CHAMBER ACTION

Senate | House

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Representative Brodeur offered the following:

Amendment to Amendment (243198) (with title amendment)

Remove lines 5-180 of the amendment and insert:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

641.31 Health maintenance contracts.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

408.036 Projects subject to review; exemptions.—

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

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

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

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

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

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

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

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

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

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

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

(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

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

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

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

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

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

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

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

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

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

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

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

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

performing nonablative aesthetic skin care services pursuant to this subparagraph.

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

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

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

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

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

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

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

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

resident lives within 30 days after the resident's admission. The support plan and the agreement may be in one document.

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

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

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

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

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

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

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

400.0074 Local ombudsman council onsite administrative assessments.—

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

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

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

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

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

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

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

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

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

409.212 Optional supplementation.—

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

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

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

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

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

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

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

429.07 License required; fee.—

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

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

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

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

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;

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

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

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

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

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

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

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

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

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

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

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

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

4.~~3.~~ A facility that is licensed to provide extended congregate care services must:

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

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

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

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

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

f. Implement the concept of managed risk.

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

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

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

written copy of facility policies governing admission and retention.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

429.14 Administrative penalties.—

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

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

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

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

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

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

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

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

3. Five or more cited class III violations ~~deficiencies~~ that have been cited on a single survey and have not been corrected within the times specified.

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

(g) Violation of a moratorium.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

429.178 Special care for persons with Alzheimer's disease or other related disorders.—

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

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

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

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

429.19 Violations; imposition of administrative fines; grounds.—

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

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

situation has occurred in several locations, or the same resident or residents have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the facility. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the facility or represent systemic failure that has affected or has the potential to affect a large portion of the facility's residents. The agency shall indicate the classification on the written notice of the violation as follows:

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

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

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

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

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

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

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

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

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

~~(c) Any previous violations.~~

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

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

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

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

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

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

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

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

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

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

429.256 Assistance with self-administration of medication.—

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

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

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

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

(d) Applying topical medications.

(e) Returning the medication container to proper storage.

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

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

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

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

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

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

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

(l) Assisting with measuring vital signs.

(m) Assisting with colostomy bags.

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

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

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

429.27 Property and personal affairs of residents.—

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

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

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

429.28 Resident bill of rights.—

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

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

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

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

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

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

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

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

429.34 Right of entry and inspection.—

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

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

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

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

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

429.41 Rules establishing standards.—

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

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

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

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

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

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

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

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

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

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

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

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

(a) The name and address of the facility.

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

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

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

(e) Proprietary or nonproprietary status of the licensee.

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

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

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

(i) The bed-hold policy.

(j) The religious affiliation, if any, of the assisted living facility.

(k) The languages spoken by the staff.

(l) Availability of nurses.

(m) Forms of payment accepted, including, but not limited to, Medicaid, Medicaid long-term managed care, private insurance, health maintenance organization, United States Department of Veterans Affairs, CHAMPUS program, or workers' compensation coverage.

(n) Indication if the licensee is operating under bankruptcy protection.

(o) Recreational and other programs available.

(p) Special care units or programs offered.

(q) Whether the facility is a part of a retirement community that offers other services pursuant to this part or part III of this chapter, part II or part III of chapter 400, or chapter 651.

(r) Links to the State Long-Term Care Ombudsman Program website and the program's statewide toll-free telephone number.

(s) Links to the websites of the providers or their affiliates.

(t) Other relevant information that the agency currently collects.

(2) Survey and violation information for the facility, including a list of the facility's violations committed during the previous 60 months, which on July 1, 2014, may include

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

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

(b) Any sanctions imposed by final order.

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

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

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

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

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

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

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

395.002 Definitions.—As used in this chapter:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

110.123 State group insurance program.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) STATE GROUP INSURANCE PROGRAM.—

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

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

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

1. Credited to the employee's flexible spending account.

2. Credited to the employee's health savings account.

3. Used to purchase additional benefits offered through the state group insurance program.

4. Used to increase the employee's salary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Employer and employee contribution policies.

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

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

This paragraph expires July 1, 2016.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

110.12304 Independent benefits consultant.—

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

(2) The independent benefits consultant may not:

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

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

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

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

(4) The independent benefits consultant shall:

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

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

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

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

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

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

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

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

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

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

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

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

(b) There shall be a 30-day supply limit for prescription card purchases<u>, a 90-day supply limit for maintenance prescription drug purchases,</u> and <u>a</u> 90-day supply limit for mail order ~~or mail order~~ prescription drug purchases. ~~The Department of Management Services may implement a 90-day supply limit~~

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

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

(3) Pharmacy reimbursement rates shall be as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. For generic drug with card.....$7.
2. For preferred brand name drug with card.....$30.
3. For nonpreferred brand name drug with card.....$50.
4. For generic mail order drug.....$14.
5. For preferred brand name mail order drug.....$60.
6. For nonpreferred brand name mail order drug.....$100.

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

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

2. Retail coinsurance for preferred brand name drug with card 30%.

3. Retail coinsurance for nonpreferred brand name drug with card.....50%.

4. Mail order coinsurance for generic drug.....30%.

5. Mail order coinsurance for preferred brand name drug30%.

6. Mail order coinsurance for nonpreferred brand name drug50%.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

382.011 Medical examiner determination of cause of death.—

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

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

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

381.004 HIV testing.—

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

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

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

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

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

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

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

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

a. Blood.

b. Semen.

c. Vaginal secretions.

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

e. Synovial fluid.

f. Pleural fluid.

g. Peritoneal fluid.

h. Pericardial fluid.

i. Amniotic fluid.

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

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

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

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

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

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

(a) Before performing an HIV test:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

456.032 Hepatitis B or HIV carriers.—

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

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

400.141 Administration and management of nursing home facilities.—

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

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

T I T L E A M E N D M E N T

Remove lines 186-210 of the amendment and insert:

An act relating to health; creating ss. 627.64194 and 627.66915, F.S., and amending s. 641.31, F.S.; requiring individual accident or health insurance policies, group, blanket, or franchise accident or health insurance policies, and managed care plans to evaluate and review coverage for orthotics and prosthetics and orthoses and prostheses; providing requirements and limitations; specifying deductible and copayment recommendations; authorizing insurers to define certain benefits limitations; providing for nonapplication to certain policy coverages; permitting a hospital that has operated as a Level I, Level II, or pediatric trauma center for a specified period and is verified by the Department of Health on or before a certain date to continue operating at that trauma center level under certain conditions, notwithstanding any other provision of law; making a hospital that complies with such requirements eligible for renewal of its 7-year approval period under s. 395.4025(6); amending s. 395.401, F.S.; restricting trauma service fees to $15,000 until July 1, 2015; amending s. 395.402, F.S.; deleting factors to be considered by the department in conducting an assessment of the trauma system; assigning Collier County to trauma service area 15 rather than area 17; amending s.

395.4025, F.S.; permitting a trauma center or hospital located in the same trauma service area to protest a decision by the department to approve another trauma center; establishing a moratorium on the approval of additional trauma centers until the earlier of July 1, 2015, or upon the effective date a rule adopted by the department allocating the number of trauma centers needed for each trauma service area; requiring a trauma center to post its trauma activation fee in the trauma center and on its website; amending s. 408.036, F.S.; providing an exemption from certificate-of-need requirements for the relocation of a specified percentage of acute care hospital beds from a licensed hospital to another location; requiring certain information to be included in a request for exemption; providing an appropriation to the Department of Health to fund the administration of the prescription drug monitoring program; amending s. 458.348, F.S.; defining the term "nonablative aesthetic skin care services"; authorizing a physician assistant who has completed specified education and clinical training requirements, or who has specified work or clinical experience, to perform nonablative aesthetic skin care services under the supervision of a physician; providing that a physician must complete a specified number of education and clinical training hours to be

qualified to supervise physician assistants performing certain services; amending s. 394.4574, F.S.; providing that Medicaid managed care plans are responsible for enrolled mental health residents; providing that managing entities under contract with the Department of Children and Families are responsible for mental health residents who are not enrolled with a Medicaid managed care plan; deleting a provision to conform to changes made by the act; requiring that the community living support plan be completed and provided to the administrator of a facility within a specified period after the resident's admission; requiring the community living support plan to be updated when there is a significant change to the mental health resident's behavioral health; requiring the case manager assigned to a mental health resident of an assisted living facility that holds a limited mental health license to keep a record of the date and time of face-to-face interactions with the resident and to make the record available to the responsible entity for inspection; requiring that the record be maintained for a specified period; requiring the responsible entity to ensure that there is adequate and consistent monitoring and implementation of community living support plans and cooperative agreements and that

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

purpose of an extended congregate care license; providing that the initial extended congregate care license of an assisted living facility is provisional under certain circumstances; requiring a licensee to notify the Agency for Health Care Administration if it accepts a resident who qualifies for extended congregate care services; requiring the agency to inspect the facility for compliance with the requirements of an extended congregate care license; requiring the issuance of an extended congregate care license under certain circumstances; requiring the licensee to immediately suspend extended congregate care services under certain circumstances; requiring a registered nurse representing the agency to visit the facility at least twice a year, rather than quarterly, to monitor residents who are receiving extended congregate care services; authorizing the agency to waive one of the required yearly monitoring visits under certain circumstances; authorizing the agency to deny or revoke a facility's extended congregate care license; requiring a registered nurse representing the agency to visit the facility at least annually, rather than twice a year, to monitor residents who are receiving limited nursing services; providing that such monitoring visits may be conducted in conjunction with other agency inspections; authorizing the agency

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

or all of its residents; amending s. 429.178, F.S.; conforming cross-references; amending s. 429.19, F.S.; providing for classification of the scope of a violation based upon number of residents affected and number of staff involved; revising the amounts and uses of administrative fines; requiring the agency to levy a fine for violations that are corrected before an inspection if noncompliance occurred within a specified period of time; deleting factors that the agency is required to consider in determining penalties and fines; amending s. 429.256, F.S.; revising the term "assistance with self-administration of medication" as it relates to the Assisted Living Facilities Act; amending s. 429.27, F.S.; revising the amount of cash for which a facility may provide safekeeping for a resident; amending s. 429.28, F.S.; providing notice requirements to inform facility residents that the identity of the resident and complainant in any complaint made to the State Long-Term Care Ombudsman Program or a local long-term care ombudsman council is confidential and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right; requiring that a facility that terminates an individual's residency after the filing of a complaint be fined if good cause is not shown for

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

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

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

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

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