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 abrogate the right of an employer under state law to conduct drug test 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. 381.21, 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; repealing s. 383.325, F.S., relating to confidentiality of inspection reports of 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; providing for certain specialty-licensed children's hospitals to provide specified obstetrical services; 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 the Division of Medical Quality Assurance of the Department of Health rather than the Division of Health Quality Assurance of the Agency for Health Care Administration; amending s. 395.1023, F.S.; providing for the Department of Children and Family Services rather than the Department of Health to perform certain functions with respect to child protection cases; requiring certain hospitals to notify the Department of Children and Family Services of compliance; amending s. 395.1041, F.S., relating to hospital emergency services and care; deleting obsolete provisions; repealing s. 395.1046, F.S., relating to complaint investigation procedures; amending s. 395.1055, F.S.; requiring that

licensed facility beds conform to standards specified by the Agency for Health Care Administration, the Florida Building Code, and the Florida Fire Prevention Code; amending s. 395.3025, F.S.; authorizing the disclosure of patient records to the Department of Health rather than the Agency for Health Care Administration in accordance with an issued subpoena; requiring the department, rather than the agency, to make available, upon written request by a practitioner against whom probable cause has been found, any patient records that form the basis of the determination of probable cause; amending s. 395.3036, F.S.; correcting a cross-reference; repealing s. 395.3037, F.S., relating to redundant definitions for the Department of Health and the Agency for Health Care Administration; amending s. 395.602, F.S.; revising the definition of the term "rural hospital" to delete an obsolete provision; amending s. 400.021, F.S.; revising the definitions of the terms "geriatric outpatient clinic" and "resident care plan"; amending s. 400.0234, F.S., relating to medical records; conforming provisions to changes made by the act; amending s. 400.0255, F.S.; correcting an obsolete cross-reference to administrative rules; amending s. 400.063, F.S.; deleting an obsolete provision governing moneys received for the care of residents in a nursing home facility; amending ss. 400.071 and 400.0712, F.S.; revising applicability of general

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

notify the agency of certain bankruptcy filings, to conform to changes made by the act; authorizing a facility to charge a fee to copy a resident's records; amending s. 400.142, F.S., relating to orders not to resuscitate; deleting provisions relating to agency adoption of rules; repealing s. 400.145, F.S., relating to requirements for furnishing the records of residents in a licensed nursing home to certain specified parties; amending s. 400.147, F.S.; revising reporting requirements for licensed nursing home facilities relating to adverse incidents; amending s. 400.19, F.S.; revising inspection requirements for nursing homes; amending s. 400.23, F.S.; deleting an obsolete provision; correcting a reference; deleting a requirement that the rules for minimum standards of care for persons under 21 years of age include a certain methodology; directing the agency to adopt rules for minimum staffing standards in nursing homes that serve persons under 21 years of age; providing minimum staffing standards; amending s. 400.275, F.S.; revising agency duties with regard to training nursing home surveyor teams; revising requirements for team members; amending s. 400.462, F.S.; redefining the term "remuneration" for purposes of the Home Health Services Act; 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 s. 400.506, F.S.; 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 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 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 ability to operate a mobile clinic; 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.; deleting an exemption from certain certificate-of-need review requirements for a hospice or a hospice inpatient facility; 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, as of a specified date, the Subscriber Assistance Program applies only to plans that meet federal requirements for the preservation of the right to maintain existing health plan coverage; amending s. 408.802, F.S.; removing applicability of part II of ch. 408, F.S., relating to general licensure requirements, to private review agents; amending s. 408.804, F.S.; providing penalties for altering, defacing, or falsifying a license certificate issued by the agency or displaying such an altered, defaced, or falsified certificate; amending s. 408.806, F.S.; revising agency responsibilities for notification of licensees of impending expiration of a license;

requiring payment of a late fee for a license application to be considered complete under certain circumstances; amending s. 408.8065, F.S.; revising the requirements for becoming licensed as a home health agency, home medical equipment provider, or health care clinic; amending s. 408.809, F.S.; revising provisions to include a schedule for background rescreenings of certain employees; 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. 409.91195, F.S.; revising the composition of the Medicaid Pharmaceutical and Therapeutics Committee; revising provisions relating to public testimony; providing for committee members to be notified in writing if the agency reverses their recommendation regarding preferred drugs; 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 ss. 409.97 and 409.975, F.S.; conforming cross-references; providing that, notwithstanding s. 409.975, F.S., any hospital, as determined by the agency, may be considered an essential provider for purposes of implementing a

Medicaid managed care network; amending s. 429.11, F.S.; revising licensure application requirements for assisted living facilities to eliminate provisional licenses; amending s. 429.294, F.S.; deleting a cross-reference; 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 and 430.81, F.S.; conforming cross-references; repealing s. 440.102(9)(d), F.S., relating to a laboratory's requirement to submit to the Agency for Health Care Administration a monthly report containing statistical information regarding the testing of employees and job applicants; amending s. 483.035, 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. 483.245, F.S.; prohibiting a clinical laboratory from placing a specimen collector or other personnel in any physician's office, unless the clinical lab and the physician's office are owned and operated by the same entity; providing for damages and injunctive relief; amending s. 483.294, F.S.; revising the frequency of agency inspections of multiphasic health testing centers; creating s. 641.3120, F.S.; requiring the Office of Insurance Regulation to adopt rules to implement the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act by a specified date; providing applicability; amending s. 627.602, F.S.; providing applicability of internal grievance procedures by a specified date; creating s. 627.6513, F.S.; providing applicability of internal grievance procedures by a specified date; amending s. 651.118, F.S.; conforming a cross-reference; amending s. 817.505, F.S.; providing an exception to provisions prohibiting patient brokering; providing a directive to the Division of Statutory Revision; providing effective dates.

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

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. 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 II of chapter 408.

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

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

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

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

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

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

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

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

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

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

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

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

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.

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

Section 3. 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:

(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 4. Section 383.325, Florida Statutes, is repealed.

Section 5. 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 6. 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) ~~s. 395.002(28)~~ and part II of chapter 408 as a specialty psychiatric hospital.

Section 7. Present subsections (15) through (33) of section 395.002, Florida Statutes, are redesignated as subsections (14) through (29), 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 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, and Det Norske Veritas.

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

~~(24) "Private review agent" means any person or entity which performs utilization review services for third-party payors on a contractual basis for outpatient or inpatient services. However, the term shall not include full-time employees, personnel, or staff of health insurers, health maintenance organizations, or hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, when performing utilization review for their respective hospitals,~~

~~health maintenance organizations, or insureds of the same insurance group. For this purpose, health insurers, health maintenance organizations, and hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, include such entities engaged as administrators of self-insurance as defined in s. 624.031.~~

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

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

(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)~~.

~~(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. It does not include the emergency department of a hospital.~~

~~(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 8. Paragraph (c) of subsection (1), paragraph (b) of subsection (2), and subsection (6) 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) ~~s. 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.

(6) A specialty hospital may not provide any service or regularly serve any population group beyond those services or groups specified in its license. A specialty-licensed children's hospital that is authorized to provide pediatric cardiac catheterization and pediatric open-heart surgery services may provide cardiovascular service to adults who, as children, were previously served by the hospital for congenital heart disease, or to those patients who are referred for a specialized procedure only for congenital heart disease by an adult hospital, without obtaining additional licensure as a provider of adult cardiovascular services. The agency may request

documentation as needed to support patient selection and treatment. This subsection does not apply to a specialty-licensed children's hospital that is already licensed to provide adult cardiovascular services. A specialty-licensed children's hospital with at least 50 total licensed neonatal intensive care unit beds may provide obstetrical services, including labor and delivery services, restricted to the diagnosis, care, and treatment of pregnant women of any age who have at least one maternal or fetal characteristic or condition which would characterize the pregnancy or delivery as high risk or pregnant women of any age who have received medical advice or a diagnosis indicating that the fetus will require at least one perinatal intervention.

Section 9. Subsection (3) of section 395.0161, Florida Statutes, is amended to read:

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 10. 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 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 finding of probable cause.

Section 11. 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 12. Subsection (2) and paragraph (d) of subsection (3) of section 395.1041, Florida Statutes, are amended to read:

395.1041 Access to emergency services and care.—

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

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

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

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

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

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

3. A hospital 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.

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 13. Section 395.1046, Florida Statutes, is repealed.

Section 14. Paragraph (e) of subsection (1) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

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

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

Section 15. 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.

Section 16. 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 17. Section 395.3037, Florida Statutes, is repealed.

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

395.602 Rural hospitals.—

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

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

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

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

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

per square mile;

~~4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent;~~

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

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

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room~~, or meets the criteria of~~

~~subparagraph 4~~. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation to the Agency for Health Care Administration.

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

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

(8) "Geriatric outpatient clinic" means a site for providing outpatient health care to persons 60 years of age or older, which is staffed by a registered nurse or a physician assistant, or 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 psychosocial well-being; a listing of services provided within or outside the facility to meet those needs; and an explanation of service goals. ~~The resident care plan must be signed by the director of nursing or another registered nurse employed by the facility to whom institutional responsibilities have been~~

~~delegated and by the resident, the resident's designee, or the resident's legal representative. The facility may not use an agency or temporary registered nurse to satisfy the foregoing requirement and must document the institutional responsibilities that have been delegated to the registered nurse.~~

Section 20. Subsection (1) of section 400.0234, Florida Statutes, is amended to read:

400.0234 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility ~~in accordance with s. 400.145~~ shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

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

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

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

(b) The department shall, by rule, establish procedures to be used for fair hearings requested by residents. These procedures shall be equivalent to the procedures used for fair

hearings for other Medicaid cases appearing in s. 409.285 and applicable rules~~, chapter 10-2, part VI, Florida Administrative Code~~. The burden of proof must be clear and convincing evidence. A hearing decision must be rendered within 90 days after receipt of the request for hearing.

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

(d) The decision of the hearing officer 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 22. Subsection (2) of section 400.063, Florida Statutes, is amended to read:

400.063 Resident protection.—

(2) The agency is authorized to establish for each facility, subject to intervention by the agency, a separate bank account for the deposit to the credit of the agency of any moneys received from the Health Care Trust Fund or any other moneys received for the maintenance and care of residents in the facility, and the agency is authorized to disburse moneys from such account to pay obligations incurred for the purposes of this section. The agency is authorized to requisition moneys from the Health Care Trust Fund in advance of an actual need for cash on the basis of an estimate by the agency of moneys to be spent under the authority of this section. Any bank account established under this section need not be approved in advance

of its creation as required by s. 17.58, but shall be secured by depository insurance equal to or greater than the balance of such account or by the pledge of collateral security ~~in conformance with criteria established in s. 18.11~~. The agency shall notify the Chief Financial Officer of any such account so established and shall make a quarterly accounting to the Chief Financial Officer for all moneys deposited in such account.

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

400.071 Application for license.—

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

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

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

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

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

~~(e) Copies of any civil verdict or judgment involving the applicant rendered within the 10 years preceding the application, relating to medical negligence, violation of residents' rights, or wrongful death. As a condition of licensure, the licensee agrees to provide to the agency copies of any new verdict or judgment involving the applicant, relating to such matters, within 30 days after filing with the clerk of the court. The information required in this paragraph shall be maintained in the facility's licensure file and in an agency database which is available as a public record.~~

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

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

400.0712 Application for inactive license.—

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

~~inactivity before receiving approval from the agency; and a licensee that violates this provision may not be issued an inactive license.~~

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

(a) An inactive license issued under this subsection may be granted for a period not to exceed the current licensure expiration date but may be renewed by the agency at the time of licensure renewal.

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

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

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

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

400.111 Disclosure of controlling interest.—In addition to the requirements of part II of chapter 408, when requested by the agency, the licensee shall submit a signed affidavit disclosing any financial or ownership interest that a

controlling interest has held within the last 5 years in any entity licensed by the state or any other state to provide health or residential care which entity has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason such entity was closed, whether voluntarily or involuntarily.

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

400.1183 Resident grievance procedures.—

(2) Each facility shall maintain records of all grievances and shall retain a log for agency inspection of ~~report to the agency at the time of relicensure~~ the total number of grievances handled ~~during the prior licensure period~~, a categorization of the cases underlying the grievances, and the final disposition of the grievances.

Section 27. Subsection (1) of section 400.141, Florida Statutes, is amended, and subsection (3) is added to that section to read:

400.141 Administration and management of nursing home facilities.—

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

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

(b) Appoint a medical director licensed pursuant to chapter 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 physicians licensed by the state.

(d) Provide for resident use of a community pharmacy as specified in s. 400.022(1)(q). Any other law to the contrary notwithstanding, a registered pharmacist licensed in Florida, that is under contract with a facility licensed under this chapter or chapter 429, shall repackage a nursing facility resident's bulk prescription medication that ~~which~~ 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 facility, if the pharmacist is requested to offer such service. 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). 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. In order to be eligible for the repackaging, a nursing facility resident for whom the medication is to be repackaged shall sign an informed consent form provided by the facility which includes an explanation of the repackaging

process and which notifies the resident of the immunities from liability provided in this paragraph. 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 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. When a geriatric outpatient nurse clinic is conducted in accordance with rules adopted by the agency, outpatients attending such clinic shall not be counted as part of the general resident population of the nursing home facility, nor 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. For each person

admitted under the respite care program, the facility licensee must:

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

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

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

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

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

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

c. Allowed to use his or her personal medications for the respite stay if permitted by facility policy. The facility must obtain a physician's order for the medications. The caregiver

may provide information regarding the medications as part of the nursing assessment and that information must be in conformance with the physician's order. Medications shall be released with the resident upon discharge in accordance with a physician's current orders.

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

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

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

6. The facility must assume the duties of the primary caregiver. To ensure continuity of care and services, the resident is entitled to retain his or her personal physician and must have access to medically necessary services such as

physical therapy, occupational therapy, or speech therapy, as needed. The facility must arrange for transportation to these services if necessary. ~~Respite care must be provided in accordance with this part and rules adopted by the agency. However, the agency shall, by rule, adopt modified requirements for resident assessment, resident care plans, resident contracts, physician orders, and other provisions, as appropriate, for short-term or temporary nursing home services.~~

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

(g) If the facility has a standard license ~~or is a Gold Seal facility~~, exceeds the minimum required hours of licensed nursing and certified nursing assistant direct care per resident per day, and is part of a continuing care facility licensed under chapter 651 or a retirement community that offers other services pursuant to part III of this chapter or part I or part

III of chapter 429 on a single campus, be allowed to share programming and staff. ~~At the time of inspection and in the semiannual report required pursuant to paragraph (o),~~ A continuing care facility or retirement community that uses this option must demonstrate through staffing records that minimum staffing requirements for the facility were met. Licensed nurses and certified nursing assistants who work in the nursing home facility may be used to provide services elsewhere on campus if the facility exceeds the minimum number of direct care hours required per resident per day and the total number of residents receiving direct care services from a licensed nurse or a certified nursing assistant does not cause the facility to violate the staffing ratios required under s. 400.23(3)(a). Compliance with the minimum staffing ratios shall be based on total number of residents receiving direct care services, regardless of where they reside on campus. If the facility receives a conditional license, it may not share staff until the conditional license status ends. This paragraph does not restrict the agency's authority under federal or state law to require additional staff if a facility is cited for deficiencies in care which are caused by an insufficient number of certified nursing assistants or licensed nurses. The agency may adopt rules for the documentation necessary to determine compliance with this provision.

(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 physicians. In 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 residents; and individual resident care plans including, but not limited to, prescribed services, service frequency and duration, and service goals. The records shall be open to inspection by the agency. The facility must maintain clinical records for each resident in accordance with accepted professional standards and practices and which are 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 any reason for termination. Any facility releasing such records pursuant to this part 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.

(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, 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)1.~~d.~~ Comply with minimum-staffing requirements. A nursing facility that fails ~~has failed~~ to comply with state minimum-staffing requirements for 2 consecutive days may not accept ~~is prohibited from accepting~~ new admissions until the facility achieves ~~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 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 fails ~~has failed~~ to meet those standards on 2 consecutive days or if it

fails ~~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 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, 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 general and professional liability insurance coverage, a state-designated teaching nursing home and its affiliated 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. 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 shall not be provided to any resident who provides documentation that he or she has been immunized as required by this paragraph. This paragraph does not prohibit a resident from receiving the immunization from his or her personal physician if he or she so chooses. A resident who chooses to receive the immunization from his or her personal physician shall provide proof of immunization to the facility. The agency may adopt and enforce any rules necessary to comply with or implement this paragraph.

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

enforce any rules necessary to comply with or implement this paragraph.

(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 comply with or implement this paragraph.

This subsection does not limit the agency's ability to impose a penalty for a deficiency or take other actions if a facility fails to maintain an adequate number of staff to meet the residents' needs.

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

400.142 Emergency medication kits; orders not to resuscitate.—

(3) Facility staff may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. ~~The agency shall adopt rules providing for the implementation of such orders.~~ Facility staff and facilities are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and are not ~~nor be~~ considered to have engaged in negligent or unprofessional

conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

Section 29. Section 400.145, Florida Statutes, is repealed.

Section 30. Present subsections (9), (11), (12), (13), (14), and (15) of section 400.147, Florida Statutes, are redesignated as subsections (8), (9), (10), (11), (12), and (13), respectively, and present subsections (7), (8), and (10) of that section are amended to read:

400.147 Internal risk management and quality assurance program.—

(7) The facility shall initiate an investigation ~~and shall notify the agency~~ within 1 business day after the risk manager or his or her designee has received a report pursuant to paragraph (1)(d). Each facility shall complete the investigation and submit a report to the agency within 15 calendar days if the incident is determined to be an adverse incident as defined in subsection (5). ~~The notification must be made in writing and be provided electronically, by facsimile device or overnight mail delivery.~~ The agency shall develop a form for reporting this information, and the notification must include the name of the risk manager of the facility, information regarding the identity of the affected resident, the type of adverse incident, the initiation of an investigation by the facility, and whether the

events causing or resulting in the adverse incident represent a potential risk to any other resident. The notification is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

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

~~(b) The information reported to the agency pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.~~

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

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

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

Section 31. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.—

(3) The agency shall every 15 months conduct at least one unannounced inspection to determine compliance by the licensee with statutes, and with rules adopted ~~promulgated~~ under the

provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. The survey shall be conducted every 6 months for the next 2-year period if the facility has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be $6,000, one-half to be paid at the completion of each survey. The agency may adjust this fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency ~~unrelated to resident rights or resident care~~ without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not less ~~fewer~~ than 5 working days according to the provisions of chapter 110.

Section 32. Subsection (5) of section 400.23, Florida

Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

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

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

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

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

Section 33. 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 34. 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, when the term is used in any provision of law relating to a health care provider, such term does not mean an item with an individual value of up to $15, including, but not limited to, plaques, certificates, trophies, or novelties that are intended solely for presentation or are customarily given away solely for promotional, recognition, or advertising purposes.

Section 35. 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 and amended 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 provisions of this act.

5. The Department of Children and Family Services.

Section 36. 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 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 investigation that results in a successful prosecution, excluding costs associated with an attorney's time.

Section 37. 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, Florida Statutes, is reenacted, and subsection (16) of that section is amended, 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.

(16) 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 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. ~~In addition to any other penalties imposed pursuant to this section or part, the agency may assess costs related to an investigation that results in a successful prosecution, excluding costs associated with an attorney's time.~~

Section 38. 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 39. 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 as defined in s. 608.4351 providing a continuum of palliative and supportive care for the terminally ill patient and his or her family.

Section 40. Paragraph (i) of subsection (1) and subsection (4) of section 400.606, Florida Statutes, are amended to read:

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

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

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

If the applicant is an existing licensed health care provider, the application must be accompanied by a copy of the most recent

profit-loss statement and, if applicable, the most recent licensure inspection report.

(4) A freestanding hospice facility that is ~~primarily~~ engaged in providing inpatient and related services and that is not otherwise licensed as a health care facility shall ~~be required to~~ obtain a certificate of need. However, a freestanding hospice facility 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 41. Section 400.915, Florida Statutes, is amended to read:

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

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

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

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

Section 42. 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 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.

Section 43. 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 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 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 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 ~~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 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 44. Subsections (4) and (7) of section 400.9905, Florida Statutes, are amended to read:

400.9905 Definitions.—

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

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

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; or entities that own, directly or indirectly, entities licensed or

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

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

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state

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

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

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

child, or sibling of that physician.

(g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, which are wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner, so long as one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) that provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

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

(i) Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 which are owned by a corporation whose shares are

publicly traded on a recognized stock exchange.

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

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

(l) Orthotic, ~~or~~ prosthetic, pediatric cardiology, 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 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 phone 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 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 45. 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 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 46. 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 47. 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 48. Paragraph (d) of subsection (1) of section 408.036, Florida Statutes, is amended to read:

408.036 Projects subject to review; exemptions.—

(1) APPLICABILITY.—Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(g), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.

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

Section 49. 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 50. Subsection (2) of section 408.043, Florida Statutes, is amended to read:

408.043 Special provisions.—

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

Section 51. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

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

(1) The agency shall require the submission by health care

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

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to: case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic

information. Reported data elements shall be reported electronically and ~~in accordance with rule 59E-7.012, Florida Administrative Code. Data submitted shall be~~ certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

Section 52. Subsection (43) of section 408.07, Florida Statutes, is amended to read:

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

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

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

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

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

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on

information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

(e) A critical access hospital.

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

Section 53. 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 54. Effective upon this act becoming a law, section 408.7056, Florida Statutes, is amended to read:

408.7056 Subscriber Assistance Program.—

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

(a) "Agency" means the Agency for Health Care Administration.

(b) "Department" means the Department of Financial Services.

(c) "Grievance procedure" means an established set of rules that specify a process for appeal of an organizational decision.

(d) "Health care provider" or "provider" means a state-licensed or state-authorized facility, a facility principally supported by a local government or by funds from a charitable organization that holds a current exemption from federal income tax under s. 501(c)(3) of the Internal Revenue Code, a licensed practitioner, a county health department established under part I of chapter 154, a prescribed pediatric extended care center defined in s. 400.902, a federally supported primary care program such as a migrant health center or a community health center authorized under s. 329 or s. 330 of the United States Public Health Services Act that delivers health care services to individuals, or a community facility that receives funds from the state under the Community Alcohol, Drug Abuse, and Mental Health Services Act and provides mental health services to

individuals.

(e) "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(f) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(g) "Panel" means a subscriber assistance panel selected as provided in subsection (11).

(2) The agency shall adopt and implement a program to provide assistance to subscribers, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber. The program shall consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to the agency or the office any actions that should be taken concerning individual cases heard by the panel. The panel shall hear every grievance filed by subscribers on behalf of subscribers, unless the grievance:

(a) Relates to a managed care entity's refusal to accept a provider into its network of providers;

(b) Is part of an internal grievance in a Medicare managed care entity or a reconsideration appeal through the Medicare appeals process which does not involve a quality of care issue;

(c) Is related to a health plan not regulated by the state such as an administrative services organization, third-party administrator, or federal employee health benefit program;

(d) Is related to appeals by in-plan suppliers and

providers, unless related to quality of care provided by the plan;

(e) Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

(f) Is the basis for an action pending in state or federal court;

(g) Is related to an appeal by nonparticipating providers, unless related to the quality of care provided to a subscriber by the managed care entity and the provider is involved in the care provided to the subscriber;

(h) Was filed before the subscriber completed the entire internal grievance procedure of the managed care entity, the managed care entity has complied with its timeframes for completing the internal grievance procedure, and the circumstances described in subsection (6) do not apply;

(i) Has been resolved to the satisfaction of the subscriber who filed the grievance, unless the managed care entity's initial action is egregious or may be indicative of a pattern of inappropriate behavior;

(j) Is limited to seeking damages for pain and suffering, lost wages, or other incidental expenses, including accrued interest on unpaid balances, court costs, and transportation costs associated with a grievance procedure;

(k) Is limited to issues involving conduct of a health care provider or facility, staff member, or employee of a managed care entity which constitute grounds for disciplinary action by the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and the

agency, office, or department has reported these grievances to the appropriate professional licensing board or to the health facility regulation section of the agency for possible investigation; or

(l) Is withdrawn by the subscriber. Failure of the subscriber to attend the hearing shall be considered a withdrawal of the grievance.

(3) The agency shall review all grievances within 60 days after receipt and make a determination whether the grievance shall be heard. Once the agency notifies the panel, the subscriber, and the managed care entity that a grievance will be heard by the panel, the panel shall hear the grievance either in the network area or by teleconference no later than 120 days after the date the grievance was filed. The agency shall notify the parties, in writing, by facsimile transmission, or by phone, of the time and place of the hearing. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. The panel shall issue a written recommendation, supported by findings of fact, to the subscriber, to the managed care entity, and to the agency or the office no later than 15 working days after hearing the grievance. If at the hearing the panel requests additional documentation or additional records, the time for issuing a recommendation is tolled until the information or documentation requested has been provided to the panel. The proceedings of the panel are not subject to chapter 120.

(4) If, upon receiving a proper patient authorization along with a properly filed grievance, the agency requests records from a health care provider or managed care entity, the health care provider or managed care entity that has custody of the records has 10 days to provide the records to the agency. Records include medical records, communication logs associated with the grievance both to and from the subscriber, and contracts. Failure to provide requested records may result in the imposition of a fine of up to $500. Each day that records are not produced is considered a separate violation.

(5) Grievances that the agency determines pose an immediate and serious threat to a subscriber's health must be given priority over other grievances. The panel may meet at the call of the chair to hear the grievances as quickly as possible but no later than 45 days after the date the grievance is filed, unless the panel receives a waiver of the time requirement from the subscriber. The panel shall issue a written recommendation, supported by findings of fact, to the office or the agency within 10 days after hearing the expedited grievance.

(6) When the agency determines that the life of a subscriber is in imminent and emergent jeopardy, the chair of the panel may convene an emergency hearing, within 24 hours after notification to the managed care entity and to the subscriber, to hear the grievance. The grievance must be heard notwithstanding that the subscriber has not completed the internal grievance procedure of the managed care entity. The panel shall, upon hearing the grievance, issue a written emergency recommendation, supported by findings of fact, to the

managed care entity, to the subscriber, and to the agency or the office for the purpose of deferring the imminent and emergent jeopardy to the subscriber's life. Within 24 hours after receipt of the panel's emergency recommendation, the agency or office may issue an emergency order to the managed care entity. An emergency order remains in force until:

(a) The grievance has been resolved by the managed care entity;

(b) Medical intervention is no longer necessary; or

(c) The panel has conducted a full hearing under subsection (3) and issued a recommendation to the agency or the office, and the agency or office has issued a final order.

(7) After hearing a grievance, the panel shall make a recommendation to the agency or the office which may include specific actions the managed care entity must take to comply with state laws or rules regulating managed care entities.

(8) A managed care entity, subscriber, or provider that is affected by a panel recommendation may within 10 days after receipt of the panel's recommendation, or 72 hours after receipt of a recommendation in an expedited grievance, furnish to the agency or office written evidence in opposition to the recommendation or findings of fact of the panel.

(9) No later than 30 days after the issuance of the panel's recommendation and, for an expedited grievance, no later than 10 days after the issuance of the panel's recommendation, the agency or the office may adopt the panel's recommendation or findings of fact in a proposed order or an emergency order, as provided in chapter 120, which it shall issue to the managed

care entity. The agency or office may issue a proposed order or an emergency order, as provided in chapter 120, imposing fines or sanctions, including those contained in ss. 641.25 and 641.52. The agency or the office may reject all or part of the panel's recommendation. All fines collected under this subsection must be deposited into the Health Care Trust Fund.

(10) In determining any fine or sanction to be imposed, the agency and the office may consider the following factors:

(a) The severity of the noncompliance, including the probability that death or serious harm to the health or safety of the subscriber will result or has resulted, the severity of the actual or potential harm, and the extent to which provisions of chapter 641 were violated.

(b) Actions taken by the managed care entity to resolve or remedy any quality-of-care grievance.

(c) Any previous incidents of noncompliance by the managed care entity.

(d) Any other relevant factors the agency or office considers appropriate in a particular grievance.

(11)(a) The panel shall consist of the Insurance Consumer Advocate, or designee thereof, established by s. 627.0613; at least two members employed by the agency and at least two members employed by the department, chosen by their respective agencies; a consumer appointed by the Governor; a physician appointed by the Governor, as a standing member; and, if necessary, physicians who have expertise relevant to the case to be heard, on a rotating basis. The agency may contract with a medical director, a primary care physician, or both, who shall

provide additional technical expertise to the panel but shall not be voting members of the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida.

(b) A majority of those panel members required under paragraph (a) shall constitute a quorum for any meeting or hearing of the panel. A grievance may not be heard or voted upon at any panel meeting or hearing unless a quorum is present, except that a minority of the panel may adjourn a meeting or hearing until a quorum is present. A panel convened for the purpose of hearing a subscriber's grievance in accordance with subsections (2) and (3) shall not consist of more than 11 members.

(12) Every managed care entity shall submit a quarterly report to the agency, the office, and the department listing the number and the nature of all subscribers' and providers' grievances which have not been resolved to the satisfaction of the subscriber or provider after the subscriber or provider follows the entire internal grievance procedure of the managed care entity. The agency shall notify all subscribers and providers included in the quarterly reports of their right to file an unresolved grievance with the panel.

(13) A proposed order issued by the agency or office which only requires the managed care entity to take a specific action under subsection (7) is subject to a summary hearing in accordance with s. 120.574, unless all of the parties agree otherwise. If the managed care entity does not prevail at the hearing, the managed care entity must pay reasonable costs and

attorney's fees of the agency or the office incurred in that proceeding.

(14)(a) Any information that identifies a subscriber which is held by the panel, agency, or department pursuant to this section is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, at the request of a subscriber or managed care entity involved in a grievance procedure, the panel, agency, or department shall release information identifying the subscriber involved in the grievance procedure to the requesting subscriber or managed care entity.

(b) Meetings of the panel shall be open to the public unless the provider or subscriber whose grievance will be heard requests a closed meeting or the agency or the department determines that information which discloses the subscriber's medical treatment or history or information relating to internal risk management programs as defined in s. 641.55(5)(c), (6), and (8) may be revealed at the panel meeting, in which case that portion of the meeting during which a subscriber's medical treatment or history or internal risk management program information is discussed shall be exempt from the provisions of s. 286.011 and s. 24(b), Art. I of the State Constitution. All closed meetings shall be recorded by a certified court reporter.

(15) Effective May 1, 2012, this section applies only to plans that meet the requirements of 45 C.F.R. s. 147.140.

Section 55. 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 56. 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 57. 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)

(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 58. 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 59. Section 408.809, Florida Statutes, is amended to read:

408.809 Background screening; prohibited offenses.—

(1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435:

(a) The licensee, if an individual.

(b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider.

(c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider.

(d) Any person who is a controlling interest if the agency has reason to believe that such person has been convicted of any offense prohibited by s. 435.04. For each controlling interest

who has been convicted of any such offense, the licensee shall submit to the agency a description and explanation of the conviction at the time of license application.

(e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients. Evidence of contractor screening may be retained by the contractor's employer or the licensee.

(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g), the person must file a complete set of fingerprints with the agency and the agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal

Bureau of Investigation for a national criminal history record check. The fingerprints may be retained by the Department of Law Enforcement under s. 943.05(2)(g). The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. Proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 satisfies the requirements of this section if the person subject to screening has not been unemployed for more than 90 days and such proof is accompanied, under penalty of perjury, by an affidavit of compliance with the provisions of chapter 435 and this section using forms provided by the agency.

(3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to

this part or authorizing statutes must not have an arrest awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(g) Section 817.234, relating to false and fraudulent insurance claims.

(h) Section 817.505, relating to patient brokering.

(i) Section 817.568, relating to criminal use of personal identification information.

(j) Section 817.60, relating to obtaining a credit card through fraudulent means.

(k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(l) Section 831.01, relating to forgery.

(m) Section 831.02, relating to uttering forged instruments.

(n) Section 831.07, relating to forging bank bills,

checks, drafts, or promissory notes.

(o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(p) Section 831.30, relating to fraud in obtaining medicinal drugs.

(q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

(5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on July 31, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015, in accordance with the schedule provided in paragraphs (a)-(c). ~~The agency may adopt rules to establish a schedule to stagger the implementation of the required rescreening over the 5-year period, beginning July 31, 2010, through July 31, 2015.~~ If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be as follows:

(a) Individuals whose last screening was conducted before December 31, 2003, must be rescreened by July 31, 2013.

(b) Individuals whose last screening was conducted between January 1, 2004, through December 31, 2007, must be rescreened by July 31, 2014.

(c) Individuals whose last screening was conducted between January 1, 2008, through July 31, 2010, must be rescreened by July 31, 2015.

(6) ~~(5)~~ The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening.

(7) ~~(6)~~ (a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who:

1. Does not have an active professional license or certification from the Department of Health; or

2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification.

(b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that

department and that person is providing a service within the scope of his or her licensed or certified practice.

(8) ~~(7)~~ The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining fingerprints pursuant to s. 943.05(2).

(9) ~~(8)~~ There is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency.

Section 60. 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

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 61. 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 62. Subsections (1), (7), and (8) of section 409.91195, Florida Statutes, are amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.—There is created a Medicaid Pharmaceutical and

Therapeutics Committee within the agency for the purpose of developing a Medicaid preferred drug list.

(1) The committee shall be composed of 11 members appointed by the Governor, consisting of one member licensed under chapter 458 or chapter 459 nominated by the Florida Medical Association; one member licensed under chapter 459 nominated by the Florida Osteopathic Medical Association; one member licensed under chapter 458 or chapter 459 nominated by the Florida chapter of the American Academy of Family Physicians; one member licensed under chapter 458 or chapter 459 nominated by the Florida chapter of the American Academy of Pediatrics; one member licensed under chapter 458 or chapter 459 nominated by the Florida Psychiatric Society; one member licensed under chapter 465 nominated by the Florida Pharmacy Association; one member licensed under chapter 465 nominated by the Florida Society of Health System Pharmacists, Inc.; one member licensed under chapter 465 nominated by the Florida Retail Federation; one member licensed under chapter 465 who works in a retail setting for an independent, nonchain pharmacy; one member licensed under chapter 458 or chapter 459 nominated by the Florida Academy of Physician Assistants; and one member who represents a patient advocacy group and who shall be a consumer representative. All members of the committee, except the consumer representative, must be licensed to practice in the state, must practice in the state, and must participate in the Florida Medicaid fee-for-service pharmacy program. ~~Four members shall be physicians, licensed under chapter 458; one member licensed under chapter 459; five members shall be pharmacists~~

~~licensed under chapter 465; and one member shall be a consumer representative.~~ The members shall be appointed to serve for terms of 2 years after ~~from~~ the date of their appointment. Members may be appointed to no more than one term. ~~The agency shall serve as staff for the committee and assist them with all ministerial duties. The Governor shall ensure that at least some of the members of the committee represent Medicaid participating physicians and pharmacies serving all segments and diversity of the Medicaid population, and have experience in either developing or practicing under a preferred drug list. At least one of the members shall represent the interests of pharmaceutical manufacturers.~~

(7) The committee shall ensure that interested parties, including pharmaceutical manufacturers agreeing to provide a supplemental rebate as outlined in this chapter, have an opportunity to present public testimony to the committee with information or evidence supporting inclusion of a product on the preferred drug list. Such public testimony shall occur prior to any recommendations made by the committee for inclusion or exclusion from the preferred drug list, allow for members of the committee to ask questions of the presenters of the public testimony, and allow 3 minutes of testimony per drug reviewed. The number of interested parties providing public testimony may not be limited by the agency. Upon timely notice, the agency shall ensure that any drug that has been approved or had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the committee at the next regularly scheduled

meeting following 3 months of distribution of the drug to the general public.

(8) The committee shall develop its preferred drug list recommendations by considering the clinical efficacy, safety, and cost-effectiveness of a product. Whenever the agency does not follow a recommendation by the committee, it must notify the committee members in writing of its action at the next committee meeting after the reversal of the committee's recommendation.

Section 63. 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 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 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, 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 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:

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

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

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

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

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

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 authorization and 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 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 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 64. Paragraph (a) of subsection (4) of section 409.97, Florida Statutes, is amended to read:

409.97 State and local Medicaid partnerships.—

(4) HOSPITAL RATE DISTRIBUTION.—

(a) The agency is authorized to implement a tiered hospital rate system to enhance Medicaid payments to all hospitals when resources for the tiered rates are available from general revenue and such contributions pursuant to subsection (1) as are authorized under the General Appropriations Act.

1. Tier 1 hospitals are statutory rural hospitals as defined in s. 395.602, statutory teaching hospitals as defined in s. 408.07(45), and specialty children's hospitals as defined in s. 395.002(26) ~~s. 395.002(28)~~.

2. Tier 2 hospitals are community hospitals not included in Tier 1 that provided more than 9 percent of the hospital's total inpatient days to Medicaid patients and charity patients,

as defined in s. 409.911, and are located in the jurisdiction of a local funding source pursuant to subsection (1).

3. Tier 3 hospitals include all community hospitals.

Section 65. Paragraph (b) of 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.

(b) 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. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

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

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(26) ~~s. 395.002(28)~~.

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 equipment, and Prescribed Pediatric Extended Care.

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments 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 to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 66. (1) Notwithstanding s. 409.975, Florida Statutes, and before the selection of managed care plans using the invitations to negotiate pursuant to s. 409.966, Florida Statutes, essential providers and hospitals determined by the Agency for Health Care Administration to be necessary for a managed care plan to demonstrate that it has an adequate provider service network shall be deemed to be part of that managed care plan's network in their application for enrollment or expansion under the Medicaid program. Payment under this section to essential providers by managed care plans shall be in accordance with s. 409.975, Florida Statutes.

(2) This section shall take effect upon this act becoming a law.

Section 67. 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 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 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 68. Subsection (1) of section 429.294, Florida Statutes, is amended to read:

429.294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility within 10 days~~, in accordance with the provisions of s. 400.145,~~ shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

Section 69. 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 of an adult family-care home or to the care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the residents, other than class I violations~~. A class II violation is subject to an administrative fine in an amount not less than $250 and not

exceeding $500 for each violation. ~~A citation for a class II violation must specify the time within which the violation is required to be corrected. If a class II violation is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.~~

(c) Class III violations are defined in s. 408.813 ~~those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of residents, other than class I or class II violations~~. A class III violation is subject to an administrative fine in an amount not less than $100 and not exceeding $250 for each violation. ~~A citation for a class III violation shall specify the time within which the violation is required to be corrected.~~ If a class III violation is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated violation ~~offense~~.

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

violation.

(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 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 70. 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 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 71. 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 72. Subsection (3) of section 430.80, Florida Statutes, is amended to read:

430.80 Implementation of a teaching nursing home pilot project.—

(3) To be designated as a teaching nursing home, a nursing

home licensee must, at a minimum:

(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) ~~s. 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 organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized to receive deposits in this state. The letter of credit shall be used to satisfy the obligation of the facility to the claimant upon presentment of a final judgment indicating liability and awarding damages to be paid by the facility or upon presentment of a settlement agreement signed by all parties to the agreement when such final judgment or settlement is a result of a liability claim against the facility.

Section 73. 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) ~~s. 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 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 when such final judgment or settlement is a result of a liability claim against the agency.

Section 74. Paragraph (d) of subsection (9) of section 440.102, Florida Statutes, is repealed.

Section 75. 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 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 76. 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 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 77. Subsection (1) of section 483.245, Florida Statutes, is amended, and subsection (3) is added to that section, to read:

483.245 Rebates prohibited; penalties.—

(1) It is unlawful for any person to pay or receive any commission, bonus, kickback, or rebate or engage in any split-fee arrangement in any form whatsoever with any dialysis facility, physician, surgeon, organization, agency, or person, either directly or indirectly, for patients referred to a clinical laboratory licensed under this part. A clinical laboratory licensed under this part is prohibited from placing, directly or indirectly, through an independent staffing company or lease arrangement, or otherwise, a specimen collector or other personnel in any physician's office, unless the clinical lab and the physician's office are owned and operated by the same entity.

(3) Any person aggrieved by a violation of this section

may bring a civil action for appropriate relief, including an action for a declaratory judgment, injunctive relief, and actual damages.

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

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

Section 79. Effective May 1, 2012, section 641.3120, Florida Statutes, is created to read:

641.3120 External review of adverse benefit determinations.—The Office of Insurance Regulation shall adopt rules to implement the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act as amended in April 2010, which provides for independent, external review of a health insurer's denial of coverage for specific procedures or services.

Section 80. 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 641.3120, relating to external review of adverse benefit determinations, 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 policies issued under this part. This paragraph does not apply to plans subject to the Subscriber Assistance Program established under s. 408.7056.

Section 81. Effective May 1, 2012, section 627.6513, Florida Statutes, is created to read:

627.6513 Internal grievance procedure applicability.—Section 641.3120, relating to external review of adverse benefit determinations, 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 policies issued under this part. This paragraph does not apply to plans subject to the Subscriber Assistance Program established under s. 408.7056.

Section 82. 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)1.d ~~s. 400.141(1)(o)1.d~~.

Section 83. 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 84. In the interim between this act becoming law and the 2013 Regular Session of the Legislature, the Division of Statutory Revision shall provide the relevant substantive committees of the Senate and the House of Representatives with assistance, upon request, to enable such committees to prepare draft legislation to correct the names of accrediting organizations in the related Florida Statutes.

Section 85. Except as otherwise expressly provided in this act, and except for this section and section 84, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2012.