in accordance with state law or in
4153 accordance with requirements of the Joint Commission ~~on~~
4154 ~~Accreditation of Healthcare Organizations~~, established and duly
4155 constituted by one or more public or licensed private hospitals
4156 or behavioral health agencies, or established by a governmental
4157 agency. To be protected by this section, the act, decision,
4158 omission, or utterance may not be made or done in bad faith or
4159 with malicious intent.
4160 Section 103. Subsection (4) of section 766.202, Florida
4161 Statutes, is amended to read:
4162 766.202 Definitions; ss. 766.201-766.212.—As used in ss.
4163 766.201-766.212, the term:
4164 (4) "Health care provider" means any hospital, ambulatory
4165 surgical center, or mobile surgical facility as defined and
4166 licensed under chapter 395; a birth center licensed under
4167 chapter 383; any person licensed under chapter 458, chapter 459,
4168 chapter 460, chapter 461, chapter 462, chapter 463, part I of
4169 chapter 464, chapter 466, chapter 467, <u>part XIV of chapter 468,</u>
4170 or chapter 486; a clinical lab licensed under chapter 483; a
4171 health maintenance organization certificated under part I of
4172 chapter 641; a blood bank; a plasma center; an industrial

4173 clinic; a renal dialysis facility; or a professional association
4174 partnership, corporation, joint venture, or other association
4175 for professional activity by health care providers.
4176 Section 104. Paragraph (j) is added to subsection (3) of
4177 section 817.505, Florida Statutes, to read:
4178 817.505 Patient brokering prohibited; exceptions;
4179 penalties.—
4180 (3) This section shall not apply to:
4181 (j) Any payments by an assisted living facility, as
4182 defined in s. 429.02, or any agreement for or solicitation,
4183 offer, or receipt of such payment by a referral service, which
4184 is permitted under s. 429.195(3).
4185 Section 105. The per-bed standard assisted living facility
4186 licensure fees, including the total fee, have been adjusted by
4187 the Consumer Price Index annually since 1998 and are not
4188 intended to be reset by this act. In addition to the Consumer
4189 Price Index adjustment, the per-bed fee is increased by $9 to
4190 neutralize the elimination of the limited nursing services
4191 specialty license fee.
4192 Section 106. This act shall take effect July 1, 2011.