

Amendment No.

CHAMBER ACTION

Senate

House

.

1 Representative Brodeur offered the following:

2
3 **Amendment to Amendment (243198) (with title amendment)**

4 Remove lines 5-180 of the amendment and insert:

5 Section 2. Section 627.64194, Florida Statutes, is created
6 to read:

7 627.64194 Coverage for orthotics and prosthetics and
8 orthoses and prostheses.—Each accident or health insurance
9 policy issued, amended, delivered, or renewed in this state on
10 or after January 1, 2015, which provides medical coverage that
11 includes physician services in a physician's office and that
12 provides major medical or similar comprehensive type coverage
13 must evaluate and review coverage for orthotics and prosthetics
14 and orthoses and prostheses as those terms are defined in s.

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15 468.80. Such evaluation and review must compare the coverage
16 provided under federal law by health insurance for the aged and
17 disabled pursuant to 42 U.S.C. ss. 1395k, 1395l, and 1395m and
18 42 C.F.R. ss. 410.100, 414.202, 414.210, and 414.228, and as
19 applicable to this section.

20 (1) The insurance policy may require recommendations for
21 orthotics and prosthetics and orthoses and prostheses in the
22 same manner that prior authorization is required for any other
23 covered benefit.

24 (2) Recommended benefits for orthoses or prostheses are
25 limited to the most appropriate model that adequately meets the
26 medical needs of the patient as determined by the insured's
27 treating physician. Subject to copayments and deductibles, the
28 repair and replacement of orthoses or prostheses are also
29 recommended unless necessitated by misuse or loss.

30 (3) An insurer may require that benefits recommended
31 pursuant to this section be covered benefits only if orthotics
32 or prosthetics are rendered by an orthotist or prosthetist and
33 the orthoses or prostheses are provided by a vendor.

34 (4) This section does not apply to insurance coverage
35 recommended benefits for hospital confinement indemnity,
36 disability income, accident only, long-term care, Medicare
37 supplement, limited benefit health, specified disease indemnity,
38 sickness or bodily injury or death by accident or both, and
39 other limited benefit policies.

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40 Section 3. Section 627.66915, Florida Statutes, is created
41 to read:

42 627.66915 Recommended coverage for orthoses and prostheses
43 and orthotics and prosthetics.—Each group, blanket, or franchise
44 accident or health insurance policy issued, amended, delivered,
45 or renewed in this state on or after January 1, 2014, which
46 recommends coverage for physician services in a physician's
47 office and that provides major medical or similar comprehensive
48 type coverage must recommend coverage for orthotics and
49 prosthetics and orthoses and prostheses as those terms are
50 defined in s. 468.80. Such recommendation must equal the
51 coverage provided under federal law by health insurance for the
52 aged and disabled pursuant to 42 U.S.C. ss. 1395k, 1395l, and
53 1395m and 42 C.F.R. ss. 410.100, 414.202, 414.210, and 414.228,
54 and as applicable to this section.

55 (1) The recommended coverage is subject to the deductible
56 and coinsurance provisions applicable to outpatient visits and
57 to all other terms and conditions applicable to other benefits.

58 (2) For an appropriate additional premium, an insurer
59 subject to this section shall make available to the
60 policyholder, as part of the application, the recommended
61 coverage in this section without such coverage being subject to
62 the deductible or coinsurance provisions of the policy.

63 (3) The insurance policy may recommend prior authorization
64 for orthotics and prosthetics and orthoses and prostheses in the

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65 same manner that prior authorization is recommended for any
66 other covered benefit.

67 (4) Recommended benefits for orthoses or prostheses are
68 limited to the most appropriate model that adequately meets the
69 medical needs of the patient as determined by the insured's
70 treating physician. Subject to copayments and deductibles, the
71 repair and replacement of orthoses or prostheses are also
72 recommended, unless necessitated by misuse or loss.

73 (5) An insurer may recommend that benefits evaluated and
74 reviewed pursuant to this section be recommended benefits only
75 if orthotics or prosthetics are rendered by an orthotist or
76 prosthetist and the orthoses or prostheses are provided by a
77 vendor.

78 (6) This section does not apply to insurance
79 recommendations providing benefits for hospital confinement
80 indemnity, disability income, accident only, long-term care,
81 Medicare supplement, limited benefit health, specified disease
82 indemnity, sickness or bodily injury or death by accident or
83 both, and other limited benefit policies.

84 Section 4. Subsection (44) is added to section 641.31,
85 Florida Statutes, to read:

86 641.31 Health maintenance contracts.-

87 (44) Each health maintenance contract issued, amended,
88 delivered, or renewed in this state on or after January 1, 2014,
89 which recommends medical coverage that includes physician
90 services in a physician's office and that recommends major

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91 medical or similar comprehensive type coverage must evaluate and
92 review coverage for orthotics and prosthetics and orthoses and
93 prostheses as those terms are defined in s. 468.80. Such
94 recommended coverage must equal the coverage provided under
95 federal law by health insurance for the aged and disabled
96 pursuant to 42 U.S.C. ss. 1395k, 1395l, and 1395m and 42 C.F.R.
97 ss. 410.100, 414.202, 414.210, and 414.228, and as applicable to
98 this section.

99 (a) The recommendation is subject to the deductible and
100 coinsurance provisions applicable to outpatient visits and to
101 all other terms and conditions applicable to other benefits.

102 (b) For an appropriate additional premium, a health
103 maintenance organization subject to this subsection shall
104 recommend to the subscriber, as part of the application, the
105 coverage required in this subsection without such coverage being
106 subject to the deductible or coinsurance provisions of the
107 contract.

108 (c) A health maintenance contract may require prior
109 authorization for orthotics and prosthetics and orthoses and
110 prostheses in the same manner that prior authorization is
111 required for any other recommended benefit.

112 (d) Recommended benefits for orthoses or prostheses are
113 limited to the most appropriate model that adequately meets the
114 medical needs of the patient as determined by the insured's
115 treating physician. Subject to copayments and deductibles, the

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116 repair and replacement of orthoses or prostheses are also
117 recommended, unless necessitated by misuse or loss.

118 (e) A health maintenance contract may require that
119 benefits recommended pursuant to this subsection be recommended
120 benefits only if orthotics or prosthetics are rendered by an
121 orthotist or prosthetist and the orthoses or prostheses are
122 provided by a vendor.

123 (f) This subsection does not apply to insurance coverage
124 providing benefits for hospital confinement indemnity,
125 disability income, accident only, long-term care, Medicare
126 supplement, limited benefit health, specified disease indemnity,
127 sickness or bodily injury or death by accident or both, and
128 other limited benefit policies.

129 Section 5. (1) Effective upon this act becoming a law and
130 notwithstanding any other provision of law, a hospital that,
131 after the enactment of chapter 2004-259, Laws of Florida, has
132 operated continuously as a verified Level I, Level II, or
133 pediatric trauma center for a consecutive 12-month period,
134 remains operational for the consecutive 12-month period
135 immediately preceding the effective date of this act, and on or
136 before April 1, 2015, certifies to the department its compliance
137 with the Florida trauma standards, may continue to operate at
138 the same trauma center level as a verified Level I, Level II, or
139 pediatric trauma center until the approval period in s.
140 395.4025(6), Florida Statutes, expires, and as long as the
141 hospital continues to meet the requirements of s. 395.4025(6),

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142 Florida Statutes, related to trauma center standards and patient
143 outcomes. A hospital that meets the requirements of this
144 section shall be eligible for renewal of its 7-year approval
145 period pursuant to s. 395.4025(6), Florida Statutes.

146 (2) Effective upon this act becoming a law and
147 notwithstanding any other provision of law, a hospital that,
148 after the enactment of chapter 2004-259, Laws of Florida, has
149 operated continuously as a provisional Level I, Level II, or
150 pediatric trauma center for a consecutive 12-month period,
151 remains operational for the consecutive 12-month period
152 immediately preceding the effective date of this act, is
153 determined to be verified by the department on or before
154 December 31, 2014, and certifies to the department on or before
155 April 1, 2015, its compliance with the Florida trauma standards,
156 may continue to operate at the same trauma center level as a
157 verified Level I, Level II, or pediatric trauma center until the
158 approval period in s. 395.4025(6), Florida Statutes, expires as
159 long as the hospital continues to meet the requirements of s.
160 395.4025(6), Florida Statutes, related to trauma center
161 standards and patient outcomes. A hospital that meets the
162 requirements of this section shall be eligible for renewal of
163 its 7-year approval period pursuant to s. 395.4025(6), Florida
164 Statutes.

165 Section 6. Effective upon this act becoming a law,
166 paragraphs (k) through (o) of subsection (1) of section 395.401,
167 Florida Statutes, are redesignated as paragraphs (1) through

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168 (p), respectively, and a new paragraph (k) is added to that
169 subsection, to read:

170 395.401 Trauma services system plans; approval of trauma
171 centers and pediatric trauma centers; procedures; renewal.—

172 (1)

173 (k) A hospital operating a trauma center may not charge a
174 trauma activation fee greater than \$15,000. This paragraph
175 expires on July 1, 2015.

176 Section 7. Paragraphs (a) and (e) of subsection (2) and
177 subsection (4) of section 395.402, Florida Statutes, are amended
178 to read:

179 395.402 Trauma service areas; number and location of
180 trauma centers.—

181 (2) Trauma service areas as defined in this section are to
182 be utilized until the Department of Health completes an
183 assessment of the trauma system and reports its finding to the
184 Governor, the President of the Senate, the Speaker of the House
185 of Representatives, and the substantive legislative committees.
186 The report shall be submitted by February 1, 2005. The
187 department shall review the existing trauma system and determine
188 whether it is effective in providing trauma care uniformly
189 throughout the state. The assessment shall:

190 ~~(a) Consider aligning trauma service areas within the~~
191 ~~trauma region boundaries as established in July 2004.~~

192 ~~(e) Review the Regional Domestic Security Task Force~~
193 ~~structure and determine whether integrating the trauma system~~

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194 ~~planning with interagency regional emergency and disaster~~
195 ~~planning efforts is feasible and identify any duplication of~~
196 ~~efforts between the two entities.~~

197 (4) Annually thereafter, the department shall review the
198 assignment of the 67 counties to trauma service areas, in
199 addition to the requirements of paragraphs (2) (a)-(f) ~~(2) (b)-(g)~~
200 and subsection (3). County assignments are made for the purpose
201 of developing a system of trauma centers. Revisions made by the
202 department shall take into consideration the recommendations
203 made as part of the regional trauma system plans approved by the
204 department and the recommendations made as part of the state
205 trauma system plan. In cases where a trauma service area is
206 located within the boundaries of more than one trauma region,
207 the trauma service area's needs, response capability, and system
208 requirements shall be considered by each trauma region served by
209 that trauma service area in its regional system plan. Until the
210 department completes the February 2005 assessment, the
211 assignment of counties shall remain as established in this
212 section.

213 (a) The following trauma service areas are hereby
214 established:

215 1. Trauma service area 1 shall consist of Escambia,
216 Okaloosa, Santa Rosa, and Walton Counties.

217 2. Trauma service area 2 shall consist of Bay, Gulf,
218 Holmes, and Washington Counties.

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219 3. Trauma service area 3 shall consist of Calhoun,
220 Franklin, Gadsden, Jackson, Jefferson, Leon, Liberty, Madison,
221 Taylor, and Wakulla Counties.

222 4. Trauma service area 4 shall consist of Alachua,
223 Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy,
224 Putnam, Suwannee, and Union Counties.

225 5. Trauma service area 5 shall consist of Baker, Clay,
226 Duval, Nassau, and St. Johns Counties.

227 6. Trauma service area 6 shall consist of Citrus,
228 Hernando, and Marion Counties.

229 7. Trauma service area 7 shall consist of Flagler and
230 Volusia Counties.

231 8. Trauma service area 8 shall consist of Lake, Orange,
232 Osceola, Seminole, and Sumter Counties.

233 9. Trauma service area 9 shall consist of Pasco and
234 Pinellas Counties.

235 10. Trauma service area 10 shall consist of Hillsborough
236 County.

237 11. Trauma service area 11 shall consist of Hardee,
238 Highlands, and Polk Counties.

239 12. Trauma service area 12 shall consist of Brevard and
240 Indian River Counties.

241 13. Trauma service area 13 shall consist of DeSoto,
242 Manatee, and Sarasota Counties.

243 14. Trauma service area 14 shall consist of Martin,
244 Okeechobee, and St. Lucie Counties.

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245 15. Trauma service area 15 shall consist of Charlotte,
246 Collier, Glades, Hendry, and Lee Counties.

247 16. Trauma service area 16 shall consist of Palm Beach
248 County.

249 ~~17. Trauma service area 17 shall consist of Collier~~
250 ~~County.~~

251 ~~17.18.~~ Trauma service area 17 ~~18~~ shall consist of Broward
252 County.

253 ~~18.19.~~ Trauma service area 18 ~~19~~ shall consist of Miami-
254 Dade and Monroe Counties.

255 (b) Each trauma service area should have at least one
256 Level I or Level II trauma center. The department shall
257 allocate, by rule, the number of trauma centers needed for each
258 trauma service area.

259 (c) There shall be no more than a total of 44 trauma
260 centers in the state.

261 Section 8. Effective upon this act becoming a law,
262 subsection (7) of section 395.4025, Florida Statutes, is amended
263 and subsections (15) and (16) are added to read:

264 395.4025 Trauma centers; selection; quality assurance;
265 records.—

266 (7) A trauma center, or a any hospital that has submitted
267 an application for selection as a trauma center within the same
268 trauma service area as another applicant for a trauma center,
269 may that wishes to protest a decision made by the department
270 based on the department's preliminary or in-depth review of

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271 applications or on the recommendations of the site visit review
272 team pursuant to this section shall proceed as provided in
273 chapter 120. Hearings held under this subsection shall be
274 conducted in the same manner as provided in ss. 120.569 and
275 120.57. Cases filed under chapter 120 may combine all disputes
276 between parties.

277 (15) The department may not designate or provisionally
278 approve any hospital to operate as a trauma center through the
279 procedures established in subsections (1) through (13). This
280 subsection expires the earlier of July 1, 2015, or upon the
281 effective date a rule adopted by the department allocating the
282 number of trauma centers needed for each trauma service area as
283 provided in s. 395.402(4).

284 (16) Each trauma center must post its trauma activation
285 fee amount in a conspicuous place within the trauma center and
286 in a prominent position on the home page of the trauma center's
287 Internet website.

288 Section 9. Paragraph (t) is added to subsection (3) of
289 section 408.036, Florida Statutes, to read:

290 408.036 Projects subject to review; exemptions.—

291 (3) EXEMPTIONS.—Upon request, the following projects are
292 subject to exemption from the provisions of subsection (1):

293 (t) For the relocation of not more than 15 percent of an
294 acute care hospital's beds licensed under chapter 395 within the
295 county in which the hospital is located. In addition to any

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296 other documentation otherwise required by the agency, a request
297 for exemption submitted under this paragraph must certify that:

298 1. The applicant is a nonpublic hospital with at least 600
299 beds licensed under chapter 395.

300 2. The hospital provides care to a greater percentage of
301 charity care as defined in s. 409.911(1)(c) than any other acute
302 care hospital operating in the same county.

303 3. At least 12.5 percent of the care provided by the
304 applicant qualifies as charity care as defined in s.
305 409.911(1)(c) measured by gross revenues or patient days for the
306 most recent fiscal year reported in the Florida Hospital Uniform
307 Reporting System.

308 4. The applicant has no greater than and no less than an
309 investment grade bond credit rating from a nationally recognized
310 statistical rating organization.

311 5. Relocation of the beds is for the purpose of enhancing
312 the fiscal stability of the applicant's facility.

313 Section 10. Notwithstanding s. 893.055, Florida Statutes,
314 for the 2014-2015 fiscal year, the sum of \$500,000 in
315 nonrecurring funds is appropriated from the General Revenue Fund
316 to the Department of Health for the general administration of
317 the prescription drug monitoring program.

318 Section 11. Paragraph (c) of subsection (4) of section
319 458.348, Florida Statutes, is amended to read:

320 458.348 Formal supervisory relationships, standing orders,
321 and established protocols; notice; standards.—

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(4) SUPERVISORY RELATIONSHIPS IN MEDICAL OFFICE SETTINGS.—

A physician who supervises an advanced registered nurse practitioner or physician assistant at a medical office other than the physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising physician, must comply with the standards set forth in this subsection. For the purpose of this subsection, a physician's "primary practice location" means the address reflected on the physician's profile published pursuant to s. 456.041.

(c) A physician who supervises an advanced registered nurse practitioner or physician assistant at a medical office other than the physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising physician and the services offered at the office are primarily dermatologic or skin care services, which include aesthetic skin care services other than plastic surgery, must comply with the standards listed in subparagraphs 1.-4. Notwithstanding s. 458.347(4)(e)6., a physician supervising a physician assistant pursuant to this paragraph may not be required to review and cosign charts or medical records prepared by such physician assistant.

1. The physician shall submit to the board the addresses of all offices where he or she is supervising an advanced

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347 registered nurse practitioner or a physician's assistant which
348 are not the physician's primary practice location.

349 2. The physician must be board certified or board eligible
350 in dermatology or plastic surgery as recognized by the board
351 pursuant to s. 458.3312.

352 3. All such offices that are not the physician's primary
353 place of practice must be within 25 miles of the physician's
354 primary place of practice or in a county that is contiguous to
355 the county of the physician's primary place of practice.
356 However, the distance between any of the offices may not exceed
357 75 miles.

358 4. The physician may supervise only one office other than
359 the physician's primary place of practice except that until July
360 1, 2011, the physician may supervise up to two medical offices
361 other than the physician's primary place of practice if the
362 addresses of the offices are submitted to the board before July
363 1, 2006. Effective July 1, 2011, the physician may supervise
364 only one office other than the physician's primary place of
365 practice, regardless of when the addresses of the offices were
366 submitted to the board.

367 5. As used in this subparagraph, the term "nonablative
368 aesthetic skin care services" includes, but is not limited to,
369 services provided using intense pulsed light, lasers, radio
370 frequency, ultrasound, injectables, and fillers.

371 a. Subparagraph 2. does not apply to offices at which
372 nonablative aesthetic skin care services are performed by a

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373 physician assistant under the supervision of a physician if the
374 physician assistant has successfully completed at least:

375 (I) Forty hours of postlicensure education and clinical
376 training on physiology of the skin, skin conditions, skin
377 disorders, skin diseases, preprocedure and postprocedure skin
378 care, and infection control, or has worked under the supervision
379 of a board-certified dermatologist within the preceding 12
380 months.

381 (II) Forty hours of postlicensure education and clinical
382 training on laser and light technologies and skin applications,
383 or has 6 months of clinical experience working under the
384 supervision of a board-certified dermatologist who is authorized
385 to perform nonablative aesthetic skin care services.

386 (III) Thirty-two hours of postlicensure education and
387 clinical training on injectables and fillers, or has 6 months of
388 clinical experience working under the supervision of a board-
389 certified dermatologist who is authorized to perform nonablative
390 aesthetic skin care services.

391 b. The physician assistant shall submit to the board
392 documentation evidencing successful completion of the education
393 and training required under this subparagraph.

394 c. For purposes of compliance with s. 458.347(3), a
395 physician who has completed 24 hours of education and clinical
396 training on nonablative aesthetic skin care services, the
397 curriculum of which has been preapproved by the Board of
398 Medicine, is qualified to supervise a physician assistant

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399 performing nonablative aesthetic skin care services pursuant to
400 this subparagraph.

401 Section 12. Section 394.4574, Florida Statutes, is amended
402 to read:

403 394.4574 ~~Department~~ Responsibilities for coordination of
404 services for a mental health resident who resides in an assisted
405 living facility that holds a limited mental health license.—

406 (1) As used in this section, the term "mental health
407 resident," ~~for purposes of this section,~~ means an individual who
408 receives social security disability income due to a mental
409 disorder as determined by the Social Security Administration or
410 receives supplemental security income due to a mental disorder
411 as determined by the Social Security Administration and receives
412 optional state supplementation.

413 (2) Medicaid managed care plans are responsible for
414 Medicaid enrolled mental health residents, and managing entities
415 under contract with the department are responsible for mental
416 health residents who are not enrolled in a Medicaid health plan.
417 A Medicaid managed care plan or a managing entity shall ~~The~~
418 ~~department must~~ ensure that:

419 (a) A mental health resident has been assessed by a
420 psychiatrist, clinical psychologist, clinical social worker, or
421 psychiatric nurse, or an individual who is supervised by one of
422 these professionals, and determined to be appropriate to reside
423 in an assisted living facility. The documentation must be
424 provided to the administrator of the facility within 30 days

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425 after the mental health resident has been admitted to the
426 facility. An evaluation completed upon discharge from a state
427 mental hospital meets the requirements of this subsection
428 related to appropriateness for placement as a mental health
429 resident if it was completed within 90 days before ~~prior to~~
430 admission to the facility.

431 (b) A cooperative agreement, as required in s. 429.075, is
432 developed by ~~between~~ the mental health care services provider
433 that serves a mental health resident and the administrator of
434 the assisted living facility with a limited mental health
435 license in which the mental health resident is living. ~~Any~~
436 ~~entity that provides Medicaid prepaid health plan services shall~~
437 ~~ensure the appropriate coordination of health care services with~~
438 ~~an assisted living facility in cases where a Medicaid recipient~~
439 ~~is both a member of the entity's prepaid health plan and a~~
440 ~~resident of the assisted living facility. If the entity is at~~
441 ~~risk for Medicaid targeted case management and behavioral health~~
442 ~~services, the entity shall inform the assisted living facility~~
443 ~~of the procedures to follow should an emergent condition arise.~~

444 (c) The community living support plan, as defined in s.
445 429.02, has been prepared by a mental health resident and his or
446 her ~~a~~ mental health case manager ~~of that resident~~ in
447 consultation with the administrator of the facility or the
448 administrator's designee. The plan must be completed and
449 provided to the administrator of the assisted living facility
450 with a limited mental health license in which the mental health

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451 resident lives within 30 days after the resident's admission.

452 The support plan and the agreement may be in one document.

453 (d) The assisted living facility with a limited mental
454 health license is provided with documentation that the
455 individual meets the definition of a mental health resident.

456 (e) The mental health services provider assigns a case
457 manager to each mental health resident for whom the entity is
458 responsible ~~who lives in an assisted living facility with a~~
459 ~~limited mental health license.~~ The case manager shall coordinate
460 ~~is responsible for coordinating~~ the development ~~of~~ and
461 implementation of the community living support plan defined in
462 s. 429.02. The plan must be updated at least annually, or when
463 there is a significant change in the resident's behavioral
464 health status, such as an inpatient admission or a change in
465 medication, level of service, or residence. Each case manager
466 shall keep a record of the date and time of any face-to-face
467 interaction with the resident and make the record available to
468 the responsible entity for inspection. The record must be
469 retained for at least 2 years after the date of the most recent
470 interaction.

471 (f) Adequate and consistent monitoring and implementation
472 of community living support plans and cooperative agreements are
473 conducted by the resident's case manager.

474 (g) Concerns are reported to the appropriate regulatory
475 oversight organization if a regulated provider fails to deliver

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476 appropriate services or otherwise acts in a manner that has the
477 potential to result in harm to the resident.

478 (3) The Secretary of Children and ~~Families~~ Family
479 ~~Services~~, in consultation with the Agency for Health Care
480 Administration, shall ~~annually~~ require each district
481 administrator to develop, with community input, a detailed
482 annual plan that demonstrates ~~detailed plans that demonstrate~~
483 how the district will ensure the provision of state-funded
484 mental health and substance abuse treatment services to
485 residents of assisted living facilities that hold a limited
486 mental health license. This plan ~~These plans~~ must be consistent
487 with the substance abuse and mental health district plan
488 developed pursuant to s. 394.75 and must address case management
489 services; access to consumer-operated drop-in centers; access to
490 services during evenings, weekends, and holidays; supervision of
491 the clinical needs of the residents; and access to emergency
492 psychiatric care.

493 Section 13. Subsection (1) of section 400.0074, Florida
494 Statutes, is amended, and paragraph (h) is added to subsection
495 (2) of that section, to read:

496 400.0074 Local ombudsman council onsite administrative
497 assessments.—

498 (1) In addition to any specific investigation conducted
499 pursuant to a complaint, the local council shall conduct, at
500 least annually, an onsite administrative assessment of each
501 nursing home, assisted living facility, and adult family-care

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502 home within its jurisdiction. This administrative assessment
503 must be comprehensive in nature and must shall focus on factors
504 affecting residents' ~~the~~ rights, health, safety, and welfare ~~of~~
505 ~~the residents~~. Each local council is encouraged to conduct a
506 similar onsite administrative assessment of each additional
507 long-term care facility within its jurisdiction.

508 (2) An onsite administrative assessment conducted by a
509 local council shall be subject to the following conditions:

510 (h) The local council shall conduct an exit consultation
511 with the facility administrator or administrator designee to
512 discuss issues and concerns in areas affecting residents'
513 rights, health, safety, and welfare and, if needed, make
514 recommendations for improvement.

515 Section 14. Subsection (2) of section 400.0078, Florida
516 Statutes, is amended to read:

517 400.0078 Citizen access to State Long-Term Care Ombudsman
518 Program services.-

519 ~~(2) Every resident or representative of a resident shall~~
520 ~~receive,~~ Upon admission to a long-term care facility, each
521 resident or representative of a resident must receive
522 information regarding the purpose of the State Long-Term Care
523 Ombudsman Program, the statewide toll-free telephone number for
524 receiving complaints, information that retaliatory action cannot
525 be taken against a resident for presenting grievances or for
526 exercising any other resident right, and other relevant
527 information regarding how to contact the program. Each resident

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528 or his or her representative ~~Residents or their representatives~~
529 must be furnished additional copies of this information upon
530 request.

531 Section 15. Paragraph (c) of subsection (4) of section
532 409.212, Florida Statutes, is amended to read:

533 409.212 Optional supplementation.—

534 (4) In addition to the amount of optional supplementation
535 provided by the state, a person may receive additional
536 supplementation from third parties to contribute to his or her
537 cost of care. Additional supplementation may be provided under
538 the following conditions:

539 (c) The additional supplementation shall not exceed four
540 ~~two~~ times the provider rate recognized under the optional state
541 supplementation program.

542 Section 16. Subsection (13) of section 429.02, Florida
543 Statutes, is amended to read:

544 429.02 Definitions.—When used in this part, the term:

545 (13) "Limited nursing services" means acts that may be
546 performed by a person licensed under ~~pursuant to~~ part I of
547 chapter 464 ~~by persons licensed thereunder while carrying out~~
548 ~~their professional duties but limited to those acts which the~~
549 ~~department specifies by rule. Acts which may be specified by~~
550 ~~rule as allowable~~ Limited nursing services shall be for persons
551 who meet the admission criteria established by the department
552 for assisted living facilities and shall not be complex enough
553 to require 24-hour nursing supervision and may include such

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554 services as the application and care of routine dressings, and
555 care of casts, braces, and splints.

556 Section 17. Paragraphs (b) and (c) of subsection (3) of
557 section 429.07, Florida Statutes, are amended to read:

558 429.07 License required; fee.—

559 (3) In addition to the requirements of s. 408.806, each
560 license granted by the agency must state the type of care for
561 which the license is granted. Licenses shall be issued for one
562 or more of the following categories of care: standard, extended
563 congregate care, limited nursing services, or limited mental
564 health.

565 (b) An extended congregate care license shall be issued to
566 each facility that has been licensed as an assisted living
567 facility for 2 or more years and that provides services
568 ~~facilities providing~~, directly or through contract, ~~services~~
569 beyond those authorized in paragraph (a), including services
570 performed by persons licensed under part I of chapter 464 and
571 supportive services, as defined by rule, to persons who would
572 otherwise be disqualified from continued residence in a facility
573 licensed under this part. An extended congregate care license
574 may be issued to a facility that has a provisional extended
575 congregate care license and meets the requirements for licensure
576 under subparagraph 2. The primary purpose of extended congregate
577 care services is to allow residents the option of remaining in a
578 familiar setting from which they would otherwise be disqualified
579 for continued residency as they become more impaired. A facility

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580 licensed to provide extended congregate care services may also
581 admit an individual who exceeds the admission criteria for a
582 facility with a standard license, if he or she is determined
583 appropriate for admission to the extended congregate care
584 facility.

585 1. In order for extended congregate care services to be
586 provided, the agency must first determine that all requirements
587 established in law and rule are met and must specifically
588 designate, on the facility's license, that such services may be
589 provided and whether the designation applies to all or part of
590 the facility. This ~~Such~~ designation may be made at the time of
591 initial licensure or relicensure, or upon request in writing by
592 a licensee under this part and part II of chapter 408. The
593 notification of approval or the denial of the request shall be
594 made in accordance with part II of chapter 408. Each existing
595 facility that qualifies ~~facilities qualifying~~ to provide
596 extended congregate care services must have maintained a
597 standard license and may not have been subject to administrative
598 sanctions during the previous 2 years, or since initial
599 licensure if the facility has been licensed for less than 2
600 years, for any of the following reasons:

- 601 a. A class I or class II violation;
- 602 b. Three or more repeat or recurring class III violations
603 of identical or similar resident care standards from which a
604 pattern of noncompliance is found by the agency;

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605 c. Three or more class III violations that were not
606 corrected in accordance with the corrective action plan approved
607 by the agency;

608 d. Violation of resident care standards which results in
609 requiring the facility to employ the services of a consultant
610 pharmacist or consultant dietitian;

611 e. Denial, suspension, or revocation of a license for
612 another facility licensed under this part in which the applicant
613 for an extended congregate care license has at least 25 percent
614 ownership interest; or

615 f. Imposition of a moratorium pursuant to this part or
616 part II of chapter 408 or initiation of injunctive proceedings.

617
618 The agency may deny or revoke a facility's extended congregate
619 care license for not meeting the criteria for an extended
620 congregate care license as provided in this subparagraph.

621 2. If an assisted living facility has been licensed for
622 less than 2 years, the initial extended congregate care license
623 must be provisional and may not exceed 6 months. Within the
624 first 3 months after the provisional license is issued, the
625 licensee shall notify the agency, in writing, when it has
626 admitted at least one extended congregate care resident, after
627 which an unannounced inspection shall be made to determine
628 compliance with the requirements of an extended congregate care
629 license. Failure to admit an extended congregate care resident
630 within the first 3 months shall render the extended congregate

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631 care license void. A licensee with a provisional extended
632 congregate care license that demonstrates compliance with all
633 the requirements of an extended congregate care license during
634 the inspection shall be issued an extended congregate care
635 license. In addition to sanctions authorized under this part, if
636 violations are found during the inspection and the licensee
637 fails to demonstrate compliance with all assisted living
638 facility requirements during a followup inspection, the licensee
639 shall immediately suspend extended congregate care services, and
640 the provisional extended congregate care license expires. The
641 agency may extend the provisional license for not more than 1
642 month in order to complete a followup visit.

643 3.2. A facility that is licensed to provide extended
644 congregate care services shall maintain a written progress
645 report on each person who receives services which describes the
646 type, amount, duration, scope, and outcome of services that are
647 rendered and the general status of the resident's health. A
648 registered nurse, or appropriate designee, representing the
649 agency shall visit the facility at least twice a year ~~quarterly~~
650 to monitor residents who are receiving extended congregate care
651 services and to determine if the facility is in compliance with
652 this part, part II of chapter 408, and relevant rules. One of
653 the visits may be in conjunction with the regular survey. The
654 monitoring visits may be provided through contractual
655 arrangements with appropriate community agencies. A registered
656 nurse shall serve as part of the team that inspects the

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657 facility. The agency may waive one of the required yearly
658 monitoring visits for a facility that has:

659 a. Held an extended congregate care license for at least
660 24 months; ~~been licensed for at least 24 months to provide~~
661 ~~extended congregate care services, if, during the inspection,~~
662 ~~the registered nurse determines that extended congregate care~~
663 ~~services are being provided appropriately, and if the facility~~
664 ~~has~~

665 b. No class I or class II violations and no uncorrected
666 class III violations; ~~and.~~

667 c. No ombudsman council complaints that resulted in a
668 citation for licensure. ~~The agency must first consult with the~~
669 ~~long-term care ombudsman council for the area in which the~~
670 ~~facility is located to determine if any complaints have been~~
671 ~~made and substantiated about the quality of services or care.~~
672 ~~The agency may not waive one of the required yearly monitoring~~
673 ~~visits if complaints have been made and substantiated.~~

674 ~~4.3.~~ A facility that is licensed to provide extended
675 congregate care services must:

676 a. Demonstrate the capability to meet unanticipated
677 resident service needs.

678 b. Offer a physical environment that promotes a homelike
679 setting, provides for resident privacy, promotes resident
680 independence, and allows sufficient congregate space as defined
681 by rule.

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682 c. Have sufficient staff available, taking into account
683 the physical plant and firesafety features of the building, to
684 assist with the evacuation of residents in an emergency.

685 d. Adopt and follow policies and procedures that maximize
686 resident independence, dignity, choice, and decisionmaking to
687 permit residents to age in place, so that moves due to changes
688 in functional status are minimized or avoided.

689 e. Allow residents or, if applicable, a resident's
690 representative, designee, surrogate, guardian, or attorney in
691 fact to make a variety of personal choices, participate in
692 developing service plans, and share responsibility in
693 decisionmaking.

694 f. Implement the concept of managed risk.

695 g. Provide, directly or through contract, the services of
696 a person licensed under part I of chapter 464.

697 h. In addition to the training mandated in s. 429.52,
698 provide specialized training as defined by rule for facility
699 staff.

700 ~~5.4.~~ A facility that is licensed to provide extended
701 congregate care services is exempt from the criteria for
702 continued residency set forth in rules adopted under s. 429.41.
703 A licensed facility must adopt its own requirements within
704 guidelines for continued residency set forth by rule. However,
705 the facility may not serve residents who require 24-hour nursing
706 supervision. A licensed facility that provides extended
707 congregate care services must also provide each resident with a

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708 written copy of facility policies governing admission and
709 retention.

710 ~~5. The primary purpose of extended congregate care~~
711 ~~services is to allow residents, as they become more impaired,~~
712 ~~the option of remaining in a familiar setting from which they~~
713 ~~would otherwise be disqualified for continued residency. A~~
714 ~~facility licensed to provide extended congregate care services~~
715 ~~may also admit an individual who exceeds the admission criteria~~
716 ~~for a facility with a standard license, if the individual is~~
717 ~~determined appropriate for admission to the extended congregate~~
718 ~~care facility.~~

719 6. Before the admission of an individual to a facility
720 licensed to provide extended congregate care services, the
721 individual must undergo a medical examination as provided in s.
722 429.26(4) and the facility must develop a preliminary service
723 plan for the individual.

724 7. If ~~When~~ a facility can no longer provide or arrange for
725 services in accordance with the resident's service plan and
726 needs and the facility's policy, the facility must ~~shall~~ make
727 arrangements for relocating the person in accordance with s.
728 429.28(1)(k).

729 ~~8. Failure to provide extended congregate care services~~
730 ~~may result in denial of extended congregate care license~~
731 ~~renewal.~~

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732 (c) A limited nursing services license shall be issued to
733 a facility that provides services beyond those authorized in
734 paragraph (a) and as specified in this paragraph.

735 1. In order for limited nursing services to be provided in
736 a facility licensed under this part, the agency must first
737 determine that all requirements established in law and rule are
738 met and must specifically designate, on the facility's license,
739 that such services may be provided. This ~~Such~~ designation may be
740 made at the time of initial licensure or licensure renewal
741 ~~relicensure~~, or upon request in writing by a licensee under this
742 part and part II of chapter 408. Notification of approval or
743 denial of such request shall be made in accordance with part II
744 of chapter 408. An existing facility that qualifies ~~facilities~~
745 ~~qualifying~~ to provide limited nursing services must ~~shall~~ have
746 maintained a standard license and may not have been subject to
747 administrative sanctions that affect the health, safety, and
748 welfare of residents for the previous 2 years or since initial
749 licensure if the facility has been licensed for less than 2
750 years.

751 2. A facility ~~Facilities~~ that is ~~are~~ licensed to provide
752 limited nursing services shall maintain a written progress
753 report on each person who receives such nursing services. The
754 ~~which~~ report must describe ~~describes~~ the type, amount, duration,
755 scope, and outcome of services that are rendered and the general
756 status of the resident's health. A registered nurse representing
757 the agency shall visit the facility ~~such facilities~~ at least

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758 annually ~~twice a year~~ to monitor residents who are receiving
759 limited nursing services and to determine if the facility is in
760 compliance with applicable provisions of this part, part II of
761 chapter 408, and related rules. The monitoring visits may be
762 provided through contractual arrangements with appropriate
763 community agencies. A registered nurse shall also serve as part
764 of the team that inspects such facility. Visits may be in
765 conjunction with other agency inspections. The agency may waive
766 the required yearly monitoring visit for a facility that has:

767 a. Had a limited nursing services license for at least 24
768 months;

769 b. No class I or class II violations and no uncorrected
770 class III violations; and

771 c. No ombudsman council complaints that resulted in a
772 citation for licensure.

773 3. A person who receives limited nursing services under
774 this part must meet the admission criteria established by the
775 agency for assisted living facilities. When a resident no longer
776 meets the admission criteria for a facility licensed under this
777 part, arrangements for relocating the person shall be made in
778 accordance with s. 429.28(1)(k), unless the facility is licensed
779 to provide extended congregate care services.

780 Section 18. Section 429.075, Florida Statutes, is amended
781 to read:

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782 429.075 Limited mental health license.—An assisted living
783 facility that serves one ~~three~~ or more mental health residents
784 must obtain a limited mental health license.

785 (1) To obtain a limited mental health license, a facility
786 must hold a standard license as an assisted living facility,
787 must not have any current uncorrected ~~deficiencies or~~
788 violations, and must ensure that, within 6 months after
789 receiving a limited mental health license, the facility
790 administrator and the staff of the facility who are in direct
791 contact with mental health residents must complete training of
792 no less than 6 hours related to their duties. This ~~Such~~
793 designation may be made at the time of initial licensure or
794 relicensure or upon request in writing by a licensee under this
795 part and part II of chapter 408. Notification of approval or
796 denial of such request shall be made in accordance with this
797 part, part II of chapter 408, and applicable rules. This
798 training must ~~will~~ be provided by or approved by the Department
799 of Children and Families ~~Family Services~~.

800 (2) A facility that is ~~Facilities~~ licensed to provide
801 services to mental health residents must ~~shall~~ provide
802 appropriate supervision and staffing to provide for the health,
803 safety, and welfare of such residents.

804 (3) A facility that has a limited mental health license
805 must:

806 (a) Have a copy of each mental health resident's community
807 living support plan and the cooperative agreement with the

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808 mental health care services provider or provide written evidence
809 that a request for the community living support plan and the
810 cooperative agreement was sent to the Medicaid managed care plan
811 or managing entity under contract with the Department of
812 Children and Families within 72 hours after admission. The
813 support plan and the agreement may be combined.

814 (b) Have documentation ~~that is~~ provided by the Department
815 of Children and Families ~~Family Services~~ that each mental health
816 resident has been assessed and determined to be able to live in
817 the community in an assisted living facility that has ~~with~~ a
818 limited mental health license or provide written evidence that a
819 request for documentation was sent to the Department of Children
820 and Families within 72 hours after admission.

821 (c) Make the community living support plan available for
822 inspection by the resident, the resident's legal guardian or
823 ~~the resident's~~ health care surrogate, and other individuals who
824 have a lawful basis for reviewing this document.

825 (d) Assist the mental health resident in carrying out the
826 activities identified in the individual's community living
827 support plan.

828 (4) A facility that has ~~with~~ a limited mental health
829 license may enter into a cooperative agreement with a private
830 mental health provider. For purposes of the limited mental
831 health license, the private mental health provider may act as
832 the case manager.

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833 Section 19. Section 429.14, Florida Statutes, is amended
834 to read:

835 429.14 Administrative penalties.—

836 (1) In addition to the requirements of part II of chapter
837 408, the agency may deny, revoke, and suspend any license issued
838 under this part and impose an administrative fine in the manner
839 provided in chapter 120 against a licensee for a violation of
840 any provision of this part, part II of chapter 408, or
841 applicable rules, or for any of the following actions by a
842 licensee, ~~for the actions of~~ any person subject to level 2
843 background screening under s. 408.809, or ~~for the actions of~~ any
844 facility staff ~~employee~~:

845 (a) An intentional or negligent act seriously affecting
846 the health, safety, or welfare of a resident of the facility.

847 (b) A ~~The~~ determination by the agency that the owner lacks
848 the financial ability to provide continuing adequate care to
849 residents.

850 (c) Misappropriation or conversion of the property of a
851 resident of the facility.

852 (d) Failure to follow the criteria and procedures provided
853 under part I of chapter 394 relating to the transportation,
854 voluntary admission, and involuntary examination of a facility
855 resident.

856 (e) A citation for ~~of~~ any of the following violations
857 ~~deficiencies~~ as specified in s. 429.19:

858 1. One or more cited class I violations ~~deficiencies~~.

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859 2. Three or more cited class II violations ~~deficiencies~~.

860 3. Five or more cited class III violations ~~deficiencies~~

861 that have been cited on a single survey and have not been
862 corrected within the times specified.

863 (f) Failure to comply with the background screening
864 standards of this part, s. 408.809(1), or chapter 435.

865 (g) Violation of a moratorium.

866 (h) Failure of the license applicant, the licensee during
867 relicensure, or a licensee that holds a provisional license to
868 meet the minimum license requirements of this part, or related
869 rules, at the time of license application or renewal.

870 (i) An intentional or negligent life-threatening act in
871 violation of the uniform firesafety standards for assisted
872 living facilities or other firesafety standards which ~~that~~
873 threatens the health, safety, or welfare of a resident of a
874 facility, as communicated to the agency by the local authority
875 having jurisdiction or the State Fire Marshal.

876 (j) Knowingly operating any unlicensed facility or
877 providing without a license any service that must be licensed
878 under this chapter or chapter 400.

879 (k) Any act constituting a ground upon which application
880 for a license may be denied.

881 (2) Upon notification by the local authority having
882 jurisdiction or by the State Fire Marshal, the agency may deny
883 or revoke the license of an assisted living facility that fails

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884 to correct cited fire code violations that affect or threaten
885 the health, safety, or welfare of a resident of a facility.

886 (3) The agency may deny or revoke a license of an ~~to any~~
887 applicant or a controlling interest as defined in part II of
888 chapter 408 which has or had a 25 percent ~~25-percent~~ or greater
889 financial or ownership interest in any other facility that is
890 licensed under this part, or in any entity licensed by this
891 state or another state to provide health or residential care, if
892 that ~~which~~ facility or entity during the 5 years prior to the
893 application for a license closed due to financial inability to
894 operate; had a receiver appointed or a license denied,
895 suspended, or revoked; was subject to a moratorium; or had an
896 injunctive proceeding initiated against it.

897 (4) The agency shall deny or revoke the license of an
898 assisted living facility if:

899 (a) There are two moratoria, issued pursuant to this part
900 or part II of chapter 408, within a 2-year period which are
901 imposed by final order;

902 (b) The facility is cited for two or more class I
903 violations arising from unrelated circumstances during the same
904 survey or investigation; or

905 (c) The facility is cited for two or more class I
906 violations arising from separate surveys or investigations
907 within a 2-year period ~~that has two or more class I violations~~
908 ~~that are similar or identical to violations identified by the~~

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909 ~~agency during a survey, inspection, monitoring visit, or~~
910 ~~complaint investigation occurring within the previous 2 years.~~

911 (5) An action taken by the agency to suspend, deny, or
912 revoke a facility's license under this part or part II of
913 chapter 408, in which the agency claims that the facility owner
914 or an employee of the facility has threatened the health,
915 safety, or welfare of a resident of the facility, must be heard
916 by the Division of Administrative Hearings of the Department of
917 Management Services within 120 days after receipt of the
918 facility's request for a hearing, unless that time limitation is
919 waived by both parties. The administrative law judge shall ~~must~~
920 render a decision within 30 days after receipt of a proposed
921 recommended order.

922 (6) As provided under s. 408.814, the agency shall impose
923 an immediate moratorium on an assisted living facility that
924 fails to provide the agency with access to the facility or
925 prohibits the agency from conducting a regulatory inspection.
926 The licensee may not restrict agency staff from accessing and
927 copying records or from conducting confidential interviews with
928 facility staff or any individual who receives services from the
929 facility provide to the Division of Hotels and Restaurants of
930 the Department of Business and Professional Regulation, on a
931 monthly basis, a list of those assisted living facilities that
932 have had their licenses denied, suspended, or revoked or that
933 are involved in an appellate proceeding pursuant to s. 120.60
934 related to the denial, suspension, or revocation of a license.

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935 (7) Agency notification of a license suspension or
936 revocation, or denial of a license renewal, shall be posted and
937 visible to the public at the facility.

938 (8) If a facility is required to relocate some or all of
939 its residents due to agency action, that facility is exempt from
940 the 45-days' notice requirement imposed under s. 429.28(1)(k).
941 This subsection does not exempt the facility from any deadlines
942 for corrective action set by the agency.

943 Section 20. Paragraphs (a) and (b) of subsection (2) of
944 section 429.178, Florida Statutes, are amended to read:

945 429.178 Special care for persons with Alzheimer's disease
946 or other related disorders.-

947 (2)(a) An individual who is employed by a facility that
948 provides special care for residents who have ~~with~~ Alzheimer's
949 disease or other related disorders, and who has regular contact
950 with such residents, must complete up to 4 hours of initial
951 dementia-specific training developed or approved by the
952 department. The training must ~~shall~~ be completed within 3 months
953 after beginning employment and satisfy ~~shall satisfy~~ the core
954 training requirements of s. 429.52(3)(g) ~~429.52(2)(g)~~.

955 (b) A direct caregiver who is employed by a facility that
956 provides special care for residents who have ~~with~~ Alzheimer's
957 disease or other related disorders, ~~and who~~ provides direct care
958 to such residents, ~~and who~~ must complete the required initial training
959 and 4 additional hours of training developed or approved by the
960 department. The training must ~~shall~~ be completed within 9 months

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961 after beginning employment and satisfy ~~shall satisfy~~ the core
962 training requirements of s. 429.52(3)(g) ~~429.52(2)(g)~~.

963 Section 21. Section 429.19, Florida Statutes, is amended
964 to read:

965 429.19 Violations; imposition of administrative fines;
966 grounds.—

967 (1) In addition to the requirements of part II of chapter
968 408, the agency shall impose an administrative fine in the
969 manner provided in chapter 120 for the violation of any
970 provision of this part, part II of chapter 408, and applicable
971 rules by an assisted living facility, for the actions of any
972 person subject to level 2 background screening under s. 408.809,
973 for the actions of any facility employee, or for an intentional
974 or negligent act seriously affecting the health, safety, or
975 welfare of a resident of the facility.

976 (2) Each violation of this part and adopted rules must
977 ~~shall~~ be classified according to the nature of the violation and
978 the gravity of its probable effect on facility residents. The
979 scope of a violation may be cited as an isolated, patterned, or
980 widespread deficiency. An isolated deficiency is a deficiency
981 affecting one or a very limited number of residents, or
982 involving one or a very limited number of staff, or a situation
983 that occurred only occasionally or in a very limited number of
984 locations. A patterned deficiency is a deficiency in which more
985 than a very limited number of residents are affected, or more
986 than a very limited number of staff are involved, or the

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987 situation has occurred in several locations, or the same
988 resident or residents have been affected by repeated occurrences
989 of the same deficient practice but the effect of the deficient
990 practice is not found to be pervasive throughout the facility. A
991 widespread deficiency is a deficiency in which the problems
992 causing the deficiency are pervasive in the facility or
993 represent systemic failure that has affected or has the
994 potential to affect a large portion of the facility's residents.

995 The agency shall indicate the classification on the written
996 notice of the violation as follows:

997 (a) Class "I" violations are defined in s. 408.813. The
998 agency shall impose an administrative fine for a cited class I
999 violation of \$5,000 for an isolated deficiency; \$7,500 for a
1000 patterned deficiency; and \$10,000 for a widespread deficiency.
1001 If the agency has knowledge of a class I violation which
1002 occurred within 12 months before an inspection, a fine must be
1003 levied for that violation, regardless of whether the
1004 noncompliance is corrected before the inspection ~~in an amount~~
1005 ~~not less than \$5,000 and not exceeding \$10,000 for each~~
1006 ~~violation.~~

1007 (b) Class "II" violations are defined in s. 408.813. The
1008 agency shall impose an administrative fine for a cited class II
1009 violation of \$1,000 for an isolated deficiency; \$3,000 for a
1010 patterned deficiency; and \$5,000 for a widespread deficiency ~~in~~
1011 ~~an amount not less than \$1,000 and not exceeding \$5,000 for each~~
1012 ~~violation.~~

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1013 (c) Class "III" violations are defined in s. 408.813. The
1014 agency shall impose an administrative fine for a cited class III
1015 violation of \$500 for an isolated deficiency; \$750 for a
1016 patterned deficiency; and \$1,000 for a widespread deficiency in
1017 ~~an amount not less than \$500 and not exceeding \$1,000 for each~~
1018 ~~violation.~~

1019 (d) Class "IV" violations are defined in s. 408.813. The
1020 agency shall impose an administrative fine for a cited class IV
1021 violation of \$100 for an isolated deficiency; \$150 for a
1022 patterned deficiency; and \$200 for a widespread deficiency in an
1023 ~~amount not less than \$100 and not exceeding \$200 for each~~
1024 ~~violation.~~

1025 (e) Any fine imposed for a class I violation or a class II
1026 violation must be doubled if a facility was previously cited for
1027 one or more class I or class II violations during the agency's
1028 last licensure inspection or any inspection or complaint
1029 investigation since the last licensure inspection.

1030 (f) Regardless of the class of violation cited, instead of
1031 the fine amounts listed in paragraphs (a)-(d), the agency shall
1032 impose an administrative fine of \$500 if a facility is found not
1033 to be in compliance with the background screening requirements
1034 as provided in s. 408.809.

1035 ~~(3) For purposes of this section, in determining if a~~
1036 ~~penalty is to be imposed and in fixing the amount of the fine,~~
1037 ~~the agency shall consider the following factors:~~

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1038 ~~(a) The gravity of the violation, including the~~
1039 ~~probability that death or serious physical or emotional harm to~~
1040 ~~a resident will result or has resulted, the severity of the~~
1041 ~~action or potential harm, and the extent to which the provisions~~
1042 ~~of the applicable laws or rules were violated.~~

1043 ~~(b) Actions taken by the owner or administrator to correct~~
1044 ~~violations.~~

1045 ~~(c) Any previous violations.~~

1046 ~~(d) The financial benefit to the facility of committing or~~
1047 ~~continuing the violation.~~

1048 ~~(e) The licensed capacity of the facility.~~

1049 (3)~~(4)~~ Each day of continuing violation after the date
1050 established by the agency ~~fixed for~~ correction ~~termination~~ of
1051 the violation, ~~as ordered by the agency,~~ constitutes an
1052 additional, separate, and distinct violation.

1053 (4)~~(5)~~ An ~~Any~~ action taken to correct a violation shall be
1054 documented in writing by the owner or administrator of the
1055 facility and verified through followup visits by agency
1056 personnel. The agency may impose a fine and, in the case of an
1057 owner-operated facility, revoke or deny a facility's license
1058 when a facility administrator fraudulently misrepresents action
1059 taken to correct a violation.

1060 (5)~~(6)~~ A ~~Any~~ facility whose owner fails to apply for a
1061 change-of-ownership license in accordance with part II of
1062 chapter 408 and operates the facility under the new ownership is
1063 subject to a fine of \$5,000.

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1064 ~~(6)-(7)~~ In addition to any administrative fines imposed,
1065 the agency may assess a survey fee, equal to the lesser of one
1066 half of the facility's biennial license and bed fee or \$500, to
1067 cover the cost of conducting initial complaint investigations
1068 that result in the finding of a violation that was the subject
1069 of the complaint or monitoring visits conducted under s.
1070 429.28(3)(c) to verify the correction of the violations.

1071 ~~(7)-(8)~~ During an inspection, the agency shall make a
1072 reasonable attempt to discuss each violation with the owner or
1073 administrator of the facility, prior to written notification.

1074 ~~(8)-(9)~~ The agency shall develop and disseminate an annual
1075 list of all facilities sanctioned or fined for violations of
1076 state standards, the number and class of violations involved,
1077 the penalties imposed, and the current status of cases. The list
1078 shall be disseminated, at no charge, to the Department of
1079 Elderly Affairs, the Department of Health, the Department of
1080 Children and Families ~~Family Services~~, the Agency for Persons
1081 with Disabilities, the area agencies on aging, the Florida
1082 Statewide Advocacy Council, and the state and local ombudsman
1083 councils. The Department of Children and Families ~~Family~~
1084 ~~Services~~ shall disseminate the list to service providers under
1085 contract to the department who are responsible for referring
1086 persons to a facility for residency. The agency may charge a fee
1087 commensurate with the cost of printing and postage to other
1088 interested parties requesting a copy of this list. This

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1089 information may be provided electronically or through the
1090 agency's website ~~Internet site~~.

1091 Section 22. Subsection (3) and paragraph (c) of subsection
1092 (4) of section 429.256, Florida Statutes, are amended to read:

1093 429.256 Assistance with self-administration of
1094 medication.—

1095 (3) Assistance with self-administration of medication
1096 includes:

1097 (a) Taking the medication, in its previously dispensed,
1098 properly labeled container, including an insulin syringe that is
1099 prefilled with the proper dosage by a pharmacist and an insulin
1100 pen that is prefilled by the manufacturer, from where it is
1101 stored, and bringing it to the resident.

1102 (b) In the presence of the resident, reading the label,
1103 opening the container, removing a prescribed amount of
1104 medication from the container, and closing the container.

1105 (c) Placing an oral dosage in the resident's hand or
1106 placing the dosage in another container and helping the resident
1107 by lifting the container to his or her mouth.

1108 (d) Applying topical medications.

1109 (e) Returning the medication container to proper storage.

1110 (f) Keeping a record of when a resident receives
1111 assistance with self-administration under this section.

1112 (g) Assisting with the use of a nebulizer, including
1113 removing the cap of a nebulizer, opening the unit dose of

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1114 nebulizer solution, and pouring the prescribed premeasured dose
1115 of medication into the dispensing cup of the nebulizer.

1116 (h) Using a glucometer to perform blood-glucose level
1117 checks.

1118 (i) Assisting with putting on and taking off antiembolism
1119 stockings.

1120 (j) Assisting with applying and removing an oxygen cannula
1121 but not with titrating the prescribed oxygen settings.

1122 (k) Assisting with the use of a continuous positive airway
1123 pressure device but not with titrating the prescribed setting of
1124 the device.

1125 (l) Assisting with measuring vital signs.

1126 (m) Assisting with colostomy bags.

1127 (4) Assistance with self-administration does not include:

1128 ~~(c) Administration of medications through intermittent~~
1129 ~~positive pressure breathing machines or a nebulizer.~~

1130 Section 23. Subsection (3) of section 429.27, Florida
1131 Statutes, is amended to read:

1132 429.27 Property and personal affairs of residents.—

1133 (3) A facility, upon mutual consent with the resident,
1134 shall provide for the safekeeping in the facility of personal
1135 effects not in excess of \$500 and funds of the resident not in
1136 excess of \$500 ~~\$200~~ cash, and shall keep complete and accurate
1137 records of all such funds and personal effects received. If a
1138 resident is absent from a facility for 24 hours or more, the

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1139 facility may provide for the safekeeping of the resident's
1140 personal effects in excess of \$500.

1141 Section 24. Paragraph (a) of subsection (3) and
1142 subsections (2), (5), and (6) of section 429.28, Florida
1143 Statutes, are amended to read:

1144 429.28 Resident bill of rights.-

1145 (2) The administrator of a facility shall ensure that a
1146 written notice of the rights, obligations, and prohibitions set
1147 forth in this part is posted in a prominent place in each
1148 facility and read or explained to residents who cannot read. The
1149 ~~This~~ notice must ~~shall~~ include the name, address, and telephone
1150 numbers of the local ombudsman council, the ~~and~~ central abuse
1151 hotline, and, if when applicable, Disability Rights Florida the
1152 ~~Advocacy Center for Persons with Disabilities, Inc., and the~~
1153 ~~Florida local advocacy council~~, where complaints may be lodged.
1154 The notice must state that a complaint made to the Office of
1155 State Long-Term Care Ombudsman or a local long-term care
1156 ombudsman council, the names and identities of the residents
1157 involved in the complaint, and the identity of complainants are
1158 kept confidential pursuant to s. 400.0077 and that retaliatory
1159 action cannot be taken against a resident for presenting
1160 grievances or for exercising any other resident right. The
1161 facility must ensure a resident's access to a telephone to call
1162 the local ombudsman council, central abuse hotline, and
1163 Disability Rights Florida ~~Advocacy Center for Persons with~~
1164 ~~Disabilities, Inc., and the Florida local advocacy council.~~

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1165 (3) (a) The agency shall conduct a survey to determine
1166 general compliance with facility standards and compliance with
1167 residents' rights as a prerequisite to initial licensure or
1168 licensure renewal. The agency shall adopt rules for uniform
1169 standards and criteria that will be used to determine compliance
1170 with facility standards and compliance with residents' rights.

1171 (5) A ~~No~~ facility or employee of a facility may not serve
1172 notice upon a resident to leave the premises or take any other
1173 retaliatory action against any person who:

1174 (a) Exercises any right set forth in this section.

1175 (b) Appears as a witness in any hearing, inside or outside
1176 the facility.

1177 (c) Files a civil action alleging a violation of the
1178 provisions of this part or notifies a state attorney or the
1179 Attorney General of a possible violation of such provisions.

1180 (6) A ~~Any~~ facility that ~~which~~ terminates the residency of
1181 an individual who participated in activities specified in
1182 subsection (5) must ~~shall~~ show good cause in a court of
1183 competent jurisdiction. If good cause is not shown, the agency
1184 shall impose a fine of \$2,500 in addition to any other penalty
1185 assessed against the facility.

1186 Section 25. Section 429.34, Florida Statutes, is amended
1187 to read:

1188 429.34 Right of entry and inspection.—

1189 (1) In addition to the requirements of s. 408.811, any
1190 duly designated officer or employee of the department, the

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1191 Department of Children and Families ~~Family Services~~, the
1192 Medicaid Fraud Control Unit of the Office of the Attorney
1193 General, the state or local fire marshal, or a member of the
1194 state or local long-term care ombudsman council has ~~shall have~~
1195 the right to enter unannounced upon and into the premises of any
1196 facility licensed pursuant to this part in order to determine
1197 the state of compliance with ~~the provisions of~~ this part, part
1198 II of chapter 408, and applicable rules. Data collected by the
1199 state or local long-term care ombudsman councils or the state or
1200 local advocacy councils may be used by the agency in
1201 investigations involving violations of regulatory standards. A
1202 person specified in this section who knows or has reasonable
1203 cause to suspect that a vulnerable adult has been or is being
1204 abused, neglected, or exploited shall immediately report such
1205 knowledge or suspicion to the central abuse hotline pursuant to
1206 chapter 415.

1207 (2) The agency shall inspect each licensed assisted living
1208 facility at least once every 24 months to determine compliance
1209 with this chapter and related rules. If an assisted living
1210 facility is cited for one or more class I violations or two or
1211 more class II violations arising from separate surveys within a
1212 60-day period or due to unrelated circumstances during the same
1213 survey, the agency must conduct an additional licensure
1214 inspection within 6 months. In addition to any fines imposed on
1215 the facility under s. 429.19, the licensee shall pay a fee for
1216 the cost of the additional inspection equivalent to the standard

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1217 assisted living facility license and per-bed fees, without
1218 exception for beds designated for recipients of optional state
1219 supplementation. The agency shall adjust the fee in accordance
1220 with s. 408.805.

1221 Section 26. Subsection (2) of section 429.41, Florida
1222 Statutes, is amended to read:

1223 429.41 Rules establishing standards.-

1224 (2) In adopting any rules pursuant to this part, the
1225 department, in conjunction with the agency, shall make distinct
1226 standards for facilities based upon facility size; the types of
1227 care provided; the physical and mental capabilities and needs of
1228 residents; the type, frequency, and amount of services and care
1229 offered; and the staffing characteristics of the facility. Rules
1230 developed pursuant to this section may ~~shall~~ not restrict the
1231 use of shared staffing and shared programming in facilities that
1232 are part of retirement communities that provide multiple levels
1233 of care and otherwise meet the requirements of law and rule. If
1234 a continuing care facility licensed under chapter 651 or a
1235 retirement community offering multiple levels of care licenses a
1236 building or part of a building designated for independent living
1237 for assisted living, staffing requirements established in rule
1238 apply only to residents who receive personal, limited nursing,
1239 or extended congregate care services under this part. Such
1240 facilities shall retain a log listing the names and unit number
1241 for residents receiving these services. The log must be
1242 available to surveyors upon request. Except for uniform

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1243 firesafety standards, the department shall adopt by rule
1244 separate and distinct standards for facilities with 16 or fewer
1245 beds and for facilities with 17 or more beds. The standards for
1246 facilities with 16 or fewer beds must ~~shall~~ be appropriate for a
1247 noninstitutional residential environment; however, provided that
1248 the structure may not be ~~is no~~ more than two stories in height
1249 and all persons who cannot exit the facility unassisted in an
1250 emergency must reside on the first floor. The department, in
1251 conjunction with the agency, may make other distinctions among
1252 types of facilities as necessary to enforce the provisions of
1253 this part. Where appropriate, the agency shall offer alternate
1254 solutions for complying with established standards, based on
1255 distinctions made by the department and the agency relative to
1256 the physical characteristics of facilities and the types of care
1257 offered ~~therein~~.

1258 Section 27. Subsections (1) through (11) of section
1259 429.52, Florida Statutes, are renumbered as subsections (2)
1260 through (12), respectively, present subsections (5) and (9) are
1261 amended, and a new subsection (1) is added to that section, to
1262 read:

1263 429.52 Staff training and educational programs; core
1264 educational requirement.—

1265 (1) Effective October 1, 2014, each new assisted living
1266 facility employee who has not previously completed core training
1267 must attend a preservice orientation provided by the facility
1268 before interacting with residents. The preservice orientation

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1269 must be at least 2 hours in duration and cover topics that help
1270 the employee provide responsible care and respond to the needs
1271 of facility residents. Upon completion, the employee and the
1272 administrator of the facility must sign a statement that the
1273 employee completed the required preservice orientation. The
1274 facility must keep the signed statement in the employee's
1275 personnel record.

1276 (6)-(5) Staff involved with the management of medications
1277 and assisting with the self-administration of medications under
1278 s. 429.256 must complete a minimum of 6 4 additional hours of
1279 training provided by a registered nurse, licensed pharmacist, or
1280 department staff. The department shall establish by rule the
1281 minimum requirements of this additional training.

1282 (10)-(9) The training required by this section other than
1283 the preservice orientation must ~~shall~~ be conducted by persons
1284 registered with the department as having the requisite
1285 experience and credentials to conduct the training. A person
1286 seeking to register as a trainer must provide the department
1287 with proof of completion of the minimum core training education
1288 requirements, successful passage of the competency test
1289 established under this section, and proof of compliance with the
1290 continuing education requirement in subsection (5) ~~(4)~~.

1291 Section 28. Section 429.55, Florida Statutes, is created
1292 to read:

1293 429.55 Consumer information website.—The Legislature finds
1294 that consumers need additional information on the quality of

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1295 care and service in assisted living facilities in order to
1296 select the best facility for themselves or their loved ones.
1297 Therefore, the Agency for Health Care Administration shall
1298 create content that is easily accessible through the home page
1299 of the agency's website either directly or indirectly through
1300 links to one or more other established websites of the agency's
1301 choosing. The website must be searchable by facility name,
1302 license type, city, or zip code. By November 1, 2014, the agency
1303 shall include all content in its possession on the website and
1304 add content when received from facilities. At a minimum, the
1305 content must include:

1306 (1) Information on each licensed assisted living facility,
1307 including, but not limited to:

1308 (a) The name and address of the facility.

1309 (b) The number and type of licensed beds in the facility.

1310 (c) The types of licenses held by the facility.

1311 (d) The facility's license expiration date and status.

1312 (e) Proprietary or nonproprietary status of the licensee.

1313 (f) Any affiliation with a company or other organization
1314 owning or managing more than one assisted living facility in
1315 this state.

1316 (g) The total number of clients that the facility is
1317 licensed to serve and the most recently available occupancy
1318 levels.

1319 (h) The number of private and semiprivate rooms offered.

1320 (i) The bed-hold policy.

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- 1321 (j) The religious affiliation, if any, of the assisted
1322 living facility.
- 1323 (k) The languages spoken by the staff.
- 1324 (l) Availability of nurses.
- 1325 (m) Forms of payment accepted, including, but not limited
1326 to, Medicaid, Medicaid long-term managed care, private
1327 insurance, health maintenance organization, United States
1328 Department of Veterans Affairs, CHAMPUS program, or workers'
1329 compensation coverage.
- 1330 (n) Indication if the licensee is operating under
1331 bankruptcy protection.
- 1332 (o) Recreational and other programs available.
- 1333 (p) Special care units or programs offered.
- 1334 (q) Whether the facility is a part of a retirement
1335 community that offers other services pursuant to this part or
1336 part III of this chapter, part II or part III of chapter 400, or
1337 chapter 651.
- 1338 (r) Links to the State Long-Term Care Ombudsman Program
1339 website and the program's statewide toll-free telephone number.
- 1340 (s) Links to the websites of the providers or their
1341 affiliates.
- 1342 (t) Other relevant information that the agency currently
1343 collects.
- 1344 (2) Survey and violation information for the facility,
1345 including a list of the facility's violations committed during
1346 the previous 60 months, which on July 1, 2014, may include

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1347 violations committed on or after July 1, 2009. The list shall be
1348 updated monthly and include for each violation:

1349 (a) A summary of the violation, including all licensure,
1350 revisit, and complaint survey information, presented in a manner
1351 understandable by the general public.

1352 (b) Any sanctions imposed by final order.

1353 (c) The date the corrective action was confirmed by the
1354 agency.

1355 (3) Links to inspection reports that the agency has on
1356 file.

1357 (4) The agency may adopt rules to administer this section.

1358 Section 29. The Legislature finds that consistent
1359 regulation of assisted living facilities benefits residents and
1360 operators of such facilities. To determine whether surveys are
1361 consistent between surveys and surveyors, the Office of Program
1362 Policy Analysis and Government Accountability shall conduct a
1363 study of intersurveyor reliability for assisted living
1364 facilities. By November 1, 2014, the Office of Program Policy
1365 Analysis and Government Accountability shall submit a report of
1366 its findings to the Governor, the President of the Senate, and
1367 the Speaker of the House of Representatives and make any
1368 recommendations for improving intersurveyor reliability.

1369 Section 30. For fiscal year 2014-2015, the sums of
1370 \$151,322 in recurring funds and \$7,986 in nonrecurring funds
1371 from the Health Care Trust Fund are appropriated to the Agency
1372 for Health Care Administration, and two full-time equivalent

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1373 positions with associated salary rate are authorized, for the
1374 purpose of carrying out the regulatory activities provided in
1375 this act.

1376 Section 31. Subsection (3) of section 395.002, Florida
1377 Statutes, is amended to read:

1378 395.002 Definitions.—As used in this chapter:

1379 (3) "Ambulatory surgical center" or "mobile surgical
1380 facility" means a facility the primary purpose of which is to
1381 provide elective surgical care, to ~~in~~ which the patient is
1382 admitted ~~to~~ and discharged ~~from such facility~~ within 24 hours
1383 ~~the same working day and is not permitted to stay overnight,~~ and
1384 which is not part of a hospital. However, a facility existing
1385 for the primary purpose of performing terminations of pregnancy,
1386 an office maintained by a physician for the practice of
1387 medicine, or an office maintained for the practice of dentistry
1388 shall not be construed to be an ambulatory surgical center,
1389 provided that any facility or office which is certified or seeks
1390 certification as a Medicare ambulatory surgical center shall be
1391 licensed as an ambulatory surgical center pursuant to s.
1392 395.003. Any structure or vehicle in which a physician maintains
1393 an office and practices surgery, and which can appear to the
1394 public to be a mobile office because the structure or vehicle
1395 operates at more than one address, shall be construed to be a
1396 mobile surgical facility.

1397 Section 32. Section 752.011, Florida Statutes, is created
1398 to read:

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1399 752.011 Petition for grandparent visitation of a minor
1400 child.—A grandparent of a minor child whose parents are
1401 deceased, missing, or in a permanent vegetative state, or whose
1402 one parent is deceased, missing, or in a permanent vegetative
1403 state and whose other parent has been convicted of a felony or
1404 an offense of violence, may petition the court for visitation
1405 with the grandchild under this section.

1406 (1) Upon the filing of a petition by a grandparent for
1407 visitation, the court shall hold a preliminary hearing to
1408 determine whether the petitioner has made a prima facie showing
1409 of parental unfitness or significant harm to the child. Absent
1410 such a showing, the court shall dismiss the petition and may
1411 award reasonable attorney fees and costs to be paid by the
1412 petitioner to the respondent.

1413 (2) If the court finds that there is prima facie evidence
1414 that a parent is unfit or that there is significant harm to the
1415 child, the court shall proceed with a final hearing, may appoint
1416 a guardian ad litem, and shall refer the matter to family
1417 mediation as provided in s. 752.015.

1418 (3) After conducting a final hearing on the issue of
1419 visitation, the court may award reasonable visitation to the
1420 grandparent with respect to the minor child if the court finds
1421 by clear and convincing evidence that a parent is unfit or that
1422 there is significant harm to the child, that visitation is in
1423 the best interest of the minor child, and that the visitation
1424 will not materially harm the parent-child relationship.

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1425 (4) In assessing the best interest of the child under
1426 subsection (3), the court shall consider the totality of the
1427 circumstances affecting the mental and emotional well-being of
1428 the minor child, including:

1429 (a) The love, affection, and other emotional ties existing
1430 between the minor child and the grandparent, including those
1431 resulting from the relationship that had been previously allowed
1432 by the child's parent.

1433 (b) The length and quality of the previous relationship
1434 between the minor child and the grandparent, including the
1435 extent to which the grandparent was involved in providing
1436 regular care and support for the child.

1437 (c) Whether the grandparent established ongoing personal
1438 contact with the minor child before the death of the parent.

1439 (d) The reasons cited by the surviving parent in ending
1440 contact or visitation between the minor child and the
1441 grandparent.

1442 (e) Whether there has been significant and demonstrable
1443 mental or emotional harm to the minor child as a result of the
1444 disruption in the family unit, whether the child derived support
1445 and stability from the grandparent, and whether the continuation
1446 of such support and stability is likely to prevent further harm.

1447 (f) The existence or threat to the minor child of mental
1448 injury as defined in s. 39.01.

1449 (g) The present mental, physical, and emotional health of
1450 the minor child.

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1451 (h) The present mental, physical, and emotional health of
1452 the grandparent.

1453 (i) The recommendations of the minor child's guardian ad
1454 litem, if one is appointed.

1455 (j) The result of any psychological evaluation of the
1456 minor child.

1457 (k) The preference of the minor child if the child is
1458 determined to be of sufficient maturity to express a preference.

1459 (l) A written testamentary statement by the deceased
1460 parent regarding visitation with the grandparent. The absence of
1461 a testamentary statement is not deemed to provide evidence that
1462 the deceased parent would have objected to the requested
1463 visitation.

1464 (m) Other factors that the court considers necessary in
1465 making its determination.

1466 (5) In assessing material harm to the parent-child
1467 relationship under subsection (3), the court shall consider the
1468 totality of the circumstances affecting the parent-child
1469 relationship, including:

1470 (a) Whether there have been previous disputes between the
1471 grandparent and the parent over childrearing or other matters
1472 related to the care and upbringing of the minor child.

1473 (b) Whether visitation would materially interfere with or
1474 compromise parental authority.

1475 (c) Whether visitation can be arranged in a manner that
1476 does not materially detract from the parent-child relationship,

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1477 including the quantity of time available for enjoyment of the
1478 parent-child relationship and any other consideration related to
1479 disruption of the schedule and routine of the parent and the
1480 minor child.

1481 (d) Whether visitation is being sought for the primary
1482 purpose of continuing or establishing a relationship with the
1483 minor child with the intent that the child benefit from the
1484 relationship.

1485 (e) Whether the requested visitation would expose the
1486 minor child to conduct, moral standards, experiences, or other
1487 factors that are inconsistent with influences provided by the
1488 parent.

1489 (f) The nature of the relationship between the child's
1490 parent and the grandparent.

1491 (g) The reasons cited by the parent in ending contact or
1492 visitation between the minor child and the grandparent which was
1493 previously allowed by the parent.

1494 (h) The psychological toll of visitation disputes on the
1495 minor child.

1496 (i) Other factors that the court considers necessary in
1497 making its determination.

1498 (6) Part II of chapter 61 applies to actions brought under
1499 this section.

1500 (7) If actions under this section and s. 61.13 are pending
1501 concurrently, the courts are strongly encouraged to consolidate

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1502 the actions in order to minimize the burden of litigation on the
1503 minor child and the other parties.

1504 (8) An order for grandparent visitation may be modified
1505 upon a showing by the person petitioning for modification that a
1506 substantial change in circumstances has occurred and that
1507 modification of visitation is in the best interest of the minor
1508 child.

1509 (9) An original action requesting visitation under this
1510 section may be filed by a grandparent only once during any 2-
1511 year period, except on good cause shown that the minor child is
1512 suffering, or may suffer, significant and demonstrable mental or
1513 emotional harm caused by a parental decision to deny visitation
1514 between a minor child and the grandparent, which was not known
1515 to the grandparent at the time of filing an earlier action.

1516 (10) This section does not provide for grandparent
1517 visitation with a minor child placed for adoption under chapter
1518 63 except as provided in s. 752.071 with respect to adoption by
1519 a stepparent or close relative.

1520 (11) Venue shall be in the county where the minor child
1521 primarily resides, unless venue is otherwise governed by chapter
1522 39, chapter 61, or chapter 63.

1523 Section 33. Section 752.071, Florida Statutes, is created
1524 to read:

1525 752.071 Effect of adoption by stepparent or close
1526 relative.—After the adoption of a minor child by a stepparent or
1527 close relative, the stepparent or close relative may petition

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1528 the court to terminate an order granting grandparent visitation
1529 under this chapter which was entered before the adoption. The
1530 court may terminate the order unless the grandparent is able to
1531 show that the criteria of s. 752.011 authorizing the visitation
1532 continue to be satisfied.

1533 Section 34. Section 752.015, Florida Statutes, is amended
1534 to read:

1535 752.015 Mediation of visitation disputes.—It is ~~shall be~~
1536 the public policy of this state that families resolve
1537 differences over grandparent visitation within the family. It is
1538 ~~shall be~~ the further public policy of this state that, when
1539 families are unable to resolve differences relating to
1540 grandparent visitation, ~~that~~ the family participate in any
1541 formal or informal mediation services that may be available. If
1542 ~~When~~ families are unable to resolve differences relating to
1543 grandparent visitation and a petition is filed pursuant to s.
1544 752.011 ~~s. 752.01~~, the court shall, if such services are
1545 available in the circuit, refer the case to family mediation in
1546 accordance with the Florida Family Law Rules of Procedure ~~rules~~
1547 ~~promulgated by the Supreme Court.~~

1548 Section 35. Section 752.01, Florida Statutes, is repealed.

1549 Section 36. Section 752.07, Florida Statutes, is repealed.

1550 Section 37. Subsection (2) and paragraphs (b), (f), (h),
1551 and (j) of subsection (3) of section 110.123, Florida Statutes,
1552 are amended, and paragraph (k) is added to subsection (3) of
1553 that section, to read:

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1554 110.123 State group insurance program.—

1555 (2) DEFINITIONS.—As used in sections 110.123-110.1239 ~~this~~
1556 ~~section~~, the term:

1557 (a) "Department" means the Department of Management
1558 Services.

1559 (b) "Enrollee" means all state officers and employees,
1560 retired state officers and employees, surviving spouses of
1561 deceased state officers and employees, and terminated employees
1562 or individuals with continuation coverage who are enrolled in an
1563 insurance plan offered by the state group insurance program.

1564 "Enrollee" includes all state university officers and employees,
1565 retired state university officers and employees, surviving
1566 spouses of deceased state university officers and employees, and
1567 terminated state university employees or individuals with
1568 continuation coverage who are enrolled in an insurance plan
1569 offered by the state group insurance program.

1570 (c) "Full-time state employees" means employees of all
1571 branches or agencies of state government holding salaried
1572 positions who are paid by state warrant or from agency funds and
1573 who work or are expected to work an average of at least 30 or
1574 more hours per week; employees paid from regular salary
1575 appropriations for 8 months' employment, including university
1576 personnel on academic contracts; and employees paid from other-
1577 personal-services (OPS) funds as described in subparagraphs 1.
1578 and 2. The term includes all full-time employees of the state

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1579 universities. The term does not include seasonal workers who are
1580 paid from OPS funds.

1581 1. For persons hired before April 1, 2013, the term
1582 includes any person paid from OPS funds who:

1583 a. Has worked an average of at least 30 hours or more per
1584 week during the initial measurement period from April 1, 2013,
1585 through September 30, 2013; or

1586 b. Has worked an average of at least 30 hours or more per
1587 week during a subsequent measurement period.

1588 2. For persons hired after April 1, 2013, the term
1589 includes any person paid from OPS funds who:

1590 a. Is reasonably expected to work an average of at least
1591 30 hours or more per week; or

1592 b. Has worked an average of at least 30 hours or more per
1593 week during the person's measurement period.

1594 (d) "Health maintenance organization" or "HMO" means an
1595 entity certified under part I of chapter 641.

1596 (e) "Health plan member" means any person participating in
1597 a state group health insurance plan, a TRICARE supplemental
1598 insurance plan, or a health maintenance organization plan under
1599 the state group insurance program, including enrollees and
1600 covered dependents thereof.

1601 (f) "Part-time state employee" means an employee of any
1602 branch or agency of state government paid by state warrant from
1603 salary appropriations or from agency funds, and who is employed
1604 for less than an average of 30 hours per week or, if on academic

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1605 contract or seasonal or other type of employment which is less
1606 than year-round, is employed for less than 8 months during any
1607 12-month period, but does not include a person paid from other-
1608 personal-services (OPS) funds. The term includes all part-time
1609 employees of the state universities.

1610 (g) "Plan year" means a calendar year.

1611 (h)~~(g)~~ "Retired state officer or employee" or "retiree"
1612 means any state or state university officer or employee who
1613 retires under a state retirement system or a state optional
1614 annuity or retirement program or is placed on disability
1615 retirement, and who was insured under the state group insurance
1616 program at the time of retirement, and who begins receiving
1617 retirement benefits immediately after retirement from state or
1618 state university office or employment. The term also includes
1619 any state officer or state employee who retires under the
1620 Florida Retirement System Investment Plan established under part
1621 II of chapter 121 if he or she:

1622 1. Meets the age and service requirements to qualify for
1623 normal retirement as set forth in s. 121.021(29); or

1624 2. Has attained the age specified by s. 72(t)(2)(A)(i) of
1625 the Internal Revenue Code and has 6 years of creditable service.

1626 (i)~~(h)~~ "State agency" or "agency" means any branch,
1627 department, or agency of state government. "State agency" or
1628 "agency" includes any state university for purposes of this
1629 section only.

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1630 (j)~~(i)~~ "Seasonal workers" has the same meaning as provided
1631 under 29 C.F.R. s. 500.20(s) (1).

1632 (k)~~(j)~~ "State group health insurance plan or plans" or
1633 "state plan or plans" mean the state self-insured health
1634 insurance plan or plans offered to state officers and employees,
1635 retired state officers and employees, and surviving spouses of
1636 deceased state officers and employees pursuant to this section.

1637 (l)~~(k)~~ "State-contracted HMO" means any health maintenance
1638 organization under contract with the department to participate
1639 in the state group insurance program.

1640 (m)~~(l)~~ "State group insurance program" or "programs" means
1641 the package of insurance plans offered to state officers and
1642 employees, retired state officers and employees, and surviving
1643 spouses of deceased state officers and employees pursuant to
1644 this section, including the state group health insurance plan or
1645 plans, health maintenance organization plans, TRICARE
1646 supplemental insurance plans, and other plans required or
1647 authorized by law.

1648 (n)~~(m)~~ "State officer" means any constitutional state
1649 officer, any elected state officer paid by state warrant, or any
1650 appointed state officer who is commissioned by the Governor and
1651 who is paid by state warrant.

1652 (o)~~(n)~~ "Surviving spouse" means the widow or widower of a
1653 deceased state officer, full-time state employee, part-time
1654 state employee, or retiree if such widow or widower was covered
1655 as a dependent under the state group health insurance plan, ~~a~~

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1656 TRICARE supplemental insurance plan, or a health maintenance
1657 organization plan established pursuant to this section at the
1658 time of the death of the deceased officer, employee, or retiree.
1659 "Surviving spouse" also means any widow or widower who is
1660 receiving or eligible to receive a monthly state warrant from a
1661 state retirement system as the beneficiary of a state officer,
1662 full-time state employee, or retiree who died prior to July 1,
1663 1979. For the purposes of this section, any such widow or
1664 widower shall cease to be a surviving spouse upon his or her
1665 remarriage.

1666 (p) ~~(e)~~ "TRICARE supplemental insurance plan" means the
1667 Department of Defense Health Insurance Program for eligible
1668 members of the uniformed services authorized by 10 U.S.C. s.
1669 1097.

1670 (3) STATE GROUP INSURANCE PROGRAM.—

1671 (b) It is the intent of the Legislature to offer a
1672 comprehensive package of health insurance and retirement
1673 benefits and a personnel system for state employees which are
1674 provided in a cost-efficient and prudent manner, and to allow
1675 state employees the option to choose benefit plans which best
1676 suit their individual needs. ~~Therefore,~~ The state group
1677 insurance program ~~is established which~~ may include the state
1678 group health insurance plan or plans, health maintenance
1679 organization plans, group life insurance plans, TRICARE
1680 supplemental insurance plans, group accidental death and
1681 dismemberment plans, ~~and~~ group disability insurance plans, and

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1682 ~~Furthermore, the department is additionally authorized to~~
1683 ~~establish and provide as part of the state group insurance~~
1684 ~~program any other group insurance plans or coverage choices, and~~
1685 ~~other benefits authorized by law that are consistent with the~~
1686 ~~provisions of this section.~~

1687 (f) Except as provided for in subparagraph (h)2., the
1688 state contribution toward the cost of any plan in the state
1689 group insurance program shall be uniform with respect to all
1690 state employees in a state collective bargaining unit
1691 participating in the same coverage tier in the same plan. This
1692 section does not prohibit the development of separate benefit
1693 plans for officers and employees exempt from the career service
1694 or the development of separate benefit plans for each collective
1695 bargaining unit. For the 2017 plan year and thereafter, if the
1696 state's contribution is more than the premium cost of the health
1697 plan selected by the employee, subject to any federal
1698 limitations, the employee may elect to have the balance:

- 1699 1. Credited to the employee's flexible spending account.
1700 2. Credited to the employee's health savings account.
1701 3. Used to purchase additional benefits offered through
1702 the state group insurance program.
1703 4. Used to increase the employee's salary.

1704 (h)1. A person eligible to participate in the state group
1705 insurance program may be authorized by rules adopted by the
1706 department, in lieu of participating in the state group health
1707 insurance plan, to exercise an option to elect membership in a

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1708 health maintenance organization plan which is under contract
1709 with the state in accordance with criteria established by this
1710 section and by said rules. The offer of optional membership in a
1711 health maintenance organization plan permitted by this paragraph
1712 may be limited or conditioned by rule as may be necessary to
1713 meet the requirements of state and federal laws.

1714 2. The department shall contract with health maintenance
1715 organizations seeking to participate in the state group
1716 insurance program through a request for proposal or other
1717 procurement process, as developed by the Department of
1718 Management Services and determined to be appropriate.

1719 a. The department shall establish a schedule of minimum
1720 benefits for health maintenance organization coverage, and that
1721 schedule shall include: physician services; inpatient and
1722 outpatient hospital services; emergency medical services,
1723 including out-of-area emergency coverage; diagnostic laboratory
1724 and diagnostic and therapeutic radiologic services; mental
1725 health, alcohol, and chemical dependency treatment services
1726 meeting the minimum requirements of state and federal law;
1727 skilled nursing facilities and services; prescription drugs;
1728 age-based and gender-based wellness benefits; and other benefits
1729 as may be required by the department. Additional services may be
1730 provided subject to the contract between the department and the
1731 HMO. As used in this paragraph, the term "age-based and gender-
1732 based wellness benefits" includes aerobic exercise, education in
1733 alcohol and substance abuse prevention, blood cholesterol

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1734 screening, health risk appraisals, blood pressure screening and
1735 education, nutrition education, program planning, safety belt
1736 education, smoking cessation, stress management, weight
1737 management, and women's health education.

1738 b. The department may establish uniform deductibles,
1739 copayments, coverage tiers, or coinsurance schedules for all
1740 participating HMO plans.

1741 c. The department may require detailed information from
1742 each health maintenance organization participating in the
1743 procurement process, including information pertaining to
1744 organizational status, experience in providing prepaid health
1745 benefits, accessibility of services, financial stability of the
1746 plan, quality of management services, accreditation status,
1747 quality of medical services, network access and adequacy,
1748 performance measurement, ability to meet the department's
1749 reporting requirements, and the actuarial basis of the proposed
1750 rates and other data determined by the director to be necessary
1751 for the evaluation and selection of health maintenance
1752 organization plans and negotiation of appropriate rates for
1753 these plans. Upon receipt of proposals by health maintenance
1754 organization plans and the evaluation of those proposals, the
1755 department may enter into negotiations with all of the plans or
1756 a subset of the plans, as the department determines appropriate.
1757 Nothing shall preclude the department from negotiating regional
1758 or statewide contracts with health maintenance organization

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1759 plans when this is cost-effective and when the department
1760 determines that the plan offers high value to enrollees.

1761 d. The department may limit the number of HMOs that it
1762 contracts with in each service area based on the nature of the
1763 bids the department receives, the number of state employees in
1764 the service area, or any unique geographical characteristics of
1765 the service area. The department shall establish by rule service
1766 areas throughout the state.

1767 e. All persons participating in the state group insurance
1768 program may be required to contribute towards a total state
1769 group health premium that may vary depending upon the plan,
1770 coverage level, and coverage tier selected by the enrollee and
1771 the level of state contribution authorized by the Legislature.

1772 3. The department is authorized to negotiate and to
1773 contract with specialty psychiatric hospitals for mental health
1774 benefits, on a regional basis, for alcohol, drug abuse, and
1775 mental and nervous disorders. The department may establish,
1776 subject to the approval of the Legislature pursuant to
1777 subsection (5), any such regional plan upon completion of an
1778 actuarial study to determine any impact on plan benefits and
1779 premiums.

1780 4. In addition to contracting pursuant to subparagraph 2.,
1781 the department may enter into contract with any HMO to
1782 participate in the state group insurance program which:

1783 a. Serves greater than 5,000 recipients on a prepaid basis
1784 under the Medicaid program;

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1785 b. Does not currently meet the 25-percent non-
1786 Medicare/non-Medicaid enrollment composition requirement
1787 established by the Department of Health excluding participants
1788 enrolled in the state group insurance program;

1789 c. Meets the minimum benefit package and copayments and
1790 deductibles contained in sub-subparagraphs 2.a. and b.;

1791 d. Is willing to participate in the state group insurance
1792 program at a cost of premiums that is not greater than 95
1793 percent of the cost of HMO premiums accepted by the department
1794 in each service area; and

1795 e. Meets the minimum surplus requirements of s. 641.225.

1796
1797 The department is authorized to contract with HMOs that meet the
1798 requirements of sub-subparagraphs a.-d. prior to the open
1799 enrollment period for state employees. The department is not
1800 required to renew the contract with the HMOs as set forth in
1801 this paragraph more than twice. Thereafter, the HMOs shall be
1802 eligible to participate in the state group insurance program
1803 only through the request for proposal or invitation to negotiate
1804 process described in subparagraph 2.

1805 5. All enrollees in a state group health insurance plan, a
1806 TRICARE supplemental insurance plan, or any health maintenance
1807 organization plan have the option of changing to any other
1808 health plan that is offered by the state within any open
1809 enrollment period designated by the department. Open enrollment
1810 shall be held at least once each calendar year.

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1811 6. When a contract between a treating provider and the
1812 state-contracted health maintenance organization is terminated
1813 for any reason other than for cause, each party shall allow any
1814 enrollee for whom treatment was active to continue coverage and
1815 care when medically necessary, through completion of treatment
1816 of a condition for which the enrollee was receiving care at the
1817 time of the termination, until the enrollee selects another
1818 treating provider, or until the next open enrollment period
1819 offered, whichever is longer, but no longer than 6 months after
1820 termination of the contract. Each party to the terminated
1821 contract shall allow an enrollee who has initiated a course of
1822 prenatal care, regardless of the trimester in which care was
1823 initiated, to continue care and coverage until completion of
1824 postpartum care. This does not prevent a provider from refusing
1825 to continue to provide care to an enrollee who is abusive,
1826 noncompliant, or in arrears in payments for services provided.
1827 For care continued under this subparagraph, the program and the
1828 provider shall continue to be bound by the terms of the
1829 terminated contract. Changes made within 30 days before
1830 termination of a contract are effective only if agreed to by
1831 both parties.

1832 7. Any HMO participating in the state group insurance
1833 program shall submit health care utilization and cost data to
1834 the department, in such form and in such manner as the
1835 department shall require, as a condition of participating in the
1836 program. The department shall enter into negotiations with its

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1837 contracting HMOs to determine the nature and scope of the data
1838 submission and the final requirements, format, penalties
1839 associated with noncompliance, and timetables for submission.
1840 These determinations shall be adopted by rule.

1841 8. The department may establish and direct, with respect
1842 to collective bargaining issues, a comprehensive package of
1843 insurance benefits that may include supplemental health and life
1844 coverage, dental care, long-term care, vision care, and other
1845 benefits it determines necessary to enable state employees to
1846 select from among benefit options that best suit their
1847 individual and family needs. Beginning with the 2015 plan year,
1848 the package of benefits may also include products and services
1849 described in s. 110.12303.

1850 a. Based upon a desired benefit package, the department
1851 shall issue a request for proposal or invitation to negotiate
1852 for ~~health insurance~~ providers interested in participating in
1853 the state group insurance program, and the department shall
1854 issue a request for proposal or invitation to negotiate for
1855 ~~insurance~~ providers interested in participating in the non-
1856 health-related components of the state group insurance program.
1857 Upon receipt of all proposals, the department may enter into
1858 contract negotiations with ~~insurance~~ providers submitting bids
1859 or negotiate a specially designed benefit package. Insurance
1860 providers offering or providing supplemental coverage as of May
1861 30, 1991, which qualify for pretax benefit treatment pursuant to
1862 s. 125 of the Internal Revenue Code of 1986, with 5,500 or more

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1863 state employees currently enrolled may be included by the
1864 department in the supplemental insurance benefit plan
1865 established by the department without participating in a request
1866 for proposal, submitting bids, negotiating contracts, or
1867 negotiating a specially designed benefit package. These
1868 contracts shall provide state employees with the most cost-
1869 effective and comprehensive coverage available; however, except
1870 as provided in subparagraph (f)3., no state or agency funds
1871 shall be contributed toward the cost of any part of the premium
1872 of such supplemental benefit plans. With respect to dental
1873 coverage, the division shall include in any solicitation or
1874 contract for any state group dental program made after July 1,
1875 2001, a comprehensive indemnity dental plan option which offers
1876 enrollees a completely unrestricted choice of dentists. If a
1877 dental plan is endorsed, or in some manner recognized as the
1878 preferred product, such plan shall include a comprehensive
1879 indemnity dental plan option which provides enrollees with a
1880 completely unrestricted choice of dentists.

1881 b. Pursuant to the applicable provisions of s. 110.161,
1882 and s. 125 of the Internal Revenue Code of 1986, the department
1883 shall enroll in the pretax benefit program those state employees
1884 who voluntarily elect coverage in any of the supplemental
1885 ~~insurance~~ benefit plans as provided by sub-subparagraph a.

1886 c. Nothing herein contained shall be construed to prohibit
1887 insurance providers from continuing to provide or offer

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1888 supplemental benefit coverage to state employees as provided
1889 under existing agency plans.

1890 (j) For the 2017 plan year and thereafter, health plans
1891 shall be offered in the following benefit levels:

1892 1. Platinum level, which shall have an actuarial value of
1893 at least 90 percent.

1894 2. Gold level, which shall have an actuarial value of at
1895 least 80 percent.

1896 3. Silver level, which shall have an actuarial value of at
1897 least 70 percent.

1898 4. Bronze level, which shall have an actuarial value of at
1899 least 60 percent ~~Notwithstanding paragraph (f) requiring uniform~~
1900 ~~contributions, and for the 2011-2012 fiscal year only, the state~~
1901 ~~contribution toward the cost of any plan in the state group~~
1902 ~~insurance plan is the difference between the overall premium and~~
1903 ~~the employee contribution. This subsection expires June 30,~~
1904 ~~2012.~~

1905 (k) In consultation with the independent benefits
1906 consultant described in s. 110.12304, the department shall
1907 develop a plan for the implementation of the benefit levels
1908 described in paragraph (j). The plan shall be submitted to the
1909 Governor, the President of the Senate, and the Speaker of the
1910 House of Representatives no later than January 1, 2016, and
1911 include recommendations for:

1912 1. Employer and employee contribution policies.

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1913 2. Steps necessary for maintaining or improving total
1914 employee compensation levels when the transition is initiated.

1915 3. An education strategy to inform employees of the
1916 additional choices available in the state group insurance
1917 program.

1918
1919 This paragraph expires July 1, 2016.

1920 Section 38. Section 110.12303, Florida Statutes, is
1921 created to read:

1922 110.12303 State group insurance program; additional
1923 benefits; price transparency pilot program; reporting.—Beginning
1924 with the 2015 plan year:

1925 (1) In addition to the comprehensive package of health
1926 insurance and other benefits required or authorized to be
1927 included in the state group insurance program, the package of
1928 benefits may also include products and services offered by:

1929 (a) Prepaid limited health service organizations as
1930 authorized by part I of chapter 636.

1931 (b) Discount medical plan organizations as authorized by
1932 part II of chapter 636.

1933 (c) Prepaid health clinics licensed under part II of
1934 chapter 641.

1935 (d) Licensed health care providers, including hospitals
1936 and other health facilities, health care clinics, and health
1937 professionals, who sell service contracts and arrangements for a
1938 specified amount and type of health services.

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1939 (e) Provider organizations, including service networks,
1940 group practices, professional associations, and other
1941 incorporated organizations of providers, who sell service
1942 contracts and arrangements for a specified amount and type of
1943 health services.

1944 (f) Corporate entities that provide specific health
1945 services in accordance with applicable state law and sell
1946 service contracts and arrangements for a specified amount and
1947 type of health services.

1948 (g) Entities that provide health services or treatments
1949 through a bidding process.

1950 (h) Entities that provide health services or treatments
1951 through bundling or aggregating the health services or
1952 treatments.

1953 (i) Entities that provide other innovative and cost-
1954 effective health service delivery methods.

1955 (2) (a) The department shall contract with at least one
1956 entity that provides comprehensive pricing and inclusive
1957 services for surgery and other medical procedures which may be
1958 accessed at the option of the enrollee. The contract shall
1959 require the entity to:

1960 1. Have procedures and evidence-based standards to ensure
1961 the inclusion of only high-quality health care providers.

1962 2. Provide assistance to the enrollee in accessing and
1963 coordinating care.

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1964 3. Provide cost savings to the state group insurance
1965 program to be shared with both the state and the enrollee.

1966 4. Provide an educational campaign for employees to learn
1967 about the services offered by the entity.

1968 (b) On or before January 15 of each year, the department
1969 shall report to the Governor, the President of the Senate, and
1970 the Speaker of the House of Representatives on the participation
1971 level and cost-savings to both the enrollee and the state
1972 resulting from the contract or contracts described in subsection
1973 (2).

1974 (3) The department shall establish a 3-year price
1975 transparency pilot project in at least one area, but not more
1976 than three areas, of the state where a substantial percentage of
1977 the state group insurance program enrollees live. The purpose of
1978 the project is to reward value-based pricing by publishing the
1979 prices of certain diagnostic and elective surgical procedures
1980 and sharing with the enrollee and the state any savings
1981 generated by the enrollee's choice of providers.

1982 (a) Participation in the project shall be voluntary for
1983 enrollees.

1984 (b) The department shall designate between 20 and 50
1985 diagnostic procedures and elective surgical procedures that are
1986 commonly utilized by enrollees.

1987 (c) Health plans shall provide the department with the
1988 contracted price by provider for each designated procedure. The
1989 department shall post the prices on its website and shall

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1990 designate one price per procedure as the benchmark price, using
1991 a mean, average, or other method of comparing the prices.

1992 (d) If an enrollee participating in the project selects a
1993 provider that performs the designated procedure at a price below
1994 the benchmark price for that procedure, the enrollee shall
1995 receive from the state 50 percent of the difference between the
1996 price of the procedure by the selected provider and the
1997 benchmark price.

1998 (e) On or before January 1 of 2016, 2017, and 2018, the
1999 department shall report to the Governor, the President of the
2000 Senate, and the Speaker of the House of Representatives on the
2001 participation level, amount paid to enrollees, and cost-savings
2002 to both the enrollees and the state resulting from the price
2003 transparency pilot project.

2004 Section 39. Section 110.12304, Florida Statutes, is
2005 created to read:

2006 110.12304 Independent benefits consultant.—

2007 (1) The department shall competitively procure an
2008 independent benefits consultant.

2009 (2) The independent benefits consultant may not:

2010 (a) Be owned or controlled by a health maintenance
2011 organization or insurer.

2012 (b) Have an ownership interest in a health maintenance
2013 organization or insurer.

2014 (c) Have a direct or indirect financial interest in a
2015 health maintenance organization or insurer.

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2016 (3) The independent benefits consultant must have
2017 substantial experience in consultation and design of employee
2018 benefit programs for large employers and public employers,
2019 including experience with plans that qualify as cafeteria plans
2020 pursuant to s. 125 of the Internal Revenue Code of 1986.

2021 (4) The independent benefits consultant shall:

2022 (a) Provide an ongoing assessment of trends in benefits
2023 and employer-sponsored insurance that affect the state group
2024 insurance program.

2025 (b) Conduct a comprehensive analysis of the state group
2026 insurance program, including available benefits, coverage
2027 options, and claims experience.

2028 (c) Identify and establish appropriate adjustment
2029 procedures necessary to respond to any risk segmentation that
2030 may occur when increased choices are offered to employees.

2031 (d) Assist the department with the submission of any
2032 needed plan revisions for federal review.

2033 (e) Assist the department in ensuring compliance with
2034 applicable federal and state regulations.

2035 (f) Assist the department in monitoring the adequacy of
2036 funding and reserves for the state self-insured plan.

2037 (g) Assist the department in preparing recommendations for
2038 any modifications to the state group insurance program which
2039 shall be submitted to the Governor, the President of the Senate,
2040 and the Speaker of the House of Representatives no later than
2041 January 1 of each year.

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2042 Section 40. Section 110.12315, Florida Statutes, is
2043 amended to read:

2044 110.12315 Prescription drug program.—The state employees'
2045 prescription drug program is established. This program shall be
2046 administered by the Department of Management Services, according
2047 to the terms and conditions of the plan as established by the
2048 relevant provisions of the annual General Appropriations Act and
2049 implementing legislation, subject to the following conditions:

2050 (1) The department ~~of Management Services~~ shall allow
2051 prescriptions written by health care providers under the plan to
2052 be filled by any licensed pharmacy pursuant to contractual
2053 claims-processing provisions. Nothing in this section may be
2054 construed as prohibiting a mail order prescription drug program
2055 distinct from the service provided by retail pharmacies.

2056 (2) In providing for reimbursement of pharmacies for
2057 prescription medicines dispensed to members of the state group
2058 health insurance plan and their dependents under the state
2059 employees' prescription drug program:

2060 (a) Retail pharmacies participating in the program must be
2061 reimbursed at a uniform rate and subject to uniform conditions,
2062 according to the terms and conditions of the plan.

2063 (b) There shall be a 30-day supply limit for prescription
2064 card purchases, a 90-day supply limit for maintenance
2065 prescription drug purchases, and a 90-day supply limit for mail
2066 order ~~or mail order~~ prescription drug purchases. ~~The Department~~
2067 ~~of Management Services may implement a 90-day supply limit~~

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2068 ~~program for certain maintenance drugs as determined by the~~
2069 ~~department at retail pharmacies participating in the program if~~
2070 ~~the department determines it to be in the best financial~~
2071 ~~interest of the state.~~

2072 (c) The ~~current~~ pharmacy dispensing fee shall be
2073 negotiated by the department ~~remains in effect.~~

2074 (3) Pharmacy reimbursement rates shall be as follows:

2075 (a) For mail order and specialty pharmacies contracting
2076 with the department, reimbursement rates shall be as established
2077 in the contract.

2078 (b) For retail pharmacies, the reimbursement rate shall be
2079 at the same rate as mail order pharmacies under contract with
2080 the department.

2081 (4) The department shall maintain the preferred brand name
2082 drug list to be used in the administration of the state
2083 employees' prescription drug program.

2084 (5) The department shall maintain a list of maintenance
2085 drugs.

2086 (a) Preferred provider organization health plan members
2087 may have prescriptions for maintenance drugs filled up to three
2088 times as a 30-day supply through a retail pharmacy; thereafter,
2089 prescriptions for the same maintenance drug must be filled as a
2090 90-day supply either through the department's contracted mail
2091 order pharmacy or through a retail pharmacy.

2092 (b) Health maintenance organization health plan members
2093 may have prescriptions for maintenance drugs filled as a 90-day

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2094 supply either through a mail order pharmacy or through a retail
2095 pharmacy.

2096 (6) Copayments made by health plan members for a 90-day
2097 supply through a retail pharmacy shall be the same as copayments
2098 made for a 90-day supply through the department's contracted
2099 mail order pharmacy.

2100 (7)-(3) The department ~~of Management Services~~ shall
2101 establish the reimbursement schedule for prescription
2102 pharmaceuticals dispensed under the program. Reimbursement rates
2103 for a prescription pharmaceutical must be based on the cost of
2104 the generic equivalent drug if a generic equivalent exists,
2105 unless the physician prescribing the pharmaceutical clearly
2106 states on the prescription that the brand name drug is medically
2107 necessary or that the drug product is included on the formulary
2108 of drug products that may not be interchanged as provided in
2109 chapter 465, in which case reimbursement must be based on the
2110 cost of the brand name drug as specified in the reimbursement
2111 schedule adopted by the department ~~of Management Services~~.

2112 (8)-(4) The department ~~of Management Services~~ shall conduct
2113 a prescription utilization review program. In order to
2114 participate in the state employees' prescription drug program,
2115 retail pharmacies dispensing prescription medicines to members
2116 of the state group health insurance plan or their covered
2117 dependents, or to subscribers or covered dependents of a health
2118 maintenance organization plan under the state group insurance
2119 program, shall make their records available for this review.

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2120 (9)~~(5)~~ The department ~~of Management Services~~ shall
 2121 implement such additional cost-saving measures and adjustments
 2122 as may be required to balance program funding within
 2123 appropriations provided, including a trial or starter dose
 2124 program and dispensing of long-term-maintenance medication in
 2125 lieu of acute therapy medication.

2126 (10)~~(6)~~ Participating pharmacies must use a point-of-sale
 2127 device or an online computer system to verify a participant's
 2128 eligibility for coverage. The state is not liable for
 2129 reimbursement of a participating pharmacy for dispensing
 2130 prescription drugs to any person whose current eligibility for
 2131 coverage has not been verified by the state's contracted
 2132 administrator or by the department ~~of Management Services~~.

2133 (11)~~(7)~~ Under the state employees' prescription drug
 2134 program copayments must be made as follows:

2135 (a) Effective January 1, 2013, for the State Group Health
 2136 Insurance Standard Plan:

- 2137 1. For generic drug with card.....\$7.
- 2138 2. For preferred brand name drug with card.....\$30.
- 2139 3. For nonpreferred brand name drug with card.....\$50.
- 2140 4. For generic mail order drug.....\$14.
- 2141 5. For preferred brand name mail order drug.....\$60.
- 2142 6. For nonpreferred brand name mail order drug.....\$100.

2143 (b) Effective January 1, 2006, for the State Group Health
 2144 Insurance High Deductible Plan:

- 2145 1. Retail coinsurance for generic drug with card.....30%.

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- 2146 2. Retail coinsurance for preferred brand name drug with
- 2147 card 30%.
- 2148 3. Retail coinsurance for nonpreferred brand name drug
- 2149 with card.....50%.
- 2150 4. Mail order coinsurance for generic drug.....30%.
- 2151 5. Mail order coinsurance for preferred brand name drug30%.
- 2152 6. Mail order coinsurance for nonpreferred brand name drug50%.

2153 (c) ~~The department of Management Services~~ shall create a
 2154 preferred brand name drug list to be used in the administration
 2155 of the state employees' prescription drug program.

2156 Section 41. Effective June 30, 2014, subsection (1) of
 2157 section 54 of chapter 2013-41, Laws of Florida, is repealed.

2158 Section 42. (1) For the 2016 plan year, the Department of
 2159 Management Services shall recommend premium alternatives with
 2160 amounts normalized to reflect benefit design and value for the
 2161 state group health insurance plans and the fully insured health
 2162 maintenance organization plans. The premium alternatives shall
 2163 be provided for both individual and family coverage. The
 2164 recommended premiums shall reflect the costs to the program for
 2165 the medical and prescription drug benefits with associated
 2166 administrative costs and fees. Each alternative shall be
 2167 presented:

2168 (a) Separately for the self-insured preferred provider
 2169 organization and for each self-insured health maintenance
 2170 organization plan.

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2171 (b) Separately for each fully insured health maintenance
2172 organization plan.

2173 (c) As a pooling of all self-insured health maintenance
2174 organization plans.

2175
2176 Prescription drug benefits shall be incorporated into the
2177 recommended premiums based on the enrolled health plan
2178 membership.

2179 (2) The Department of Management Services shall provide
2180 the premium alternatives to the Governor, the President of the
2181 Senate, and the Speaker of the House of Representatives no later
2182 than December 1, 2014.

2183 (3) For the 2016 plan year, the General Appropriations Act
2184 shall establish premiums for enrollees that reflect the
2185 differences in benefit design and value among the health
2186 maintenance organization plan options and the preferred provider
2187 plan options offered in the state group insurance program.

2188 Section 43. (1) For the 2014-2015 fiscal year, the sums
2189 of \$151,216 in recurring funds and \$507,546 in nonrecurring
2190 funds are appropriated from the State Employees Health Insurance
2191 Trust Fund to the Department of Management Services, and 2 full-
2192 time equivalent positions and associated salary rate of 120,000
2193 are authorized, for the purpose of implementing this act.

2194 (2) (a) The recurring funds appropriated in this section
2195 shall be allocated to the following specific appropriation
2196 categories within the Insurance Benefits Administration Program:

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2197 \$150,528 in Salaries and Benefits and \$688 in Special Categories
2198 Transfer to Department of Management Services - Human Resources
2199 Purchased per Statewide Contract.

2200 (b) The nonrecurring funds appropriated in this section
2201 shall be allocated to the following specific appropriation
2202 categories: \$500,000 in Special Categories Contracted Services
2203 and \$7,546 in Expenses.

2204 Section 44. Subsection (1) of section 382.011, Florida
2205 Statutes, is amended to read:

2206 382.011 Medical examiner determination of cause of death.—

2207 (1) In the case of any death or fetal death involving the
2208 circumstances due to causes or conditions listed in s. 406.11(1)
2209 406.11, any death that occurred more than 12 months after the
2210 decedent was last treated by a primary or attending physician as
2211 defined in s. 382.008(3), or any death for which there is reason
2212 to believe that the death may have been due to an unlawful act
2213 or neglect, the funeral director or other person to whose
2214 attention the death may come shall refer the case to the
2215 district medical examiner of the county in which the death
2216 occurred or the body was found for investigation and
2217 determination of the cause of death. A member of the public may
2218 not be charged a fee by a county or district medical examiner
2219 for any examination, investigation, or autopsy performed to
2220 determine the cause of death pursuant to s. 406.11(1). However,
2221 a county, by resolution or ordinance of the board of county
2222 commissioners, may charge a medical examiner approval fee not to

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2223 exceed \$50 when a body is to be cremated, buried at sea, or
2224 dissected.

2225 Section 45. Subsection (1), paragraphs (a), (b), (g), and
2226 (h) of subsection (2), and paragraph (d) of subsection (4) of
2227 section 381.004, Florida Statutes, are amended, and subsection
2228 (1) of that section is reordered, to read:

2229 381.004 HIV testing.—

2230 (1) DEFINITIONS.—As used in this section:

2231 (a) "Health care setting" means a setting devoted to both
2232 the diagnosis and care of persons, such as county health
2233 department clinics, hospital emergency departments, urgent care
2234 clinics, substance abuse treatment clinics, primary care
2235 settings, community clinics, mobile medical clinics, and
2236 correctional health care facilities.

2237 (b) (a) "HIV test" means a test ordered after July 6, 1988,
2238 to determine the presence of the antibody or antigen to human
2239 immunodeficiency virus or the presence of human immunodeficiency
2240 virus infection.

2241 (c) (b) "HIV test result" means a laboratory report of a
2242 human immunodeficiency virus test result entered into a medical
2243 record on or after July 6, 1988, or any report or notation in a
2244 medical record of a laboratory report of a human
2245 immunodeficiency virus test. ~~As used in this section,~~ The term
2246 ~~"HIV test result"~~ does not include test results reported to a
2247 health care provider by a patient.

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2248 (d) "Nonhealth care setting" means a site that conducts
2249 HIV testing for the sole purpose of identifying HIV infection.
2250 Such setting does not provide medical treatment but may include
2251 community-based organizations, outreach settings, county health
2252 department HIV testing programs, and mobile vans.

2253 (f)(e) "Significant exposure" means:

2254 1. Exposure to blood or body fluids through needlestick,
2255 instruments, or sharps;

2256 2. Exposure of mucous membranes to visible blood or body
2257 fluids, to which universal precautions apply according to the
2258 National Centers for Disease Control and Prevention, including,
2259 without limitations, the following body fluids:

2260 a. Blood.

2261 b. Semen.

2262 c. Vaginal secretions.

2263 d. Cerebrospinal ~~Cerebro-spinal~~ fluid (CSF).

2264 e. Synovial fluid.

2265 f. Pleural fluid.

2266 g. Peritoneal fluid.

2267 h. Pericardial fluid.

2268 i. Amniotic fluid.

2269 j. Laboratory specimens that contain HIV (e.g.,
2270 suspensions of concentrated virus); or

2271 3. Exposure of skin to visible blood or body fluids,
2272 especially when the exposed skin is chapped, abraded, or

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2273 afflicted with dermatitis or the contact is prolonged or
2274 involving an extensive area.

2275 (e)~~(d)~~ "Preliminary HIV test" means an antibody or
2276 antibody-antigen screening test, such as the ~~enzyme-linked~~
2277 immunosorbent assays (IA), or a rapid test approved by the
2278 federal Food and Drug Administration (ELISAs) or the Single-Use
2279 Diagnostic System (SUDS).

2280 (g)~~(e)~~ "Test subject" or "subject of the test" means the
2281 person upon whom an HIV test is performed, or the person who has
2282 legal authority to make health care decisions for the test
2283 subject.

2284 (2) HUMAN IMMUNODEFICIENCY VIRUS TESTING; INFORMED
2285 CONSENT; RESULTS; COUNSELING; CONFIDENTIALITY.—

2286 (a) Before performing an HIV test:

2287 1. In a health care setting, the person to be tested shall
2288 be provided information about the test and shall be notified
2289 that the test is planned, that he or she has the right to
2290 decline the test, and that he or she has the right to
2291 confidential treatment of information identifying the subject of
2292 the test and of the results of the test as provided by law. If
2293 the person to be tested declines the test, such decision shall
2294 be documented in the person's medical record. ~~No person in this~~
2295 state shall order a test designed to identify the human
2296 immunodeficiency virus, or its antigen or antibody, without
2297 first obtaining the informed consent of the person upon whom the
2298 test is being performed, except as specified in paragraph (h).

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2299 ~~Informed consent shall be preceded by an explanation of the~~
2300 ~~right to confidential treatment of information identifying the~~
2301 ~~subject of the test and the results of the test to the extent~~
2302 ~~provided by law. Information shall also be provided on the fact~~
2303 ~~that a positive HIV test result will be reported to the county~~
2304 ~~health department with sufficient information to identify the~~
2305 ~~test subject and on the availability and location of sites at~~
2306 ~~which anonymous testing is performed. As required in paragraph~~
2307 ~~(3) (c), each county health department shall maintain a list of~~
2308 ~~sites at which anonymous testing is performed, including the~~
2309 ~~locations, phone numbers, and hours of operation of the sites.~~
2310 ~~Consent need not be in writing provided there is documentation~~
2311 ~~in the medical record that the test has been explained and the~~
2312 ~~consent has been obtained.~~

2313 2. In a nonhealth care setting, a provider shall obtain
2314 the informed consent of the person upon whom the test is being
2315 performed. Informed consent shall be preceded by an explanation
2316 of the right to confidential treatment of information
2317 identifying the subject of the test and the results of the test
2318 as provided by law.

2319
2320 The test subject shall also be informed that a positive HIV test
2321 result will be reported to the county health department with
2322 sufficient information to identify the test subject and on the
2323 availability and location of sites at which anonymous testing is
2324 performed. As required in paragraph (3) (c), each county health

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2325 department shall maintain a list of sites at which anonymous
2326 testing is performed, including the locations, telephone
2327 numbers, and hours of operation of the sites.

2328 (b) Except as provided in paragraph (h), informed consent
2329 must be obtained from a legal guardian or other person
2330 authorized by law if ~~when~~ the person:

2331 1. Is not competent, is incapacitated, or is otherwise
2332 unable to make an informed judgment; or

2333 2. Has not reached the age of majority, except as provided
2334 in s. 384.30.

2335 (g) Human immunodeficiency virus test results contained in
2336 the medical records of a hospital licensed under chapter 395 may
2337 be released in accordance with s. 395.3025 without being subject
2338 to ~~the requirements of~~ subparagraph (e)2., subparagraph (e)9.,
2339 or paragraph (f) if; ~~provided~~ the hospital has notified the
2340 patient of the limited confidentiality protections afforded HIV
2341 test results contained in hospital medical records obtained
2342 ~~written informed consent for the HIV test in accordance with~~
2343 ~~provisions of this section.~~

2344 (h) Notwithstanding ~~the provisions of~~ paragraph (a),
2345 informed consent is not required:

2346 1. When testing for sexually transmissible diseases is
2347 required by state or federal law, or by rule including the
2348 following situations:

2349 a. HIV testing pursuant to s. 796.08 of persons convicted
2350 of prostitution or of procuring another to commit prostitution.

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2351 b. HIV testing of inmates pursuant to s. 945.355 before
2352 ~~prior to their~~ release from prison by reason of parole,
2353 accumulation of gain-time credits, or expiration of sentence.

2354 c. Testing for HIV by a medical examiner in accordance
2355 with s. 406.11.

2356 d. HIV testing of pregnant women pursuant to s. 384.31.

2357 2. Those exceptions provided for blood, plasma, organs,
2358 skin, semen, or other human tissue pursuant to s. 381.0041.

2359 3. For the performance of an HIV-related test by licensed
2360 medical personnel in bona fide medical emergencies if ~~when~~ the
2361 test results are necessary for medical diagnostic purposes to
2362 provide appropriate emergency care or treatment to the person
2363 being tested and the patient is unable to consent, as supported
2364 by documentation in the medical record. Notification of test
2365 results in accordance with paragraph (c) is required.

2366 4. For the performance of an HIV-related test by licensed
2367 medical personnel for medical diagnosis of acute illness where,
2368 in the opinion of the attending physician, providing
2369 notification ~~obtaining informed consent~~ would be detrimental to
2370 the patient, as supported by documentation in the medical
2371 record, and the test results are necessary for medical
2372 diagnostic purposes to provide appropriate care or treatment to
2373 the person being tested. Notification of test results in
2374 accordance with paragraph (c) is required if it would not be
2375 detrimental to the patient. This subparagraph does not authorize

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2376 the routine testing of patients for HIV infection without
2377 notification ~~informed consent~~.

2378 5. If ~~When~~ HIV testing is performed as part of an autopsy
2379 for which consent was obtained pursuant to s. 872.04.

2380 6. For the performance of an HIV test upon a defendant
2381 pursuant to the victim's request in a prosecution for any type
2382 of sexual battery where a blood sample is taken from the
2383 defendant voluntarily, pursuant to court order for any purpose,
2384 or pursuant to ~~the provisions of~~ s. 775.0877, s. 951.27, or s.
2385 960.003; however, the results of an ~~any~~ HIV test performed shall
2386 be disclosed solely to the victim and the defendant, except as
2387 provided in ss. 775.0877, 951.27, and 960.003.

2388 7. If ~~When~~ an HIV test is mandated by court order.

2389 8. For epidemiological research pursuant to s. 381.0031,
2390 for research consistent with institutional review boards created
2391 by 45 C.F.R. part 46, or for the performance of an HIV-related
2392 test for the purpose of research, if the testing is performed in
2393 a manner by which the identity of the test subject is not known
2394 and may not be retrieved by the researcher.

2395 9. If ~~When~~ human tissue is collected lawfully without the
2396 consent of the donor for corneal removal as authorized by s.
2397 765.5185 or enucleation of the eyes as authorized by s. 765.519.

2398 10. For the performance of an HIV test upon an individual
2399 who comes into contact with medical personnel in such a way that
2400 a significant exposure has occurred during the course of
2401 employment or within the scope of practice and where a blood

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2402 sample is available which ~~that~~ was taken from that individual
2403 voluntarily by medical personnel for other purposes. The term
2404 "medical personnel" includes a licensed or certified health care
2405 professional; an employee of a health care professional or
2406 health care facility; employees of a laboratory licensed under
2407 chapter 483; personnel of a blood bank or plasma center; a
2408 medical student or other student who is receiving training as a
2409 health care professional at a health care facility; and a
2410 paramedic or emergency medical technician certified by the
2411 department to perform life-support procedures under s. 401.23.

2412 a. Before performing ~~Prior to performance of~~ an HIV test
2413 on a voluntarily obtained blood sample, the individual from whom
2414 the blood was obtained shall be requested to consent to the
2415 performance of the test and to the release of the results. If
2416 consent cannot be obtained within the time necessary to perform
2417 the HIV test and begin prophylactic treatment of the exposed
2418 medical personnel, all information concerning the performance of
2419 an HIV test and any HIV test result shall be documented only in
2420 the medical personnel's record unless the individual gives
2421 written consent to entering this information on the individual's
2422 medical record.

2423 b. Reasonable attempts to locate the individual and to
2424 obtain consent shall be made, and all attempts must be
2425 documented. If the individual cannot be found or is incapable of
2426 providing consent, an HIV test may be conducted on the available
2427 blood sample. If the individual does not voluntarily consent to

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2428 the performance of an HIV test, the individual shall be informed
2429 that an HIV test will be performed, and counseling shall be
2430 furnished as provided in this section. However, HIV testing
2431 shall be conducted only after appropriate medical personnel
2432 under the supervision of a licensed physician documents, in the
2433 medical record of the medical personnel, that there has been a
2434 significant exposure and that, in accordance with the written
2435 protocols based on the National Centers for Disease Control and
2436 Prevention guidelines on HIV postexposure prophylaxis and in the
2437 physician's medical judgment, the information is medically
2438 necessary to determine the course of treatment for the medical
2439 personnel.

2440 c. Costs of an ~~any~~ HIV test of a blood sample performed
2441 with or without the consent of the individual, as provided in
2442 this subparagraph, shall be borne by the medical personnel or
2443 the employer of the medical personnel. However, costs of testing
2444 or treatment not directly related to the initial HIV tests or
2445 costs of subsequent testing or treatment may not be borne by the
2446 medical personnel or the employer of the medical personnel.

2447 d. In order to use ~~utilize~~ the provisions of this
2448 subparagraph, the medical personnel must ~~either~~ be tested for
2449 HIV pursuant to this section or provide the results of an HIV
2450 test taken within 6 months before ~~prior to~~ the significant
2451 exposure if such test results are negative.

2452 e. A person who receives the results of an HIV test
2453 pursuant to this subparagraph shall maintain the confidentiality

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2454 of the information received and of the persons tested. Such
2455 confidential information is exempt from s. 119.07(1).

2456 f. If the source of the exposure will not voluntarily
2457 submit to HIV testing and a blood sample is not available, the
2458 medical personnel or the employer of such person acting on
2459 behalf of the employee may seek a court order directing the
2460 source of the exposure to submit to HIV testing. A sworn
2461 statement by a physician licensed under chapter 458 or chapter
2462 459 that a significant exposure has occurred and that, in the
2463 physician's medical judgment, testing is medically necessary to
2464 determine the course of treatment constitutes probable cause for
2465 the issuance of an order by the court. The results of the test
2466 shall be released to the source of the exposure and to the
2467 person who experienced the exposure.

2468 11. For the performance of an HIV test upon an individual
2469 who comes into contact with medical personnel in such a way that
2470 a significant exposure has occurred during the course of
2471 employment or within the scope of practice of the medical
2472 personnel while the medical personnel provides emergency medical
2473 treatment to the individual; or notwithstanding s. 384.287, an
2474 individual who comes into contact with nonmedical personnel in
2475 such a way that a significant exposure has occurred while the
2476 nonmedical personnel provides emergency medical assistance
2477 during a medical emergency. For the purposes of this
2478 subparagraph, a medical emergency means an emergency medical
2479 condition outside of a hospital or health care facility that

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2480 provides physician care. The test may be performed only during
2481 the course of treatment for the medical emergency.

2482 a. An individual who is capable of providing consent shall
2483 be requested to consent to an HIV test before ~~prior to the~~
2484 testing. If consent cannot be obtained within the time necessary
2485 to perform the HIV test and begin prophylactic treatment of the
2486 exposed medical personnel and nonmedical personnel, all
2487 information concerning the performance of an HIV test and its
2488 result, shall be documented only in the medical personnel's or
2489 nonmedical personnel's record unless the individual gives
2490 written consent to entering this information in ~~on~~ the
2491 individual's medical record.

2492 b. HIV testing shall be conducted only after appropriate
2493 medical personnel under the supervision of a licensed physician
2494 documents, in the medical record of the medical personnel or
2495 nonmedical personnel, that there has been a significant exposure
2496 and that, in accordance with the written protocols based on the
2497 National Centers for Disease Control and Prevention guidelines
2498 on HIV postexposure prophylaxis and in the physician's medical
2499 judgment, the information is medically necessary to determine
2500 the course of treatment for the medical personnel or nonmedical
2501 personnel.

2502 c. Costs of any HIV test performed with or without the
2503 consent of the individual, as provided in this subparagraph,
2504 shall be borne by the medical personnel or the employer of the
2505 medical personnel or nonmedical personnel. However, costs of

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2506 testing or treatment not directly related to the initial HIV
2507 tests or costs of subsequent testing or treatment may not be
2508 borne by the medical personnel or the employer of the medical
2509 personnel or nonmedical personnel.

2510 d. In order to use ~~utilize~~ the provisions of this
2511 subparagraph, the medical personnel or nonmedical personnel
2512 shall be tested for HIV pursuant to this section or shall
2513 provide the results of an HIV test taken within 6 months before
2514 ~~prior to~~ the significant exposure if such test results are
2515 negative.

2516 e. A person who receives the results of an HIV test
2517 pursuant to this subparagraph shall maintain the confidentiality
2518 of the information received and of the persons tested. Such
2519 confidential information is exempt from s. 119.07(1).

2520 f. If the source of the exposure will not voluntarily
2521 submit to HIV testing and a blood sample was not obtained during
2522 treatment for the medical emergency, the medical personnel, the
2523 employer of the medical personnel acting on behalf of the
2524 employee, or the nonmedical personnel may seek a court order
2525 directing the source of the exposure to submit to HIV testing. A
2526 sworn statement by a physician licensed under chapter 458 or
2527 chapter 459 that a significant exposure has occurred and that,
2528 in the physician's medical judgment, testing is medically
2529 necessary to determine the course of treatment constitutes
2530 probable cause for the issuance of an order by the court. The

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2531 results of the test shall be released to the source of the
2532 exposure and to the person who experienced the exposure.

2533 12. For the performance of an HIV test by the medical
2534 examiner or attending physician upon an individual who expired
2535 or could not be resuscitated while receiving emergency medical
2536 assistance or care and who was the source of a significant
2537 exposure to medical or nonmedical personnel providing such
2538 assistance or care.

2539 a. HIV testing may be conducted only after appropriate
2540 medical personnel under the supervision of a licensed physician
2541 documents in the medical record of the medical personnel or
2542 nonmedical personnel that there has been a significant exposure
2543 and that, in accordance with the written protocols based on the
2544 National Centers for Disease Control and Prevention guidelines
2545 on HIV postexposure prophylaxis and in the physician's medical
2546 judgment, the information is medically necessary to determine
2547 the course of treatment for the medical personnel or nonmedical
2548 personnel.

2549 b. Costs of an ~~any~~ HIV test performed under this
2550 subparagraph may not be charged to the deceased or to the family
2551 of the deceased person.

2552 c. For ~~the provisions of~~ this subparagraph to be
2553 applicable, the medical personnel or nonmedical personnel must
2554 be tested for HIV under this section or must provide the results
2555 of an HIV test taken within 6 months before the significant
2556 exposure if such test results are negative.

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2557 d. A person who receives the results of an HIV test
2558 pursuant to this subparagraph shall comply with paragraph (e).

2559 13. For the performance of an HIV-related test medically
2560 indicated by licensed medical personnel for medical diagnosis of
2561 a hospitalized infant as necessary to provide appropriate care
2562 and treatment of the infant if ~~when~~, after a reasonable attempt,
2563 a parent cannot be contacted to provide consent. The medical
2564 records of the infant must ~~shall~~ reflect the reason consent of
2565 the parent was not initially obtained. Test results shall be
2566 provided to the parent when the parent is located.

2567 14. For the performance of HIV testing conducted to
2568 monitor the clinical progress of a patient previously diagnosed
2569 to be HIV positive.

2570 15. For the performance of repeated HIV testing conducted
2571 to monitor possible conversion from a significant exposure.

2572 (4) HUMAN IMMUNODEFICIENCY VIRUS TESTING REQUIREMENTS;
2573 REGISTRATION WITH THE DEPARTMENT OF HEALTH; EXEMPTIONS FROM
2574 REGISTRATION.—No county health department and no other person in
2575 this state shall conduct or hold themselves out to the public as
2576 conducting a testing program for acquired immune deficiency
2577 syndrome or human immunodeficiency virus status without first
2578 registering with the Department of Health, reregistering each
2579 year, complying with all other applicable provisions of state
2580 law, and meeting the following requirements:

2581 (d) A program in a health care setting shall meet the
2582 notification criteria contained in subparagraph (2)(a)1. A

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2583 program in a nonhealth care setting shall meet all informed
2584 consent criteria contained in subparagraph (2) (a) 2. ~~The program~~
2585 ~~must meet all the informed consent criteria contained in~~
2586 ~~subsection (2).~~

2587 Section 46. Subsection (2) of section 456.032, Florida
2588 Statutes, is amended to read:

2589 456.032 Hepatitis B or HIV carriers.-

2590 (2) Any person licensed by the department and any other
2591 person employed by a health care facility who contracts a blood-
2592 borne infection shall have a rebuttable presumption that the
2593 illness was contracted in the course and scope of his or her
2594 employment, provided that the person, as soon as practicable,
2595 reports to the person's supervisor or the facility's risk
2596 manager any significant exposure, as that term is defined in s.
2597 381.004(1) (f) ~~381.004(1) (e)~~, to blood or body fluids. The
2598 employer may test the blood or body fluid to determine if it is
2599 infected with the same disease contracted by the employee. The
2600 employer may rebut the presumption by the preponderance of the
2601 evidence. Except as expressly provided in this subsection, there
2602 shall be no presumption that a blood-borne infection is a job-
2603 related injury or illness.

2604 Section 47. Paragraph (t) of subsection (1) of section
2605 400.141, Florida Statutes, is amended to read:

2606 400.141 Administration and management of nursing home
2607 facilities.-

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2608 (1) Every licensed facility shall comply with all
2609 applicable standards and rules of the agency and shall:

2610 (t) Assess all residents within 5 working days after
2611 admission for eligibility for pneumococcal ~~polysaccharide~~
2612 vaccination or revaccination (PPV) and vaccinate residents when
2613 indicated within 60 days ~~after the effective date of this act~~ in
2614 accordance with the recommendations of the United States Centers
2615 for Disease Control and Prevention, subject to exemptions for
2616 medical contraindications and religious or personal beliefs.
2617 ~~Residents admitted after the effective date of this act shall be~~
2618 ~~assessed within 5 working days of admission and, when indicated,~~
2619 ~~vaccinated within 60 days in accordance with the recommendations~~
2620 ~~of the United States Centers for Disease Control and Prevention,~~
2621 ~~subject to exemptions for medical contraindications and~~
2622 ~~religious or personal beliefs.~~ Immunization shall not be
2623 provided to any resident who provides documentation that he or
2624 she has been immunized as required by this paragraph. This
2625 paragraph does not prohibit a resident from receiving the
2626 immunization from his or her personal physician if he or she so
2627 chooses. A resident who chooses to receive the immunization from
2628 his or her personal physician shall provide proof of
2629 immunization to the facility. The agency may adopt and enforce
2630 any rules necessary to comply with or implement this paragraph.

2631
2632 -----
2633 **T I T L E A M E N D M E N T**

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Amendment No.

2634 Remove lines 186-210 of the amendment and insert:
2635 An act relating to health; creating ss. 627.64194 and
2636 627.66915, F.S., and amending s. 641.31, F.S.;
2637 requiring individual accident or health insurance
2638 policies, group, blanket, or franchise accident or
2639 health insurance policies, and managed care plans to
2640 evaluate and review coverage for orthotics and
2641 prosthetics and orthoses and prostheses; providing
2642 requirements and limitations; specifying deductible
2643 and copayment recommendations; authorizing insurers to
2644 define certain benefits limitations; providing for
2645 nonapplication to certain policy coverages; permitting
2646 a hospital that has operated as a Level I, Level II,
2647 or pediatric trauma center for a specified period and
2648 is verified by the Department of Health on or before a
2649 certain date to continue operating at that trauma
2650 center level under certain conditions, notwithstanding
2651 any other provision of law; making a hospital that
2652 complies with such requirements eligible for renewal
2653 of its 7-year approval period under s. 395.4025(6);
2654 amending s. 395.401, F.S.; restricting trauma service
2655 fees to \$15,000 until July 1, 2015; amending s.
2656 395.402, F.S.; deleting factors to be considered by
2657 the department in conducting an assessment of the
2658 trauma system; assigning Collier County to trauma
2659 service area 15 rather than area 17; amending s.

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2660 395.4025, F.S.; permitting a trauma center or hospital
2661 located in the same trauma service area to protest a
2662 decision by the department to approve another trauma
2663 center; establishing a moratorium on the approval of
2664 additional trauma centers until the earlier of July 1,
2665 2015, or upon the effective date a rule adopted by the
2666 department allocating the number of trauma centers
2667 needed for each trauma service area; requiring a
2668 trauma center to post its trauma activation fee in the
2669 trauma center and on its website; amending s. 408.036,
2670 F.S.; providing an exemption from certificate-of-need
2671 requirements for the relocation of a specified
2672 percentage of acute care hospital beds from a licensed
2673 hospital to another location; requiring certain
2674 information to be included in a request for exemption;
2675 providing an appropriation to the Department of Health
2676 to fund the administration of the prescription drug
2677 monitoring program; amending s. 458.348, F.S.;

2678 defining the term "nonablative aesthetic skin care
2679 services"; authorizing a physician assistant who has
2680 completed specified education and clinical training
2681 requirements, or who has specified work or clinical
2682 experience, to perform nonablative aesthetic skin care
2683 services under the supervision of a physician;

2684 providing that a physician must complete a specified
2685 number of education and clinical training hours to be

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2686 qualified to supervise physician assistants performing
2687 certain services; amending s. 394.4574, F.S.;

2688 providing that Medicaid managed care plans are
2689 responsible for enrolled mental health residents;

2690 providing that managing entities under contract with
2691 the Department of Children and Families are
2692 responsible for mental health residents who are not
2693 enrolled with a Medicaid managed care plan; deleting a
2694 provision to conform to changes made by the act;

2695 requiring that the community living support plan be
2696 completed and provided to the administrator of a
2697 facility within a specified period after the
2698 resident's admission; requiring the community living
2699 support plan to be updated when there is a significant
2700 change to the mental health resident's behavioral
2701 health; requiring the case manager assigned to a
2702 mental health resident of an assisted living facility
2703 that holds a limited mental health license to keep a
2704 record of the date and time of face-to-face
2705 interactions with the resident and to make the record
2706 available to the responsible entity for inspection;

2707 requiring that the record be maintained for a
2708 specified period; requiring the responsible entity to
2709 ensure that there is adequate and consistent
2710 monitoring and implementation of community living
2711 support plans and cooperative agreements and that

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2712 concerns are reported to the appropriate regulatory
2713 oversight organization under certain circumstances;
2714 amending s. 400.0074, F.S.; requiring that an
2715 administrative assessment conducted by a local council
2716 be comprehensive in nature and focus on factors
2717 affecting the rights, health, safety, and welfare of
2718 nursing home residents; requiring a local council to
2719 conduct an exit consultation with the facility
2720 administrator or administrator designee to discuss
2721 issues and concerns in areas affecting the rights,
2722 health, safety, and welfare of residents and make
2723 recommendations for improvement; amending s. 400.0078,
2724 F.S.; requiring that a resident or a representative of
2725 a resident of a long-term care facility be informed
2726 that retaliatory action cannot be taken against a
2727 resident for presenting grievances or for exercising
2728 any other resident right; amending s. 409.212, F.S.;
2729 increasing the cap on additional supplementation a
2730 person may receive under certain conditions; amending
2731 s. 429.02, F.S.; revising the definition of the term
2732 "limited nursing services"; amending s. 429.07, F.S.;
2733 requiring that an extended congregate care license be
2734 issued to certain facilities that have been licensed
2735 as assisted living facilities under certain
2736 circumstances and authorizing the issuance of such
2737 license if a specified condition is met; providing the

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2738 purpose of an extended congregate care license;
2739 providing that the initial extended congregate care
2740 license of an assisted living facility is provisional
2741 under certain circumstances; requiring a licensee to
2742 notify the Agency for Health Care Administration if it
2743 accepts a resident who qualifies for extended
2744 congregate care services; requiring the agency to
2745 inspect the facility for compliance with the
2746 requirements of an extended congregate care license;
2747 requiring the issuance of an extended congregate care
2748 license under certain circumstances; requiring the
2749 licensee to immediately suspend extended congregate
2750 care services under certain circumstances; requiring a
2751 registered nurse representing the agency to visit the
2752 facility at least twice a year, rather than quarterly,
2753 to monitor residents who are receiving extended
2754 congregate care services; authorizing the agency to
2755 waive one of the required yearly monitoring visits
2756 under certain circumstances; authorizing the agency to
2757 deny or revoke a facility's extended congregate care
2758 license; requiring a registered nurse representing the
2759 agency to visit the facility at least annually, rather
2760 than twice a year, to monitor residents who are
2761 receiving limited nursing services; providing that
2762 such monitoring visits may be conducted in conjunction
2763 with other agency inspections; authorizing the agency

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2764 to waive the required yearly monitoring visit for a
2765 facility that is licensed to provide limited nursing
2766 services under certain circumstances; amending s.
2767 429.075, F.S.; requiring an assisted living facility
2768 that serves one or more mental health residents to
2769 obtain a limited mental health license; revising the
2770 methods employed by a limited mental health facility
2771 relating to placement requirements to include
2772 providing written evidence that a request for a
2773 community living support plan, a cooperative
2774 agreement, and assessment documentation was sent to
2775 the Department of Children and Families within 72
2776 hours after admission; amending s. 429.14, F.S.;
2777 revising the circumstances under which the agency may
2778 deny, revoke, or suspend the license of an assisted
2779 living facility and impose an administrative fine;
2780 requiring the agency to deny or revoke the license of
2781 an assisted living facility under certain
2782 circumstances; requiring the agency to impose an
2783 immediate moratorium on the license of an assisted
2784 living facility under certain circumstances; deleting
2785 a provision requiring the agency to provide a list of
2786 facilities with denied, suspended, or revoked licenses
2787 to the Department of Business and Professional
2788 Regulation; exempting a facility from the 45-day
2789 notice requirement if it is required to relocate some

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2790 or all of its residents; amending s. 429.178, F.S.;

2791 conforming cross-references; amending s. 429.19, F.S.;

2792 providing for classification of the scope of a

2793 violation based upon number of residents affected and

2794 number of staff involved; revising the amounts and

2795 uses of administrative fines; requiring the agency to

2796 levy a fine for violations that are corrected before

2797 an inspection if noncompliance occurred within a

2798 specified period of time; deleting factors that the

2799 agency is required to consider in determining

2800 penalties and fines; amending s. 429.256, F.S.;

2801 revising the term "assistance with self-administration

2802 of medication" as it relates to the Assisted Living

2803 Facilities Act; amending s. 429.27, F.S.; revising the

2804 amount of cash for which a facility may provide

2805 safekeeping for a resident; amending s. 429.28, F.S.;

2806 providing notice requirements to inform facility

2807 residents that the identity of the resident and

2808 complainant in any complaint made to the State Long-

2809 Term Care Ombudsman Program or a local long-term care

2810 ombudsman council is confidential and that retaliatory

2811 action cannot be taken against a resident for

2812 presenting grievances or for exercising any other

2813 resident right; requiring that a facility that

2814 terminates an individual's residency after the filing

2815 of a complaint be fined if good cause is not shown for

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2816 the termination; requiring the agency to adopt rules
2817 to determine compliance with facility standards and
2818 resident's rights; amending s. 429.34, F.S.; requiring
2819 certain persons to report elder abuse in assisted
2820 living facilities; requiring the agency to regularly
2821 inspect every licensed assisted living facility;
2822 requiring the agency to conduct more frequent
2823 inspections under certain circumstances; requiring the
2824 licensee to pay a fee for the cost of additional
2825 inspections; requiring the agency to annually adjust
2826 the fee; amending s. 429.41, F.S.; providing that
2827 certain staffing requirements apply only to residents
2828 in continuing care facilities who are receiving the
2829 relevant service; amending s. 429.52, F.S.; requiring
2830 each newly hired employee of an assisted living
2831 facility to attend a preservice orientation provided
2832 by the assisted living facility; requiring the
2833 employee and administrator to sign a statement that
2834 the employee completed the orientation and keep the
2835 signed statement in the employee's personnel record;
2836 requiring additional hours of training for assistance
2837 with medication; conforming a cross-reference;
2838 creating s. 429.55, F.S.; directing the agency to
2839 create a consumer information website that publishes
2840 specified information regarding assisted living
2841 facilities; providing criteria for webpage content;

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2842 providing for inclusion of all content in the agency's
2843 possession by a specified date; authorizing the agency
2844 to adopt rules; requiring the Office of Program Policy
2845 Analysis and Government Accountability to study the
2846 reliability of facility surveys and submit to the
2847 Governor and the Legislature its findings and
2848 recommendations; providing appropriations and
2849 authorizing positions; amending s. 395.002, F.S.;
2850 amending the definition of the term "ambulatory
2851 surgical center"; creating s. 752.011, F.S.;
2852 authorizing the grandparent of a minor child to
2853 petition a court for visitation under certain
2854 circumstances; requiring a preliminary hearing;
2855 providing for the payment of attorney fees and costs
2856 by a petitioner who fails to make a prima facie
2857 showing of harm; authorizing grandparent visitation
2858 upon specific court findings; providing factors for
2859 court consideration; providing for application of the
2860 Uniform Child Custody Jurisdiction and Enforcement
2861 Act; encouraging the consolidation of certain
2862 concurrent actions; providing for modification of an
2863 order awarding grandparent visitation; limiting the
2864 frequency of actions seeking visitation; limiting
2865 application to a minor child placed for adoption;
2866 providing for venue; creating s. 752.071, F.S.;
2867 providing conditions under which a court may terminate

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2868 a grandparent visitation order upon adoption of a
2869 minor child by a stepparent or close relative;
2870 amending s. 752.015, F.S.; conforming provisions and
2871 cross-references to changes made by the act; repealing
2872 s. 752.01, F.S., relating to actions by a grandparent
2873 for visitation rights; repealing s. 752.07, F.S.,
2874 relating to the effect of adoption of a child by a
2875 stepparent on grandparent visitation rights; amending
2876 s. 110.123, F.S.; revising applicability of certain
2877 definitions; defining the term "plan year";
2878 authorizing the program to include additional
2879 benefits; authorizing an employee to use a certain
2880 portion of the state's contribution to purchase
2881 additional program benefits and supplemental benefits
2882 under specified circumstances; providing for the
2883 program to offer health plans in specified benefit
2884 levels; providing for the Department of Management
2885 Services to develop a plan for implementation of the
2886 benefit levels; providing reporting requirements;
2887 providing for expiration of the implementation plan;
2888 creating s. 110.12303, F.S.; authorizing additional
2889 benefits to be included in the program; providing that
2890 the department shall contract with at least one entity
2891 that provides comprehensive pricing and inclusive
2892 services for surgery and other medical procedures;
2893 providing contract requirements; providing reporting

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2894 requirements; providing for the department to
2895 establish a 3-year price transparency pilot project in
2896 certain areas of the state; providing project
2897 requirements; providing reporting requirements;
2898 creating s. 110.12304, F.S.; directing the department
2899 to contract with an independent benefits consultant;
2900 providing qualifications and duties of the independent
2901 benefits consultant; providing reporting requirements;
2902 amending s. 110.12315, F.S., relating to the state
2903 employees' prescription drug program; deleting a
2904 requirement that the department base its decision as
2905 to whether to implement a certain 90-day supply limit
2906 on a determination that it would be in the best
2907 financial interest of the state; revising the pharmacy
2908 dispensing fee; authorizing a retail pharmacy to fill
2909 a 90-day supply of certain drugs; repealing s. 54(1)
2910 of chapter 2013-41, Laws of Florida; abrogating the
2911 scheduled reversion of provisions relating to the
2912 state employees' prescription drug program; directing
2913 the department to provide premium alternatives to the
2914 Governor and Legislature by a specified date;
2915 providing criteria for calculating premium
2916 alternatives; providing that the General
2917 Appropriations Act shall establish premiums for
2918 enrollees that reflect the differences in benefit
2919 design and value among the health maintenance

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2920 organization plan options and the preferred provider
2921 organization plan options; providing an appropriation
2922 and authorizing positions; amending s. 382.011, F.S.;
2923 revising provisions related to medical examiner
2924 determinations of causes of death; amending s.
2925 381.004, F.S.; revising and adding definitions;
2926 differentiating between the notification and consent
2927 procedures for performing an HIV test in a health care
2928 setting and a nonhealth care setting; amending s.
2929 456.032, F.S.; conforming a cross-reference; amending
2930 s. 400.141, F.S.; revising the type of pneumococcal
2931 vaccine given to nursing home residents; deleting
2932 obsolete language; revising
2933

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