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LEGISLATIVE ACTION

Senate . House

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Senator Garcia moved the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (1) of section 83.42, Florida Statutes, is amended to read:

83.42 Exclusions from application of part.—This part does not apply to:

(1) Residency or detention in a facility, whether public or private, when residence or detention is incidental to the provision of medical, geriatric, educational, counseling, religious, or similar services. For residents of a facility licensed under part II of chapter 400, the provisions of s.


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400.0255 are the exclusive procedures for all transfers and discharges.

Section 2. 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

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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


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employee or job applicant pursuant to subparagraph (8)(b)2. and a positive confirmed drug test result.

A ~~No~~ report may not ~~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) ~~(10)(g)~~.

3. Award back pay and benefits.

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

Section 3. 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 4. Subsection (15) of section 318.21, Florida Statutes, is amended to read:

318.21 Disposition of civil penalties by county courts.—All civil penalties received by a county court pursuant to the provisions of this chapter shall be distributed and paid monthly as follows:


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(15) Of the additional fine assessed under s. 318.18(3)(e) for a violation of s. 316.1893, 50 percent of the moneys received from the fines shall be remitted to the Department of Revenue and deposited into the Brain and Spinal Cord Injury Trust Fund of Department of Health and appropriated to the Department of Health ~~Agency for Health Care Administration~~ as general revenue to ~~provide an enhanced Medicaid payment to nursing homes that~~ serve Medicaid recipients who have ~~with~~ brain and spinal cord injuries that are medically complex and who are technologically and respiratory dependent. The remaining 50 percent of the moneys received from the enhanced fine imposed under s. 318.18(3)(e) shall be remitted to the Department of Revenue and deposited into the Department of Health Emergency Medical Services Trust Fund to provide financial support to certified trauma centers in the counties where enhanced penalty zones are established to ensure the availability and accessibility of trauma services. Funds deposited into the Emergency Medical Services Trust Fund under this subsection shall be allocated as follows:

(a) Fifty percent shall be allocated equally among all Level I, Level II, and pediatric trauma centers in recognition of readiness costs for maintaining trauma services.

(b) Fifty percent shall be allocated among Level I, Level II, and pediatric trauma centers based on each center’s relative volume of trauma cases as reported in the Department of Health Trauma Registry.

Section 5. Paragraph (g) of subsection (1) of section 383.011, Florida Statutes, is amended to read:

383.011 Administration of maternal and child health


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programs.—

(1) The Department of Health is designated as the state agency for:

(g) Receiving the federal funds for the "Special Supplemental Nutrition Program for Women, Infants, and Children," or WIC, authorized by the Child Nutrition Act of 1966, as amended, and for providing clinical leadership for ~~administering~~ the statewide WIC program.

1. The department shall establish an interagency agreement with the Department of Children and Family Services for management of the program. Responsibilities are delegated to each department as follows:

a. The department shall provide clinical leadership, manage program eligibility, and distribute nutritional guidance and information to participants.

b. The Department of Children and Family Services shall develop and implement an electronic benefits transfer system.

c. The Department of Children and Family Services shall develop a cost containment plan that provides timely and accurate adjustments based on wholesale price fluctuations and adjusts for the number of cash registers in calculating statewide averages.

d. The department shall coordinate submission of information to appropriate federal officials in order to obtain approval of the electronic benefits system and cost containment plan, which must include the participation of WIC-only stores.

2. The department shall assist the Department of Children and Family Services in the development of the electronic benefits system to ensure full implementation no later than July


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1, 2013.

Section 6. Section 383.141, Florida Statutes, is created to read:

383.141 Prenatally diagnosed conditions; patient to be provided information; definitions; clearinghouse of information; advisory council.—

(1) The Legislature finds that pregnant women who choose to undergo prenatal testing for developmental disabilities should have access to timely and informative counseling about the conditions being tested for, the accuracy of such tests, and resources for obtaining support services for such conditions. It is especially essential for a pregnant woman whose unborn child has been diagnosed with a developmental disability through prenatal testing to be adequately informed of the accuracy of such testing, implications of the diagnosis, possible treatment options, and available support networks, as the results of such testing and that the counseling that follows may lead to the unnecessary abortion of unborn humans.

(2) As used in this section, the term:

(a) "Down syndrome" means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

(b) "Developmental disability" includes Down syndrome and other developmental disabilities defined by s. 393.063(9).

(c) "Health care provider" means a practitioner licensed or registered under chapter 458 or chapter 459 or an advanced registered nurse practitioner certified under chapter 464.

(d) "Prenatally diagnosed condition" means an adverse fetal health condition identified by prenatal testing.

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(e) "Prenatal test" or "prenatal testing" means a diagnostic procedure or screening procedure performed on a pregnant woman or her unborn offspring to obtain information about her offspring's health or development.

(3) When a developmental disability is diagnosed based on the results of a prenatal test, the health care provider who ordered the prenatal test, or his or her designee, shall provide the patient with current information about the nature of the developmental disability, the accuracy of the prenatal test, and resources for obtaining relevant support services, including hotlines, resource centers, and information clearinghouses related to Down syndrome or other prenatally diagnosed developmental disabilities; support programs for parents and families; and developmental evaluation and intervention services under s. 391.303.

(4) The Department of Health shall establish a clearinghouse of information related to developmental disabilities concerning providers of supportive services, information hotlines specific to Down syndrome and other prenatally diagnosed developmental disabilities, resource centers, educational programs, other support programs for parents and families, and developmental evaluation and intervention services under s. 391.303. Such information shall be made available to health care providers for use in counseling pregnant women whose unborn children have been prenatally diagnosed with developmental disabilities.

(a) There is established an advisory council within the Department of Health which consists of health care providers and caregivers who perform health care services for persons who have

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developmental disabilities, including Down syndrome and autism. This group shall consist of nine members:

1. Three members appointed by the Governor;

2. Three members appointed by the President of the Senate; and

3. Three members appointed by the Speaker of the House of Representatives.

(b) The advisory council shall provide technical assistance to the Department of Health in the establishment of the information clearinghouse and give the department the benefit of the council members' knowledge and experience relating to the needs of patients and families of patients with developmental disabilities and available support services.

(c) Members of the council shall elect a chairperson and a vice chairperson. The elected chairperson and vice chairperson shall serve in these roles until their terms of appointment on the council expire.

(d) The advisory council shall meet quarterly to review this clearinghouse of information, and may meet more often at the call of the chairperson or as determined by a majority of members.

(e) The council members shall be appointed to 4-year terms, except that, to provide for staggered terms, one initial appointee each from the Governor, the President of the Senate, and the Speaker of the House of Representatives shall be appointed to a 2-year term, one appointee each from these officials shall be appointed to a 3-year term, and the remaining initial appointees shall be appointed to 4-year terms. All subsequent appointments shall be for 4-year terms. A vacancy

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shall be filled for the remainder of the unexpired term in the same manner as the original appointment.

(f) Members of the council shall serve without compensation but are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061.

(g) The Department of Health shall provide administrative support for the advisory council.

Section 7. Section 383.325, Florida Statutes, is repealed.

Section 8. Section 385.2031, Florida Statutes, is created to read:

385.2031 Resource for research in the prevention and treatment of diabetes.—The Florida Hospital/Sanford-Burnham Translational Research Institute for Metabolism and Diabetes is designated as a resource in this state for research in the prevention and treatment of diabetes.

Section 9. 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) ~~395.002(28)~~ and part II of chapter 408 as a specialty psychiatric hospital.

Section 10. 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

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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 11. Present subsections (15) through (33) of

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section 395.002, Florida Statutes, are redesignated as subsections (14) through (30), respectively, and present subsections (1), (14), (24), (28), (30), and (31) 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-~~


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~~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:

(a) The range of medical services offered by general hospitals, but restricted to a defined age or gender group of the population;

(b) A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or

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

(28)~~(30)~~ "Urgent care center" means a facility or clinic that provides immediate but not emergent ambulatory medical care to patients ~~with or without an appointment~~. The term includes an offsite ~~It does not include the~~ emergency department of a hospital that is presented to the general public in any manner as a department where immediate and not only emergent medical care is provided. The term also includes:

(a) An offsite facility of a facility licensed under chapter 395, or a joint venture between a facility licensed under chapter 395 and a provider licensed under chapter 458 or chapter 459, that does not require a patient to make an appointment and is presented to the general public in any manner as a facility where immediate but not emergent medical care is provided.

(b) A clinic organization that is licensed under part X of chapter 400, maintains three or more locations using the same or a similar name, does not require a patient to make an


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appointment, and holds itself out to the general public in any manner as a facility or clinic where immediate but not emergent medical care is provided.

~~(31) "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.~~

Section 12. 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) ~~395.002(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 13. Subsection (3) of section 395.0161, Florida Statutes, is amended to read:

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395.0161 Licensure inspection.—

(3) 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. With the exception of state-operated licensed facilities, each facility licensed under this part shall pay to the agency~~, at the time of inspection,~~ the following fees:

(a) *Inspection for licensure.*—A fee shall be paid which is not less than $8 per hospital bed, nor more than $12 per hospital bed, except that the minimum fee shall be $400 per facility.

(b) *Inspection for lifesafety only.*—A fee shall be paid which is not less than 75 cents per hospital bed, nor more than $1.50 per hospital bed, except that the minimum fee shall be $40 per facility.

Section 14. Subsections (2) and (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 must ~~shall~~ include:

(a) Mechanism for choosing the membership of the body or bodies that conduct peer review.

(b) Adoption of rules of order for the peer review process.

(c) Fair review of the case with the physician involved.

(d) Mechanism to identify and avoid conflict of interest on

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the part of the peer review panel members.

(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~~.

(f) Review, at least annually, of the peer review procedures by the governing board of the licensed facility.

(g) Focus of the peer review process on review of professional practices at the facility to reduce morbidity and mortality and to improve patient care.

(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

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finding of probable cause.

Section 15. 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 16. Subsection (2) and paragraph (d) of subsection

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(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


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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 is ~~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.

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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 after ~~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 17. Section 395.1046, Florida Statutes, is repealed.

Section 19. Section 395.107, Florida Statutes, is amended to read:

395.107 Urgent care centers; publishing and posting schedule of charges; penalties.—

(1) An urgent care center must publish and post a schedule of charges for the medical services offered to patients.

(2) The schedule of charges must describe the medical services in language comprehensible to a layperson. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area ~~of the urgent care center~~ and must include, but is not limited to, the 50 services most frequently provided ~~by~~

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~~the urgent care center~~. The schedule may group services by three price levels, listing services in each price level. The posting may be a sign, which must be at least 15 square feet in size, or may be through an electronic messaging board. If an urgent care center is affiliated with a facility licensed under this chapter, the schedule must include text that notifies the insured patients whether the charges for medical services received at the center will be the same as, or more than, charges for medical services received at the affiliated hospital. The text notifying the patient of the schedule of charges shall be in a font size equal to or greater than the font size used for prices and must be in a contrasting color. The text that notifies the insured patients whether the charges for medical services received at the center will be the same as, or more than, charges for medical services received at the affiliated hospital shall be included in all media and Internet advertisements for the center and in language comprehensible to a layperson.

(3) The posted text describing the medical services must fill at least 12 square feet of the posting. A center may use an electronic device or messaging board to post the schedule of charges. Such a device must be at least 3 square feet and patients must be able to access the schedule during all hours of operation of the urgent care center.

(4) An urgent care center that is operated and used exclusively for employees and the dependents of employees of the business that owns or contracts for the urgent care center is exempt from this section.

(5) The failure of an urgent care center to publish and

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post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted.

Section 20. Paragraph (e) of subsection (4) of section 395.3025, Florida Statutes, is amended to read:

395.3025 Patient and personnel records; copies; examination.—

(4) Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative, but appropriate disclosure may be made without such consent to:

(e) The department ~~agency~~ upon subpoena issued pursuant to s. 456.071.~~, but~~ The records obtained thereby must be used solely for the purpose of the agency, the department, and the appropriate professional board in an ~~its~~ investigation, prosecution, and appeal of disciplinary proceedings. If the department ~~agency~~ requests copies of the records, the facility shall charge a fee pursuant to this section ~~no more than its actual copying costs, including reasonable staff time~~. The records must be sealed and must not be available to the public pursuant to s. 119.07(1) or any other statute providing access to records, nor may they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency, the department, or the appropriate regulatory board. However, the department ~~agency~~ must make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause.


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Section 21. 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 22. Section 395.3037, Florida Statutes, is repealed.

Section 23. 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

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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 24. 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;

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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


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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 25. 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 by a licensed practical nurse who is under the direct supervision of a registered nurse, an advanced registered nurse practitioner, a physician assistant, or a 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

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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 26. 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 27. 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 <u>requested</u> under this section.

<u>(a)</u> The office shall notify the facility of a resident's request for a hearing.

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(b) The department shall, by rule, establish procedures to be used for ~~fair~~ hearings requested by residents. The ~~These~~ procedures must ~~shall~~ be equivalent to the procedures used for ~~fair~~ hearings for other Medicaid cases brought pursuant to 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 is ~~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 28. 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, may establish 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 may ~~the agency is authorized to~~ disburse moneys from such account to pay obligations incurred for the purposes of this section. The agency may ~~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

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agency of moneys to be spent under the authority of this section. A ~~Any~~ bank account established under this section need not be approved in advance of its creation as required by s. 17.58, but must ~~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 an ~~any such~~ account so established and ~~shall~~ make a quarterly accounting to the Chief Financial Officer for all moneys deposited in such account.

Section 29. 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 must ~~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.~~

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~~(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 30. 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~~

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~~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 of ~~to~~ a nursing home facility 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) The ~~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) A facility ~~Nursing homes~~ that receives ~~receive~~ an inactive license to provide alternative services may ~~shall~~ not be given ~~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 administer ~~implement~~ this section.

Section 31. 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, the nursing home

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facility, if requested by the agency, ~~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 32. Subsection (2) of section 400.1183, Florida Statutes, is amended to read:

400.1183 Resident grievance procedures.—

(2) Each nursing home facility shall maintain records of all grievances and a ~~shall~~ report, subject to agency inspection, of ~~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 33. Section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.—

(1) A nursing home facility must ~~Every licensed facility shall~~ comply with all applicable standards and rules of the agency and must ~~shall~~:

(a) Be under the administrative direction and charge of a licensed administrator.

(b) Appoint a medical director licensed pursuant to chapter


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458 or chapter 459. The agency may establish by rule more specific criteria for the appointment of a medical director.

(c) Have available the regular, consultative, and emergency services of state-licensed physicians ~~licensed by the state~~.

(d) Provide for resident use of a community pharmacy as specified in s. 400.022(1)(q). Notwithstanding any other law ~~to the contrary notwithstanding~~, a registered pharmacist licensed in this state who ~~in Florida, that~~ is under contract with a facility licensed under this chapter or chapter 429 must~~, shall~~ repackage a nursing facility resident's bulk prescription medication, which was ~~has been~~ packaged by another pharmacist licensed in any state, ~~in the United States~~ into a unit dose system compatible with the system used by the nursing home facility~~,~~ if the pharmacist is requested to offer such service.

1. In order to be eligible for the repackaging, a resident or the resident's spouse must receive prescription medication benefits provided through a former employer as part of his or her retirement benefits, a qualified pension plan as specified in s. 4972 of the Internal Revenue Code, a federal retirement program as specified under 5 C.F.R. s. 831, or a long-term care policy as defined in s. 627.9404(1).

2. A pharmacist who correctly repackages and relabels the medication and the ~~nursing~~ facility that ~~which~~ correctly administers such repackaged medication ~~under this paragraph~~ may not be held liable in any civil or administrative action arising from the repackaging.

3. In order to be eligible for the repackaging, a ~~nursing facility~~ resident for whom the medication is to be repackaged must ~~shall~~ sign an informed consent form provided by the

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facility which includes an explanation of the repackaging process and ~~which~~ notifies the resident of the immunities from liability provided under ~~in~~ this paragraph.

4. A pharmacist who repackages and relabels prescription medications~~, as authorized under this paragraph,~~ may charge a reasonable fee for costs resulting from the implementation of this provision.

(e) Provide ~~for the access of the facility~~ residents with access to dental and other health-related services, recreational services, rehabilitative services, and social work services appropriate to their needs and conditions and not directly furnished by the licensee. If ~~When~~ a geriatric outpatient nurse clinic is conducted in accordance with rules adopted by the agency, outpatients attending such clinic may ~~shall~~ not be counted as part of the general resident population of the ~~nursing home~~ facility, nor may ~~shall~~ the nursing staff of the geriatric outpatient clinic be counted as part of the nursing staff of the facility, until the outpatient clinic load exceeds 15 a day.

(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, if for each person admitted under the respite care program, the licensee:.

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

b. Has a written abbreviated plan of care that, at a minimum, includes nutritional requirements, medication orders, physician assessments and orders, nursing assessments, and dietary preferences. The physician or nursing assessments may take the place of all other assessments required for full-time residents; and

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

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

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

b. 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

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nursing assessment which must agree with the physician's order. Medications shall be released with the respite resident upon discharge in accordance with current physician's orders; and

c. Exempt from rule requirements related to discharge planning.

3. A person receiving respite care is entitled to reside in the facility for a total of 60 days within a contract year or 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. The respite resident must provide medical information from a physician, physician assistant, or nurse practitioner and other information from the primary caregiver as may be required by the facility before or at the time of admission. 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.

5. A person receiving respite care resides in a licensed nursing home bed.

6. The facility assumes the duties of the primary caregiver. To ensure continuity of care and services, the respite 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

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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 allows ~~shall allow~~ for shared programming and staff in a facility that ~~which~~ meets minimum standards and offers services pursuant to this paragraph, but, if the facility is cited for deficiencies in patient care, the agency 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 must ~~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


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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 must ~~shall~~ be based on the 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.

(h) Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.

(i) If the licensee furnishes food service, provide a wholesome and nourishing diet sufficient to meet generally accepted standards of proper nutrition for its residents and provide such therapeutic diets as may be prescribed by attending

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physicians. In adopting ~~making~~ rules to implement this paragraph, the agency shall be guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics.

(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 resident ~~residents~~; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must ~~shall~~ be open to agency inspection ~~by the agency~~. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized.

(k) Keep such fiscal records of its operations and conditions as may be necessary to provide information pursuant to this part.

(l) Furnish copies of personnel records for employees affiliated with such facility~~,~~ to any other facility licensed by this state requesting this information pursuant to this part. Such information contained in the records may include, but is not limited to, disciplinary matters and reasons ~~any reason~~ for termination. A ~~Any~~ facility releasing such records pursuant to this part is ~~shall be~~ considered to be acting in good faith and may not be held liable for information contained in such records, absent a showing that the facility maliciously falsified such records.

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(m) Publicly display a poster provided by the agency containing the names, addresses, and telephone numbers for the state's abuse hotline, the State Long-Term Care Ombudsman, the Agency for Health Care Administration consumer hotline, the Advocacy Center for Persons with Disabilities, the Florida Statewide Advocacy Council, and the Medicaid Fraud Control Unit, with a clear description of the assistance to be expected from each.

~~(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.~~

~~(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,~~

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~~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.~~

(n) Comply with state minimum staffing requirements:

1.~~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 subparagraph ~~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 by the facility to impose such an admissions moratorium is subject to a $1,000 fine ~~constitutes a class II deficiency~~.

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

~~2. This paragraph does not limit the agency's ability to~~

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~~impose a deficiency or take other actions if a facility does not have enough staff to meet the residents' needs.~~

(o) ~~(p)~~ Notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall ~~arrange~~, with the appropriate health care provider, arrange for the necessary care and services to treat the condition.

(p) ~~(q)~~ If the facility implements a dining and hospitality attendant program, ensure that the program is developed and implemented under the supervision of the facility director of nursing. A licensed nurse, licensed speech or occupational therapist, or a registered dietitian must conduct training of dining and hospitality attendants. A person employed by a facility as a dining and hospitality attendant must perform tasks under the direct supervision of a licensed nurse.

~~(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.~~

(q) ~~(s)~~ Maintain general and professional liability insurance coverage that is in force at all times. In lieu of such ~~general and professional liability insurance~~ coverage, a state-designated teaching nursing home and its affiliated

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assisted living facilities created under s. 430.80 may demonstrate proof of financial responsibility as provided in s. 430.80(3)(g).

(r) ~~(t)~~ Maintain in the medical record for each resident a daily chart of certified nursing assistant services provided to the resident. The certified nursing assistant who is caring for the resident must complete this record by the end of his or her shift. The ~~This~~ record must indicate assistance with activities of daily living, assistance with eating, and assistance with drinking, and must record each offering of nutrition and hydration for those residents whose plan of care or assessment indicates a risk for malnutrition or dehydration.

(s) ~~(u)~~ Before November 30 of each year, subject to the availability of an adequate supply of the necessary vaccine, provide for immunizations against influenza viruses to all its consenting residents in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Subject to these exemptions, any consenting person who becomes a resident of the facility after November 30 but before March 31 of the following year must be immunized within 5 working days after becoming a resident. Immunization may ~~shall~~ not be provided to any resident who provides documentation that he or she has been immunized as required by this paragraph. This paragraph does not prohibit a resident from receiving the immunization from his or her personal physician if he or she so chooses. A resident who chooses to receive the immunization from his or her personal physician shall provide proof of immunization to the facility.


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The agency may adopt and enforce any rules necessary to administer ~~comply with or implement~~ this paragraph.

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

(u) ~~(w)~~ Annually encourage and promote to its employees the benefits associated with immunizations against influenza viruses in accordance with the recommendations of the United States Centers for Disease Control and Prevention. The agency may adopt and enforce any rules necessary to administer ~~comply with or~~


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~~implement~~ this paragraph.

This subsection 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 residents' needs.

(2) Facilities that have been awarded a Gold Seal under the program established in s. 400.235 may develop a plan to provide certified nursing assistant training as prescribed by federal regulations and state rules and may apply to the agency for approval of their program.

Section 34. 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 are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, or ~~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 35. Subsections (9) through (15) of section 400.147, Florida Statutes, are renumbered as subsections (8) through (13), respectively, and present subsections (7), (8),

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and (10) of that section are amended to read:

400.147 Internal risk management and quality assurance program.—

(7) The nursing home 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). The facility must complete the investigation and submit a report to the agency within 15 calendar days after the adverse incident occurred. ~~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 the report which ~~notification~~ must include the name of the risk manager, 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 report ~~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~~


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~~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~~

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~~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 36. Section 400.148, Florida Statutes, is repealed.

Section 37. 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 every 15 months to determine the licensee's compliance ~~by the licensee~~ with statutes~~,~~ and related ~~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 must ~~shall~~ be conducted every 6 months for the next 2-year period if the nursing home 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 under ~~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 is ~~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

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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 at least ~~not fewer than~~ 5 working days according to the provisions of chapter 110.

Section 38. Present subsection (6) of section 400.191, Florida Statutes, is renumbered as subsection (7) and a new subsection (6) is added to that section to read:

400.191 Availability, distribution, and posting of reports and records.—

(6) A nursing home facility may charge a reasonable fee for copying resident records. The fee may not exceed $1 per page for the first 25 pages and 25 cents per page for each page in excess of 25 pages.

Section 39. Subsection (5) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

(5) The agency, in collaboration with the Division of Children's Medical Services of the Department of Health, must~~,~~ ~~no later than December 31, 1993,~~ adopt rules for:

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(a) 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 exempted ~~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) Minimum staffing requirements for persons under 21 years of age who reside in nursing home facilities, which apply in lieu of the requirements contained in subsection (3).

1. For persons under 21 years of age who require skilled care:

a. A minimum combined average of 3.9 hours of direct care per resident per day must be provided by licensed nurses, respiratory therapists, respiratory care practitioners, and certified nursing assistants.

b. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day must be provided.

c. No more than 1.5 hours of certified nursing assistant care per resident per day may be counted in determining the minimum direct care hours required.

d. One registered nurse must be on duty on the site 24 hours per day on the unit where children reside.

2. For persons under 21 years of age who are medically fragile:

a. A minimum combined average of 5.0 hours of direct care per resident per day must be provided by licensed nurses, respiratory therapists, respiratory care practitioners, and

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certified nursing assistants.

b. A minimum licensed nursing staffing of 1.7 hours of direct care per resident per day must be provided.

c. No more than 1.5 hours of certified nursing assistant care per resident per day may be counted in determining the minimum direct care hours required.

d. One registered nurse must be on duty on the site 24 hours per day on the unit where children reside.

Section 40. 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 41. Subsection (27) of section 400.462, Florida Statutes, is amended to read:

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

(27) "Remuneration" means any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind. However, if the term is used in any provision of law relating to health care providers, the term does not apply to an item that


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has an individual value of up to $15, including, but not limited to, a plaque, a certificate, a trophy, or a novelty item that is intended solely for presentation or is customarily given away solely for promotional, recognition, or advertising purposes.

Section 42. For the purpose of incorporating the amendment made by this act to section 400.509, Florida Statutes, in a reference thereto, paragraph (b) of subsection (5) of section 400.464, Florida Statutes, is reenacted to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(5) The following are exempt from the licensure requirements of this part:

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons with developmental disabilities, as defined in s. 393.063.

4. Companion and sitter organizations that were registered under s. 400.509(1) on January 1, 1999, and were authorized to provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding the

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provisions of this act.

5. The Department of Children and Family Services.

Section 43. Subsection (6) of section 400.474, Florida Statutes, is amended, present subsection (7) is redesignated as subsection (8), and a new subsection (7) is added to that section, to read:

400.474 Administrative penalties.—

(6) The agency may deny, revoke, or suspend the license of a home health agency and shall impose a fine of $5,000 against a home health agency that:

(a) Gives remuneration for staffing services to:

1. Another home health agency with which it has formal or informal patient-referral transactions or arrangements; or

2. A health services pool with which it has formal or informal patient-referral transactions or arrangements,

unless the home health agency has activated its comprehensive emergency management plan in accordance with s. 400.492. This paragraph does not apply to a Medicare-certified home health agency that provides fair market value remuneration for staffing services to a non-Medicare-certified home health agency that is part of a continuing care facility licensed under chapter 651 for providing services to its own residents if each resident receiving home health services pursuant to this arrangement attests in writing that he or she made a decision without influence from staff of the facility to select, from a list of Medicare-certified home health agencies provided by the facility, that Medicare-certified home health agency to provide the services.


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(b) Provides services to residents in an assisted living facility for which the home health agency does not receive fair market value remuneration.

(c) Provides staffing to an assisted living facility for which the home health agency does not receive fair market value remuneration.

(d) Fails to provide the agency, upon request, with copies of all contracts with assisted living facilities which were executed within 5 years before the request.

(e) Gives remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395, chapter 429, or this chapter from whom the home health agency receives referrals.

~~(f) Fails to submit to the agency, within 15 days after the end of each calendar quarter, a written report that includes the following data based on data as it existed on the last day of the quarter:~~

~~1. The number of insulin-dependent diabetic patients receiving insulin-injection services from the home health agency;~~

~~2. The number of patients receiving both home health services from the home health agency and hospice services;~~

~~3. The number of patients receiving home health services from that home health agency; and~~

~~4. The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.~~

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(f) ~~(g)~~ Gives cash, or its equivalent, to a Medicare or Medicaid beneficiary.

(g) ~~(h)~~ Has more than one medical director contract in effect at one time or more than one medical director contract and one contract with a physician-specialist whose services are mandated for the home health agency in order to qualify to participate in a federal or state health care program at one time.

(h) ~~(i)~~ Gives remuneration to a physician without a medical director contract being in effect. The contract must:

1. Be in writing and signed by both parties;

2. Provide for remuneration that is at fair market value for an hourly rate, which must be supported by invoices submitted by the medical director describing the work performed, the dates on which that work was performed, and the duration of that work; and

3. Be for a term of at least 1 year.

The hourly rate specified in the contract may not be increased during the term of the contract. The home health agency may not execute a subsequent contract with that physician which has an increased hourly rate and covers any portion of the term that was in the original contract.

(i) ~~(j)~~ Gives remuneration to:

1. A physician, and the home health agency is in violation of paragraph (g) ~~(h)~~ or paragraph (h) ~~(i)~~;

2. A member of the physician's office staff; or

3. An immediate family member of the physician,

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if the home health agency has received a patient referral in the preceding 12 months from that physician or physician's office staff.

(j) ~~(k)~~ Fails to provide to the agency, upon request, copies of all contracts with a medical director which were executed within 5 years before the request.

(k) ~~(l)~~ Demonstrates a pattern of billing the Medicaid program for services to Medicaid recipients which are medically unnecessary as determined by a final order. A pattern may be demonstrated by a showing of at least two such medically unnecessary services within one Medicaid program integrity audit period.

Nothing in paragraph (e) or paragraph (i) ~~(j)~~ shall be interpreted as applying to or precluding any discount, compensation, waiver of payment, or payment practice permitted by 42 U.S.C. s. 1320a-7(b) or regulations adopted thereunder, including 42 C.F.R. s. 1001.952 or s. 1395nn or regulations adopted thereunder.

(7) Each home health agency shall submit to the agency, within 15 days after the end of each calendar quarter, a written report that includes the following data as it existed on the last day of the quarter:

(a) The number of insulin-dependent diabetic patients receiving insulin-injection services from the home health agency.

(b) The number of patients receiving home health services from the home health agency who are also receiving hospice services.

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(c) The number of patients receiving home health services from the home health agency.

(d) The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.

(e) The number of physicians who were paid by the home health agency for professional services of any kind during the calendar quarter, the amount paid to each physician, and the number of hours each physician spent performing those services.

If the quarterly report is not received by the agency on or before the deadline, the agency shall impose a fine in the amount of $200 for each day that the report is late, which may not exceed $5,000 per quarter.

Section 44. Section 400.484, Florida Statutes, is amended to read:

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

(1) In addition to the requirements of s. 408.811, the agency may make such inspections and investigations as are necessary in order to determine the state of compliance with this part, part II of chapter 408, and applicable rules.

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

(a) A class I violation is defined in s. 408.813 ~~deficiency is any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at~~

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~~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) A class II violation is defined in s. 408.813 ~~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) A class III violation is defined in s. 408.813 ~~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) A class IV violation is defined in s. 408.813 ~~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.

(3) In addition to any other penalties imposed pursuant to this section or part, the agency may assess costs related to an

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investigation that results in a successful prosecution, excluding costs associated with an attorney's time.

Section 45. For the purpose of incorporating the amendment made by this act to section 400.509, Florida Statutes, in a reference thereto, paragraph (a) of subsection (6) of section 400.506 is reenacted, present subsection (17) of that section is renumbered as subsection (18), and a new subsection (17) is added to that section, to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(6)(a) A nurse registry may refer for contract in private residences registered nurses and licensed practical nurses registered and licensed under part I of chapter 464, certified nursing assistants certified under part II of chapter 464, home health aides who present documented proof of successful completion of the training required by rule of the agency, and companions or homemakers for the purposes of providing those services authorized under s. 400.509(1). A licensed nurse registry shall ensure that each certified nursing assistant referred for contract by the nurse registry and each home health aide referred for contract by the nurse registry is adequately trained to perform the tasks of a home health aide in the home setting. Each person referred by a nurse registry must provide current documentation that he or she is free from communicable diseases.

(17) An administrator may manage only one nurse registry, except that an administrator may manage up to five registries if all five registries have identical controlling interests as defined in s. 408.803 and are located within one agency


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geographic service area or within an immediately contiguous county. An administrator shall designate, in writing, for each licensed entity, a qualified alternate administrator to serve during the administrator's absence.

Section 46. Subsection (1) of section 400.509, Florida Statutes, is amended to read:

400.509 Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.—

(1) Any organization that provides companion services or homemaker services and does not provide a home health service to a person is exempt from licensure under this part. However, any organization that provides companion services or homemaker services must register with the agency. An organization under contract with the Agency for Persons with Disabilities which provides companion services only for persons with a developmental disability, as defined in s. 393.063, is exempt from registration.

Section 47. Subsection (3) of section 400.601, Florida Statutes, is amended to read:

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

(3) "Hospice" means a centrally administered corporation or a limited liability company that provides ~~providing~~ a continuum of palliative and supportive care for the terminally ill patient and his or her family.

Section 48. 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.—

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(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 that has ~~with~~ six or fewer beds is ~~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 49. 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

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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 50. 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 51. Section 400.931, Florida Statutes, is amended to read:

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

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

(a) A report, by category, of the equipment to be provided, indicating those offered either directly by the applicant or through contractual arrangements with existing providers. Categories of equipment include:

1. Respiratory modalities.

2. Ambulation aids.

3. Mobility aids.

4. Sickroom setup.

5. Disposables.

(b) A report, by category, of the services to be provided, indicating those offered either directly by the applicant or through contractual arrangements with existing providers. Categories of services include:

1. Intake.

2. Equipment selection.

3. Delivery.

4. Setup and installation.

5. Patient training.

6. Ongoing service and maintenance.

7. Retrieval.

(c) A listing of those with whom the applicant contracts, both the providers the applicant uses to provide equipment or services to its consumers and the providers for whom the applicant provides services or equipment.

(2) An applicant for initial licensure, change of ownership, or license renewal to operate a licensed home medical equipment provider at a location outside the state must submit documentation of accreditation or an application for accreditation from an accrediting organization that is recognized by the agency. An applicant that has applied for accreditation must provide proof of accreditation that is not conditional or provisional within 120 days after the date the agency receives the application for licensure or the application shall be withdrawn from further consideration. Such accreditation must be maintained by the home medical equipment provider in order to maintain licensure. ~~As an alternative to~~


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~~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.~~

(3) As specified in part II of chapter 408, the home medical equipment provider must also obtain and maintain professional and commercial liability insurance. Proof of liability insurance, as defined in s. 624.605, must be submitted with the application. The agency shall set the required amounts of liability insurance by rule, but the required amount must not be less than $250,000 per claim. In the case of contracted services, it is required that the contractor have liability insurance not less than $250,000 per claim.

(4) When a change of the general manager of a home medical equipment provider occurs, the licensee must notify the agency of the change within 45 days.

(5) In accordance with s. 408.805, an applicant or a 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 and may not exceed $300 per biennium. The agency shall set the fees in an amount that is sufficient to cover its costs in carrying out its responsibilities under this part. However, state, county, or municipal governments applying for licenses under this part are exempt from the payment of license fees.

(6) An applicant for initial licensure, renewal, or change of ownership shall also pay an inspection fee not to exceed $400, which shall be paid by all applicants except those not subject to licensure inspection by the agency as described in s. 400.933.

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Section 52. Section 400.967, Florida Statutes, is amended to read:

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

(1) It is the intent of the Legislature that rules adopted and enforced under this part and part II of chapter 408 include criteria by which a reasonable and consistent quality of resident care may be ensured, the results of such resident care can be demonstrated, and safe and sanitary facilities can be provided.

(2) Pursuant to the intention of the Legislature, the agency, in consultation with the Agency for Persons with Disabilities and the Department of Elderly Affairs, shall adopt and enforce rules to administer this part and part II of chapter 408, which shall include reasonable and fair criteria governing:

(a) The location and construction of the facility; including fire and life safety, plumbing, heating, cooling, lighting, ventilation, and other housing conditions that ensure the health, safety, and comfort of residents. The agency shall establish standards for facilities and equipment to increase the extent to which new facilities and a new wing or floor added to an existing facility after July 1, 2000, are structurally capable of serving as shelters only for residents, staff, and families of residents and staff, and equipped to be self-supporting during and immediately following disasters. The agency shall update or revise the criteria as the need arises. All facilities must comply with those lifesafety code requirements and building code standards applicable at the time of approval of their construction plans. The agency may require


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alterations to a building if it determines that an existing condition constitutes a distinct hazard to life, health, or safety. The agency shall adopt fair and reasonable rules setting forth conditions under which existing facilities undergoing additions, alterations, conversions, renovations, or repairs are required to comply with the most recent updated or revised standards.

(b) The number and qualifications of all personnel, including management, medical nursing, and other personnel, having responsibility for any part of the care given to residents.

(c) All sanitary conditions within the facility and its surroundings, including water supply, sewage disposal, food handling, and general hygiene, which will ensure the health and comfort of residents.

(d) The equipment essential to the health and welfare of the residents.

(e) A uniform accounting system.

(f) The care, treatment, and maintenance of residents and measurement of the quality and adequacy thereof.

(g) The preparation and annual update of a comprehensive emergency management plan. The agency shall adopt rules establishing minimum criteria for the plan after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and


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transfer of records; and responding to family inquiries. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(h) The use of restraint and seclusion. Such rules must be consistent with recognized best practices; prohibit inherently dangerous restraint or seclusion procedures; establish limitations on the use and duration of restraint and seclusion; establish measures to ensure the safety of clients and staff during an incident of restraint or seclusion; establish procedures for staff to follow before, during, and after incidents of restraint or seclusion, including individualized plans for the use of restraints or seclusion in emergency situations; establish professional qualifications of and training for staff who may order or be engaged in the use of restraint or seclusion; establish requirements for facility data collection and reporting relating to the use of restraint and seclusion; and establish procedures relating to the documentation of the use of restraint or seclusion in the client’s facility or program record.

(3) The agency shall adopt rules to provide that, when the

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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 violation ~~deficiencies~~ as follows:

(a) A class I violation is defined in s. 408.813 ~~deficiencies are 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) A class II violation is defined in s. 408.813 ~~deficiencies are 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) A class III violation is defined in s. 408.813

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~~deficiencies are 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 violation ~~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) A class IV violation is 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.

(4) The agency shall approve or disapprove the plans and specifications within 60 days after receipt of the final plans and specifications. The agency may be granted one 15-day extension for the review period, if the secretary of the agency so approves. If the agency fails to act within the specified time, it is deemed to have approved the plans and specifications. When the agency disapproves plans and specifications, it must set forth in writing the reasons for disapproval. Conferences and consultations may be provided as necessary.

(5) The agency may charge an initial fee of $2,000 for review of plans and construction on all projects, no part of which is refundable. The agency may also collect a fee, not to exceed 1 percent of the estimated construction cost or the


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actual cost of review, whichever is less, for the portion of the review which encompasses initial review through the initial revised construction document review. The agency may collect its actual costs on all subsequent portions of the review and construction inspections. Initial fee payment must accompany the initial submission of plans and specifications. Any subsequent payment that is due is payable upon receipt of the invoice from the agency. Notwithstanding any other provision of law, all money received by the agency under this section shall be deemed to be trust funds, to be held and applied solely for the operations required under this section.

Section 53. 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


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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

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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, perinatology, or anesthesia 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 when 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

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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.

(o) Entities that employ 50 or more licensed health care practitioners licensed under chapter 458 or chapter 459 when the billing for medical services is under a single tax identification number. The application for exemption from licensure requirements under this paragraph shall contain the name, residence address, business address, and telephone numbers of the entity that owns the clinic; a complete list of the names and contact information of all the officers and directors of the corporation; the name, residence address, business address, and medical practitioner license number of each health care practitioner employed by the entity; the corporate tax identification number of the entity seeking an exemption; a listing of health care services to be provided by the entity at the health care clinics owned or operated by the entity; and a certified statement prepared by an independent certified public accountant which states that the entity and the health care clinics owned or operated by the entity have not received payment for health care services under personal injury protection insurance coverage for the preceding year. If the agency determines that an entity that is exempt under this paragraph has received payments for medical services under


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personal injury protection insurance coverage, the agency may deny or revoke the exemption from licensure under 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 54. Paragraph (b) of subsection (1) and 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:

(a) A listing of services to be provided either directly by the applicant or through contractual arrangements with existing providers;

(b) The number and discipline of each professional staff

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member to be employed; and

(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 55. Paragraphs (g) and (i) 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

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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.

(i) Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area of the urgent care center and must include, but is not limited to, the 50 services most frequently provided by the clinic. The schedule may group services by three price levels, listing services in each price level. The posting may be a sign that must be at least 15 square feet in size or through an electronic messaging board that is at least 3 square feet in size. The failure of a clinic to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted.

(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

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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 56. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birthing centers, clinical laboratories except community nonprofit blood

banks and clinical laboratories operated by practitioners for exclusive use regulated under s. 483.035, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, health care clinics, and multiphasic testing centers and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 57. 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 58. 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.

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

Section 59. Paragraph (c) of subsection (1) of section 408.037, Florida Statutes, is amended to read:

408.037 Application content.—

(1) Except as provided in subsection (2) for a general hospital, an application for a certificate of need must contain:

(c) An audited financial statement of the applicant or the applicant's parent corporation if audited financial statements of the applicant do not exist. In an application submitted by an existing health care facility, health maintenance organization, or hospice, financial condition documentation must include, but need not be limited to, a balance sheet and a profit-and-loss statement of the 2 previous fiscal years' operation.

Section 60. 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 otherwiselicensed as ~~a~~ another type 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 61. 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


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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 62. 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

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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 63. 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

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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


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application, including supporting documentation, to the Agency for Health Care Administration.

Section 64. 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 65. Effective May 1, 2012, subsection (15) is added to section 408.7056, Florida Statutes, to read:

408.7056 Subscriber Assistance Program.—

(15) This section applies only to prepaid health clinics certified under chapter 641, Florida Healthy Kids plans, and health plan insurance policies or health maintenance contracts that meet the requirements of 45 C.F.R. s. 147.140 and only if the health plan has not elected to have all of its health insurance policies or health maintenance contracts subject to the applicable internal grievance and external review processes by an independent review organization. A health plan must notify the agency in writing if it elects to have all of its health insurance policies or health maintenance contracts subject to

the processes of external review by an independent review organization.

Section 66. 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 67. 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 68. Paragraph (d) of subsection (2) of section 408.806, Florida Statutes, is amended, and paragraph (e) is added to that subsection, to read:

408.806 License application process.—

(2)

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(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 before the expiration of a license. This courtesy notice must inform 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.

(e) The applicant must pay the late fee before a late application is considered complete and failure to pay the late fee is considered an omission from the application for licensure pursuant to paragraph (3)(b).

Section 69. Paragraph (b) of subsection (1) of section 408.8065, Florida Statutes, is amended to read:

408.8065 Additional licensure requirements for home health agencies, home medical equipment providers, and health care

clinics.—

(1) An applicant for initial licensure, or initial licensure due to a change of ownership, as a home health agency, home medical equipment provider, or health care clinic shall:

(b) Submit projected ~~pro forma~~ financial statements, including a balance sheet, income and expense statement, and a statement of cash flows for the first 2 years of operation which provide evidence that the applicant has sufficient assets, credit, and projected revenues to cover liabilities and expenses.

All documents required under this subsection must be prepared in accordance with generally accepted accounting principles and may be in a compilation form. The financial statements must be signed by a certified public accountant.

Section 70. Subsection (9) of section 408.810, Florida Statutes, is amended to read:

408.810 Minimum licensure requirements.—In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(9) A controlling interest may not withhold from the agency any evidence of financial instability, including, but not limited to, checks returned due to insufficient funds, delinquent accounts, nonpayment of withholding taxes, unpaid utility expenses, nonpayment for essential services, or adverse court action concerning the financial viability of the provider or any other provider licensed under this part that is under the


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control of the controlling interest. A controlling interest shall notify the agency within 10 days after a court action to initiate bankruptcy, foreclosure, or eviction proceedings concerning the provider in which the controlling interest is a petitioner or defendant. Any person who violates this subsection commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation is a separate offense.

Section 71. 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 may not exceed $500 for each violation. Unclassified violations 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 72. Subsection (37) 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 are not 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

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necessary to administer these policies.

(37)(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 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 may 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 administer 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

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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 lowest of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

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.

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

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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 if 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.

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.

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

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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.

7. The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, 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 guarantees 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 may 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. Value-added programs as a substitution for supplemental rebates are prohibited. The agency may seek any federal waivers

to implement this initiative.

8. The agency shall expand home delivery of pharmacy products. The agency may amend the state plan and issue a procurement, as necessary, in order to implement this program. The procurements must include agreements with a pharmacy or pharmacies located in the state to provide mail order delivery services at no cost to the recipients who elect to receive home delivery of pharmacy products. The procurement must focus on serving recipients with chronic diseases for which pharmacy expenditures represent a significant portion of Medicaid pharmacy expenditures or which impact a significant portion of the Medicaid population. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

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

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 may 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:

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(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

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

11. The agency shall implement a Medicaid prescription drug management system.

a. 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 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 recipients 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.

12. The agency may 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.

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.

14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may 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 shall ~~may~~ post prior

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authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's ~~an~~ Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization ~~without amending its rule or engaging in additional rulemaking~~.

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.

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 before 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


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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.

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

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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.

(b) The agency shall implement this subsection to the extent that funds are appropriated to administer the Medicaid prescribed-drug spending-control program. The agency may contract all or any part of this program to private organizations.

(c) The agency shall submit quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include, but need not be limited to, the progress made in implementing this subsection and its effect on Medicaid prescribed-drug expenditures.

Section 73. Effective upon this act becoming a law, subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(b). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a)1. Plans must include all providers in the region that are classified by the agency as essential Medicaid providers for

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the essential services they provide, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

a.~~1.~~ Federally qualified health centers.

b.~~2.~~ Statutory teaching hospitals as defined in s. 408.07(45).

c.~~3.~~ Hospitals that are trauma centers as defined in s. 395.4001(14).

d.~~4.~~ Hospitals located at least 25 miles from any other hospital with similar services.

2. Until the selection of managed care plans as specified in s. 409.966, each essential Medicaid provider and each hospital that is necessary in order for a managed care plan to demonstrate an adequate network, as determined by the agency, is deemed a part of that managed care plan's network for purposes of the plan's enrollment or expansion in the Medicaid program. A hospital that is necessary for a managed care plan to demonstrate an adequate network is an essential hospital. An

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essential Medicaid provider is deemed a part of a managed care plan's network for the essential services it provides for purposes of the plan's enrollment or expansion in the Medicaid program. The managed care plan, each essential Medicaid provider, and each essential hospital shall negotiate in good faith to enter into a provider network contract. During the plan selection process, the managed care plan is not required to have written agreements or contracts with essential Medicaid providers or essential hospitals.

3. Managed care plans that have not contracted with all essential Medicaid providers or essential hospitals in the region as of the first date of recipient enrollment, or with whom an essential Medicaid provider or essential hospital has terminated its contract, must continue to negotiate in good faith with such essential Medicaid providers or essential hospitals for 1 year, ~~or~~ until an agreement is reached, or until a complaint is resolved as provided in paragraph (e), whichever is first. Each essential Medicaid provider must continue to negotiate in good faith during that year to enter into a provider network contract for at least the essential services it provides. Each essential hospital must continue to negotiate in good faith during that year to enter into a provider network contract. Payments for services rendered by a nonparticipating essential Medicaid provider or essential hospital shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential Medicaid providers and essential hospitals shall be attached to the contract between the agency and the plan.

4. After 1 year, managed care plans that are unable to

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contract with essential Medicaid providers and essential hospitals shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential Medicaid providers and essential hospitals after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. If the alternative arrangement is not approved by the agency, payment to nonparticipating essential Medicaid providers and essential hospitals shall equal 110 percent of the applicable Medicaid rate.

(b)1. Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks for the essential services they provide. Statewide essential providers include:

a.~~1.~~ Faculty plans of Florida medical schools.

b.~~2.~~ Regional perinatal intensive care centers as defined in s. 383.16(2).

c.~~3.~~ Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

d.~~4.~~ Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical

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equipment, and Prescribed Pediatric Extended Care.

2. Until the selection of managed care plans as specified in s. 409.966, each statewide essential provider is deemed a part of that managed care plan's network for the essential services they provide and for purposes of the plan's enrollment or expansion in the Medicaid program. The managed care plan and each statewide essential provider shall negotiate in good faith to enter into a provider network contract. During the plan selection process, the managed care plan is not required to have written agreements or contracts with statewide essential providers or essential hospitals.

3. Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment and all statewide essential providers that have not entered into a contract with each managed care plan must continue to negotiate in good faith~~.~~ to enter into a provider network contract for at least the essential services. As of the first day of the contract between the agency and the plan, and until a provider network contract is signed, payments: ~~Payments~~

a. To physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. ~~Payments~~

b. For services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate ~~as of the first day of the contract between the agency and the plan~~. ~~Payments~~

c. To nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that

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provider and any other Medicaid managed care plan.

(c) After 12 months of active participation in a plan's network, the plan may exclude any essential provider from the network for failure to meet quality or performance criteria. If the plan excludes an essential provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days before the effective date of the exclusion.

(d) Each managed care plan must offer a network contract to each home medical equipment and supplies provider in the region which meets quality and fraud prevention and detection standards established by the plan and which agrees to accept the lowest price previously negotiated between the plan and another such provider.

(e)1. At any time during negotiations a managed care plan, an essential Medicaid provider, an essential hospital, or a statewide essential provider may file a complaint with the agency alleging that, in provider network negotiations, the other party is not negotiating in good faith. The agency shall review each complaint and make a determination as to whether one or both parties have failed to negotiate in good faith. If the agency determines that:

a. The managed care plan was not negotiating in good faith, payment to the nonparticipating essential Medicaid provider, essential hospital, or statewide essential provider shall equal 110 percent of the applicable Medicaid rate or the highest contracted rate the provider has with a plan, whichever is higher.

b. The essential Medicaid provider, essential hospital, or

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statewide essential provider was not negotiating in good faith, payment to the nonparticipating provider shall equal 90 percent of the applicable Medicaid rate or the lowest contracted rate the provider has with a plan, whichever is lower.

c. Both parties were not negotiating in good faith, payment to the nonparticipating provider shall be made at the applicable Medicaid rate.

2. In making a determination under this paragraph regarding a managed care plan's good faith efforts to negotiate, the agency shall, at a minimum, consider whether the managed care plan has:

a. Offered payment rates that are comparable to other managed care plan rates to the provider or that are comparable to fee-for-service rates for the provider.

b. Proposed its prepayment edits and audits and prior authorizations in a manner comparable to other managed care plans or comparable to current fee for service utilization management and prior authorization procedures for non-emergent services.

c. Offered to pay the provider's undisputed claims faster or equal to existing Medicaid managed care plan contract standards and, if the managed care plan's claims payment system has been used in other markets, has it failed to meet these standards.

d. Offered a provider dispute resolution system that meets or exceeds existing Medicaid managed care plan contract requirements.

e. If the provider is a hospital essential provider, offered a reasonable payment amount for utilization of the


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hospital emergency room for non-emergent care, developed referral arrangements with the hospital for non-emergent care, and offered reasonable prior or post authorization requirements for non-emergent care in the emergency room.

f. Attempted to work with the provider to assist the provider with any patient volume arrangements and whether patient volume arrangements benefit the provider.

g. Demonstrated its financial viability and commitment to meeting its financial obligations.

h. Demonstrated its ability to support HIPAA-compliant electronic data interchange transactions.

3. In making a determination under this paragraph regarding a provider's good faith efforts to negotiate, the agency shall, at a minimum, consider whether the provider has:

a. Met with the managed care plan at a reasonable frequency and involved empowered decision makers in the meetings.

b. Offered reasonable rates that are comparable to other managed care plan rates or comparable to fee-for-service rates to the provider.

c. Negotiated managed care plan prepayment edits, audits, and prior authorizations in a manner comparable to other managed care plans or comparable to fee for service utilization management and prior authorization procedures for nonemergent services.

d. Negotiated reasonable payment timeframes for payment of undisputed claims that are comparable to existing Medicaid managed care plan standards or comparable to fee-for-service experience.

e. Researched other providers' experience with the managed

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care plan's claims payment system for timeliness of payment.

f. Negotiated with the managed care plan regarding a provider dispute resolution system that meets or exceeds the managed care plan's Medicaid contract requirements.

g. If the provider is an essential hospital, negotiated with the managed care plan regarding primary care alternatives to nonemergent use of the emergency room.

h. Negotiated patient volume arrangements with the managed care plan.

i. Developed, or is developing, a hospital-based provider service network.

j. Already contracted with other Medicaid managed care plans.

4. Either party may appeal a determination by the agency under this paragraph pursuant to chapter 120. The party appealing the agency's determination shall pay the appellee's attorney fees and costs, accrued from the date the agency began its review of the complaint, in an amount up to $1 million if it loses the appeal.

Section 74. Section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license~~; provisional license~~.—

(1) Each applicant for licensure must comply with all provisions of part II of chapter 408 and must:

(a) Identify all other homes or facilities, including the addresses and the license or licenses under which they operate, if applicable, which are currently operated by the applicant or administrator and which provide housing, meals, and personal

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services to residents.

(b) Provide the location of the facility for which a license is sought and documentation, signed by the appropriate local government official, which states that the applicant has met local zoning requirements.

(c) Provide the name, address, date of birth, social security number, education, and experience of the administrator, if different from the applicant.

(2) The applicant shall provide proof of liability insurance as defined in s. 624.605.

(3) If the applicant is a community residential home, the applicant must provide proof that it has met the requirements specified in chapter 419.

(4) The applicant must furnish proof that the facility has received a satisfactory firesafety inspection. The local authority having jurisdiction or the State Fire Marshal must conduct the inspection within 30 days after written request by the applicant.

(5) The applicant must furnish documentation of a satisfactory sanitation inspection of the facility by the county health department.

~~(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.~~

(6)~~(7)~~ A county or municipality may not issue an occupational license that is being obtained for the purpose of


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operating a facility regulated under this part without first ascertaining that the applicant has been licensed to operate such facility at the specified location or locations by the agency. The agency shall furnish to local agencies responsible for issuing occupational licenses sufficient instruction for making such determinations.

Section 75. Section 429.71, Florida Statutes, is 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~~

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~~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

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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.

(2) The agency may impose an administrative fine for violations which do not qualify as class I, class II, class III, or class IV violations. The amount of the fine shall not exceed $250 for each violation or $2,000 in the aggregate. Unclassified violations may include:

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

(b) Violating any provision of this part, part II of chapter 408, or applicable rules.

(c) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of adult family-care home residents.

(d) Exceeding licensed capacity.

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

(f) Violating a moratorium.

(3) Each day during which a violation occurs constitutes a separate offense.

(4) In determining whether a penalty is to be imposed, and in fixing the amount of any penalty to be imposed, the agency must consider:

(a) The gravity of the violation.

(b) Actions taken by the provider to correct a violation.

(c) Any previous violation by the provider.

(d) The financial benefit to the provider of committing or

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continuing the 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.~~

(5)~~(6)~~ The department shall set forth, by rule, notice requirements and procedures for correction of deficiencies.

Section 76. Section 429.195, Florida Statutes, is amended to read:

429.195 Rebates prohibited; penalties.—

(1) It is unlawful for any assisted living facility licensed under this part to contract or promise to pay or receive any commission, bonus, kickback, or rebate or engage in any split-fee arrangement in any form whatsoever with any person, health care provider, or health care facility as provided in s. 817.505 ~~physician, surgeon, organization, agency, or person, either directly or indirectly, for residents referred to an assisted living facility licensed under this part~~. ~~A facility may employ or contract with persons to market the facility, provided the employee or contract provider clearly indicates that he or she represents the facility. A person or agency independent of the facility may provide placement or referral services for a fee to individuals seeking assistance in finding a suitable facility; however, any fee paid for placement or referral services must be paid by the individual looking for a facility, not by the facility.~~

(2) This section does not apply to:

(a) An individual employed by the assisted living facility

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or with whom the facility contracts to market the facility, if the individual clearly indicates that he or she works with or for the facility.

(b) Payments by an assisted living facility to a referral service that provides information, consultation, or referrals to consumers to assist them in finding appropriate care or housing options for seniors or disabled adults if such referred consumers are not Medicaid recipients.

(c) A resident of an assisted living facility who refers a friend, family member, or other individuals with whom the resident has a personal relationship to the assisted living facility, in which case the assisted living facility may provide a monetary reward to the resident for making such referral.

(3) ~~(2)~~ A violation of this section shall be considered patient brokering and is punishable as provided in s. 817.505.

Section 77. 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 78. Subsection (3) of section 430.80, Florida Statutes, is amended to read:

430.80 Implementation of a teaching nursing home pilot project.—

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

(a) Provide a comprehensive program of integrated senior services that include institutional services and community-based services;

(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;

(c) Have been in business in this state for a minimum of 10 consecutive years;

(d) Demonstrate an active program in multidisciplinary education and research that relates to gerontology;

(e) Have a formalized contractual relationship with at least one accredited health profession education program located in this state;

(f) Have senior staff members who hold formal faculty appointments at universities, which must include at least one accredited health profession education program; and

(g) Maintain insurance coverage pursuant to s. 400.141(1)(q) ~~400.141(1)(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

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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 which ~~that~~ has its principal place of business in this state or has a branch office that ~~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 if ~~when~~ such final judgment or settlement is a result of a liability claim against the facility.

Section 79. Paragraph (h) of subsection (2) of section 430.81, Florida Statutes, is amended to read:

430.81 Implementation of a teaching agency for home and community-based care.—

(2) The Department of Elderly Affairs may designate a home health agency as a teaching agency for home and community-based care if the home health agency:

(h) Maintains insurance coverage pursuant to s. 400.141(1)(q) ~~400.141(1)(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 authorized to do business in this state. This letter of credit

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shall be used to satisfy the obligation of the agency to the claimant upon presentation 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 if ~~when~~ such final judgment or settlement is a result of a liability claim against the agency.

Section 80. Paragraph (d) of subsection (9) of section 440.102, Florida Statutes, is amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(9) DRUG-TESTING STANDARDS FOR LABORATORIES.—

~~(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 report must include information on the methods of analysis conducted, the drugs tested for, the number of positive and negative results for both initial tests and confirmation tests, and any other information deemed appropriate by the Agency for Health Care Administration. A monthly report must not identify specific employees or job applicants.~~

Section 81. 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

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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 82. Subsection (9) is added to section 465.014, Florida Statutes, to read:

465.014 Pharmacy technician.—

(9) This section does not apply to a practitioner authorized to dispense drugs under s. 465.0276 or any medical assistant or licensed health care professional acting under the

direct supervision of such practitioner if the practitioner is treating a patient who provides proof of insurance through a public or private payor source. Medical personnel under the direct supervision of the practitioner may perform all activities required by s. 465.0276.

Section 83. Paragraph (a) of subsection (2) of section 468.1695, Florida Statutes, is amended to read:

468.1695 Licensure by examination.—

(2) The department shall examine each applicant who the board certifies has completed the application form and remitted an examination fee set by the board not to exceed $250 and who:

(a)1. Holds a baccalaureate degree from an accredited college or university and majored in health care administration, health services administration, or an equivalent major, or has credit for at least 60 semester hours in subjects, as prescribed by rule of the board, which prepare the applicant for total management of a nursing home; and

2. Has fulfilled the requirements of a college-affiliated or university-affiliated internship in nursing home administration or of a 1,000-hour nursing home administrator-in-training program prescribed by the board; or

Section 84. Subsection (1) of section 483.035, Florida Statutes, is amended to read:

483.035 Clinical laboratories operated by practitioners for exclusive use; licensure and regulation.—

(1) A clinical laboratory operated by one or more practitioners licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, ~~or~~ chapter 466, or as an advanced registered nurse practitioner licensed under part I in chapter

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464, exclusively in connection with the diagnosis and treatment of their own patients, must be licensed under this part and must comply with the provisions of this part, except that the agency shall adopt rules for staffing, for personnel, including education and training of personnel, for proficiency testing, and for construction standards relating to the licensure and operation of the laboratory based upon and not exceeding the same standards contained in the federal Clinical Laboratory Improvement Amendments of 1988 and the federal regulations adopted thereunder.

Section 85. Subsections (1) and (9) of section 483.051, Florida Statutes, are amended to read:

483.051 Powers and duties of the agency.—The agency shall adopt rules to implement this part, which rules must include, but are not limited to, the following:

(1) LICENSING; QUALIFICATIONS.—The agency shall provide for biennial licensure of all nonwaived clinical laboratories meeting the requirements of this part and shall prescribe the qualifications necessary for such licensure, including, but not limited to, application for or proof of a federal Clinical Laboratory Improvement Amendment (CLIA) certificate. For purposes of this section, the term "nonwaived clinical laboratories" means laboratories that perform any test that the Centers for Medicare and Medicaid Services has determined does not qualify for a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 and the federal rules adopted thereunder.

(9) ALTERNATE-SITE TESTING.—The agency, in consultation with the Board of Clinical Laboratory Personnel, shall adopt, by

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rule, the criteria for alternate-site testing to be performed under the supervision of a clinical laboratory director. The elements to be addressed in the rule include, but are not limited to: a hospital internal needs assessment; a protocol of implementation including tests to be performed and who will perform the tests; criteria to be used in selecting the method of testing to be used for alternate-site testing; minimum training and education requirements for those who will perform alternate-site testing, such as documented training, licensure, certification, or other medical professional background not limited to laboratory professionals; documented inservice training as well as initial and ongoing competency validation; an appropriate internal and external quality control protocol; an internal mechanism for identifying and tracking alternate-site testing by the central laboratory; and recordkeeping requirements. ~~Alternate-site testing locations must register when the clinical laboratory applies to renew its license.~~ For purposes of this subsection, the term "alternate-site testing" means any laboratory testing done under the administrative control of a hospital, but performed out of the physical or administrative confines of the central laboratory.

Section 86. Subsection (1) of section 483.23, Florida Statutes, is amended to read:

483.23 Offenses; criminal penalties.—

(1)(a) It is unlawful for any person to:

1. Operate, maintain, direct, or engage in the business of operating a clinical laboratory unless she or he has obtained a clinical laboratory license from the agency or is exempt under s. 483.031.

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2. Conduct, maintain, or operate a clinical laboratory, other than an exempt laboratory or a laboratory operated under s. 483.035, unless the clinical laboratory is under the direct and responsible supervision and direction of a person licensed under part III of this chapter.

3. Allow any person other than an individual licensed under part III of this chapter to perform clinical laboratory procedures, except in the operation of a laboratory exempt under s. 483.031 or a laboratory operated under s. 483.035.

4. Violate or aid and abet in the violation of any provision of this part or the rules adopted under this part.

(b) The performance of any act specified in paragraph (a) shall be referred by the agency to the local law enforcement agency and constitutes a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Additionally, the agency may issue and deliver a notice to cease and desist from such act and may impose by citation an administrative penalty not to exceed $5,000 per act. Each day that unlicensed activity continues after issuance of a notice to cease and desist constitutes a separate act.

Section 87. 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 88. Paragraph (a) of subsection (54) of section 499.003, Florida Statutes, is amended to read:

499.003 Definitions of terms used in this part.—As used in


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this part, the term:

(54) "Wholesale distribution" means distribution of prescription drugs to persons other than a consumer or patient, but does not include:

(a) Any of the following activities, which is not a violation of s. 499.005(21) if such activity is conducted in accordance with s. 499.01(2)(g):

1. The purchase or other acquisition by a hospital or other health care entity that is a member of a group purchasing organization of a prescription drug for its own use from the group purchasing organization or from other hospitals or health care entities that are members of that organization.

2. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug by a charitable organization described in s. 501(c)(3) of the Internal Revenue Code of 1986, as amended and revised, to a nonprofit affiliate of the organization to the extent otherwise permitted by law.

3. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug among hospitals or other health care entities that are under common control. For purposes of this subparagraph, "common control" means the power to direct or cause the direction of the management and policies of a person or an organization, whether by ownership of stock, by voting rights, by contract, or otherwise.

4. The sale, purchase, trade, or other transfer of a prescription drug from or for any federal, state, or local government agency or any entity eligible to purchase

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prescription drugs at public health services prices pursuant to Pub. L. No. 102-585, s. 602 to a contract provider or its subcontractor for eligible patients of the agency or entity under the following conditions:

a. The agency or entity must obtain written authorization for the sale, purchase, trade, or other transfer of a prescription drug under this subparagraph from the State Surgeon General or his or her designee.

b. The contract provider or subcontractor must be authorized by law to administer or dispense prescription drugs.

c. In the case of a subcontractor, the agency or entity must be a party to and execute the subcontract.

~~d. A contract provider or subcontractor must maintain separate and apart from other prescription drug inventory any prescription drugs of the agency or entity in its possession.~~

d.~~e.~~ The contract provider and subcontractor must maintain and produce immediately for inspection all records of movement or transfer of all the prescription drugs belonging to the agency or entity, including, but not limited to, the records of receipt and disposition of prescription drugs. Each contractor and subcontractor dispensing or administering these drugs must maintain and produce records documenting the dispensing or administration. Records that are required to be maintained include, but are not limited to, a perpetual inventory itemizing drugs received and drugs dispensed by prescription number or administered by patient identifier, which must be submitted to the agency or entity quarterly.

e.~~f.~~ The contract provider or subcontractor may administer or dispense the prescription drugs only to the eligible patients


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of the agency or entity or must return the prescription drugs for or to the agency or entity. The contract provider or subcontractor must require proof from each person seeking to fill a prescription or obtain treatment that the person is an eligible patient of the agency or entity and must, at a minimum, maintain a copy of this proof as part of the records of the contractor or subcontractor required under sub-subparagraph e.

f.~~g.~~ In addition to the departmental inspection authority set forth in s. 499.051, the establishment of the contract provider and subcontractor and all records pertaining to prescription drugs subject to this subparagraph shall be subject to inspection by the agency or entity. All records relating to prescription drugs of a manufacturer under this subparagraph shall be subject to audit by the manufacturer of those drugs, without identifying individual patient information.

Section 89. Section 624.49, Florida Statutes, is created to read:

624.49 Prohibition on contracts.—Notwithstanding any other provision of law, a managed care entity, insurance carrier, self-insured entity, or third-party administrator, or an agent thereof which is governed by state law, may not impose a contracted reimbursement rate on a medical provider for goods or services provided or rendered pursuant to chapter 440 unless the carrier directly contracts with the provider for that rate.

Section 90. 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

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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 91. Effective May 1, 2012, paragraph (h) is added to subsection (1) of section 627.602, Florida Statutes, to read:

627.602 Scope, format of policy.—

(1) Each health insurance policy delivered or issued for delivery to any person in this state must comply with all applicable provisions of this code and all of the following requirements:

(h) Section 641.32 and the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances. This paragraph does not apply to a health insurance policy that is subject to the Subscriber Assistance Program in s. 408.7056 or to the types of health benefit plans listed in s. 627.6561(5)(b)-(e) issued in any market.

Section 92. Effective May 1, 2012, section 627.6513, Florida Statutes, is created to read:

627.6513 Section 641.312 and the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances, apply to all group health insurance policies issued under this part. This section does not apply to a group health insurance policy that is subject to the Subscriber Assistance Program in s. 408.7056 or to the types of


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health benefit plans listed in s. 627.6561(5)(b)-(e) issued in any market.

Section 93. 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

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amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.

Section 94. 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 95. 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

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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 96. Effective May 1, 2012, section 641.312, Florida Statutes, is created to read:

641.312 The Financial Services Commission may adopt rules to administer the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act, dated April 2010. This section does not apply to a health maintenance contract that is subject to the Subscriber Assistance Program in s. 408.7056 or to the types of health benefit plans listed in s. 625.6561(5)(b)-(e) issued in any market.

Section 97. Subsection (12) of section 641.495, Florida Statutes, is amended to read:

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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 98. 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) ~~400.141(1)(o)1.d~~.

Section 99. 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,

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omission, or utterance may not be made or done in bad faith or with malicious intent.

Section 100. Paragraph (j) is added to subsection (3) of section 817.505, Florida Statutes, to read:

817.505 Patient brokering prohibited; exceptions; penalties.—

(3) This section shall not apply to:

(j) Payments by an assisted living facility, as defined in s. 429.02, or an agreement for or solicitation, offer, or receipt of such payment by a referral service permitted under s. 429.195(2).

Section 101. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2012.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health care facilities; amending s. 83.42, F.S., relating to exclusions from part II of ch. 83, F.S., the Florida Residential Landlord and Tenant Act; clarifying that the procedures in s. 400.0255, F.S., for transfers and discharges are exclusive to residents of a nursing home licensed under part II of ch. 400, F.S.; amending s. 112.0455, F.S., relating to the Drug-Free Workplace Act; deleting a provision regarding retroactivity of the act; deleting a provision that the act does not

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abrogate the right of an employer under state law to conduct drug tests before a specified date; 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; amending s. 318.21, F.S.; providing that a portion of the additional fines assessed for traffic violations within an enhanced penalty zone be remitted to the Department of Revenue and deposited into the Brain and Spinal Cord Injury Trust Fund of the Department of Health to serve certain Medicaid recipients; amending s. 383.011, F.S.; requiring the Department of Health to establish an interagency agreement with the Department of Children and Family Services for management of the Special Supplemental Nutrition Program for Women, Infants, and Children; specifying responsibilities of each department; creating s. 383.141, F.S.; providing legislative findings; providing definitions; requiring that health care providers provide pregnant women with current information about the nature of the developmental disabilities tested for in certain prenatal tests, the accuracy of such tests, and resources for obtaining support services for Down syndrome and other prenatally diagnosed developmental disabilities and that the counseling that follows such diagnosis may lead to the unnecessary abortion of unborn humans; providing duties for the Department of Health


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concerning establishment of an information clearinghouse; creating an advocacy council within the Department of Health to provide technical assistance in forming the clearinghouse; providing membership for the council; providing duties of the council; providing terms for members of the council; providing for election of a chairperson and vice chairperson; providing meeting times for the council; requiring the members to serve without compensation but be reimbursed for per diem and travel expenses; requiring the Department of Health to provide administrative support; repealing s. 383.325, F.S., relating to confidentiality of inspection reports of a licensed birth center facilities; creating s. 385.2031, F.S.; designating the Florida Hospital/Sandford-Burnham Translational Research Institute for Metabolism and Diabetes as a resource for research in the prevention and treatment of diabetes; amending s. 394.4787, F.S.; conforming a cross-reference; amending s. 395.002, F.S.; revising and deleting definitions applicable to the 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. 395.0161, F.S.; deleting a requirement that facilities licensed under part I of ch. 395, F.S., pay licensing fees at the time of inspection; amending s. 395.0193, F.S.; requiring a licensed facility to report certain peer review information and final disciplinary actions to

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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 procedures employed by the Agency for Health Care Administration when investigating complaints against hospitals; amending s. 400.0239, F.S.; conforming a provision to changes made by the act; amending s. 400.0255, F.S.; revising provisions relating to hearings on resident transfer or discharge; amending s. 400.063, F.S.; deleting an obsolete cross-reference; amending s. 400.071, F.S.; deleting provisions requiring a license applicant to submit a signed affidavit relating to financial or ownership interests, the number of beds, copies of civil verdicts or judgments involving the applicant, and a plan for quality assurance and risk management; amending s. 400.0712, F.S.; revising provisions relating to the issuance of inactive licenses; amending s. 400.111, F.S.; providing that a licensee must provide certain information relating to financial

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or ownership interests if requested by the Agency for Health Care Administration; amending s. 400.1183, F.S.; revising requirements relating to nursing home facility grievance reports; amending s. 400.141, F.S.; revising provisions relating to the provision of respite care in a facility; deleting requirements for the submission of certain reports to the agency relating to ownership interests, staffing ratios, and bankruptcy; deleting an obsolete provision; amending s. 400.142, F.S.; deleting the agency's authority to adopt rules relating to orders not to resuscitate; amending s. 400.147, F.S.; revising provisions relating to adverse incident reports; deleting certain reporting requirements; repealing s. 400.148, F.S., relating to the Medicaid "Up-or-Out" Quality of Care Contract Management Program; amending s. 400.19, F.S.; revising provisions relating to agency inspections of nursing home facilities; amending s. 400.191, F.S.; authorizing the facility to charge a fee for copies of resident records; amending s. 400.23, F.S.; specifying the content of rules relating to nursing home facility staffing requirements for residents under 21 years of age; amending s. 400.275, F.S.; revising agency duties with regard to training nursing home surveyor teams; revising requirements for team members; amending s. 400.462, F.S.; revising the definition of "remuneration" to exclude items having a value of $15 or less; amending s. 400.474, F.S.; revising the requirements for a quarterly report submitted to the

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Agency for Health Care Administration by each home health agency; amending s. 400.484, F.S.; revising the classification of violations by a home health agency for which the agency imposes an administrative fine; amending and reenacting s. 400.506, F.S., relating to licensure of nurse registries, to incorporate the amendment made to s. 400.509, F.S., in a reference thereto; authorizing an administrator to manage up to five nurse registries under certain circumstances; requiring an administrator to designate, in writing, for each licensed entity, a qualified alternate administrator to serve during the administrator's absence; amending s. 400.509, F.S.; providing that organizations that provide companion or homemaker services only to persons with developmental disabilities, under contract with the Agency for Persons with Disabilities, are exempt from registration with the Agency for Health Care Administration; reenacting ss. 400.464(5)(b) and 400.506(6)(a), F.S., relating to home health agencies and licensure of nurse registries, respectively, to incorporate the amendment made to s. 400.509, F.S., in references thereto; amending s. 400.601, F.S.; revising the definition of the term "hospice" to include limited liability companies; 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

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for certain hospice facilities; amending s. 400.915, F.S.; correcting an obsolete cross-reference to administrative rules; amending s. 400.931, F.S.; requiring each applicant for initial licensure, change of ownership, or license renewal to operate a licensed home medical equipment provider at a location outside the state to submit documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the Agency for Health Care Administration; requiring an applicant that has applied for accreditation to provide proof of accreditation within a specified time; deleting a requirement that an applicant for a home medical equipment provider license submit a surety bond to the agency; amending s. 400.967, F.S.; revising the classification of violations by 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"; revising requirements for an application for exemption from health care clinic licensure requirements for certain entities; providing for the agency to deny or revoke the exemption under certain circumstances; including health services provided to multiple locations within the definition of the term "portable health service or equipment provider"; amending s. 400.991, F.S.; conforming terminology; revising application requirements relating to documentation of financial

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ability to operate a mobile clinic; amending s. 400.9935, F.S.; adding additional responsibilities of medical and clinic directors with respect to the posting of a schedule of charges for services; amending s. 408.033, F.S.; providing that fees assessed on selected health care facilities and organizations may be collected prospectively at the time of licensure renewal and prorated for the licensing period; 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.; conforming provisions to changes made by the act; amending s. 408.037, F.S.; revising requirements for the financial information to be included in an application for a certificate of need; 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 data reporting requirements for health care facilities; amending s. 408.07, F.S.; deleting a cross-reference; amending s. 408.10, F.S.; removing agency authority to investigate certain consumer complaints; amending s. 408.7056, F.S.; providing that the Subscriber Assistance Program applies to clinics and health plans that meet certain requirements; 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

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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. 408.8065, F.S.; revising the requirements for becoming licensed as a home health agency, home medical equipment provider, or health care clinic; amending s. 408.810, F.S.; requiring that the controlling interest of a health care licensee notify the agency of certain court proceedings; providing a penalty; 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. 409.912, F.S.; revising provisions requiring the agency to post certain information relating to drugs subject to prior authorization on its Internet website; providing a definition of the term "step edit"; amending s. 409.975, F.S.; requiring good faith negotiations between Medicaid managed care plans and essential Medicaid providers; providing that a statewide essential provider is part of a Medicaid managed care plan's network for purposes of the managed care plan's application for enrollment or expansion in the Medicaid program; requiring good faith negotiations between Medicaid managed care plans and statewide essential providers; authorizing

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Medicaid managed care plans and certain Medicaid providers to file a complaint alleging that, in provider network negotiations, the other party is not negotiating in good faith; requiring the Agency for Health Care Administration to review such complaints and make a determination as to whether one or both parties have failed to negotiate in good faith; providing criteria for the agency to consider in making a determination about good faith negotiations; providing financial penalties for parties that do not negotiate in good faith; authorizing appeal of the agency's determination pursuant to chapter 120, F.S.; providing for payment of attorney's fees and costs; amending s. 429.11, F.S.; revising licensure application requirements for assisted living facilities to eliminate provisional licenses; amending s. 429.71, F.S.; revising the classification of violations by adult family-care homes; amending s. 429.195, F.S.; providing exceptions to applicability of assisted living facility rebate restrictions; amending s. 429.915, F.S.; revising agency responsibilities regarding the issuance of conditional licenses; amending ss. 430.80, 430.81, and 651.118, F.S.; conforming cross-references; amending s. 440.102, F.S.; removing a requirement that a laboratory submit to the Agency for Health Care Administration a monthly report containing statistical information regarding the testing of employees and job applicants; amending s. 465.014, F.S.; providing that

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the provisions governing pharmacy technicians do not apply to a practitioner authorized to dispense drugs or a medical assistant or licensed health care professional acting under the direct supervision of such a practitioner under certain circumstances; amending s. 468.1695, F.S.; providing that a health services administration or equivalent major satisfies the education requirements for nursing home administrator applicants; amending s. 483.035, F.S.; providing for a clinical laboratory to be operated by certain nurses; amending s. 483.051, F.S.; requiring the Agency for Health Care Administration to provide for biennial licensure of all nonwaived laboratories that meet certain requirements; requiring the agency to prescribe qualifications for such licensure; defining nonwaived laboratories as laboratories that do not have a certificate of waiver from the Centers for Medicare and Medicaid Services; deleting requirements for the registration of an alternate site testing location when the clinical laboratory applies to renew its license; amending s. 483.23, F.S.; providing that certain violations relating to the operation of a clinical laboratory be referred by the Agency for Health Care Administration to the local law enforcement agency; authorizing the Agency for Health Care Administration to provide a cease and desist notice and impose administrative penalties and fines; amending s. 483.294, F.S.; revising the frequency of agency inspections of multiphasic health testing

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centers; amending s. 499.003, F.S.; removing the requirement for certain prescription drug purchasers to maintain a separate inventory of certain prescription drugs; creating s. 624.49, F.S.; prohibiting a managed care entity, insurance carrier, self-insured entity, or third-party administrator, or an agent thereof, from imposing a contracted reimbursement rate on a medical provider for certain goods or services unless the carrier directly contracts with the provider for that rate; amending and creating, respectively, ss. 627.602 and 627.6513, F.S.; providing that the Uniform Health Carrier External Review Model Act and the Employee Retirement Income Security Act apply to individual and group health insurance policies except those subject to the Subscriber Assistance Program under s. 408.7056, F.S.; creating s. 641.312, F.S.; allowing the Office of Insurance Regulation to adopt rules to administer the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act; providing that the Uniform Health Carrier External Review Model Act does not apply to a health maintenance contract that is subject to the Subscriber Assistance Program under s. 408.7056, F.S. or certain other health benefit plans; amending s. 817.505, F.S.; providing an exception to provisions prohibiting patient brokering; providing effective dates.