**By** Senator Latvala

16-00957E-11 20111736__

A bill to be entitled

An act relating to health care; amending s. 112.0455, F.S., relating to the Drug-Free Workplace Act; deleting an obsolete provision; deleting a provision that requires a laboratory to submit to the Agency for Health Care Administration a monthly report containing statistical information regarding the testing of employees and job applicants; repealing s. 383.325, F.S., relating to confidentiality of inspection reports of licensed birth center facilities; amending s. 395.002, F.S.; revising and deleting definitions applicable to regulation of hospitals and other licensed facilities; conforming a cross-reference; amending s. 395.003, F.S.; deleting an obsolete provision; conforming a cross-reference; amending s. 395.0193, F.S.; requiring a licensed facility to report certain peer review information and final disciplinary actions to the Division of Medical Quality Assurance of the Department of Health rather than the Division of Health Quality Assurance of the Agency for Health Care Administration; amending s. 395.1023, F.S.; providing for the Department of Children and Family Services rather than the Department of Health to perform certain functions with respect to child protection cases; requiring certain hospitals to notify the Department of Children and Family Services of compliance; amending s. 395.1041, F.S., relating to hospital emergency services and care; deleting obsolete provisions; repealing s.

395.1046, F.S., relating to complaint investigation procedures; amending s. 395.1055, F.S.; requiring licensed facility beds to conform to standards specified by the Agency for Health Care Administration, the Florida Building Code, and the Florida Fire Prevention Code; amending s. 395.10972, F.S.; revising a reference to the Florida Society of Healthcare Risk Management to conform to the current designation; amending s. 395.2050, F.S.; revising a reference to the federal Health Care Financing Administration to conform to the current designation; amending s. 395.3036, F.S.; correcting a reference; repealing s. 395.3037, F.S., relating to redundant definitions; amending ss. 154.11, 394.741, 395.3038, 400.925, 400.9935, 408.05, 440.13, 627.645, 627.668, 627.669, 627.736, 641.495, and 766.1015, F.S.; revising references to the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, and the Council on Accreditation to conform to their current designations; amending s. 395.602, F.S.; revising the definition of the term "rural hospital" to delete an obsolete provision; amending s. 400.021, F.S.; revising the definition of the terms "geriatric outpatient clinic" and "resident care plan"; amending s. 400.0255, F.S.; correcting an obsolete cross-reference to administrative rules; amending s. 400.063, F.S.; deleting an obsolete provision; amending ss. 400.071 and 400.0712, F.S.;

revising applicability of general licensure requirements under part II of ch. 408, F.S., to applications for nursing home licensure; revising provisions governing inactive licenses; amending s. 400.111, F.S.; providing for disclosure of controlling interest of a nursing home facility upon request by the Agency for Health Care Administration; amending s. 400.1183, F.S.; revising grievance record maintenance and reporting requirements for nursing homes; amending s. 400.141, F.S.; providing criteria for the provision of respite services by nursing homes; requiring a written plan of care; requiring a contract for services; requiring resident release to caregivers to be designated in writing; providing an exemption to the application of discharge planning rules; providing for residents' rights; providing for use of personal medications; providing terms of respite stay; providing for communication of patient information; requiring a physician's order for care and proof of a physical examination; providing for services for respite patients and duties of facilities with respect to such patients; conforming a cross-reference; requiring facilities to maintain clinical records that meet specified standards; providing a fine relating to an admissions moratorium; deleting requirement for facilities to submit certain information related to management companies to the agency; deleting a requirement for facilities to notify the agency of certain bankruptcy filings to conform to changes made

by the act; amending s. 400.142, F.S.; deleting language relating to agency adoption of rules; amending 400.147, F.S.; revising reporting requirements for licensed nursing home facilities relating to adverse incidents; repealing s. 400.148, F.S., relating to the Medicaid "Up-or-Out" Quality of Care Contract Management Program; amending s. 400.179, F.S.; deleting an obsolete provision; amending s. 400.19, F.S.; revising inspection requirements; amending s. 400.23, F.S.; deleting an obsolete provision; correcting a reference; deleting a requirement that the rules for minimum standards of care for persons under 21 years of age include a certain methodology; directing the agency to adopt rules for minimum staffing standards in nursing homes that serve persons under 21 years of age; providing minimum staffing standards; amending s. 400.275, F.S.; revising agency duties with regard to training nursing home surveyor teams; revising requirements for team members; amending s. 400.484, F.S.; revising the schedule of home health agency inspection violations; amending s. 400.606, F.S.; revising the content requirements of the plan accompanying an initial or change-of-ownership application for licensure of a hospice; revising requirements relating to certificates of need for certain hospice facilities; amending s. 400.607, F.S.; revising grounds for agency action against a hospice; amending s. 400.915, F.S.; correcting an obsolete cross-reference to

administrative rules; amending s. 400.931, F.S.; deleting a requirement that an applicant for a home medical equipment provider license submit a surety bond to the agency; amending s. 400.932, F.S.; revising grounds for the imposition of administrative penalties for certain violations by an employee of a home medical equipment provider; amending s. 400.967, F.S.; revising the schedule of inspection violations for intermediate care facilities for the developmentally disabled; providing a penalty for certain violations; amending s. 400.9905, F.S.; revising the definitions of the terms "clinic" and "portable equipment provider"; providing that part X of ch. 400, F.S., the Health Care Clinic Act, does not apply to certain clinical facilities, an entity owned by a corporation with a specified amount of annual sales of health care services under certain circumstances, or an entity owned or controlled by a publicly traded entity with a specified amount of annual revenues; amending s. 400.991, F.S.; conforming terminology; revising application requirements relating to documentation of financial ability to operate a mobile clinic; amending s. 408.034, F.S.; revising agency authority relating to licensing of intermediate care facilities for the developmentally disabled; amending s. 408.036, F.S.; deleting an exemption from certain certificate-of-need review requirements for a hospice or a hospice inpatient facility; amending s. 408.043, F.S.; revising

requirements for certain freestanding inpatient hospice care facilities to obtain a certificate of need; amending s. 408.061, F.S.; revising health care facility data reporting requirements; amending s. 408.10, F.S.; removing agency authority to investigate certain consumer complaints; amending s. 408.802, F.S.; removing applicability of part II of ch. 408, F.S., relating to general licensure requirements, to private review agents; amending s. 408.804, F.S.; providing penalties for altering, defacing, or falsifying a license certificate issued by the agency or displaying such an altered, defaced, or falsified certificate; amending s. 408.806, F.S.; revising agency responsibilities for notification of licensees of impending expiration of a license; requiring payment of a late fee for a license application to be considered complete under certain circumstances; amending s. 408.813, F.S.; authorizing the agency to impose fines for unclassified violations of part II of ch. 408, F.S.; amending s. 408.815, F.S.; authorizing the agency to extend a license expiration date under certain circumstances; amending s. 409.91196, F.S.; conforming a cross-reference; amending s. 409.912, F.S.; revising procedures for implementation of a Medicaid prescribed-drug spending-control program; amending s. 409.91255, F.S.; transferring administrative responsibility for the application procedure for federally qualified health centers from the Department of Health to the Agency for Health Care

Administration; requiring the Florida Association of Community Health Centers, Inc., to provide support and assume administrative costs for the program; amending s. 429.07, F.S.; deleting the requirement for an assisted living facility to obtain an additional license in order to provide limited nursing services; deleting the requirement for the agency to conduct quarterly monitoring visits of facilities that hold a license to provide extended congregate care services; deleting the requirement for the department to report annually on the status of and recommendations related to extended congregate care; deleting the requirement for the agency to conduct monitoring visits at least twice a year to facilities providing limited nursing services; increasing the licensure fees and the maximum fee required for the standard license; increasing the licensure fees for the extended congregate care license; eliminating the license fee for the limited nursing services license; transferring from another provision of law the requirement that a biennial survey of an assisted living facility include specific actions to determine whether the facility is adequately protecting residents' rights; providing that under specified conditions an assisted living facility that has a class I or class II violation is subject to periodic unannounced monitoring; requiring a registered nurse to participate in certain monitoring visits; amending s. 429.11, F.S.; revising licensure application requirements for assisted living

facilities to eliminate provisional licenses; amending s. 429.12, F.S.; deleting a requirement that a transferor of an assisted living facility advise the transferee to submit a plan for correction of certain deficiencies to the Agency for Health Care Administration before ownership of the facility is transferred; amending s. 429.17, F.S.; deleting provisions relating to the limited nursing services license; revising agency responsibilities regarding the issuance of conditional licenses; amending s. 429.19, F.S.; clarifying that a monitoring fee may be assessed in addition to an administrative fine; amending s. 429.23, F.S.; deleting reporting requirements for assisted living facilities relating to liability claims; amending s. 429.255, F.S.; eliminating provisions authorizing the use of volunteers to provide certain health-care-related services in assisted living facilities; authorizing assisted living facilities to provide limited nursing services; requiring an assisted living facility to be responsible for certain recordkeeping and staff to be trained to monitor residents receiving certain health-care-related services; amending s. 429.28, F.S.; deleting a requirement for a biennial survey of an assisted living facility, to conform to changes made by the act; conforming a cross-reference; amending s. 429.35, F.S.; authorizing the agency to provide certain information relating to the inspections of assisted living facilities electronically or through

the agency's Internet website; amending s. 429.41, F.S., relating to rulemaking; conforming provisions to changes made by the act; amending s. 429.53, F.S.; revising provisions relating to consultation by the agency; revising a definition; amending s. 429.54, F.S.; requiring licensed assisted living facilities to electronically report certain data semiannually to the agency in accordance with rules adopted by the department; amending s. 429.71, F.S.; revising schedule of inspection violations for adult family-care homes; amending s. 429.915, F.S.; revising agency responsibilities regarding the issuance of conditional licenses; repealing s. 440.102(9)(d), F.S., relating to a laboratory's requirement to submit to the Agency for Health Care Administration a monthly report containing statistical information regarding the testing of employees and job applicants; amending s. 483.294, F.S.; revising frequency of agency inspections of multiphasic health testing centers; amending s. 626.9541, F.S.; authorizing an insurer offering a group or individual health benefit plan to offer a wellness program; authorizing rewards or incentives; providing for verification of a member's inability to participate for medical reasons; providing that such rewards or incentives are not insurance benefits; amending s. 766.202, F.S.; adding persons licensed under part XIV of ch. 468, F.S., to the definition of "health care provider"; amending ss. 394.4787, 400.0239, 408.07, 430.80, and 651.118, F.S.;

conforming terminology and references to changes made by the act; revising a reference; providing an effective date.

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

Section 1. Present paragraphs (f) through (k) of subsection (10) of section 112.0455, Florida Statutes, are redesignated as paragraphs (e) through (j), respectively, and present paragraph (e) of subsection (10), subsection (12), and paragraph (e) of subsection (14) of that section are amended to read:

112.0455 Drug-Free Workplace Act.—

(10) EMPLOYER PROTECTION.—

~~(e) Nothing in this section shall be construed to operate retroactively, and nothing in this section shall abrogate the right of an employer under state law to conduct drug tests prior to January 1, 1990. A drug test conducted by an employer prior to January 1, 1990, is not subject to this section.~~

(12) DRUG-TESTING STANDARDS; LABORATORIES.—

(a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this section and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to this section. A license issued by the agency is required in order to operate a laboratory.

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

1. The laboratory is licensed and approved by the Agency for Health Care Administration using criteria established by the

United States Department of Health and Human Services as general guidelines for modeling the state drug testing program and in accordance with part II of chapter 408. Each applicant for licensure and licensee must comply with all requirements of part II of chapter 408.

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

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

a. The use of internal quality controls including the use of samples of known concentrations which are used to check the performance and calibration of testing equipment, and periodic use of blind samples for overall accuracy.

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

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

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

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

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

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

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

conducted.

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

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

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

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

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

(14) DISCIPLINE REMEDIES.—

(e) Upon resolving an appeal filed pursuant to paragraph (c), and finding a violation of this section, the commission may order the following relief:

1. Rescind the disciplinary action, expunge related records

from the personnel file of the employee or job applicant and reinstate the employee.

2. Order compliance with paragraph (10)(f)~~(g)~~.

3. Award back pay and benefits.

4. Award the prevailing employee or job applicant the necessary costs of the appeal, reasonable attorney's fees, and expert witness fees.

Section 2. Paragraph (n) of subsection (1) of section 154.11, Florida Statutes, is amended to read:

154.11 Powers of board of trustees.—

(1) The board of trustees of each public health trust shall be deemed to exercise a public and essential governmental function of both the state and the county and in furtherance thereof it shall, subject to limitation by the governing body of the county in which such board is located, have all of the powers necessary or convenient to carry out the operation and governance of designated health care facilities, including, but without limiting the generality of, the foregoing:

(n) To appoint originally the staff of physicians to practice in any designated facility owned or operated by the board and to approve the bylaws and rules to be adopted by the medical staff of any designated facility owned and operated by the board, such governing regulations to be in accordance with the standards of the Joint Commission ~~on the Accreditation of Hospitals~~ which provide, among other things, for the method of appointing additional staff members and for the removal of staff members.

Section 3. Section 383.325, Florida Statutes, is repealed.

Section 4. Subsection (7) of section 394.4787, Florida

Statutes, is amended to read:

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

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(26) ~~(28)~~ and part II of chapter 408 as a specialty psychiatric hospital.

Section 5. Subsection (2) of section 394.741, Florida Statutes, is amended to read:

394.741 Accreditation requirements for providers of behavioral health care services.—

(2) Notwithstanding any provision of law to the contrary, accreditation shall be accepted by the agency and department in lieu of the agency's and department's facility licensure onsite review requirements and shall be accepted as a substitute for the department's administrative and program monitoring requirements, except as required by subsections (3) and (4), for:

(a) Any organization from which the department purchases behavioral health care services that is accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~ or the Council on Accreditation ~~for Children and Family Services~~, or has those services that are being purchased by the department accredited by the Commission on Accreditation of Rehabilitation Facilities ~~CARF–the Rehabilitation Accreditation Commission~~.

(b) Any mental health facility licensed by the agency or any substance abuse component licensed by the department that is accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the Commission on Accreditation of

Rehabilitation Facilities ~~CARF-the Rehabilitation Accreditation Commission~~, or the Council on Accreditation ~~of Children and Family Services~~.

(c) Any network of providers from which the department or the agency purchases behavioral health care services accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the Commission on Accreditation of Rehabilitation Facilities ~~CARF-the Rehabilitation Accreditation Commission~~, the Council on Accreditation ~~of Children and Family Services~~, or the National Committee for Quality Assurance. A provider organization, which is part of an accredited network, is afforded the same rights under this part.

Section 6. Present subsections (15) through (32) of section 395.002, Florida Statutes, are renumbered as subsections (14) through (28), respectively, and present subsections (1), (14), (24), (30), and (31) and paragraph (c) of present subsection (28) of that section are amended to read:

395.002 Definitions.—As used in this chapter:

(1) "Accrediting organizations" means nationally recognized or approved accrediting organizations whose standards incorporate comparable licensure requirements as determined by the agency ~~the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care, Inc~~.

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

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

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

(c) Intensive residential treatment programs for children and adolescents as defined in subsection (14) ~~(15)~~.

~~(30) "Utilization review" means a system for reviewing the medical necessity or appropriateness in the allocation of health care resources of hospital services given or proposed to be given to a patient or group of patients.~~

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

Section 7. Paragraph (c) of subsection (1) and paragraph (b) of subsection (2) of section 395.003, Florida Statutes, are amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(1)

~~(c) Until July 1, 2006, additional emergency departments located off the premises of licensed hospitals may not be authorized by the agency.~~

(2)

(b) The agency shall, at the request of a licensee that is a teaching hospital as defined in s. 408.07(45), issue a single license to a licensee for facilities that have been previously licensed as separate premises, provided such separately licensed facilities, taken together, constitute the same premises as defined in s. 395.002(22) ~~(23)~~. Such license for the single premises shall include all of the beds, services, and programs that were previously included on the licenses for the separate premises. The granting of a single license under this paragraph shall not in any manner reduce the number of beds, services, or programs operated by the licensee.

Section 8. Paragraph (e) of subsection (2) and subsection (4) of section 395.0193, Florida Statutes, are amended to read:

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

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

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

~~the agency~~.

(4) Pursuant to ss. 458.337 and 459.016, any disciplinary actions taken under subsection (3) shall be reported in writing to the Division of Medical Quality Assurance of the department ~~Health Quality Assurance of the agency~~ within 30 working days after its initial occurrence, regardless of the pendency of appeals to the governing board of the hospital. The notification shall identify the disciplined practitioner, the action taken, and the reason for such action. All final disciplinary actions taken under subsection (3), if different from those which were reported to the department ~~agency~~ within 30 days after the initial occurrence, shall be reported within 10 working days to the Division of Medical Quality Assurance of the department ~~Health Quality Assurance of the agency~~ in writing and shall specify the disciplinary action taken and the specific grounds therefor. The division shall review each report and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case s. 456.073 shall apply. The reports are not subject to inspection under s. 119.07(1) even if the division's investigation results in a finding of probable cause.

Section 9. Section 395.1023, Florida Statutes, is amended to read:

395.1023 Child abuse and neglect cases; duties.—Each licensed facility shall adopt a protocol that, at a minimum, requires the facility to:

(1) Incorporate a facility policy that every staff member has an affirmative duty to report, pursuant to chapter 39, any actual or suspected case of child abuse, abandonment, or

neglect; and

(2) In any case involving suspected child abuse, abandonment, or neglect, designate, at the request of the Department of Children and Family Services, a staff physician to act as a liaison between the hospital and the Department of Children and Family Services office which is investigating the suspected abuse, abandonment, or neglect, and the child protection team, as defined in s. 39.01, when the case is referred to such a team.

Each general hospital and appropriate specialty hospital shall comply with the provisions of this section and shall notify the agency and the Department of Children and Family Services of its compliance by sending a copy of its policy to the agency and the Department of Children and Family Services as required by rule. The failure by a general hospital or appropriate specialty hospital to comply shall be punished by a fine not exceeding $1,000, to be fixed, imposed, and collected by the agency. Each day in violation is considered a separate offense.

Section 10. Subsection (2) and paragraph (d) of subsection (3) of section 395.1041, Florida Statutes, are amended to read:

395.1041 Access to emergency services and care.—

(2) INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The agency shall establish and maintain an inventory of hospitals with emergency services. The inventory shall list all services within the service capability of the hospital, and such services shall appear on the face of the hospital license. Each hospital having emergency services shall notify the agency of its service capability in the manner and form prescribed by the agency. The

agency shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the general public. ~~On or before August 1, 1992, the agency shall request that each hospital identify the services which are within its service capability. On or before November 1, 1992, the agency shall notify each hospital of the service capability to be included in the inventory. The hospital has 15 days from the date of receipt to respond to the notice. By December 1, 1992, the agency shall publish a final inventory.~~ Each hospital shall reaffirm its service capability when its license is renewed and shall notify the agency of the addition of a new service or the termination of a service prior to a change in its service capability.

(3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(d)1. Every hospital shall ensure the provision of services within the service capability of the hospital, at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangements. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirement, and appropriate compensation or other reasonable conditions may be negotiated for these backup services.

2. If any arrangement requires the provision of emergency medical transportation, such arrangement must be made in consultation with the applicable provider and may not require the emergency medical service provider to provide transportation

that is outside the routine service area of that provider or in a manner that impairs the ability of the emergency medical service provider to timely respond to prehospital emergency calls.

3. A hospital shall not be required to ensure service capability at all times as required in subparagraph 1. if, prior to the receiving of any patient needing such service capability, such hospital has demonstrated to the agency that it lacks the ability to ensure such capability and it has exhausted all reasonable efforts to ensure such capability through backup arrangements. In reviewing a hospital's demonstration of lack of ability to ensure service capability, the agency shall consider factors relevant to the particular case, including the following:

a. Number and proximity of hospitals with the same service capability.

b. Number, type, credentials, and privileges of specialists.

c. Frequency of procedures.

d. Size of hospital.

4. The agency shall publish ~~proposed~~ rules implementing a reasonable exemption procedure ~~by November 1, 1992~~. ~~Subparagraph 1. shall become effective upon the effective date of said rules or January 31, 1993, whichever is earlier. For a period not to exceed 1 year from the effective date of subparagraph 1., a hospital requesting an exemption shall be deemed to be exempt from offering the service until the agency initially acts to deny or grant the original request.~~ The agency has 45 days <u>after</u> ~~from~~ the date of receipt of the request to approve or deny the

request. ~~After the first year from the effective date of subparagraph 1.,~~ If the agency fails to initially act within that ~~the~~ time period, the hospital is deemed to be exempt from offering the service until the agency initially acts to deny the request.

Section 11. Section 395.1046, Florida Statutes, is repealed.

Section 12. Paragraph (e) of subsection (1) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(e) Licensed facility beds conform to minimum space, equipment, and furnishings standards as specified by the agency, the Florida Building Code, and the Florida Fire Prevention Code ~~department~~.

Section 13. Subsection (1) of section 395.10972, Florida Statutes, is amended to read:

395.10972 Health Care Risk Manager Advisory Council.—The Secretary of Health Care Administration may appoint a seven-member advisory council to advise the agency on matters pertaining to health care risk managers. The members of the council shall serve at the pleasure of the secretary. The council shall designate a chair. The council shall meet at the call of the secretary or at those times as may be required by rule of the agency. The members of the advisory council shall receive no compensation for their services, but shall be reimbursed for travel expenses as provided in s. 112.061. The

council shall consist of individuals representing the following areas:

(1) Two shall be active health care risk managers, including one risk manager who is recommended by and a member of the Florida Society for ~~of~~ Healthcare Risk Management and Patient Safety.

Section 14. Subsection (3) of section 395.2050, Florida Statutes, is amended to read:

395.2050 Routine inquiry for organ and tissue donation; certification for procurement activities; death records review.—

(3) Each organ procurement organization designated by the federal Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~ and licensed by the state shall conduct an annual death records review in the organ procurement organization's affiliated donor hospitals. The organ procurement organization shall enlist the services of every Florida licensed tissue bank and eye bank affiliated with or providing service to the donor hospital and operating in the same service area to participate in the death records review.

Section 15. Subsection (2) of section 395.3036, Florida Statutes, is amended to read:

395.3036 Confidentiality of records and meetings of corporations that lease public hospitals or other public health care facilities.—The records of a private corporation that leases a public hospital or other public health care facility are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution, and the meetings of the governing board of a private corporation are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution when

the public lessor complies with the public finance accountability provisions of s. 155.40(5) with respect to the transfer of any public funds to the private lessee and when the private lessee meets at least three of the five following criteria:

(2) The public lessor and the private lessee do not commingle any of their funds in any account maintained by either of them, other than the payment of the rent and administrative fees or the transfer of funds pursuant to s. 155.40 ~~subsection (2)~~.

Section 16. Section 395.3037, Florida Statutes, is repealed.

Section 17. Subsections (1), (4), and (5) of section 395.3038, Florida Statutes, are amended to read:

395.3038 State-listed primary stroke centers and comprehensive stroke centers; notification of hospitals.—

(1) The agency shall make available on its website and to the department a list of the name and address of each hospital that meets the criteria for a primary stroke center and the name and address of each hospital that meets the criteria for a comprehensive stroke center. The list of primary and comprehensive stroke centers shall include only those hospitals that attest in an affidavit submitted to the agency that the hospital meets the named criteria, or those hospitals that attest in an affidavit submitted to the agency that the hospital is certified as a primary or a comprehensive stroke center by the Joint Commission ~~on Accreditation of Healthcare Organizations~~.

(4) The agency shall adopt by rule criteria for a primary

stroke center which are substantially similar to the certification standards for primary stroke centers of the Joint Commission ~~on Accreditation of Healthcare Organizations~~.

(5) The agency shall adopt by rule criteria for a comprehensive stroke center. However, if the Joint Commission ~~on Accreditation of Healthcare Organizations~~ establishes criteria for a comprehensive stroke center, the agency shall establish criteria for a comprehensive stroke center which are substantially similar to those criteria established by the Joint Commission ~~on Accreditation of Healthcare Organizations~~.

Section 18. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

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

(e) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile;

2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

~~4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local~~

~~option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;~~

4.~~5.~~ A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

5.~~6.~~ A hospital designated as a critical access hospital, as defined in s. 408.07(15).

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room~~, or meets the criteria of subparagraph 4~~. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation to the Agency

for Health Care Administration.

Section 19. Subsections (8) and (16) of section 400.021, Florida Statutes, are amended to read:

400.021 Definitions.—When used in this part, unless the context otherwise requires, the term:

(8) "Geriatric outpatient clinic" means a site for providing outpatient health care to persons 60 years of age or older, which is staffed by a registered nurse or a physician assistant, or a licensed practical nurse under the direct supervision of a registered nurse, advanced registered nurse practitioner, or physician.

(16) "Resident care plan" means a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and the resident or his or her designee or legal representative, which includes a comprehensive assessment of the needs of an individual resident; the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being; a listing of services provided within or outside the facility to meet those needs; and an explanation of service goals. ~~The resident care plan must be signed by the director of nursing or another registered nurse employed by the facility to whom institutional responsibilities have been delegated and by the resident, the resident's designee, or the resident's legal representative. The facility may not use an agency or temporary registered nurse to satisfy the foregoing requirement and must document the institutional responsibilities that have been delegated to the registered nurse.~~

Section 20. Paragraph (g) of subsection (2) of section 400.0239, Florida Statutes, is amended to read:

400.0239 Quality of Long-Term Care Facility Improvement Trust Fund.—

(2) Expenditures from the trust fund shall be allowable for direct support of the following:

(g) Other initiatives authorized by the Centers for Medicare and Medicaid Services for the use of federal civil monetary penalties~~, including projects recommended through the Medicaid "Up-or-Out" Quality of Care Contract Management Program pursuant to s. 400.148~~.

Section 21. Subsection (15) of section 400.0255, Florida Statutes, is amended to read

400.0255 Resident transfer or discharge; requirements and procedures; hearings.—

(15)(a) The department's Office of Appeals Hearings shall conduct hearings under this section. The office shall notify the facility of a resident's request for a hearing.

(b) The department shall, by rule, establish procedures to be used for fair hearings requested by residents. These procedures shall be equivalent to the procedures used for fair hearings for other Medicaid cases appearing in s. 409.285 and applicable rules~~, chapter 10-2, part VI, Florida Administrative Code~~. The burden of proof must be clear and convincing evidence. A hearing decision must be rendered within 90 days after receipt of the request for hearing.

(c) If the hearing decision is favorable to the resident who has been transferred or discharged, the resident must be readmitted to the facility's first available bed.

(d) The decision of the hearing officer shall be final. Any aggrieved party may appeal the decision to the district court of appeal in the appellate district where the facility is located. Review procedures shall be conducted in accordance with the Florida Rules of Appellate Procedure.

Section 22. Subsection (2) of section 400.063, Florida Statutes, is amended to read:

400.063 Resident protection.—

(2) The agency is authorized to establish for each facility, subject to intervention by the agency, a separate bank account for the deposit to the credit of the agency of any moneys received from the Health Care Trust Fund or any other moneys received for the maintenance and care of residents in the facility, and the agency is authorized to disburse moneys from such account to pay obligations incurred for the purposes of this section. The agency is authorized to requisition moneys from the Health Care Trust Fund in advance of an actual need for cash on the basis of an estimate by the agency of moneys to be spent under the authority of this section. Any bank account established under this section need not be approved in advance of its creation as required by s. 17.58, but shall be secured by depository insurance equal to or greater than the balance of such account or by the pledge of collateral security ~~in conformance with criteria established in s. 18.11~~. The agency shall notify the Chief Financial Officer of any such account so established and shall make a quarterly accounting to the Chief Financial Officer for all moneys deposited in such account.

Section 23. Subsections (1) and (5) of section 400.071, Florida Statutes, are amended to read:

400.071 Application for license.—

(1) In addition to the requirements of part II of chapter 408, the application for a license shall be under oath and must contain the following:

(a) The location of the facility for which a license is sought and an indication, as in the original application, that such location conforms to the local zoning ordinances.

~~(b) A signed affidavit disclosing any financial or ownership interest that a controlling interest as defined in part II of chapter 408 has held in the last 5 years in any entity licensed by this state or any other state to provide health or residential care which has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason any such entity was closed, whether voluntarily or involuntarily.~~

~~(c) The total number of beds and the total number of Medicare and Medicaid certified beds.~~

(b) ~~(d)~~ Information relating to the applicant and employees which the agency requires by rule. The applicant must demonstrate that sufficient numbers of qualified staff, by training or experience, will be employed to properly care for the type and number of residents who will reside in the facility.

~~(e) Copies of any civil verdict or judgment involving the applicant rendered within the 10 years preceding the application, relating to medical negligence, violation of residents' rights, or wrongful death. As a condition of~~

~~licensure, the licensee agrees to provide to the agency copies of any new verdict or judgment involving the applicant, relating to such matters, within 30 days after filing with the clerk of the court. The information required in this paragraph shall be maintained in the facility's licensure file and in an agency database which is available as a public record.~~

(5) As a condition of licensure, each facility must establish ~~and submit with its application~~ a plan for quality assurance and for conducting risk management.

Section 24. Section 400.0712, Florida Statutes, is amended to read:

400.0712 Application for inactive license.—

~~(1) As specified in this section, the agency may issue an inactive license to a nursing home facility for all or a portion of its beds. Any request by a licensee that a nursing home or portion of a nursing home become inactive must be submitted to the agency in the approved format. The facility may not initiate any suspension of services, notify residents, or initiate inactivity before receiving approval from the agency; and a licensee that violates this provision may not be issued an inactive license.~~

(1)~~(2)~~ In addition to the powers granted under part II of chapter 408, the agency may issue an inactive license for a portion of the total beds to a nursing home that chooses to use an unoccupied contiguous portion of the facility for an alternative use to meet the needs of elderly persons through the use of less restrictive, less institutional services.

(a) An inactive license issued under this subsection may be granted for a period not to exceed the current licensure

expiration date but may be renewed by the agency at the time of licensure renewal.

(b) A request to extend the inactive license must be submitted to the agency in the approved format and approved by the agency in writing.

(c) Nursing homes that receive an inactive license to provide alternative services shall not receive preference for participation in the Assisted Living for the Elderly Medicaid waiver.

(2) ~~(3)~~ The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 necessary to implement this section.

Section 25. Section 400.111, Florida Statutes, is amended to read:

400.111 Disclosure of controlling interest.—In addition to the requirements of part II of chapter 408, when requested by the agency, the licensee shall submit a signed affidavit disclosing any financial or ownership interest that a controlling interest has held within the last 5 years in any entity licensed by the state or any other state to provide health or residential care which entity has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason such entity was closed, whether voluntarily or involuntarily.

Section 26. Subsection (2) of section 400.1183, Florida Statutes, is amended to read:

400.1183 Resident grievance procedures.—

(2) Each facility shall maintain records of all grievances

and shall retain a log for agency inspection of ~~report to the agency at the time of relicensure~~ the total number of grievances handled ~~during the prior licensure period~~, a categorization of the cases underlying the grievances, and the final disposition of the grievances.

Section 27. Paragraphs (o) through (w) of subsection (1) of section 400.141, Florida Statutes, are redesignated as paragraphs (n) through (u), respectively, and present paragraphs (f), (g), (j), (n), (o), and (r) of that subsection are 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:

(f) Be allowed and encouraged by the agency to provide other needed services under certain conditions. If the facility has a standard licensure status~~, and has had no class I or class II deficiencies during the past 2 years or has been awarded a Gold Seal under the program established in s. 400.235~~, it may ~~be encouraged by the agency to~~ provide services, including, but not limited to, respite and adult day services, which enable individuals to move in and out of the facility. A facility is not subject to any additional licensure requirements for providing these services, under the following conditions:~~.~~

1. Respite care may be offered to persons in need of short-term or temporary nursing home services. For each person admitted under the respite care program, the facility licensee must:

a. Have a written abbreviated plan of care that, at a

minimum, includes nutritional requirements, medication orders, physician orders, nursing assessments, and dietary preferences. The nursing or physician assessments may take the place of all other assessments required for full-time residents.

b. Have a contract that, at a minimum, specifies the services to be provided to the respite resident, including charges for services, activities, equipment, emergency medical services, and the administration of medications. If multiple respite admissions for a single person are anticipated, the original contract is valid for 1 year after the date of execution.

c. Ensure that each resident is released to his or her caregiver or an individual designated in writing by the caregiver.

2. A person admitted under the respite care program is:

a. Exempt from requirements in rule related to discharge planning.

b. Covered by the residents' rights set forth in s. 400.022(1)(a)-(o) and (r)-(t). Funds or property of the resident shall not be considered trust funds subject to the requirements of s. 400.022(1)(h) until the resident has been in the facility for more than 14 consecutive days.

c. Allowed to use his or her personal medications for the respite stay if permitted by facility policy. The facility must obtain a physician's order for the medications. The caregiver may provide information regarding the medications as part of the nursing assessment and that information must agree with the physician's order. Medications shall be released with the resident upon discharge in accordance with current physician's

orders.

3. A person receiving respite care is entitled to reside in the facility for a total of 60 days within a contract year or within a calendar year if the contract is for less than 12 months. However, each single stay may not exceed 14 days. If a stay exceeds 14 consecutive days, the facility must comply with all assessment and care planning requirements applicable to nursing home residents.

4. A person receiving respite care must reside in a licensed nursing home bed.

5. A prospective respite resident must provide medical information from a physician, a physician assistant, or a nurse practitioner and other information from the primary caregiver as may be required by the facility prior to or at the time of admission to receive respite care. The medical information must include a physician's order for respite care and proof of a physical examination by a licensed physician, physician assistant, or nurse practitioner. The physician's order and physical examination may be used to provide intermittent respite care for up to 12 months after the date the order is written.

6. The facility must assume the duties of the primary caregiver. To ensure continuity of care and services, the resident is entitled to retain his or her personal physician and must have access to medically necessary services such as physical therapy, occupational therapy, or speech therapy, as needed. The facility must arrange for transportation to these services if necessary. ~~Respite care must be provided in accordance with this part and rules adopted by the agency. However, the agency shall, by rule, adopt modified requirements~~

~~for resident assessment, resident care plans, resident contracts, physician orders, and other provisions, as appropriate, for short-term or temporary nursing home services.~~

7. The agency shall allow for shared programming and staff in a facility which meets minimum standards and offers services pursuant to this paragraph, but, if the facility is cited for deficiencies in patient care, may require additional staff and programs appropriate to the needs of service recipients. A person who receives respite care may not be counted as a resident of the facility for purposes of the facility's licensed capacity unless that person receives 24-hour respite care. A person receiving either respite care for 24 hours or longer or adult day services must be included when calculating minimum staffing for the facility. Any costs and revenues generated by a nursing home facility from nonresidential programs or services shall be excluded from the calculations of Medicaid per diems for nursing home institutional care reimbursement.

(g) If the facility has a standard license ~~or is a Gold Seal facility~~, exceeds the minimum required hours of licensed nursing and certified nursing assistant direct care per resident per day, and is part of a continuing care facility licensed under chapter 651 or a retirement community that offers other services pursuant to part III of this chapter or part I or part III of chapter 429 on a single campus, be allowed to share programming and staff. ~~At the time of inspection and in the semiannual report required pursuant to paragraph (o),~~ A continuing care facility or retirement community that uses this option must demonstrate through staffing records that minimum staffing requirements for the facility were met. Licensed nurses

and certified nursing assistants who work in the nursing home facility may be used to provide services elsewhere on campus if the facility exceeds the minimum number of direct care hours required per resident per day and the total number of residents receiving direct care services from a licensed nurse or a certified nursing assistant does not cause the facility to violate the staffing ratios required under s. 400.23(3)(a). Compliance with the minimum staffing ratios shall be based on total number of residents receiving direct care services, regardless of where they reside on campus. If the facility receives a conditional license, it may not share staff until the conditional license status ends. This paragraph does not restrict the agency's authority under federal or state law to require additional staff if a facility is cited for deficiencies in care which are caused by an insufficient number of certified nursing assistants or licensed nurses. The agency may adopt rules for the documentation necessary to determine compliance with this provision.

(j) Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the residents; and individual resident care plans including, but not limited to, prescribed services, service frequency and duration, and service goals. The records shall be open to inspection by the agency. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically

organized.

~~(n) Submit to the agency the information specified in s. 400.071(1)(b) for a management company within 30 days after the effective date of the management agreement.~~

(n) ~~(o)~~1. ~~Submit semiannually to the agency, or more frequently if requested by the agency, information regarding facility staff-to-resident ratios, staff turnover, and staff stability, including information regarding certified nursing assistants, licensed nurses, the director of nursing, and the facility administrator. For purposes of this reporting:~~

~~a. Staff-to-resident ratios must be reported in the categories specified in s. 400.23(3)(a) and applicable rules. The ratio must be reported as an average for the most recent calendar quarter.~~

~~b. Staff turnover must be reported for the most recent 12-month period ending on the last workday of the most recent calendar quarter prior to the date the information is submitted. The turnover rate must be computed quarterly, with the annual rate being the cumulative sum of the quarterly rates. The turnover rate is the total number of terminations or separations experienced during the quarter, excluding any employee terminated during a probationary period of 3 months or less, divided by the total number of staff employed at the end of the period for which the rate is computed, and expressed as a percentage.~~

~~c. The formula for determining staff stability is the total number of employees that have been employed for more than 12 months, divided by the total number of employees employed at the end of the most recent calendar quarter, and expressed as a~~

~~percentage.~~

~~d.~~ A nursing facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for a period of 6 consecutive days. For the purposes of this sub-subparagraph, any person who was a resident of the facility and was absent from the facility for the purpose of receiving medical care at a separate location or was on a leave of absence is not considered a new admission. Failure to impose such an admissions moratorium is subject to a $1,000 fine ~~constitutes a class II deficiency~~.

2.~~e.~~ A nursing facility which does not have a conditional license may be cited for failure to comply with the standards in s. 400.23(3)(a)1.b. and c. only if it has failed to meet those standards on 2 consecutive days or if it has failed to meet at least 97 percent of those standards on any one day.

3.~~f.~~ A facility which has a conditional license must be in compliance with the standards in s. 400.23(3)(a) at all times.

(r)~~2.~~ This subsection ~~paragraph~~ does not limit the agency's ability to impose a deficiency or take other actions if a facility does not have enough staff to meet the residents' needs.

~~(r) Report to the agency any filing for bankruptcy protection by the facility or its parent corporation, divestiture or spin-off of its assets, or corporate reorganization within 30 days after the completion of such activity.~~

Section 28. Subsection (3) of section 400.142, Florida Statutes, is amended to read:

400.142 Emergency medication kits; orders not to resuscitate.—

(3) Facility staff may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. ~~The agency shall adopt rules providing for the implementation of such orders.~~ Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

Section 29. Present subsections (9), (11), (12), (13), (14), and (15) of section 400.147, Florida Statutes, are renumbered as subsections (8), (9), (10), (11), (12), and (13), respectively, and present subsections (7), (8), and (10) of that section are amended to read:

400.147 Internal risk management and quality assurance program.—

(7) The facility shall initiate an investigation ~~and shall notify the agency~~ within 1 business day after the risk manager or his or her designee has received a report pursuant to paragraph (1)(d). Each facility shall complete the investigation and submit a report to the agency within 15 calendar days if the incident is determined to be an adverse incident as defined in subsection (5). ~~The notification must be made in writing and be provided electronically, by facsimile device or overnight mail~~

~~delivery.~~ The agency shall develop a form for reporting this information, and the notification must include the name of the risk manager of the facility, information regarding the identity of the affected resident, the type of adverse incident, the initiation of an investigation by the facility, and whether the events causing or resulting in the adverse incident represent a potential risk to any other resident. The notification is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each report ~~incident~~ and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

~~(8)(a) Each facility shall complete the investigation and submit an adverse incident report to the agency for each adverse incident within 15 calendar days after its occurrence. If, after a complete investigation, the risk manager determines that the incident was not an adverse incident as defined in subsection (5), the facility shall include this information in the report. The agency shall develop a form for reporting this information.~~

~~(b) The information reported to the agency pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care~~

~~professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.~~

~~(c) The report submitted to the agency must also contain the name of the risk manager of the facility.~~

~~(d) The adverse incident report is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board.~~

~~(10) By the 10th of each month, each facility subject to this section shall report any notice received pursuant to s. 400.0233(2) and each initial complaint that was filed with the clerk of the court and served on the facility during the previous month by a resident or a resident's family member, guardian, conservator, or personal legal representative. The report must include the name of the resident, the resident's date of birth and social security number, the Medicaid identification number for Medicaid-eligible persons, the date or dates of the incident leading to the claim or dates of residency, if applicable, and the type of injury or violation of rights alleged to have occurred. Each facility shall also submit a copy of the notices received pursuant to s. 400.0233(2) and complaints filed with the clerk of the court. This report is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.~~

Section 30. Section 400.148, Florida Statutes, is repealed.

Section 31. Paragraph (e) of subsection (2) of section 400.179, Florida Statutes, is amended to read:

400.179 Liability for Medicaid underpayments and overpayments.—

(2) Because any transfer of a nursing facility may expose the fact that Medicaid may have underpaid or overpaid the transferor, and because in most instances, any such underpayment or overpayment can only be determined following a formal field audit, the liabilities for any such underpayments or overpayments shall be as follows:

~~(c) For the 2009-2010 fiscal year only, the provisions of paragraph (d) shall not apply. This paragraph expires July 1, 2010.~~

Section 32. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.—

(3) The agency shall every 15 months conduct at least one unannounced inspection to determine compliance by the licensee with statutes, and with rules promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. The survey shall be conducted every 6 months for the next 2-year period if the facility has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be $6,000, one-half to be paid at the completion of each

survey. The agency may adjust this fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency ~~unrelated to resident rights or resident care~~ without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to the provisions of chapter 110.

Section 33. Subsection (5) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

(5)(a) The agency, in collaboration with the Division of Children's Medical Services Network of the Department of Health, must~~, no later than December 31, 1993,~~ adopt rules for minimum standards of care for persons under 21 years of age who reside in nursing home facilities. ~~The rules must include a methodology for reviewing a nursing home facility under ss. 408.031-408.045 which serves only persons under 21 years of age.~~ A facility may be exempt from these standards for specific persons between 18 and 21 years of age, if the person's physician agrees that minimum standards of care based on age are not necessary.

(b) The agency, in collaboration with the Division of Children's Medical Services Network, shall adopt rules for minimum staffing requirements for nursing home facilities that serve persons under 21 years of age, which shall apply in lieu of the standards contained in subsection (3).

1. For persons under 21 years of age who require skilled care, the requirements shall include a minimum combined average of licensed nurses, respiratory therapists, respiratory care practitioners, and certified nursing assistants of 3.9 hours of direct care per resident per day for each nursing home facility.

2. For persons under 21 years of age who are fragile, the requirements shall include a minimum combined average of licensed nurses, respiratory therapists, respiratory care practitioners, and certified nursing assistants of 5 hours of direct care per resident per day for each nursing home facility.

Section 34. Subsection (1) of section 400.275, Florida Statutes, is amended to read:

400.275 Agency duties.—

(1) ~~The agency shall ensure that each newly hired nursing home surveyor, as a part of basic training, is assigned full-time to a licensed nursing home for at least 2 days within a 7-day period to observe facility operations outside of the survey process before the surveyor begins survey responsibilities. Such observations may not be the sole basis of a deficiency citation against the facility.~~ The agency may not assign an individual to be a member of a survey team for purposes of a survey, evaluation, or consultation visit at a nursing home facility in which the surveyor was an employee within the preceding 2 ~~5~~ years.

Section 35. Subsection (2) of section 400.484, Florida Statutes, is amended to read:

400.484 Right of inspection; violations ~~deficiencies~~; fines.—

(2) The agency shall impose fines for various classes of violations ~~deficiencies~~ in accordance with the following schedule:

(a) Class I violations are defined in s. 408.813. ~~A class I deficiency is any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at imminent risk of death, disablement, or permanent injury.~~ Upon finding a class I violation ~~deficiency~~, the agency shall impose an administrative fine in the amount of $15,000 for each occurrence and each day that the violation ~~deficiency~~ exists.

(b) Class II violations are defined in s. 408.813. ~~A class II deficiency is any act, omission, or practice that has a direct adverse effect on the health, safety, or security of a patient.~~ Upon finding a class II violation ~~deficiency~~, the agency shall impose an administrative fine in the amount of $5,000 for each occurrence and each day that the violation ~~deficiency~~ exists.

(c) Class III violations are defined in s. 408.813. ~~A class III deficiency is any act, omission, or practice that has an indirect, adverse effect on the health, safety, or security of a patient.~~ Upon finding an uncorrected or repeated class III violation ~~deficiency~~, the agency shall impose an administrative fine not to exceed $1,000 for each occurrence and each day that the uncorrected or repeated violation ~~deficiency~~ exists.

(d) Class IV violations are defined in s. 408.813. ~~A class IV deficiency is any act, omission, or practice related to required reports, forms, or documents which does not have the potential of negatively affecting patients. These violations are of a type that the agency determines do not threaten the health, safety, or security of patients.~~ Upon finding an uncorrected or repeated class IV violation ~~deficiency~~, the agency shall impose an administrative fine not to exceed $500 for each occurrence and each day that the uncorrected or repeated violation ~~deficiency~~ exists.

Section 36. Paragraph (i) of subsection (1) and subsection (4) of section 400.606, Florida Statutes, are amended to read:

400.606 License; application; renewal; conditional license or permit; certificate of need.—

(1) In addition to the requirements of part II of chapter 408, the initial application and change of ownership application must be accompanied by a plan for the delivery of home, residential, and homelike inpatient hospice services to terminally ill persons and their families. Such plan must contain, but need not be limited to:

~~(i) The projected annual operating cost of the hospice.~~

If the applicant is an existing licensed health care provider, the application must be accompanied by a copy of the most recent profit-loss statement and, if applicable, the most recent licensure inspection report.

(4) A freestanding hospice facility that is ~~primarily~~ engaged in providing inpatient and related services and that is not otherwise licensed as a health care facility shall be

required to obtain a certificate of need. However, a freestanding hospice facility with six or fewer beds shall not be required to comply with institutional standards such as, but not limited to, standards requiring sprinkler systems, emergency electrical systems, or special lavatory devices.

Section 37. Subsection (2) of section 400.607, Florida Statutes, is amended to read:

400.607 Denial, suspension, revocation of license; emergency actions; imposition of administrative fine; grounds.—

(2) A violation of this part, part II of chapter 408, or applicable rules ~~Any of the following actions~~ by a licensed hospice or any of its employees shall be grounds for administrative action by the agency against a hospice.~~:~~

~~(a) A violation of the provisions of this part, part II of chapter 408, or applicable rules.~~

~~(b) An intentional or negligent act materially affecting the health or safety of a patient.~~

Section 38. Section 400.915, Florida Statutes, is amended to read:

400.915 Construction and renovation; requirements.—The requirements for the construction or renovation of a PPEC center shall comply with:

(1) The provisions of chapter 553, which pertain to building construction standards, including plumbing, electrical code, glass, manufactured buildings, accessibility for the physically disabled;

(2) The provisions of s. 633.022 and applicable rules pertaining to physical ~~minimum~~ standards for nonresidential child care ~~physical~~ facilities ~~in rule 10M-12.003, Florida~~

~~Administrative Code, Child Care Standards~~; and

(3) The standards or rules adopted pursuant to this part and part II of chapter 408.

Section 39. Subsection (1) of section 400.925, Florida Statutes, is amended to read:

400.925 Definitions.—As used in this part, the term:

(1) "Accrediting organizations" means the Joint Commission ~~on Accreditation of Healthcare Organizations~~ or other national accreditation agencies whose standards for accreditation are comparable to those required by this part for licensure.

Section 40. Subsections (3) through (6) of section 400.931, Florida Statutes, are renumbered as subsections (2) through (5), respectively, and present subsection (2) of that section is amended to read:

400.931 Application for license; fee~~; provisional license; temporary permit~~.—

~~(2) As an alternative to submitting proof of financial ability to operate as required in s. 408.810(8), the applicant may submit a $50,000 surety bond to the agency.~~

Section 41. Subsection (2) of section 400.932, Florida Statutes, is amended to read:

400.932 Administrative penalties.—

(2) A violation of this part, part II of chapter 408, or applicable rules ~~Any of the following actions~~ by an employee of a home medical equipment provider shall be ~~are~~ grounds for administrative action or penalties by the agency.~~:~~

~~(a) Violation of this part, part II of chapter 408, or applicable rules.~~

~~(b) An intentional, reckless, or negligent act that~~

~~materially affects the health or safety of a patient.~~

Section 42. Subsection (3) of section 400.967, Florida Statutes, is amended to read:

400.967 Rules and classification of violations ~~deficiencies~~.—

(3) The agency shall adopt rules to provide that, when the criteria established under this part and part II of chapter 408 are not met, such violations ~~deficiencies~~ shall be classified according to the nature of the violation ~~deficiency~~. The agency shall indicate the classification on the face of the notice of deficiencies as follows:

(a) Class I violations ~~deficiencies~~ are defined in s. 408.813 ~~those which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that death or serious physical harm would result therefrom~~. ~~The condition or practice constituting a class I violation must be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction.~~ A class I violation ~~deficiency~~ is subject to a civil penalty in an amount not less than $5,000 and not exceeding $10,000 for each violation ~~deficiency~~. A fine may be levied notwithstanding the correction of the violation ~~deficiency~~.

(b) Class II violations ~~deficiencies~~ are defined in s. 408.813 ~~those which the agency determines have a direct or immediate relationship to the health, safety, or security of the facility residents, other than class I deficiencies~~. A class II violation ~~deficiency~~ is subject to a civil penalty in an amount not less than $1,000 and not exceeding $5,000 for each violation

~~deficiency~~. A citation for a class II violation ~~deficiency~~ shall specify the time within which the violation ~~deficiency~~ must be corrected. If a class II violation ~~deficiency~~ is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.

(c) Class III violations ~~deficiencies~~ are defined in s. 408.813 ~~those which the agency determines to have an indirect or potential relationship to the health, safety, or security of the facility residents, other than class I or class II deficiencies~~. A class III violation ~~deficiency~~ is subject to a civil penalty of not less than $500 and not exceeding $1,000 for each deficiency. A citation for a class III violation ~~deficiency~~ shall specify the time within which the violation ~~deficiency~~ must be corrected. If a class III violation ~~deficiency~~ is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.

(d) Class IV violations are defined in s. 408.813. Upon finding an uncorrected or repeated class IV violation, the agency shall impose an administrative fine not to exceed $500 for each occurrence and each day that the uncorrected or repeated violation exists.

Section 43. Subsections (4) and (7) of section 400.9905, Florida Statutes, are amended to read:

400.9905 Definitions.—

(4) "Clinic" means an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable health service or equipment provider. For purposes of this part, the term does not include and the licensure

requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; or entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; or entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an

entity licensed or registered by the state pursuant to chapter 395; or entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; or entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter

395.

(e) An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan under 26 U.S.C. s. 409 that has a board of trustees not less than two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof.

(f) A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by s. 627.419, that is directly supervised by one or more of such physicians, and that is wholly owned by one or more of those physicians or by a physician and the spouse, parent, child, or sibling of that physician.

(g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, which are wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner, so long as one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's

compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) that provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

(h) Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(i) Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 which are owned by a corporation whose shares are publicly traded on a recognized stock exchange.

(j) Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.

(k) Entities that provide licensed practitioners to staff emergency departments or to deliver anesthesia services in facilities licensed under chapter 395 and that derive at least 90 percent of their gross annual revenues from the provision of such services. Entities claiming an exemption from licensure under this paragraph must provide documentation demonstrating compliance.

(l) Orthotic, ~~or~~ prosthetic, pediatric cardiology, or perinatology clinical facilities that are a publicly traded corporation or that are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a

publicly traded corporation is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

(m) Entities that are owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners if one or more of the owners of the entity is a health care practitioner who is licensed in this state, is responsible for supervising the business activities of the entity, and is legally responsible for the entity's compliance with state law for purposes of this section.

(n) Entities that are owned or controlled, directly or indirectly, by a publicly traded entity with $100 million or more, in the aggregate, in total annual revenues derived from providing health care services by licensed health care practitioners that are employed or contracted by an entity described in this paragraph.

(7) "Portable health service or equipment provider" means an entity that contracts with or employs persons to provide portable health services or equipment to multiple locations ~~performing treatment or diagnostic testing of individuals~~, that bills third-party payors for those services, and that otherwise meets the definition of a clinic in subsection (4).

Section 44. Paragraph (b) of subsection (1) and paragraph (c) of subsection (4) of section 400.991, Florida Statutes, are amended to read:

400.991 License requirements; background screenings; prohibitions.—

(1)

(b) Each mobile clinic must obtain a separate health care clinic license and must provide to the agency, at least quarterly, its projected street location to enable the agency to locate and inspect such clinic. A portable health service or equipment provider must obtain a health care clinic license for a single administrative office and is not required to submit quarterly projected street locations.

(4) In addition to the requirements of part II of chapter 408, the applicant must file with the application satisfactory proof that the clinic is in compliance with this part and applicable rules, including:

(c) Proof of financial ability to operate as required under ss. ~~s.~~ 408.810(8) and 408.8065. ~~As an alternative to submitting proof of financial ability to operate as required under s. 408.810(8), the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic, payable to the agency. The agency may adopt rules to specify related requirements for such surety bond.~~

Section 45. Paragraph (g) of subsection (1) and paragraph (a) of subsection (7) of section 400.9935, Florida Statutes, are amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(g) Conduct systematic reviews of clinic billings to ensure

that the billings are not fraudulent or unlawful. Upon discovery of an unlawful charge, the medical director or clinic director shall take immediate corrective action. If the clinic performs only the technical component of magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography, and provides the professional interpretation of such services, in a fixed facility that is accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~ or the Accreditation Association for Ambulatory Health Care, and the American College of Radiology; and if, in the preceding quarter, the percentage of scans performed by that clinic which was billed to all personal injury protection insurance carriers was less than 15 percent, the chief financial officer of the clinic may, in a written acknowledgment provided to the agency, assume the responsibility for the conduct of the systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful.

(7)(a) Each clinic engaged in magnetic resonance imaging services must be accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the American College of Radiology, or the Accreditation Association for Ambulatory Health Care, within 1 year after licensure. A clinic that is accredited by the American College of Radiology or is within the original 1-year period after licensure and replaces its core magnetic resonance imaging equipment shall be given 1 year after the date on which the equipment is replaced to attain accreditation. However, a clinic may request a single, 6-month extension if it provides evidence to the agency establishing that, for good cause shown, such clinic cannot be accredited

within 1 year after licensure, and that such accreditation will be completed within the 6-month extension. After obtaining accreditation as required by this subsection, each such clinic must maintain accreditation as a condition of renewal of its license. A clinic that files a change of ownership application must comply with the original accreditation timeframe requirements of the transferor. The agency shall deny a change of ownership application if the clinic is not in compliance with the accreditation requirements. When a clinic adds, replaces, or modifies magnetic resonance imaging equipment and the accreditation agency requires new accreditation, the clinic must be accredited within 1 year after the date of the addition, replacement, or modification but may request a single, 6-month extension if the clinic provides evidence of good cause to the agency.

Section 46. Subsection (2) of section 408.034, Florida Statutes, is amended to read:

408.034 Duties and responsibilities of agency; rules.—

(2) In the exercise of its authority to issue licenses to health care facilities and health service providers, as provided under chapters 393 and 395 and parts II, ~~and~~ IV, and VIII of chapter 400, the agency may not issue a license to any health care facility or health service provider that fails to receive a certificate of need or an exemption for the licensed facility or service.

Section 47. Paragraph (d) of subsection (1) of section 408.036, Florida Statutes, is amended to read:

408.036 Projects subject to review; exemptions.—

(1) APPLICABILITY.—Unless exempt under subsection (3), all

health-care-related projects, as described in paragraphs (a)-(g), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.

(d) The establishment of a hospice or hospice inpatient facility~~, except as provided in s. 408.043~~.

Section 48. Subsection (2) of section 408.043, Florida Statutes, is amended to read:

408.043 Special provisions.—

(2) HOSPICES.—When an application is made for a certificate of need to establish or to expand a hospice, the need for such hospice shall be determined on the basis of the need for and availability of hospice services in the community. The formula on which the certificate of need is based shall discourage regional monopolies and promote competition. The inpatient hospice care component of a hospice which is a freestanding facility, or a part of a facility, ~~which is primarily engaged in providing inpatient care and related services~~ and is not licensed as a health care facility shall also be required to obtain a certificate of need. Provision of hospice care by any current provider of health care is a significant change in service and therefore requires a certificate of need for such services.

Section 49. Paragraph (k) of subsection (3) of section 408.05, Florida Statutes, is amended to read:

408.05 Florida Center for Health Information and Policy Analysis.—

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to

produce comparable and uniform health information and statistics for the development of policy recommendations, the agency shall perform the following functions:

(k) Develop, in conjunction with the State Consumer Health Information and Policy Advisory Council, and implement a long-range plan for making available health care quality measures and financial data that will allow consumers to compare health care services. The health care quality measures and financial data the agency must make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall update the plan and report on the status of its implementation annually. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, any barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:

1. Make available patient-safety indicators, inpatient quality indicators, and performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The terms "patient-safety indicators" and "inpatient quality indicators" shall be as defined by the Centers for Medicare and Medicaid Services, the National Quality Forum, the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the

performance of health care providers, or by other states. The agency shall determine which conditions, procedures, health care quality measures, and patient charge data to disclose based upon input from the council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which health care quality measures to disclose, the agency:

a. Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable.

b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.

When determining which patient charge data to disclose, the agency shall include such measures as the average of undiscounted charges on frequently performed procedures and preventive diagnostic procedures, the range of procedure charges from highest to lowest, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others.

2. Make available performance measures, benefit design, and

premium cost data from health plans licensed pursuant to chapter 627 or chapter 641. The agency shall determine which health care quality measures and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health plans shall make available to the agency any such data or information that is not currently reported to the agency or the office.

3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the State Consumer Health Information and Policy Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include such additional information as is determined necessary to ensure that the website enhances informed decisionmaking among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider.

4. Publish on its website undiscounted charges for no fewer

than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures.

Section 50. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(1) The agency shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties. Specifications for data to be collected under this section shall be developed by the agency with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to: case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the

expected useful life of the property and equipment involved, and demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information. Reported data elements shall be reported electronically and ~~in accordance with rule 59E-7.012, Florida Administrative Code. Data submitted shall be~~ certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

Section 51. Subsection (43) of section 408.07, Florida Statutes, is amended to read:

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(43) "Rural hospital" means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county;

(c) A hospital supported by a tax district or subdistrict

whose boundaries encompass a population of 100 persons or fewer per square mile;

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

(e) A critical access hospital.

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

Section 52. Section 408.10, Florida Statutes, is amended to read:

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

~~(1)~~ publish and make available to the public a toll-free telephone number for the purpose of handling consumer complaints

and shall serve as a liaison between consumer entities and other private entities and governmental entities for the disposition of problems identified by consumers of health care.

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

Section 53. Subsections (12) through (30) of section 408.802, Florida Statutes, are renumbered as subsections (11) through (29), respectively, and present subsection (11) of that section is amended to read:

408.802 Applicability.—The provisions of this part apply to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, 483, and 765:

~~(11) Private review agents, as provided under part I of chapter 395.~~

Section 54. Subsection (3) is added to section 408.804, Florida Statutes, to read:

408.804 License required; display.—

(3) Any person who knowingly alters, defaces, or falsifies a license certificate issued by the agency, or causes or procures any person to commit such an offense, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s 775.083. Any licensee or provider who displays an altered, defaced, or falsified license certificate is subject to

the penalties set forth in s. 408.815 and an administrative fine of $1,000 for each day of illegal display.

Section 55. Paragraph (d) of subsection (2) of section 408.806, Florida Statutes, is amended, to read:

408.806 License application process.—

(2)

(d) ~~The agency shall notify the licensee by mail or electronically at least 90 days before the expiration of a license that a renewal license is necessary to continue operation.~~ The licensee's failure to timely file ~~submit~~ a renewal application and license application fee with the agency shall result in a $50 per day late fee charged to the licensee by the agency; however, the aggregate amount of the late fee may not exceed 50 percent of the licensure fee or $500, whichever is less. The agency shall provide a courtesy notice to the licensee by United States mail, electronically, or by any other manner at its address of record or mailing address, if provided, at least 90 days prior to the expiration of a license informing the licensee of the expiration of the license. If the agency does not provide the courtesy notice or the licensee does not receive the courtesy notice, the licensee continues to be legally obligated to timely file the renewal application and license application fee with the agency and is not excused from the payment of a late fee. If an application is received after the required filing date and exhibits a hand-canceled postmark obtained from a United States post office dated on or before the required filing date, no fine will be levied. Payment of the late fee is required in order for a late application to be considered complete, and failure to pay the late fee is

considered an omission from the application.

Section 56. Subsection (3) is added to section 408.813, Florida Statutes, to read:

408.813 Administrative fines; violations.—As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine.

(3) The agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class IV violation. Unless otherwise specified by law, the amount of the fine shall not exceed $500 for each violation. Unclassified violations may include:

(a) Violating any term or condition of a license.

(b) Violating any provision of this part, authorizing statutes, or applicable rules.

(c) Exceeding licensed capacity.

(d) Providing services beyond the scope of the license.

(e) Violating a moratorium imposed pursuant to s. 408.814.

Section 57. Subsection (5) is added to section 408.815, Florida Statutes, to read:

408.815 License or application denial; revocation.—

(5) In order to ensure the health, safety, and welfare of clients when a license has been denied, revoked, or is set to terminate, the agency may extend the license expiration date for a period of up to 30 days for the sole purpose of allowing the safe and orderly discharge of clients. The agency may impose conditions on the extension, including, but not limited to, prohibiting or limiting admissions, expedited discharge planning, required status reports, and mandatory monitoring by the agency or third parties. When imposing these conditions, the

agency shall take into consideration the nature and number of clients, the availability and location of acceptable alternative placements, and the ability of the licensee to continue providing care to the clients. The agency may terminate the extension or modify the conditions at any time. This authority is in addition to any other authority granted to the agency under chapter 120, this part, and authorizing statutes but creates no right or entitlement to an extension of a license expiration date.

Section 58. Subsection (1) of section 409.91196, Florida Statutes, is amended to read:

409.91196 Supplemental rebate agreements; public records and public meetings exemption.—

(1) The rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebate, and other trade secrets as defined in s. 688.002 that the agency has identified for use in negotiations, held by the Agency for Health Care Administration under s. 409.912(39)(a)8.~~7.~~ are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Section 59. Paragraph (a) of subsection (39) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to

emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider’s professional peers or the national guidelines of a provider’s professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is

authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(39)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list, which shall be a listing

of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the preferred drug list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency is authorized to seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to implement this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

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

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

2. Reimbursement to pharmacies for Medicaid prescribed

drugs shall be set at the lesser of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

3. For a prescribed drug billed as a 340B prescribed medication, the claim must meet the requirements of the Deficit Reduction Act of 2005 and the federal 340B program, contain a national drug code, and be billed at the actual acquisition cost or payment shall be denied.

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

5.~~4.~~ The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations,

credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

6.~~5.~~ The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

7.~~6.~~ The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug

manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

8.~~7.~~ The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Effective July 1, 2004, value-added programs as a

substitution for supplemental rebates are prohibited. The agency is authorized to seek any federal waivers to implement this initiative.

9.~~8.~~ The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

10.~~9.~~ The agency shall limit to one dose per month any drug prescribed to treat erectile dysfunction.

11.~~10.~~a. The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency is authorized to seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Family Services, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill

individuals and emotionally disturbed children who are high users of care.

12.~~11.~~a. The agency shall implement a Medicaid prescription drug management system. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the development and adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

(V) Track spending trends for prescription drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement disease management programs in cooperation with physicians and pharmacists, along with a model quality-based medication component for individuals having chronic medical conditions.

13.~~12.~~ The agency is authorized to contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

14.~~13.~~ The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective

prescribing practices.

15.~~14.~~ The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may, but is not required to, prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency may post prior authorization criteria and protocol and updates to the list of drugs that are subject to prior authorization on an Internet website without amending its rule or engaging in additional rulemaking.

16.~~15.~~ The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

17.~~16.~~ The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months prior to the

alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or

c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

18.~~17.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and

reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused. The agency's conclusion and recommendations shall be reported to the Legislature by December 1, 2005.

Section 60. Section 409.91255, Florida Statutes, is amended to read:

409.91255 Federally qualified health center access program.—

(1) SHORT TITLE.—This section may be cited as the "Community Health Center Access Program Act."

(2) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that, despite significant investments in health care programs, nearly 6 ~~more than 2~~ million low-income Floridians, primarily the working poor and minority populations, continue to lack access to basic health care services. Further, the Legislature recognizes that federally qualified health centers have a proven record of providing cost-effective, comprehensive primary and preventive health care and are uniquely qualified to address the lack of adequate health care services for the uninsured.

(b) It is the intent of the Legislature to recognize the

significance of increased federal investments in federally qualified health centers and to leverage that investment through the creation of a program to provide for the expansion of the primary and preventive health care services offered by federally qualified health centers. Further, such a program will support the coordination of federal, state, and local resources to assist such health centers in developing an expanded community-based primary care delivery system.

(3) ASSISTANCE TO FEDERALLY QUALIFIED HEALTH CENTERS.—The agency shall administer ~~Department of Health shall develop~~ a program for the expansion of federally qualified health centers for the purpose of providing comprehensive primary and preventive health care and urgent care services that may reduce the morbidity, mortality, and cost of care among the uninsured population of the state. The program shall provide for distribution of financial assistance to federally qualified health centers that apply and demonstrate a need for such assistance in order to sustain or expand the delivery of primary and preventive health care services. In selecting centers to receive this financial assistance, the program:

(a) Shall give preference to communities that have few or no community-based primary care services or in which the current services are unable to meet the community's needs. To assist in the assessment and identification of areas of critical need, the Florida Association of Community Health Centers, Inc., shall develop, every 5 years, beginning January 1, 2012, a federally qualified health center based statewide assessment and strategic plan.

(b) Shall require that primary care services be provided to

the medically indigent using a sliding fee schedule based on income.

(c) Shall promote ~~allow~~ innovative and creative uses of federal, state, and local health care resources.

(d) Shall require that the funds provided be used to pay for operating costs of a projected expansion in patient caseloads or services or for capital improvement projects. Capital improvement projects may include renovations to existing facilities or construction of new facilities, provided that an expansion in patient caseloads or services to a new patient population will occur as a result of the capital expenditures. The agency ~~department~~ shall include in its standard contract document a requirement that any state funds provided for the purchase of or improvements to real property are contingent upon the contractor granting to the state a security interest in the property at least to the amount of the state funds provided for at least 5 years from the date of purchase or the completion of the improvements or as further required by law. The contract must include a provision that, as a condition of receipt of state funding for this purpose, the contractor agrees that, if it disposes of the property before the agency's ~~department's~~ interest is vacated, the contractor will refund the proportionate share of the state's initial investment, as adjusted by depreciation.

(e) Shall ~~May~~ require in-kind support from other sources.

(f) Shall promote ~~May encourage~~ coordination among federally qualified health centers, other private sector providers, and publicly supported programs.

(g) Shall promote ~~allow~~ the development of community

emergency room diversion programs in conjunction with local resources, providing extended hours of operation to urgent care patients. Diversion programs shall include case management for emergency room followup care.

(4) EVALUATION OF APPLICATIONS.—A review panel shall be established, consisting of four persons appointed by the Secretary of Health Care Administration ~~State Surgeon General~~ and three persons appointed by the chief executive officer of the Florida Association of Community Health Centers, Inc., to review all applications for financial assistance under the program. Applicants shall specify in the application whether the program funds will be used for the expansion of patient caseloads or services or for capital improvement projects to expand and improve patient facilities. The panel shall use the following elements in reviewing application proposals and shall determine the relative weight for scoring and evaluating these elements:

(a) The target population to be served.

(b) The health benefits to be provided.

(c) The methods that will be used to measure cost-effectiveness.

(d) How patient satisfaction will be measured.

(e) The proposed internal quality assurance process.

(f) Projected health status outcomes.

(g) How data will be collected to measure cost-effectiveness, health status outcomes, and overall achievement of the goals of the proposal.

(h) All resources, including cash, in-kind, voluntary, or other resources that will be dedicated to the proposal.

(5) ADMINISTRATION AND TECHNICAL ASSISTANCE.—The agency shall ~~Department of Health may~~ contract with the Florida Association of Community Health Centers, Inc., to develop and coordinate ~~administer~~ the program and provide technical assistance to the federally qualified health centers selected to receive financial assistance. The contracted entity shall be responsible for program support and assume all costs related to administration of this program.

Section 61. Subsections (3) and (4) of section 429.07, Florida Statutes, are amended, and subsections (6) and (7) are added to that section, to read:

429.07 License required; fee; inspections.—

(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.

(a) A standard license shall be issued to a facility ~~facilities~~ providing one or more of the personal services identified in s. 429.02. Such licensee ~~facilities~~ may also employ or contract with a person ~~licensed under part I of chapter 464~~ to ~~administer medications and~~ perform other tasks as specified in s. 429.255.

(b) An extended congregate care license shall be issued to a licensee ~~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.

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. 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. An existing licensee ~~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.

2. A facility that is licensed to provide extended congregate care services shall maintain a written progress report for ~~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 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 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 no class I or class II violations and no uncorrected class III violations. 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.~~

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.

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. When a <u>licensee</u> ~~facility~~ can no longer provide or arrange for services in accordance with the resident's service plan and needs and the <u>licensee's</u> ~~facility's~~ policy, the <u>licensee</u> ~~facility~~ 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. 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 part II of chapter 408. Existing facilities qualifying to provide limited nursing services 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. Facilities that are licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services, which report 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 such facilities at least 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.~~

~~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.~~

(4) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this part, part II of chapter 408, and applicable rules. The amount of the fee shall be established by rule.

(a) The biennial license fee required of a facility is $371 ~~$300~~ per license, with an additional fee of $71 ~~$50~~ per resident based on the total licensed resident capacity of the facility, except that no additional fee will be assessed for beds designated for recipients of optional state supplementation payments provided for in s. 409.212. The total fee may not exceed $18,000 ~~$10,000~~.

(b) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide extended congregate care services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $523 ~~$400~~ per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.

~~(c) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide limited nursing services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $250 per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.~~

(6) In order to determine whether the facility is adequately protecting residents' rights as provided in s. 429.28, the agency shall conduct a standard licensure survey, which shall include private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss residents' experiences within the facility.

(7) An assisted living facility that has been cited within the previous 24-month period for a class I or class II violation, regardless of the status of any enforcement or disciplinary action, is subject to periodic unannounced monitoring to determine if the facility is in compliance with this part, part II of chapter 408, and applicable rules. Monitoring may occur through a desk review or an onsite assessment. If the class I or class II violation relates to providing or failing to provide nursing care, a registered nurse must participate in monitoring activities during the 12-month period following the violation.

Section 62. Subsection (7) of section 429.11, Florida Statutes, is renumbered as subsection (6), and present subsection (6) of that section is amended to read:

429.11 Initial application for license~~; provisional~~

~~license~~.—

~~(6) In addition to the license categories available in s. 408.808, a provisional license may be issued to an applicant making initial application for licensure or making application for a change of ownership. A provisional license shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency.~~

Section 63. Section 429.12, Florida Statutes, is amended to read:

429.12 Sale or transfer of ownership of a facility.—It is the intent of the Legislature to protect the rights of the residents of an assisted living facility when the facility is sold or the ownership thereof is transferred. Therefore, in addition to the requirements of part II of chapter 408, whenever a facility is sold or the ownership thereof is transferred, including leasing, ~~:~~

~~(1)~~ the transferee shall notify the residents, in writing, of the change of ownership within 7 days after receipt of the new license.

~~(2) The transferor of a facility the license of which is denied pending an administrative hearing shall, as a part of the written change-of-ownership contract, advise the transferee that a plan of correction must be submitted by the transferee and approved by the agency at least 7 days before the change of ownership and that failure to correct the condition which resulted in the moratorium pursuant to part II of chapter 408 or denial of licensure is grounds for denial of the transferee's license.~~

Section 64. Subsections (1), (4), and (5) of section

429.17, Florida Statutes, are amended to read:

429.17 Expiration of license; renewal; conditional license.—

(1) ~~Limited nursing,~~ Extended congregate care~~,~~ and limited mental health licenses shall expire at the same time as the facility's standard license, regardless of when issued.

(4) In addition to the license categories available in s. 408.808, a conditional license may be issued to an applicant for license renewal if the applicant fails to meet all standards and requirements for licensure. A conditional license issued under this subsection shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency~~, and shall be accompanied by an agency-approved plan of correction~~.

(5) When an extended congregate care ~~or limited nursing~~ license is requested during a facility's biennial license period, the fee shall be prorated in order to permit the additional license to expire at the end of the biennial license period. The fee shall be calculated as of the date the additional license application is received by the agency.

Section 65. Subsection (7) of section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

(7) In addition to any administrative fines imposed, the agency may assess a survey or monitoring 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 to monitor the health, safety, or security of residents under s. 429.07(7) ~~monitoring visits conducted under s. 429.28(3)(c) to verify the correction of the violations~~.

Section 66. Subsections (6) through (10) of section 429.23, Florida Statutes, are renumbered as subsections (5) through (9), respectively, and present subsection (5) of that section is amended to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

~~(5) Each facility shall report monthly to the agency any liability claim filed against it. The report must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.~~

Section 67. Paragraph (a) of subsection (1) and subsection (2) of section 429.255, Florida Statutes, are amended to read:

429.255 Use of personnel; emergency care.—

(1)(a) Persons under contract to the facility or~~,~~ facility staff~~, or volunteers,~~ who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), and others as defined by rule, may administer medications to residents, take residents' vital signs, manage individual weekly pill organizers for residents who self-administer medication, give prepackaged enemas ordered by a physician, observe residents, document observations on the appropriate resident's record, report observations to the resident's physician, and

contract or allow residents or a resident's representative, designee, surrogate, guardian, or attorney in fact to contract with a third party, provided residents meet the criteria for appropriate placement as defined in s. 429.26. Persons under contract to the facility or facility staff who are licensed according to part I of chapter 464 may provide limited nursing services. Nursing assistants certified pursuant to part II of chapter 464 may take residents' vital signs as directed by a licensed nurse or physician. The facility is responsible for maintaining documentation of services provided under this paragraph and as required by rule and ensuring that staff are adequately trained to monitor residents receiving these services.

(2) In facilities licensed to provide extended congregate care, persons under contract to the facility or, facility staff, ~~or volunteers,~~ who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), or those persons certified as nursing assistants pursuant to part II of chapter 464, may also perform all duties within the scope of their license or certification, as approved by the facility administrator and pursuant to this part.

Section 68. Subsections (4), (5), (6), and (7) of section 429.28, Florida Statutes, are renumbered as subsections (3), (4), (5), and (6), respectively, and present subsections (3) and (6) of that section are amended to read:

429.28 Resident bill of rights.—

~~(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.~~

~~(b) In order to determine whether the facility is adequately protecting residents' rights, the biennial survey shall include private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss residents' experiences within the facility.~~

~~(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.~~

~~(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.~~

~~(e) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.~~

(5) ~~(6)~~ Any facility which terminates the residency of an individual who participated in activities specified in subsection (4) ~~(5)~~ shall show good cause in a court of competent jurisdiction.

Section 69. Subsection (2) of section 429.35, Florida Statutes, is amended to read:

429.35 Maintenance of records; reports.—

(2) Within 60 days after the date of the biennial inspection visit required under s. 408.811 or within 30 days

after the date of any interim visit, the agency shall forward the results of the inspection to the local ombudsman council in whose planning and service area, as defined in part II of chapter 400, the facility is located; to at least one public library or, in the absence of a public library, the county seat in the county in which the inspected assisted living facility is located; and, when appropriate, to the district Adult Services and Mental Health Program Offices. This information may be provided electronically or through the agency's Internet website.

Section 70. Paragraphs (i) and (j) of subsection (1) of section 429.41, Florida Statutes, are amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with the agency, the Department of Children and Family Services, and the Department of Health, shall adopt rules, policies, and

procedures to administer this part, which must include reasonable and fair minimum standards in relation to:

(i) Facilities holding an ~~a limited nursing,~~ extended congregate care~~,~~ or limited mental health license.

(j) The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, ~~limited nursing,~~ extended congregate care, and limited mental health license.

Section 71. Subsections (1) and (2) of section 429.53, Florida Statutes, are amended to read:

429.53 Consultation by the agency.—

(1) The ~~area offices of licensure and certification of the~~ agency shall provide consultation to the following upon request:

(a) A licensee of a facility.

(b) A person interested in obtaining a license to operate a facility under this part.

(2) As used in this section, "consultation" includes:

(a) An explanation of the requirements of this part and rules adopted pursuant thereto;

(b) An explanation of the license application and renewal procedures; and

~~(c) The provision of a checklist of general local and state approvals required prior to constructing or developing a facility and a listing of the types of agencies responsible for such approvals;~~

~~(d) An explanation of benefits and financial assistance available to a recipient of supplemental security income residing in a facility;~~

(c) ~~(e)~~ Any other information which the agency deems

necessary to promote compliance with the requirements of this part~~; and~~

~~(f) A preconstruction review of a facility to ensure compliance with agency rules and this part~~.

Section 72. Subsections (1) and (2) of section 429.54, Florida Statutes, are renumbered as subsections (2) and (3), respectively, and a new subsection (1) is added to that section to read:

429.54 Collection of information; local subsidy.—

(1) A facility that is licensed under this part must report electronically to the agency semiannually data related to the facility, including, but not limited to, the total number of residents, the number of residents who are receiving limited mental health services, the number of residents who are receiving extended congregate care services, the number of residents who are receiving limited nursing services, and professional staffing employed by or under contract with the licensee to provide resident services. The department, in consultation with the agency, shall adopt rules to administer this subsection.

Section 73. Subsections (1) and (5) of section 429.71, Florida Statutes, are amended to read:

429.71 Classification of violations ~~deficiencies~~; administrative fines.—

(1) In addition to the requirements of part II of chapter 408 and in addition to any other liability or penalty provided by law, the agency may impose an administrative fine on a provider according to the following classification:

(a) Class I violations are defined in s. 408.813 ~~those~~

~~conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice that constitutes a class I violation must be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction~~. A class I violation ~~deficiency~~ is subject to an administrative fine in an amount not less than $500 and not exceeding $1,000 for each violation. ~~A fine may be levied notwithstanding the correction of the deficiency.~~

(b) Class II violations are defined in s. 408.813 ~~those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the residents, other than class I violations~~. A class II violation is subject to an administrative fine in an amount not less than $250 and not exceeding $500 for each violation. ~~A citation for a class II violation must specify the time within which the violation is required to be corrected. If a class II violation is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.~~

(c) Class III violations are defined in s. 408.813 ~~those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of residents,~~

~~other than class I or class II violations~~. A class III violation is subject to an administrative fine in an amount not less than $100 and not exceeding $250 for each violation. ~~A citation for a class III violation shall specify the time within which the violation is required to be corrected.~~ If a class III violation is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated violation ~~offense~~.

(d) Class IV violations are defined in s. 408.813 ~~those conditions or occurrences related to the operation and maintenance of an adult family-care home, or related to the required reports, forms, or documents, which do not have the potential of negatively affecting the residents~~. ~~A provider that does not correct~~ A class IV violation ~~within the time limit specified by the agency~~ is subject to an administrative fine in an amount not less than $50 and not exceeding $100 for each violation. Any class IV violation that is corrected during the time the agency survey is conducted will be identified as an agency finding and not as a violation, unless it is a repeat violation.

~~(5) As an alternative to or in conjunction with an administrative action against a provider, the agency may request a plan of corrective action that demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.~~

Section 74. Section 429.915, Florida Statutes, is amended to read:

429.915 Conditional license.—In addition to the license categories available in part II of chapter 408, the agency may issue a conditional license to an applicant for license renewal

or change of ownership if the applicant fails to meet all standards and requirements for licensure. A conditional license issued under this subsection must be limited to a specific period not exceeding 6 months, as determined by the agency~~, and must be accompanied by an approved plan of correction~~.

Section 75. Paragraphs (b) and (g) of subsection (3) of section 430.80, Florida Statutes, are amended to read:

430.80 Implementation of a teaching nursing home pilot project.—

(3) To be designated as a teaching nursing home, a nursing home licensee must, at a minimum:

(b) Participate in a nationally recognized accreditation program and hold a valid accreditation, such as the accreditation awarded by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, or, at the time of initial designation, possess a Gold Seal Award as conferred by the state on its licensed nursing home;

(g) Maintain insurance coverage pursuant to s. 400.141(1)(q)~~(s)~~ or proof of financial responsibility in a minimum amount of $750,000. Such proof of financial responsibility may include:

1. Maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52; or

2. Obtaining and maintaining pursuant to chapter 675 an unexpired, irrevocable, nontransferable and nonassignable letter of credit issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a

branch office which is authorized to receive deposits in this state. The letter of credit shall be used to satisfy the obligation of the facility to the claimant upon presentment of a final judgment indicating liability and awarding damages to be paid by the facility or upon presentment of a settlement agreement signed by all parties to the agreement when such final judgment or settlement is a result of a liability claim against the facility.

Section 76. Paragraph (d) of subsection (9) of section 440.102, Florida Statutes, is repealed.

Section 77. Paragraph (a) of subsection (2) of section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—

(a) Subject to the limitations specified elsewhere in this chapter, the employer shall furnish to the employee such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, which is in accordance with established practice parameters and protocols of treatment as provided for in this chapter, including medicines, medical supplies, durable medical equipment, orthoses, prostheses, and other medically necessary apparatus. Remedial treatment, care, and attendance, including work-hardening programs or pain-management programs accredited by the Commission on Accreditation of Rehabilitation Facilities or the Joint Commission ~~on the Accreditation of Health Organizations~~ or pain-management programs affiliated with medical schools, shall be considered as covered treatment only

when such care is given based on a referral by a physician as defined in this chapter. Medically necessary treatment, care, and attendance does not include chiropractic services in excess of 24 treatments or rendered 12 weeks beyond the date of the initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employee is catastrophically injured.

Failure of the carrier to timely comply with this subsection shall be a violation of this chapter and the carrier shall be subject to penalties as provided for in s. 440.525.

Section 78. Section 483.294, Florida Statutes, is amended to read:

483.294 Inspection of centers.—In accordance with s. 408.811, the agency shall biennially~~, at least once annually,~~ inspect the premises and operations of all centers subject to licensure under this part.

Section 79. Subsection (4) is added to section 626.9541, Florida Statutes, to read:

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined; alternative rates of payment; wellness programs.—

(4) WELLNESS PROGRAMS.—An insurer issuing a group or individual health benefit plan may offer a voluntary wellness or health-improvement program that allows for rewards or incentives, including, but not limited to, merchandise, gift cards, debit cards, premium discounts or rebates, contributions towards a member's health savings account, modifications to copayment, deductible, or coinsurance amounts, or any

combination of these incentives, to encourage or reward participation in the program. The health plan member may be required to provide verification, such as a statement from his or her physician, that a medical condition makes it unreasonably difficult or medically inadvisable for the individual to participate in the wellness program. Any reward or incentive established under this subsection is not an insurance benefit and does not violate this section. This subsection does not prohibit an insurer from offering incentives or rewards to members for adherence to wellness or health improvement programs if otherwise allowed by state or federal law. Notwithstanding any provision of this subsection, no insurer, nor its agent, may use any incentive authorized by this subsection for the purpose of redirecting patients from one health care insurance plan to another.

Section 80. Subsection (1) of section 627.645, Florida Statutes, is amended to read:

627.645 Denial of health insurance claims restricted.—

(1) No claim for payment under a health insurance policy or self-insured program of health benefits for treatment, care, or services in a licensed hospital which is accredited by the Joint Commission ~~on the Accreditation of Hospitals~~, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities shall be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability.

Section 81. Paragraph (c) of subsection (2) of section 627.668, Florida Statutes, is amended to read:

627.668 Optional coverage for mental and nervous disorders required; exception.—

(2) Under group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors shall not be less favorable than for physical illness generally, except that:

(c) Partial hospitalization benefits shall be provided under the direction of a licensed physician. For purposes of this part, the term "partial hospitalization services" is defined as those services offered by a program accredited by the Joint Commission ~~on Accreditation of Hospitals (JCAH)~~ or in compliance with equivalent standards. Alcohol rehabilitation programs accredited by the Joint Commission ~~on Accreditation of Hospitals~~ or approved by the state and licensed drug abuse rehabilitation programs shall also be qualified providers under this section. In any benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are utilized, the total benefits paid for all such services shall not exceed the cost of 30 days of inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond the limits set forth in this paragraph, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.

Section 82. Subsection (3) of section 627.669, Florida Statutes, is amended to read:

627.669 Optional coverage required for substance abuse impaired persons; exception.—

(3) The benefits provided under this section shall be applicable only if treatment is provided by, or under the supervision of, or is prescribed by, a licensed physician or licensed psychologist and if services are provided in a program accredited by the Joint Commission ~~on Accreditation of Hospitals~~ or approved by the state.

Section 83. Paragraph (a) of subsection (1) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—Every insurance policy complying with the security requirements of s. 627.733 shall provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the provisions of subsection (2) and paragraph (4)(e), to a limit of $10,000 for loss sustained by any such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services. However, the medical benefits shall provide

reimbursement only for such services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided by any of the following persons or entities:

1. A hospital or ambulatory surgical center licensed under chapter 395.

2. A person or entity licensed under ss. 401.2101-401.45 that provides emergency transportation and treatment.

3. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioner or practitioners and the spouse, parent, child, or sibling of that practitioner or those practitioners.

4. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

5. A health care clinic licensed under ss. 400.990-400.995 that is:

a. Accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

b. A health care clinic that:

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years

or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in subparagraph 3., subparagraph 4., or subparagraph 5. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and no such insurer shall require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such required benefits. Insurers may not require that

property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance; and any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those which may be afforded elsewhere in the insurance code.

Section 84. Subsection (12) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(12) The provisions of part I of chapter 395 do not apply to a health maintenance organization that, on or before January 1, 1991, provides not more than 10 outpatient holding beds for short-term and hospice-type patients in an ambulatory care facility for its members, provided that such health maintenance organization maintains current accreditation by the Joint Commission ~~on Accreditation of Health Care Organizations~~, the Accreditation Association for Ambulatory Health Care, or the National Committee for Quality Assurance.

Section 85. Subsection (13) of section 651.118, Florida Statutes, is amended to read:

651.118 Agency for Health Care Administration; certificates

of need; sheltered beds; community beds.—

(13) Residents, as defined in this chapter, are not considered new admissions for the purpose of s. 400.141(1)(n) ~~(o)~~1.d.

Section 86. Subsection (2) of section 766.1015, Florida Statutes, is amended to read:

766.1015 Civil immunity for members of or consultants to certain boards, committees, or other entities.—

(2) Such committee, board, group, commission, or other entity must be established in accordance with state law or in accordance with requirements of the Joint Commission ~~on Accreditation of Healthcare Organizations~~, established and duly constituted by one or more public or licensed private hospitals or behavioral health agencies, or established by a governmental agency. To be protected by this section, the act, decision, omission, or utterance may not be made or done in bad faith or with malicious intent.

Section 87. Subsection (4) of section 766.202, Florida Statutes, is amended to read:

766.202 Definitions; ss. 766.201-766.212.—As used in ss. 766.201-766.212, the term:

(4) "Health care provider" means any hospital, ambulatory surgical center, or mobile surgical facility as defined and licensed under chapter 395; a birth center licensed under chapter 383; any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, part I of chapter 464, chapter 466, chapter 467, part XIV of chapter 468, or chapter 486; a clinical lab licensed under chapter 483; a health maintenance organization certificated under part I of

chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.

Section 88. This act shall take effect July 1, 2011.