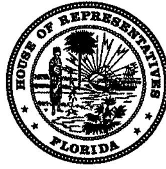
Health Care Regulation Policy Committee

Wednesday, March 31, 2010
11:00 AM – 11:45 AM
Morris Hall (17 HOB)

MEETING PACKET

Larry Cretul
Speaker

Nick Thompson
Chair



The Florida House of Representatives

Health Care Regulation Policy Committee

AGENDA

March 31, 2010
11:00 AM - 11:45 AM
Morris Hall (17 HOB)

I. Opening Remarks by Chair Thompson

II. Consideration of the following bill(s):

HB 7 Coverage for Mental and Nervous Disorders by Rep. Homan

HB 509 Blood Establishments by Rep. Tobia

HB 715 Health Services Claims by Rep. Patronis

HB 1503 Health Care by Rep. Flores

III. Closing Remarks by Chair

IV. Adjournment

HB 7

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7 Coverage for Mental and Nervous Disorders
SPONSOR(S): Homan and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 182

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Policy Committee		Shaw	Calamas
2) Insurance, Business & Financial Affairs Policy Committee			
3) Government Operations Appropriations Committee			
4) General Government Policy Council			
5)			

SUMMARY ANALYSIS

Section 627.668, F.S., regulates the provision of mental and nervous disorder services by insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations providing group health insurance or prepaid health care. Specifically, these entities must make mental and nervous disorder services available to a policyholder for an additional premium; however, these services do not have to be the same as those offered for physical illness. Florida mandates mental and nervous disorder coverage, but does not mandate parity of coverage.

House Bill 7 amends s. 627.668, F.S., to impose a mandated health insurance offering for the care and treatment of schizophrenia and psychotic disorders, mood disorders, anxiety disorders, substance abuse disorders, eating disorders, and childhood ADD/ADHD at full parity with coverage offered for physical illness. The bill maintains the partial parity of current law with respect to all other mental disorders, but with increased benefits as follows:

- The limit on inpatient benefits is increased from 30 to 45 days per benefit year;
- The limit on outpatient benefits is changed from $1,000 per year to 60 visits per year for consultations with a physician, psychologist, mental health counselor, marriage and family therapist, and a clinical social worker; and
- The limit on partial hospitalization services, or a combination of inpatient and partial hospitalization services, is increased from the cost of 30 days to 45 days of inpatient hospitalization for psychiatric services, including physician fees.

The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 presently requires large group insurers to provide mental and nervous disorder parity; therefore, it appears the provisions of HB 7 allowing partial parity for certain conditions will only apply to small group insurers.

The Department of Management Services states that the state's group health insurance plans are in compliance with federal law; therefore, the bill will have no additional fiscal impact on the state employee plans.

The bill has an effective date of January 1, 2011, and shall apply to policies and contracts issued or renewed on or after that date.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Regulation of Health Plans

Health plans are regulated at both the state and federal level. At the federal level, the Employee Retirement Income and Security Act (ERISA) regulates the operation of voluntary employer-sponsored benefits including pension plans and health plans. Congress also has enacted several laws that regulate the operation of all health benefits regardless of the method insurance including the Health Insurance Portability and Accountability Act of 1996; the Newborns' and Mothers' Health Protection Act of 1996; the Mental Health Parity Act of 1996; and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. ERISA provides an explicit exemption from state regulation for health plans that are self-funded. State regulations apply to health benefits purchased through private health insurance plans and health maintenance organizations (HMOs).

Health Insurance Mandates and Mandated Offerings

A health insurance mandate is a legal requirement that an insurance company or health plan cover services by particular health care providers, specific benefits, or specific patient groups.

Mandated offerings, on the other hand, do not mandate that certain benefits be provided. Rather, a mandated offering law can require that insurers offer an option for coverage for a particular benefit or specific patient groups, which may require a higher premium and which the insured is free to accept or reject. A mandated offering law in the context of mental health can: require that insurers offer an option of coverage for mental illness, which may require a higher premium and which the insured is free to accept or reject; or, require that if insurers offer mental illness coverage, the benefits must be equivalent to other types of benefits.

Florida currently has at least 52 mandates.[1] The Council for Affordable Health Insurance estimates that mandated benefits currently increase the cost of basic health coverage from a little less than 20 percent to perhaps 50 percent, depending on the number of mandates, the benefit design and the cost of the

[1] Office of Insurance Regulation list of state health insurance mandates on file with Health Care Regulation Policy Committee staff; and "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance; *available* at: http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf. (last viewed March 9, 2010)

initial premium.[2] Each mandate adds to the cost of a plan's premiums, in a range of less than 1 percent to 10 percent, depending on the mandate.[3] Higher costs resulting from mandates are most likely to be experienced in the small group market since these are the plans that are subject to state regulations. The national average cost of insurance for a family of four is $13,375.[4]

Mental Health Parity

Parity in mental health coverage generally refers to equivalent benefits and limits for mental illness as compared to medical and surgical benefits. According to the United States General Accounting Office, most private health insurance plans limit mental health coverage in three areas:

- Lower annual or lifetime dollar limits;
- Lower service limits, including number of covered hospital days or outpatient office visits; and
- Higher cost-sharing for mental health benefits.

According to the National Conference of State Legislators, 49 states currently regulate the provision of mental health services in three categories:

- Mental health parity;
- Minimum mental health benefits; and
- Mandated mental health offering. [5]

As of 2009, a majority of states now provide a variety of forms of mental health parity.[6]

Mental Health and Substance Abuse Coverage in Florida

Section 627.668, F.S., regulates the provision of mental and nervous disorder services by insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations providing group health insurance or prepaid health care. Specifically, these entities must make mental and nervous disorder services available to a policyholder for an additional premium. Florida's law is a mandated offering law.

Mental health services must generally include the "necessary care and treatment of mental and nervous disorders, as defined in the standard nomenclature of the American Psychiatric Association."

The Florida mandated offering does not provide full mental health parity.[7] With regard to group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits with durational limits, any dollar amounts deductibles and coinsurance factors may not be "less favorable" than those for treatment of physical illness. However, Florida law creates exceptions to parity. Such policies may limit mental and nervous disorder benefits as follows:

- Inpatient benefits may be limited to 30 days per benefit year;

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[2] "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance; *available* at: http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf. (last viewed March 9, 2010)

[3] *Id.*

[4] Kaiser Family Foundation, Employer Health Benefits 2009 Annual Survey, *available* at: http://ehbs.kff.org/?CFID=20695941&CFTOKEN=84763322&jsessionid=6030bac21268c605c7863526585a397e6175 (last viewed March 9, 2010).

[5] National Conference of State Legislators, State Laws Mandating or Regulating Mental Health Benefits, February 2009; reposted with additions February 11, 2010, available at http://www.ncsl.org/programs/health/mentalben.htm.

[6] *Id.*

[7] Prior Florida law imposed a limited mental health parity mandated offering. Section 627.6685, F.S., required parity between mental health benefits and medical/surgical benefits as to lifetime limits and annual limits, if any. The parity requirement expressly did not apply to other terms and conditions, such as cost-sharing, visits or days limits, medical necessity requirements and limits on amount, duration and scope of mental health benefits. The statute did not apply to benefits offered after September 2001, and was repealed in 2005. S. 627.6685(5), F.S.; Ch. 2005-2, § 119, Laws of Florida.

- Outpatient benefits may be limited to $1,000 for consultations with a physician, psychologist, mental health counselor, marriage and family therapist, and a clinical social worker;
- Partial hospitalization benefits must be provided under the direction of a physician, including services offered by a program accredited by the Joint Commission such as alcohol rehabilitation and licensed drug abuse rehabilitation; and
- Partial hospitalization services, or a combination of inpatient and partial hospitalization services, are limited to the cost of 30 days of inpatient hospitalization for psychiatric services, including physician fees.

Section 627.669, F.S., regulates the provision of substance abuse services by insurers, HMOs, and nonprofit health care services plans providing group health insurance or prepaid hospital and medical service plan corporations providing group health insurance or prepaid health care. Specifically, these entities must make substance abuse services available to a policyholder. Florida's law is a mandated offering law.

The substance abuse mandated offering does not provide any form of parity with other kinds of coverage. Rather, it requires coverage entities to provide a specific level of benefits, subject to the group policyholder's right to select alternative benefits or level of benefits offered, as follows:

- Minimum lifetime benefit of $2,000
- Outpatient visits may be limited to a maximum of 44
- The benefit payable for an outpatient visit shall not exceed $35
- Detoxification shall not be considered an outpatient benefit

Mental Health Parity and Addiction Equity Act

On October 2, 2008, President George W. Bush signed into law H.R. 1424, which contains the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Act). The Act applies to employer-sponsored ERISA group health plans and large group health insurance plans. The Act will preempt all state laws that apply to the same group health insurance policies (large group plans) while allowing for state laws that expand upon the federal mandate. Any state parity legislation regarding group health insurance will only apply to small group health insurance (2-50 employees) and large group health insurance to the extent that the state act expands the benefits provided under the Act.

Pursuant to the Act, a group health plan that provides medical and surgical benefits and offers benefits for the treatment of mental health conditions or substance abuse must apply financial requirements and treatment limitations to mental health disorders and substance abuse that are no more restrictive than those predominantly applied to medical and surgical benefits under the policy. Parity with regard to financial requirements includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but not annual and lifetime limits. Parity with regard to treatment limitations includes limits on treatment frequency, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Annual and lifetime coverage limits for mental health benefits must be equivalent to the limits on substantially all medical and surgical benefits; if no limit is applied to medical and surgical benefits then a limit may not be applied to mental health benefits. Additionally, out-of-network benefits for mental health and substance abuse treatment must be provided on par with out-of-network medical and surgical benefits.

The Act does not specify a set of mental health benefits that must be provided. Instead, the Act requires that benefits for mental health and substance abuse be defined under the terms of the health care plan, in accordance with applicable state and federal law. As discussed above, current Florida law requires an offer of coverage for mental and nervous disorders as defined by the standard nomenclature of the American Psychiatric Association (APA) subject to the right of the applicant for a group policy or contract to select any alternative benefits or level of benefits as may be offered. Thus, insurers must offer a policy covering all conditions defined by the APA, but may also offer policies that provide benefits for a greater or lesser number of conditions, so long as the benefits are provided in accordance with the minimum limits contained in statute.

It appears that under the Act, in Florida a large group health plan will have to offer a coverage plan providing coverage for mental and nervous disorders as defined by the standard nomenclature of the APA and that meets the requirements of the federal parity law. Alternative coverage plans may also be offered pursuant to Florida law, but such coverage would have to provide benefits in conformity with the federal parity mandate.

The Act exempts employers that have an average of between two and 50 employees (small groups). The Act also exempts health plans if application of parity for benefits results in a 2 percent or greater increase in total plan costs for the first year parity is applied, and an increase of 1 percent or greater in subsequent plan years. To qualify for an exemption, the determination that plan costs exceed the applicable percentage must be made in a written report by a qualified and licensed actuary that is a member in good standing of the American Academy of Actuaries. If an insurer or group health plan claims an exemption it must notify federal and state regulators, as well as plan participants and beneficiaries. Federal and state regulators both are authorized to conduct an audit of the books, records, and actuarial reports of a group health plan or insurer claiming an exemption.

Cost of Mental Health Parity

Many studies have examined the effect of mental health parity laws on the cost of health care coverage, with varying results. Recognizing these differing results, the Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services designed a study to analyze the costs of parity.[8] At the time of the study most states had parity laws that were limited to serious mental illnesses and did not include substance abuse, small plans, or government employees. The study found that these types of plans with tightly managed care have a small effect on premiums; however, plans with full parity for mental health and substance abuse increased premiums by an average of 3.6 percent.[9]

The Office of the Insurance Commissioner for the State of West Virginia examined mental health parity in that state. The Office found four of 31 insurance companies experienced significant increases in the cost of providing mental health benefits (100 percent, 90 percent or 80 percent) as a result of parity. These companies represented less than 5 percent of the market; other companies experienced small or no increases.[10] West Virginia's parity provisions contain authority for plans to use additional cost containment measures if parity would result in a premium cost increase of 2 percent or more. Some insurers incurred such increased costs, but none exercised their option to use additional cost containment measures.[11] Similarly, the Mental Health Parity Act of 1996[12] contained an exemption for plans that would incur a premium cost increase of at least 1 percent as a result of parity.

One study analyzed the impact of mental health parity in an unnamed state on a large employer group.[13] That study looked at a fee for service insurer which responded to a state parity mandate by instituting a managed care carve-out for those services. In a managed care carve-out, the insurer carves out the mental health benefits and manages them separately from the physical benefits, perhaps by contracting with a behavioral managed care company to perform that service. The insurer in the study used network management, prior authorization and concurrent utilization review to manage the mental health benefits. The study found that while costs were expected to increase substantially as a result of a state parity mandate, costs actually declined, as a result of managed care techniques. While treatment prevalence rose 50 percent, per member plan costs declined almost 40 percent. The study found this was primarily due to reduced lengths of stay for inpatient treatment, attributable to the managed care carve-out. The study concluded that the increased case management offset the costs of

[8] Merrile Sing, et al, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, DHHS Publication No. MC99-80 (1998), Substance Abuse and Mental Health Services Administration, available at http://mentalhealth.samhsa.gov/publications/allpubs/Mc99%2D80/Prtyfnix.asp.
[9] Id.
[10] Office of the Insurance Commissioner, State of West Virginia, Mental Health Parity Analysis Report, December 2006.
[11] Id.
[12] The Act was in effect at the time of the study, but expired December 31, 2007.
[13] See Samuel H. Zuvekas, et al, The Impacts of Mental Health Parity and Managed Care In One Large Employer Group, 21 *Health Affairs* 3 (2002).

parity's increased benefits. This study looked at a large employer group with over 100,000 enrollees. Smaller group plans will likely experience parity differently.

SAMHSA studied the effect of a parity law for both mental health and substance abuse in Vermont.[14] For one plan, spending for mental health and substance abuse services increased 4 percent; for the other plan, which utilized managed care to achieve the purposes of the parity requirement, spending for those services decreased 9 percent. Consumers' share in spending dropped as well. The SAMHSA study found while more people received outpatient mental health services under parity, fewer people received any substance abuse services. The Vermont statute specifically authorized a managed care carve-out.[15] Significantly, the SAMHSA study found that managed care for these services was an important factor in controlling the costs of parity.

The Maryland Health Care Commissioner produced a report finding that Maryland's mental health and substance abuse mandate was the most expensive mandate imposed on insurers, with a cost ranging from 4.9 percent to 6.6 percent of the premium.[16] The Commissioner found parity was the second most expensive mandate on a marginal cost basis (after IVF), and noted that the actual cost varies based on the level of managed care or whether a managed care carve-out is used.[17] Older data on Maryland found parity raised costs .6 percent, which was attributed to high levels of managed care.[18]

The staff of the Senate Banking and Insurance Committee issued an interim project report, The Effect of Mandating Coverage for Mental and Nervous Disorders (Florida Senate Interim Project 2008-103). After distinguishing between mandated offers and mandated coverage, Senate staff recommended that group insurers and HMOs be required to offer coverage for mental and nervous disorders that is on par with benefits for physical illness, and that any benefit limitations should not be more restrictive than those applied to medical and surgical benefits under the plan. However, the recommendation was to limit this parity requirement to biologically-based mental and nervous disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of the American Psychological Association, including, or specifically limited to, schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, and obsessive-compulsive disorder.[19] For mental and nervous disorders not covered in this category or not specifically listed in statute, the current requirements of ss. 627.668 and 627.669, F.S., should continue to apply, which allow for specified benefit limitations.

The Senate interim project report also recommended a cost exemption that would exempt group plans from the requirement of offering full parity if such coverage would result in a cost increase over a specified percentage. If the exemption applied, then the current requirements and allowable benefit limitations of ss. 627.668, F.S., would apply to all mental and nervous disorders, as defined in the standard nomenclature of the American Psychiatric Association.

Health Insurance Mandate Report

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[14] See Margo Rosenbach, et al, Effects of the Vermont Mental Health and Substance Abuse Parity Law, DHHS Pub. No. (SMA) 03-3822 (2003), Substance Abuse and Mental Health Services Administration, available at http://mentalhealth.samhsa.gov/publications/allpubs/sma03-3822/default.asp.

[15] See 8 V.S.A. § 4089b (2008).

[16] Maryland Health Commission, Study of Mandated Health Insurance Services: A Comparative Evaluation, January 2008, available at http://mhcc.maryland.gov/health_insurance/required_benefits.html.

[17] Id. Maryland's parity statute specifically authorizes the use of managed care. MD Code, Insurance, § 15-802 (2008).

[18] Bruce Lubotsky Levin, Dr.P.H., et al, Mental Health Parity: National and State Perspectives 1999, Louis de la Parte Florida Mental Health Institute and College of Public Health University of South Florida, available at www.fmhi.usf.edu/institute/pubs/pdf/parity/parity1999.pdf.

[19] The Diagnostic and Statistics Manual of the American Psychiatric Association (DSM) includes universally accepted definitions and descriptions of mental illnesses and conditions. There are 13 DSM diagnoses commonly referred to as biologically-based mental illnesses by mental health providers and consumer organizations. Between 3 and 13 of these diagnoses are referred to in various state parity laws. For example, in Alabama, mental illness is defined as: 1) schizophrenia, schizophrenia form disorder, schizo-affective disorder; 2) bipolar disorder; 3) panic disorder; 4) obsessive-compulsive disorder; 5) major depressive disorder; 6) anxiety disorders; 7) mood disorders; 8) Any condition or disorder involving mental illness, excluding alcohol and substance abuse, that falls under any of the diagnostic categories listed in the mental disorders section of the International Classification of Disease, as periodically revised. See, "State Laws Mandating or Regulating Mental Health Benefits," National Conference of State Legislatures, February 2009; reposted with additions February 11, 2010, available at http://www.ncsl.org/programs/health/mentalben.htm.

Florida enacted section 624.215, F.S., to take into account the impact of insurance mandates and mandated offerings on premiums when making policy decisions. That section requires that any proposal for legislation that mandates health benefit coverage or mandatorily offered health coverage must be submitted with a report to AHCA and the legislative committee having jurisdictions. The report must assess the social and financial impact of the proposed coverage to the extent information is available, shall include:

- To what extent is the treatment or service generally used by a significant portion of the population.[20]
- To what extent is the insurance coverage generally available.[21]
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.[22]
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.[23]
- The level of public demand for the treatment or service.[24]
- The level of public demand for insurance coverage of the treatment or service.[25]
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.[26]
- To what extent will the coverage increase or decrease the cost of the treatment or service.[27]
- To what extent will the coverage increase the appropriate uses of the treatment or service.[28]
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.[29]
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.[30]
- The impact of this coverage on the total cost of health care.[31]

Effects of the Bill

House Bill 7 amends s. 627.668, F.S., to impose a mandated offering for the care and treatment of schizophrenia and psychotic disorders, mood disorders, anxiety disorders, substance abuse disorders, eating disorders, and childhood ADD/ADHD at full parity with coverage offered for physical illness.

The bill maintains the partial parity of current law with respect to all other mental disorders, but with increased benefits as follows:

- The limit on inpatient benefits is increased from 30 to 45 days per benefit year;
- The limit on outpatient benefits is changed from $1,000 per year to 60 visits per year for consultations with a physician, psychologist, mental health counselor, marriage and family therapist, and a clinical social worker; and

[20] s. 624.215(2)(a), F.S.
[21] s. 624.215(2)(b), F.S.
[22] s. 624.215(2)(c), F.S.
[23] s. 624.215(2)(d), F.S.
[24] s. 624.215(2)(e), F.S.
[25] s. 624.215(2)(f), F.S.
[26] s. 624.215(2)(g), F.S.
[27] s. 624.215(2)(h), F.S.
[28] s. 624.215(2)(i), F.S.
[29] s. 624.215(2)(j), F.S.
[30] s. 624.215(2)(k), F.S.
[31] s. 624.215(2)(l), F.S.

- The limit on partial hospitalization services, or a combination of inpatient and partial hospitalization services, is increased from the cost of 30 days to 45 days of inpatient hospitalization for psychiatric services, including physician fees.

It appears that the provisions of the bill providing partial parity for certain conditions will only apply to small group insurers since the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires large group insurers to provide full parity.

Current law refers to mental and nervous disorders "as defined by standard nomenclature of the American Psychiatric Association." The bill replaces "standard nomenclature" with a specific reference to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)[32] published by the American Psychiatric Association. The DSM lists the conditions that qualify as mental disorders and contains various diagnostic criteria that a person must meet in order to have a particular diagnosis applied to him or her.

The bill states an insurer or HMO may impose financial incentives, peer review, utilization requirements, and other methods used for the management of benefits provided for other medical conditions in order to reduce service costs and utilization without compromising quality of care.

The bill provides an exemption for a group health plan or insurance provided in connection with a group health plan if the mandated care causes an increase in plan costs of more than 2 percent. The determination of the plan cost increase must be certified by an independent actuary to the Office of Insurance Regulation. This provision will exempt a plan from all the requirements of the section, not only the parity requirements.

The bill repeals s. 627.669, F.S., which currently requires insurers and HMOs to offer optional coverage for the treatment of substance abuse within group health insurance or prepaid health care plans. Instead, the bill requires an offer of coverage for mental and nervous disorders that includes treatment of substance abuse disorders that is on-par with coverage generally provided under the policy for physical illness.

The bill provides that the mandated care for mental and nervous disorders also apply to state group insurance policies.

The Health Insurance Mandate Report

The health insurance mandate report[33], dated February 2, 2010, was submitted by the bill sponsor to the Health Regulation Policy Committee. Section 624.215, F.S., provides that the report must assess the social and financial impacts of "the proposed coverage." The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 mandates parity of coverage for mental and nervous disorders for large group insurers, thus, the "proposed converge" would be primarily for small group insurers. Many of the responses submitted in the report appear to be an assessment of the social and financial impacts of mental illness rather than of the effect of the specific insurance coverage proposed by the bill.

The report provided a response to each provision of s. 624.215, F.S.[34]

Extent to which the treatment or service generally used by a significant portion of the population.[35]

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[32] Available at: http://allpsych.com/disorders/dsm.html

[33] The health insurance mandate report is on file with Health Care Regulation Policy Committee staff.

[34] The report itself provides no citation to any supporting data, report, or study. Reference materials were attached to the report and the report noted that more information could be found at www.edhoman.com. Staff reviewed the attached material and information on the website in an attempt to find the appropriate reference to the assertions in the report.

[35] s. 624.215(2)(a), F.S.

The proponent states the following: "22% at some time during their lifespan and by 10% on any given day according to published research."

These statistics appear to be the portion of the population that have mental or substance abuse disorders rather than the extent to which the treatment or service is generally used.

Extent to which the insurance coverage is generally available.[36]

The proponent states the following: "either not available or at a restricted amount according to statute."

No documentation was provided supporting this assertion. Federal law currently mandates parity of coverage for large group insurers and Florida law currently mandates that more limited coverage be offered.

Extent to which the lack of insurance coverage results in persons avoiding necessary health care treatment, if insurance coverage is not generally available.[37]

The proponent states the following: "significantly under treated at great social expense."

In the supporting documentation, the proponent references a study published in 2001 using data collected from respondents to a 1996 survey. The study concludes that even among those with the most serious and impairing mental illness, only 25 percent received guideline-concordant treatment.[38] Predictors of receiving guideline-concordant care included being white, female, severely ill, and having mental health insurance coverage.[39] It is unclear if the results of this study can be extrapolated to Florida today since the study was conducted before the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which made mental health coverage widely available.

Extent to which insurance coverage is generally not available and results in an unreasonable financial hardship.[40]

The proponent states the following: "Significant rates of unemployment and under employment. A very large percentage of incarcerated people have mental illness creating a financial hardship for themselves and for society. The mental hospitals of the past nave a new name – prisons."

No documentation was provided linking lack of availability of insurance to unemployment, under employment, or incarceration. Federal law currently mandates parity of coverage for large group insurers and Florida law currently mandates that more limited coverage be offered.

The level of public demand for the treatment or service.[41]

The proponent states the following: "46 other states and Congress have passed "parity" legislation".

Florida presently mandates an offering of coverage for mental and nervous disorders and Florida insurers are subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. No documentation was provided to support demand for more treatment or services than what is presently available.

The level of public demand for insurance coverage of the treatment or service.[42]

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[36] s. 624.215(2)(b), F.S.
[37] s. 624.215(2)(c), F.S.
[38] Wang, et. Al, *Recent Care of Common Mental Disorders in the United States*, Journal of General Internal Medicine, Volume 15 Issue 5, Pages 284 – 292 (2001) Available at: http://www3.interscience.wiley.com/journal/120137964/abstract
[39] Id.
[40] s. 624.215(2)(d), F.S.
[41] s. 624.215(2)(e), F.S.

The proponent states the following: "26%. The only more common disease is hypertension at 35% of the adult population."

These appears to be statistics on the prevalence of mental disorders in the adult population rather than as assessment of the level of public demand for insurance coverage for the treatment or service. No documentation was provided to support demand for coverage broader than what is presently available..

The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.[43]

Insufficient documentation was provided to determine the interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts. Since Florida insurers are subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 it is unlikely that collective bargaining would be necessary for inclusion of mental and nervous disorders in most group contracts.

Extent to which the coverage increases or decreases the cost of the treatment or service.[44]

The proponent states the following: "Treating mental illness will lower the costs of treating the costs of accompanying medical illness."

A study of the Federal Employees Health Benefits Program found that mental health parity reduced the out of pocket expenses of those employees who took advantage of the benefits; however, having coverage did not significantly increase the use of the benefits.[45] Consequently, the study concluded that when coupled with care management, implementation of parity in insurance benefits for behavioral health care can "improve insurance protection without increasing total costs."

Extent to which the coverage increases the appropriate uses of the treatment or service.[46]

The proponent states the following: "Covering specialty psychiatric care and medication will improve both mental and physical health."

The proponent provides documentation which quotes a benefits guide for federal employees which states "adequate mental health and substance abuse benefits coverage has been shown to improve patient health, provide patients with greater financial protection against unforeseen costs, and to reduce work place absences and employee disabilities."[47]

Extent to which the mandated treatment or service be a substitute for a more expensive treatment or service.[48]

The proponent states the following: "Hospitalization for mental "breakdowns" is exceedingly more expensive than medication to prevent such events. Decreases in "absenteeism" and "presenteeism" at work also pay for mental illness treatment many times over."

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[42] s. 624.215(2)(f), F.S.
[43] s. 624.215(2)(g), F.S.
[44] s. 624.215(2)(h), F.S.
[45] Goldman, Frank, et. al., *Behavioral Health Insurance Parity for Federal Employees*, N Engl J Med 2006 354: 137-1386;
[46] s. 624.215(2)(i), F.S.
[47] Federal Employee Health Benefits Program guide available at:
http://www.opm.gov/insure/archive/health/consumers/parity/faq.asp#3 (last viewed on March 24, 2010)
[48] s. 624.215(2)(j), F.S.

Extent to which the coverage increases or decreases the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.[49]

The proponent states the following: "Minimal as experienced by national health care companies like Cigna, United, and Aetna. These companies already do this is 46 other states."

The documentation provided related to the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. No documentation was provided that related to the proposed coverage.

The impact of this coverage on the total cost of health care.[50]

The proponent states the following: "The experience documented by other states is that health care insurance premiums increased by less than 1% in the group market and less than 2% in the individual market."

See discussion above, Cost of Mental Health Parity.

The bill takes effect January 1, 2011, and shall apply to policies and contracts issued or renewed on or after that date.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.668, F.S., relating to optional coverage for mental and nervous disorders required.
Section 2: Amends s. 627.6675, F.S., relating to conversion on termination of eligibility.
Section 3: Repeals s. 627.669, F.S., relating to optional coverage required for substance abuse impaired persons.
Section 4: Provides the bill shall take effect January 1, 2011, and shall apply to policies and contracts issued or renewed on or after that date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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[49] s. 624.215(2)(k), F.S.
[50] s. 624.215(2)(l), F.S.

The bill requires all small and large group health insurance plans governed by Florida law to offer coverage for mental and nervous disorders and substance abuse. The impact of the bill will be greater on small groups. The recently passed federal parity act applies only to large groups; small group health plans currently need only comply with the state law requiring an offer coverage, which does not require full parity of coverage. Thus, even though the bill applies equally to large and small groups, the increase in benefits will have a greater impact on small groups. Employers purchasing small group insurance may incur additional costs through increased utilization and claims costs. Any increased costs will likely be passed through to policyholders in the form of increased premiums.

D. FISCAL COMMENTS:

The Department of Management Services states that since the state's group health insurance plans are in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 there will be no additional fiscal impacts related to the bill.

The Office of Insurance Regulation states that the review and approval of new policy forms and contracts needed to implement the bill will increase the workload of the OIR's Life and Health Product Review (LHPR) staff; however, it is expected that the increase in workload can be absorbed within current resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None; however, the Office of Insurance Regulation is concerned that it may have difficulty implementing the bill without specific rulemaking authority.[51]

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Office of Insurance Regulation notes the following technical concerns:[52]

- The Insurance Code does not govern the state group health insurance program – even by narrative cross-reference. Technically correct drafting would dictate that the benefit requirements proposed in this legislation be either replicated within Chapter 110 or at the very minimum, be established by cross reference in those Chapter 110 statutes governing the State Employee Health Insurance Plan.
- [The bill] inserts standards for insurer business practices ("financial incentives," other methods", "quality of care") that are not otherwise defined or governed within the Insurance Code. Quality of care for medical services provided by an HMO is regulated by the Agency for Health Care Administration. Violations of a standard of care by a provider under contract to an insurer are likely to be governed by that practitioner's/facility's licensing board.
- The Office notes the proposal does contain some level of ambiguity related to the "2% trigger" – i.e., it may be more appropriate to further define "increase in costs" to reference experience rating factors, total claims costs or other factors more precisely related to claims expense related to this required benefit.

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[51] Office of Insurance Regulation, 2010 Bill Analysis of HB 7, on file with the Health Regulation Policy Committee.
[52] *Id.*

- The HMO conversion statute s. 641.3922(8) will need to be amended to reference s. 627.668.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to coverage for mental and nervous
3 disorders; amending s. 627.668, F.S.; revising
4 requirements and limitations for optional coverage for
5 mental and nervous disorders; specifying nonapplication
6 under certain circumstances; amending s. 627.6675, F.S.;
7 conforming a cross-reference; repealing s. 627.669, F.S.,
8 relating to optional coverage required for substance abuse
9 impaired persons; providing for application; providing an
10 effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Section 627.668, Florida Statutes, is amended
15 to read:
16 627.668 Optional coverage for mental and nervous disorders
17 required; exception.--
18 (1) Every insurer, health maintenance organization, and
19 nonprofit hospital and medical service plan corporation
20 transacting group health insurance or providing prepaid health
21 care in this state shall make available to the policyholder as
22 part of the application, for an appropriate additional premium
23 under a group hospital and medical expense-incurred insurance
24 policy, under a group prepaid health care contract, and under a
25 group hospital and medical service plan contract, the benefits
26 or level of benefits specified in subsections ~~subsection~~ (2) and
27 (3) for the necessary care and treatment of mental and nervous
28 disorders, as defined in the most recent edition of the

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 Diagnostic and Statistical Manual of Mental Disorders published
30 by ~~standard nomenclature of~~ the American Psychiatric
31 Association, subject to the right of the applicant for a group
32 policy or contract to select any alternative benefits or level
33 of benefits as may be offered by the insurer, health maintenance
34 organization, or service plan corporation, provided that, if
35 alternate inpatient, outpatient, or partial hospitalization
36 benefits are selected, such benefits shall not be less than the
37 level of benefits required under subsections (2) and (3)
38 ~~paragraph (2)(a), paragraph (2)(b), or paragraph (2)(c),~~
39 ~~respectively~~. With respect to the state group insurance program,
40 the term "policyholder" means the State of Florida.
41 (2) Under group policies or contracts, inpatient hospital
42 benefits, partial hospitalization benefits, and outpatient
43 benefits consisting of durational limits, dollar amounts,
44 deductibles, and coinsurance factors shall not be less favorable
45 than for physical illness generally for the necessary care and
46 treatment of schizophrenia and psychotic disorders, mood
47 disorders, anxiety disorders, substance abuse disorders, eating
48 disorders, and childhood ADD/ADHD.
49 (3)~~(2)~~ Under group policies or contracts, inpatient
50 hospital benefits, partial hospitalization benefits, and
51 outpatient benefits for mental health disorders not listed in
52 subsection (2) ~~consisting of durational limits, dollar amounts,~~
53 ~~deductibles, and coinsurance factors~~ shall not be less favorable
54 than for physical illness generally, except that:
55 (a) Inpatient benefits may be limited to not less than 45
56 ~~30~~ days per benefit year as defined in the policy or contract.

57 If inpatient hospital benefits are provided beyond 45 ~~30~~ days
58 per benefit year, the durational limits, dollar amounts, and
59 coinsurance factors thereto need not be the same as applicable
60 to physical illness generally.
61 (b) Outpatient benefits may be limited to 60 visits per
62 benefit year ~~$1,000~~ for consultations with a licensed physician,
63 a psychologist licensed pursuant to chapter 490, a mental health
64 counselor licensed pursuant to chapter 491, a marriage and
65 family therapist licensed pursuant to chapter 491, and a
66 clinical social worker licensed pursuant to chapter 491. If
67 benefits are provided beyond the 60 visits ~~$1,000~~ per benefit
68 year, the durational limits, dollar amounts, and coinsurance
69 factors thereof need not be the same as applicable to physical
70 illness generally.
71 (c) Partial hospitalization benefits shall be provided
72 under the direction of a licensed physician. For purposes of
73 this part, the term "partial hospitalization services" is
74 defined as those services offered by a program accredited by the
75 Joint Commission on Accreditation of Hospitals (JCAH) or in
76 compliance with equivalent standards. Alcohol rehabilitation
77 programs accredited by the Joint Commission on Accreditation of
78 Hospitals or approved by the state and licensed drug abuse
79 rehabilitation programs shall also be qualified providers under
80 this section. In any benefit year, if partial hospitalization
81 services or a combination of inpatient and partial
82 hospitalization are utilized, the total benefits paid for all
83 such services shall not exceed the cost of 45 ~~30~~ days of
84 inpatient hospitalization for psychiatric services, including

85 physician fees, which prevail in the community in which the
86 partial hospitalization services are rendered. If partial
87 hospitalization services benefits are provided beyond the limits
88 set forth in this paragraph, the durational limits, dollar
89 amounts, and coinsurance factors thereof need not be the same as
90 those applicable to physical illness generally.
91 (4) In providing the benefits under this section, the
92 insurer or health maintenance organization may impose
93 appropriate financial incentives, peer review, utilization
94 requirements, and other methods used for the management of
95 benefits provided for other medical conditions, to reduce
96 service costs and utilization without compromising quality of
97 care.
98 (5) ~~(3)~~ Insurers must maintain strict confidentiality
99 regarding psychiatric and psychotherapeutic records submitted to
100 an insurer for the purpose of reviewing a claim for benefits
101 payable under this section. These records submitted to an
102 insurer are subject to the limitations of s. 456.057, relating
103 to the furnishing of patient records.
104 (6) This section does not apply with respect to a group
105 health plan, or health insurance coverage offered in connection
106 with a group health plan, if the application of this section to
107 such plan or coverage has caused an increase in the costs under
108 the plan or for such coverage of more than 2 percent, as
109 determined and certified by an independent actuary to the Office
110 of Insurance Regulation.
111 Section 2. Paragraph (b) of subsection (8) of section
112 627.6675, Florida Statutes, is amended to read:

113 627.6675 Conversion on termination of
114 eligibility.--Subject to all of the provisions of this section,
115 a group policy delivered or issued for delivery in this state by
116 an insurer or nonprofit health care services plan that provides,
117 on an expense-incurred basis, hospital, surgical, or major
118 medical expense insurance, or any combination of these
119 coverages, shall provide that an employee or member whose
120 insurance under the group policy has been terminated for any
121 reason, including discontinuance of the group policy in its
122 entirety or with respect to an insured class, and who has been
123 continuously insured under the group policy, and under any group
124 policy providing similar benefits that the terminated group
125 policy replaced, for at least 3 months immediately prior to
126 termination, shall be entitled to have issued to him or her by
127 the insurer a policy or certificate of health insurance,
128 referred to in this section as a "converted policy." A group
129 insurer may meet the requirements of this section by contracting
130 with another insurer, authorized in this state, to issue an
131 individual converted policy, which policy has been approved by
132 the office under s. 627.410. An employee or member shall not be
133 entitled to a converted policy if termination of his or her
134 insurance under the group policy occurred because he or she
135 failed to pay any required contribution, or because any
136 discontinued group coverage was replaced by similar group
137 coverage within 31 days after discontinuance.
138 (8) BENEFITS OFFERED.--

139 (b) An insurer shall offer the benefits specified in s.
140 627.668 ~~and the benefits specified in s. 627.669~~ if those
141 benefits were provided in the group plan.
142 Section 3. <u>Section 627.669, Florida Statutes, is repealed.</u>
143 Section 4. This act shall take effect January 1, 2011, and
144 shall apply to policies and contracts issued or renewed on or
145 after that date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 509 Blood Establishments
SPONSOR(S): Tobia
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Policy Committee		Holt	Calamas
2) Health Care Appropriations Committee			
3) Health & Family Services Policy Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 509 amends s. 381.06014, F.S., relating to blood establishments.

- Exempts hospitals licensed under chapter 395 "Hospital Licensing and Regulations" from the definition of blood establishments.
- Creates an annual disclosure requirement to be filed with the Agency for Health Care Administration (AHCA) for all blood establishments, except hospitals. The disclosure includes the following information:
  - Audited Financial Statements.
  - An inventory of blood products, by type, for the beginning and ending of the reporting period.
  - The source of the blood products collected during the reporting period.
  - General administrative and overhead costs, including salaries, associated with blood products.
  - The destination of all blood products disseminated by the blood establishment.
  - The blood establishment's net pricing (price less all applicable discounts, rebates, and any other contractual or policy deductions) for the blood establishment's 25 largest providers or recipients of certain blood products.
- Establishes a $10,000 fee for collecting the financial and disclosure information.
- Provides AHCA rulemaking authority to implement the provisions of s. 381.06014, F.S.

The bill will have an insignificant positive fiscal impact to the Health Care Trust Fund within AHCA (See Fiscal Impact).

The bill takes effect upon becoming law.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Regulatory Background

A blood establishment is defined in s. 381.06014, F.S., to mean any person, entity, or organization, operating within Florida, which examines an individual for the purpose of blood donation or which collects, processes, stores, tests, or distributes blood or blood components collected from the human body for the purpose of transfusion, for any other medical purpose, or for the production of any biological product.

The state of Florida does not issue a specific license as a blood establishment. Florida law[1] requires a blood establishment operating in Florida to operate in a manner consistent with the provisions of federal law in Title 21 Code of Federal Regulations (C.F.R.) parts 211 and 600 640, relating to the manufacture and regulation of blood and blood components. If the blood establishment does not operate accordingly, and is operating in a manner that constitutes a danger to the health or well-being of blood donors or recipients, the Agency for Health Care Administration (AHCA), or any state attorney may bring an action for an injunction to restrain such operations or enjoin the future operation of the establishment.

Federal law classifies blood establishments as follows:[2] community (non-hospital) blood bank ("community blood center"), hospital blood bank, plasmapheresis center, product testing laboratory, hospital transfusion service, component preparation facility, collection facility, distribution center, broker/warehouse, and other. Community blood centers are primarily engaged in collecting blood and blood components from voluntary donors to make a safe and adequate supply of these products available to hospitals and other health care providers in the community for transfusion. Blood establishments that focus on the collection of plasma that is not intended for transfusion, but is intended to be sold for the manufacture of blood derivatives[3] routinely pay donors.

Community blood centers in Florida are licensed as clinical laboratories by AHCA, unless otherwise exempt.[4] As a part of the clinical laboratory license, the facility is inspected at least every two years.

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[1] s. 381.06014, F.S.

[2] A description of these classifications may be found at: <http://www.fda.gov/BiologicsBloodVaccines/GuidanceCompliance RegulatoryInformation/EstablishmentRegistration/BloodEstablishmentRegistration/ucm055484.htm> (Last visited March 29, 2010).

[3] Blood derivatives are classified as prescription drugs.

[4] Rule 59A-7.019, F.A.C., and part I of ch. 483, F.S., related to Health Testing Services.

AHCA may accept surveys or inspections conducted by a private accrediting organization in lieu of conducting its own inspection. The clinical laboratory personnel are required to maintain professional licensure by the Department of Health (DOH). Community blood centers must also have appropriate licenses issued by DOH and must comply with laws related to biomedical waste[5] and radiation services.

Blood and Blood Components

Blood may be transfused to patients as whole blood or as one of its primary components: red blood cells (RBCs), plasma, platelets, and cryoprecipitated antihemophilic factor (AHF).[6]

RBCs are prepared from whole blood by removing the plasma, and are given to surgery and trauma patients, along with patients with blood disorders like anemia and sickle cell disease. RBCs have a shelf life of 42 days, or they may be treated and frozen for storage of up to 10 years. Leukoreduced RBCs are filtered to contain a lesser amount of white blood cells than would normally be present in whole blood or RBC units. Leukoreduction is recommended to improve the safety of blood transfusions by reducing the possibility of post-transfusion infection or reaction that may result from pathogens concentrated in white blood cells.

Plasma is the liquid portion of the blood that carries clotting factors and nutrients. It may be obtained through apheresis[7] or separated from whole blood, which is referred to as recovered plasma. It is given to trauma patients, organ transplant recipients, newborns and patients with clotting disorders. Fresh frozen plasma (FFP) is plasma frozen within hours after donation in order to preserve clotting factors and may be stored up to seven years. It is thawed before it is transfused.

Cryoprecipitated AHF is the portion of plasma that is rich in certain clotting factors. It is removed from plasma by freezing and then slowly thawing the plasma. Cryoprecipitated AHF is used to prevent or control bleeding in individuals with hemophilia and von Willebrand's disease.

Platelets control blood clotting in the body, and are used to stop bleeding associated with cancer and surgery. Units of platelets are prepared by using a centrifuge to separate the platelet-rich plasma from the donated unit of whole blood. Platelets also may be obtained from a donor by the process of apheresis, which results in about six times as many platelets as a unit of platelets obtained from the whole blood. Platelets are stored at room temperature for up to five days.

Florida Community Blood Centers

Many blood banks operate, collect and distribute in a local community, and any excess blood is distributed to other communities in Florida, or nationally, as needed. Accordingly, the community blood centers generally collect and provide blood services to health care facilities in the same geographic area. Community blood centers occasionally overlap in their collection in certain counties.

Currently, there are six not-for-profit corporations that operate community blood centers in Florida and one for-profit corporation. The not-for-profit corporations include: Community Blood Centers of South Florida; Florida Blood Services (includes the recent mergers of Bloodnet USA, Northwest Florida Blood Services, and Southeastern Community Blood Center); Florida's Blood Centers; LifeSouth Community Blood Centers; Suncoast Communities Blood Bank; and The Blood Alliance, formerly Florida Georgia Blood Alliance and the Blood Center of the St. Johns. The for-profit corporation is United States Blood Bank (USBB). Several hospital-owned blood centers operate in this state as well, primarily collecting for their own use. At least one community blood center that does not have a fixed location in Florida

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[5] Rule ch. 64E-16, F.A.C., Biomedical Waste, and s. 381.0098, F.S.
[6] Blood component definitions from: AABB "Whole Blood and Blood Components" *available* at: http://www.aabb.org/Content/About_Blood/Facts_About_Blood_and_Blood_Banking/fabloodwhole.htm (Last visited on March 29, 2010).
[7] *Ibid.* Apheresis is a process in which blood is drawn from the donor into an apheresis instrument that separates the blood into its components, retains the desired component, and returns the remainder of the blood to the donor.

collects blood and blood components using a mobile blood-collection vehicle from volunteer donors and distributes blood and blood components to health care providers in Florida.

Community blood centers collect about 93–94 percent, hospitals collect 5–6 percent, and the military collects 1-2 percent of the national blood supply.[8]

Pricing

The cost of blood and blood components is primarily based on the cost of labor and required testing to ensure the safety of the blood collected. A donor must be educated and screened to ensure they are in good health prior to making a donation. Each specimen of blood taken is subject to an initial test, which can cost $52 - $66 per unit. If an initial test reveals a positive condition that would make the unit unusable, the unit is subject to confirmatory testing. The price of a confirmatory test varies considerably depending upon the test(s) that must be run, one of which may cost as much as $170.

In addition to screening, collecting, processing (separation), and testing, blood centers must ensure that they implement procedures for labeling, including expiration dating; tracking and tracing the donation; deferral; public health reporting and donor follow-up as applicable; blood component quarantining in temperature-controlled environments until testing indicates the unit may be released for use; continued storage in temperature-controlled environments for released units; transportation and handling; and environmentally appropriate disposal of supplies and unusable units.

Generally, the median fees charged by community blood centers in Florida are at, or near, the lowest median fees nationally.[9]

Corporate Information

Section 220.22, F.S., requires corporations and artificial entities that conduct business, or earn or receive income in Florida, including out-of-state corporations, to file a Florida corporate income tax return unless exempt, regardless of whether a tax is due.

Section 607.1620, F.S., requires for profit corporations to file annual financial statements with shareholders within a 120 days of the close of each fiscal year. For nonprofit corporations, s. 607.1605, F.S., entitles a director of a corporation to inspect and copy the books, records, and documents of a corporation at a reasonable time to the extent reasonably related to the performance of a director's duties.

The revised IRS Form 990, for 2008 (for filings beginning in 2009) solicits additional information pertaining to governance, management, and certain disclosures provide for more transparency in activities of tax exempt organizations. Of particular importance are questions concerning whether the organization has a written conflict of interest policy that requires the annual disclosure of interests that could give rise to conflicts, whether the organization monitors and enforces compliance with that policy, and more detailed information about determining the compensation of the organization's CEO/Executive Director.[10]

Senate Interim Project Report 2010-119

During the 2009-2010 interim, the Senate Committee on Health Regulation reviewed the regulation of blood banks (a.k.a. community blood centers). The recommendations concerning legislative action in the resulting report included:

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[8] The Florida Senate, Committee on Health Regulation, Interim Report 2010-119 (December 2009).
[9] The regional median fees were provided by ABC in an email to staff in the Florida Senate Health Regulation Committee dated November 17, 2009. The median fees for Florida were obtained from information submitted by the community blood centers in response to a committee survey.
[10] A description of the changes to IRS Form 990 may be found at: http://www.irs.gov/charities/article/0,,id=218938,00.html

- Improve the transparency concerning blood collection and distribution activities.
- Provide information pertaining to the blood center's policies for related-party transactions.
- Identify members of the board of directors and the compensation of officers, directors, and key employees.
- Identify costs involved in collecting, processing, and distributing donated blood.
- Prohibit public agencies from restricting the access to public facilities based on the tax status of the community blood center.
- Address the statutory obstacle that prohibits a community blood center, because it is a health care entity, from maintaining licensure as a prescription drug wholesale distributor and engaging in the wholesale distribution of prescription drugs.
- Prohibit a community blood center from using the tax status of a hospital or other health care facility as the sole factor when determining the price for the sale of blood or blood components.

Effects of the Bill

The bill provides legislative findings that blood establishments in the state have historically not been subject to financial disclosure or public disclosure of their basic operations. It provides for legislative intent that blood establishments in the state be subject to financial reporting requirements and transparency concerning the supply, sources, cost, pricing, and destinations of blood products.

The bill amends s. 381.06014, F.S., exempting hospitals licensed under chapter 395 "Hospital Licensing and Regulations" from the definition of blood establishments and creating an annual disclosure requirement for blood establishments.

The bill requires blood establishments to file an annual report with AHCA and disclose the following information:

- Audited Financial Statements
- An inventory of blood products, by type, for the beginning and ending of the reporting period
- The source of the blood products collected during the reporting period, including:
  - Individual donors (identity not disclosed)
  - Blood service providers (name, business address and quantity)
- General administrative and overhead costs, including salaries, associated with blood products and itemized by:
  - Collection costs
  - Processing costs
  - Testing costs
  - Storage costs
  - Distribution costs
- The destination of all blood products disseminated by the blood establishment, including:
  - Name of the recipient
  - Delivery in-state or out-of state
  - Blood product type and quantity
- The blood establishment's net pricing (price less all applicable discounts, rebates, and any other contractual or policy deductions) for the blood establishment's 25 largest providers or recipients of the following blood products:
  - Leukocyte-reduced red blood cells
  - Non-leukocyte-reduced red blood cells
  - Leukocyte-reduced platelet pheresis
  - Leukocyte-reduced platelets
  - Fresh frozen plasma, and cryoprecipitate

The bill also requires AHCA to assess a $10,000 fee to cover the costs of collecting the required disclosure information.

Finally, the bill grants AHCA rulemaking authority to implement the provisions of s. 381.06014, F.S.

B. SECTION DIRECTORY:

Section 1. Creates an unnumbered section relating to legislative findings and intent.
Section 2. Amends s. 381.06014, F.S., relating to blood establishments.
Section 3. Provides that the bill takes effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill establishes a fee that has an insignificant positive fiscal impact to the Health Care Trust Fund within AHCA (see Fiscal Comments below).

2. Expenditures:

None. AHCA staff indicated its current Fiscal Analysis Unit performs a comparable function and could incorporate seven additional reporting units into its current workload.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Entities that meet the definition of blood establishments pursuant to s. 381.06014, F.S., will be assessed a $10,000 fee to cover cost of collecting and maintaining the information obtained from the annual disclosure requirements established by the bill.

D. FISCAL COMMENTS:

The complete fiscal impact is unknown. However, seven community blood centers are identified in "The Florida Senate Interim Report 2010-119 *Review of the Regulation of Blood Banks*" which could generate $70,000 in fees.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable, the bill does not appear to affect municipal or county governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides the AHCA rulemaking authority to implement the provisions of s.381.06014, F.S., (establishing the annual disclosure requirements for blood establishments and the related fee).

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill does not distinguish between blood establishments utilizing volunteer donors versus paid donors, a factor used to separate community blood centers from the other blood establishments which would include plasmapheresis centers and others.

The bill as currently drafted does not clearly indicate how "general administrative and overhead costs" are to be "itemized separately and with specificity".

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to blood establishments; providing
3 legislative findings and intent; amending s. 381.06014,
4 F.S.; revising the definition of the term "blood
5 establishment"; requiring a blood establishment to report
6 certain financial information to the Agency for Health
7 Care Administration; requiring a blood establishment to
8 identify suppliers, sources, costs, destinations, and
9 pricing structure of its inventory of blood products;
10 providing for a fee; authorizing the agency to adopt
11 rules; providing an effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Legislative findings and intent.—The
16 Legislature finds that blood establishments in the state have
17 historically not been subject to financial disclosure or to
18 public disclosure of their basic operations despite the fact
19 that they are responsible for providing blood products on a vast
20 scale for use in transfusions and other vital and necessary
21 services to the citizens of the state. The Legislature intends
22 that blood establishments in the state be subject to financial
23 reporting requirements and transparency concerning the supply,
24 sources, cost, pricing, and destinations of blood products.
25 Section 2. Section 381.06014, Florida Statutes, is amended
26 to read:
27 381.06014 Blood establishments.—
28 (1) As used in this section, the term "blood

29 establishment" means any person, entity, or organization,
30 operating within the state, which examines an individual for the
31 purpose of blood donation or which collects, processes, stores,
32 tests, or distributes blood or blood components collected from
33 the human body for the purpose of transfusion, for any other
34 medical purpose, or for the production of any biological
35 product. The term does not include a hospital licensed under
36 chapter 395.
37 (2) Any blood establishment operating in the state may not
38 conduct any activity defined in subsection (1) unless that blood
39 establishment is operated in a manner consistent with the
40 provisions of Title 21 parts 211 and 600-640, Code of Federal
41 Regulations. In addition, any blood establishment operating in
42 the state shall file an annual report with the Agency for Health
43 Care Administration disclosing the following information:
44 (a) The blood establishment's audited financial
45 statements, prepared according to generally accepted accounting
46 principles, disclosing all assets, liabilities, operating and
47 nonoperating revenues, operating and nonoperating expenses, net
48 income, cash flow, and accountants' notes.
49 (b) The quantity of blood products, by type, that are
50 within the blood establishment's inventory at the beginning and
51 at the end of the reporting period.
52 (c) The source of blood products collected during the
53 reporting period. This component of the report shall indicate
54 the extent to which blood was collected by the blood
55 establishment from individual donors within the state and the
56 extent to which blood was obtained by the blood establishment

57 from blood service providers within or outside of the state. The
58 identity of any individual donor shall not be disclosed. The
59 name, business address, and quantity of blood product received
60 from any other blood establishment within or outside of the
61 state shall be disclosed.
62 (d) The blood establishment's general administrative and
63 overhead costs, including salaries, associated with collecting,
64 processing, testing, storing, and distributing blood products,
65 itemized separately and with specificity.
66 (e) The destination of all blood products disseminated by
67 the blood establishment during the reporting period, indicating
68 the quantity, type of blood product, and name and business
69 address of the recipient. The sale or delivery of blood products
70 outside of the state and outside of the United States must be
71 separately designated in this report.
72 (f) The blood establishment net pricing, which is the list
73 price minus all applicable discounts, rebates, and any other
74 contractual or policy deductions, for the blood establishment's
75 25 largest providers or recipients of the following blood
76 products: leukocyte-reduced red blood cells, non-leukocyte-
77 reduced red blood cells, leukocyte-reduced platelet pheresis,
78 leukocyte-reduced platelets, fresh frozen plasma, and
79 cryoprecipitate.
80 (3) Any blood establishment determined to be operating in
81 the state in a manner not consistent with the provisions of
82 Title 21 parts 211 and 600-640, Code of Federal Regulations, and
83 in a manner that constitutes a danger to the health or well-
84 being of donors or recipients as evidenced by the federal Food

85 and Drug Administration's inspection reports and the revocation
86 of the blood establishment's license or registration shall be in
87 violation of this chapter and shall immediately cease all
88 operations in the state.
89 (4) The operation of a blood establishment in a manner not
90 consistent with the provisions of Title 21 parts 211 and 600-
91 640, Code of Federal Regulations, and in a manner that
92 constitutes a danger to the health or well-being of blood donors
93 or recipients as evidenced by the federal Food and Drug
94 Administration's inspection process is declared a nuisance and
95 inimical to the public health, welfare, and safety. The Agency
96 for Health Care Administration or any state attorney may bring
97 an action for an injunction to restrain such operations or
98 enjoin the future operation of the blood establishment.
99 <u>(5) The Agency for Health Care Administration shall assess</u>
100 <u>each blood establishment an annual fee of $10,000 for the cost</u>
101 <u>of collecting and maintaining the information required by</u>
102 <u>subsection (2).</u>
103 <u>(6) The Agency for Health Care Administration may adopt</u>
104 <u>rules to implement the provisions of this section.</u>
105 Section 3. This act shall take effect upon becoming a law.

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

Amendment No. 1

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)
ADOPTED AS AMENDED __ (Y/N)
ADOPTED W/O OBJECTION __ (Y/N)
FAILED TO ADOPT __ (Y/N)
WITHDRAWN __ (Y/N)
OTHER ______

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1 Council/Committee hearing bill: Health Care Regulation Policy
2 Committee
3 Representative Tobia offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Subsections (5) and (6) are added to section
8 381.06014, Florida Statutes, to read:
9 381.06014 Blood establishments.—
10 (5) A local government may not restrict the access to or
11 use of any public facility or infrastructure for the collection
12 of blood or blood components from volunteer donors based on
13 whether the blood establishment is operating as a for-profit
14 organization or a not-for-profit organization.
15 (6) In determining the price of blood or blood components
16 that are received from volunteer donors and sold to hospitals or
17 other health care providers, a blood establishment may not base
18 the price of the blood or blood component solely on whether the

Amendment No. 1

19 purchasing entity is a for-profit organization or a not-for-
20 profit organization.
21 Section 2. Paragraphs (e) and (f) of subsection (53) of
22 section 499.003, Florida Statutes, are redesignated as
23 paragraphs (f) and (g), respectively, and a new paragraph (e) is
24 added to that subsection to read:
25 499.003 Definitions of terms used in this part.—As used in
26 this part, the term:
27 (53) "Wholesale distribution" means distribution of
28 prescription drugs to persons other than a consumer or patient,
29 but does not include:
30 (e) The sale, purchase, or trade or the offer to sell,
31 purchase, or trade, by a registered blood establishment that
32 qualifies as a health care entity of any:
33 1. Drug indicated for a bleeding or clotting disorder or
34 anemia;
35 2. Blood collection container approved under section 505
36 of the Prescription Drug Marketing Act;
37 3. Drug that is a blood derivative, or a recombinant or
38 synthetic form of a blood derivative, as long as the health care
39 services provided by the blood establishment are related to its
40 activities as a registered blood establishment or the health
41 care services provided by the blood establishment consist of
42 collecting, processing, storing, or administering human
43 hematopoietic stem or progenitor cells or performing diagnostic
44 testing of specimens that are tested together with specimens
45 undergoing routine donor testing; or

46 4. Drug necessary to collect blood or blood components
47 from volunteer blood donors; for blood establishment personnel
48 to perform therapeutic procedures under the direction and
49 supervision of a licensed physician; and to diagnose, treat,
50 manage, and prevent any reaction of either a volunteer blood
51 donor or a patient undergoing a therapeutic procedure performed
52 under the direction and supervision of a licensed physician.
53
54 A blood establishment whose distribution of products is excluded
55 under this paragraph must satisfy all other requirements of this
56 part applicable to a wholesale distributor or retail pharmacy.
57 Section 3. Paragraph (a) of subsection (2) of section
58 499.01, Florida Statutes, is amended to read:
59 499.01 Permits.—
60 (2) The following permits are established:
61 (a) Prescription drug manufacturer permit.—A prescription
62 drug manufacturer permit is required for any person that is a
63 manufacturer of a prescription drug and that manufactures or
64 distributes such prescription drugs in this state.
65 1. A person that operates an establishment permitted as a
66 prescription drug manufacturer may engage in wholesale
67 distribution of prescription drugs manufactured at that
68 establishment and must comply with all of the provisions of this
69 part, except s. 499.01212, and the rules adopted under this
70 part, except s. 499.01212, that apply to a wholesale
71 distributor.
72 2. A prescription drug manufacturer must comply with all
73 appropriate state and federal good manufacturing practices.

Amendment No. 1

74 3. A blood establishment, as defined in s. 381.06014,
75 operating in a manner consistent with 21 C.F.R. parts 211 and
76 660-640 and manufacturing only the prescription drugs described
77 in s. 499.003(53)(d) and (e) is not required to obtain a permit
78 as a prescription drug manufacturer under this paragraph or
79 register products under s. 499.015.
80 Section 4. This act shall take effect upon becoming a law.
81
82 ---
83 **T I T L E A M E N D M E N T**
84 Remove the entire title and insert:
85 A bill to be entitled
86 An act relating to blood establishments; amending s.
87 381.06014, F.S.; prohibiting a local government from
88 restricting access to or use of public facilities or
89 infrastructure for the collection of blood or blood
90 components from volunteer donors based on certain
91 criteria; prohibiting blood establishments from
92 determining the price of blood or blood components based
93 on certain criteria; amending s. 499.003, F.S.; revising
94 the definition of the term "wholesale distribution" to
95 exclude certain drugs and products distributed by blood
96 establishments; amending s. 499.01, F.S.; excluding
97 certain blood establishments from the requirement to
98 obtain a prescription drug manufacturer permit; providing
99 an effective date.

HB 715

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 715 Health Services Claims
SPONSOR(S): Patronis
TIED BILLS: **IDEN./SIM. BILLS:** SB 1232

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee		Holt	Calamas
2)	Insurance, Business & Financial Affairs Policy Committee			
3)	Government Operations Appropriations Committee			
4)	General Government Policy Council			
5)				

SUMMARY ANALYSIS

The bill provides a provider or claimant an opportunity to appeal a claim submitted to a health insurer or health maintenance organization (HMO) if the claim or a portion of the claim was denied because the provider or claimant failed to obtain the necessary authorization due to unintentional act or error or omission.

The bill requires the health insurer or HMO to conduct a retrospective review of the medical necessity of the service within 30 days after the provider or claimant submits an appeal. If the service is determined to be medically necessary, the health insurer or HMO is required to reverse the denial and pay the claim. If the service is determined not to be medically necessary, the health insurer or HMO must provide a written clinical justification of the denial.

The bill will have an indeterminate negative fiscal impact to the State Group Insurance Program, within the Department of Management Services (See Fiscal Comments).

The bill takes effect July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Regulation of Health Insurers and HMOs

The Office of Insurance Regulation regulates health insurance contracts and rates under Part VI of Chapter 627, F.S., and Health Maintenance Organization (HMO) contracts and rates under Part I of Chapter 641, F.S., while the Agency for Health Care Administration regulates the quality of care provided by HMOs under Part III of Chapter 641, F.S.

Employee Retirement Income Security Act of 1974

The Employee Retirement Income Security Act of 1974 (ERISA)[1] is a federal law that sets minimum standards for retirement and health benefit plans in private industry. ERISA places the regulation of employee benefit plans (including health plans) primarily under federal jurisdiction.[2] ERISA does not require any employer to establish a plan. ERISA only requires that those who establish plans must meet certain minimum standards.[3] ERISA contains an express preemption provision that provides, "[ERISA] supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...."[4] This portion of ERISA was designed to ensure that plans would be subject to the same benefit laws across all states.[5] However, the wording "relates to" is not precise, and as a result, the courts continue to define this term, case by case.[6]

Another provision, s. 514(b)(2)(A), referred to as the "savings" clause, retains state authority over the business of insurance.[7] The business of insurance typically refers to the regulation of plan solvency,

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[1] Public Law 93-406.
[2] Congressional Research Service, Report for Congress, ERISA Regulation of Health Plans: Fact Sheet (RS20315), March 6, 2003.
[3] Department of Labor, Employee Benefits Security Administration, Compliance Assistance, available at: http://www.dol.gov/ebsa/compliance_assistance.html (last viewed March 25, 2010).
[4] 29 U.S.C. s. 1144(a).
[5] Congressional Research Service, Report for Congress, ERISA Regulation of Health Plans: Fact Sheet (RS20315), March 6, 2003.
[6] *See, e.g., Shaw v. Delta Air Lines*, 463 U.S. 85 (1983) (finding that a state law "relates to" an employee benefit plan "if it has a connection with or reference to such plan," while recognizing that some state actions may be too remote or tenuous to warrant a finding that the law relates to an employee benefits plan); *see, e.g., Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341 (8th Cir. 1991).
[7] Congressional Research Service, Report for Congress, ERISA Regulation of Health Plans: Fact Sheet (RS20315), March 6, 2003.

marketing, information disclosure, consumer grievances and may also include mandating benefits, taxing insurance premiums, and mandating participation in state risk pools and uncompensated care plans.[8]

Lastly, s. 514(b)(2)(B), referred to as the "deemer" clause, does not allow states to deem an employee benefit plan to be in the business of insurance.[9] The effect of this clause is that self-insured plans are not subject to state rules governing the business of insurance.[10]

According to the Department of Financial Services, ERISA poses the most significant obstacle to state regulators' efforts to expand or enforce provisions governing consumer rights related to health insurance contracts.[11]

Health Insurers

Section 627.6141, F.S., requires each claimant, or provider acting for a claimant, who has had a claim denied as not medically necessary to be provided an opportunity for an appeal to the insurer's licensed physician who is responsible for the medical necessity reviews under the plan or is a member of the plan's peer review group. Currently, an appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.[12]

Currently s. 627.6686(6), F.S., provides that an insurer may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual because the individual is diagnosed as having a developmental disability.

Health Maintenance Organizations

Section 641.3156, F.S., requires a HMO to pay any hospital service or referral service claim for treatment for an eligible subscriber if the services or referral was authorized by an approved HMO provider who is tasked to direct the patient's utilization of health care services. An HMO does not have to pay for any hospital services or referral services for treatment if the approved HMO provider provided information to the HMO with the willful intention to misinform.[13] In addition, a claim for treatment may not be denied if a provider follows the HMOs authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the HMO with the willful intention to misinform the HMO.[14]

Currently, an HMO is required to provide coverage for medically necessary services under the following circumstances:

- Section 641.315(9), F.S., provides that a contract between a HMO and a contracted primary care or admitting physician may not contain any provision that prohibits such physician from providing inpatient services in a contracted hospital to a subscriber if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

- Section 641.31089(6), F.S. provides that a HMO may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual solely because the individual is diagnosed as having a developmental disability.

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[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] Department of Financial Services, Bill Analysis and Fiscal Impact Statement of House Bill 243 (January 20, 2009).
[12] s. 627.6141, F.S.
[13] s. 641.31569(1), F.S
[14] s. 641.31569(2), F.S.

In addition HMOs are required to provide coverage for emergency services and care, and may not:[15]

- Require prior authorization for the receipt of pre-hospital transport or treatment or for emergency services and care.[16]
- Indicate that emergencies are covered only if care is secured within a certain period of time.[17]
- Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.[18]
- Deny payment based on the subscriber's failure to notify the health maintenance organization in advance of seeking treatment or within a certain period of time after the care is given.[19]

EFFECTS OF THE BILL

Health Insurers

The bill provides that an opportunity to appeal applies if the claim or a portion of the claim is denied because the provider or claimant failed to obtain the necessary authorization due to unintentional act or error or omission.

The bill extends the reasonable time period to respond from 15 days to 30 days. The bill deletes provisions that allow appeals to be submitted by telephone and removes the ability of medical necessity reviews to be conducted by a member of the plan's peer review group. Removing the ability of medical necessity reviews to be conducted by a member of the plan's peer review group may impact the business model of some organizations.

The bill requires health insurers to cover services that are medically necessary, this provision may have an unintended consequence of requiring plans cover services that may not be covered or a benefit under a specific health insurance policy.

Health Maintenance Organizations

The bill provides a provider or claimant an opportunity to appeal a claim submitted an HMO if the claim or a portion of the claim is denied because the provider or claimant failed to obtain the necessary authorization due to unintentional act or error or omission.

The bill provides that if the provider or claimant appeals the denial, an HMO is required to conduct and complete a retrospective review of the medical necessity of the service within 30 days after submitting the appeal. The bill provides that if service was determined to be medically necessary, than the health insurance is required to reverse the denial and pay the claim. Moreover, the bill provides that if the service was determined not to be medically necessary, than the health insurer or HMO must provide a written clinical justification of the denial.

The bill requires HMOs to cover services that are medically necessary, this provision may have an unintended consequence of requiring plans cover services that may not be covered or a benefit under a specific health insurance policy.

The bill takes effect July 1, 2010.

B. SECTION DIRECTORY:

Section 1. Amends s. 627.6141, F.S., relating to denial of claims.
Section 2. Amends s. 641.3156, F.S., relating to treatment authorization and payment of claims.
Section 3. Provides that the bill takes effect July 1, 2010.

[15] s. 641.315(1), F.S.
[16] s. 641.315(1)(a), F.S.
[17] s. 641.315(1)(b), F.S.
[18] s. 641.315(1)(c), F.S.
[19] s. 641.315(1)(d), F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

D. FISCAL COMMENTS:

According to the Department of Management Services, the bill would have a negative fiscal impact on the State Group Insurance Program.[20] The provisions could negate the pre-admission certification provisions contained within the PPO Plan resulting in the payment of hospital admissions that would have otherwise been denied or subject to a penalty.[21]

In addition, the provisions of the bill may reduce the ability of the health plans in the State Group Insurance Program to implement cost control measures (i.e. referrals and prior authorization).[22] To the extent that the bill limits the effectiveness of prior authorization programs, there could be an indeterminate negative fiscal impact to the contracted State PPO Plan and State HMO Plans. Two State HMO Plan vendors estimated that this legislation could result in a program cost increase of $3.15 to $4 per member per month.[23]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Office of Insurance Regulation has sufficient rule making authority to implement the provisions of the bill.

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[20] Department of Management Services 2009 Analysis of House Bill 243 (March 25, 2009).
[21] *Id.*
[22] Department of Management Services 2010 Analysis of House Bill 715 (March 26, 2010).
[23] *Id.*

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill provides when a provider appeals a denial, a health insurer or HMO is required to complete and submit a retrospective review of the medical necessity of a service within 30 business days. The bill does not mention what happens if additional information is required after the appeal is submitted.

According to the Office of Insurance Regulation, the bill requires the health insurer or HMO to provide clinical justification for determining a specific medical service or treatment is not "medically necessary." This would require the health insurer or HMO to periodically re-examine its policies and procedures to determine "medical necessity" as medical services and treatments evolve.[24]

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

[24] Office of Insurance Regulation 2009 Bill Analysis of House Bill 243 (March 12, 2009).

1 A bill to be entitled
2 An act relating to health services claims; amending s.
3 627.6141, F.S.; authorizing appeals from denials of
4 certain claims for certain services; requiring a health
5 insurer to conduct a retrospective review of the medical
6 necessity of a service under certain circumstances;
7 requiring the health insurer to submit a written
8 justification for a determination that a service was not
9 medically necessary and provide a process for appealing
10 the determination; amending s. 641.3156, F.S.; authorizing
11 appeals from denials of certain claims for certain
12 services; requiring a health maintenance organization to
13 conduct a retrospective review of the medical necessity of
14 a service under certain circumstances; requiring the
15 health maintenance organization to submit a written
16 justification for a determination that a service was not
17 medically necessary and provide a process for appealing
18 the determination; providing an effective date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21
22 Section 1. Section 627.6141, Florida Statutes, is amended
23 to read:
24 627.6141 Denial of claims.—Each claimant, or provider
25 acting for a claimant, who has had a claim denied or a portion
26 of a claim denied because the provider failed to obtain the
27 necessary authorization due to an unintentional act or error or
28 omission ~~as not medically necessary~~ must be provided an

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 opportunity for an appeal to the insurer's licensed physician
30 who is responsible for the medical necessity reviews under the
31 plan ~~or is a member of the plan's peer review group~~. If the
32 provider appeals the denial, the health insurer shall conduct
33 and complete a retrospective review of the medical necessity of
34 the service within 30 business days after the submitted appeal.
35 If the insurer determines upon review that the service was
36 medically necessary, the insurer shall reverse the denial and
37 pay the claim. If the insurer determines that the service was
38 not medically necessary, the insurer shall submit to the
39 provider specific written clinical justification for the
40 determination. ~~The appeal may be by telephone, and the insurer's~~
41 ~~licensed physician must respond within a reasonable time, not to~~
42 ~~exceed 15 business days.~~
43 Section 2. Subsection (3) of section 641.3156, Florida
44 Statutes, is renumbered as subsection (4), and a new subsection
45 (3) is added to that section to read:
46 641.3156 Treatment authorization; payment of claims.—
47 (3) If a provider claim or a portion of a provider claim
48 is denied because the provider, due to an unintentional act of
49 error or omission, failed to obtain the necessary authorization,
50 the provider may appeal the denial to the health maintenance
51 organization's licensed physician who is responsible for medical
52 necessity reviews. The health maintenance organization shall
53 conduct and complete a retrospective review of the medical
54 necessity of the service within 30 business days after the
55 submitted appeal. If the health maintenance organization
56 determines that the service is medically necessary, the health

57 maintenance organization shall reverse the denial and pay the
58 claim. If the health maintenance organization determines that
59 the service is not medically necessary, the health maintenance
60 organization shall provide the provider with specific written
61 clinical justification for the determination.
62 Section 3. This act shall take effect July 1, 2010.

Amendment No. 1

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Council/Committee hearing bill: Health Care Regulation Policy
2 Committee
3 Representative Patronis offered the following:
4
5 **Amendment**
6 Remove lines 24-61 and insert:
7 627.6141 Denial of claims.—Each claimant, or hospital
8 ~~provider~~ acting for a claimant, who has had a claim denied or a
9 portion of a claim denied because the hospital failed to obtain
10 the necessary authorization due to an unintentional act or error
11 or omission ~~as not medically necessary~~ must be provided an
12 opportunity for an appeal to the insurer's licensed physician
13 who is responsible for the medical necessity reviews under the
14 plan ~~or is a member of the plan's peer review group~~. If the
15 hospital appeals the denial, the health insurer shall conduct
16 and complete a retrospective review of the medical necessity of
17 the service within 30 business days after the submitted appeal.
18 If the insurer determines upon review that the service was
19 medically necessary, the insurer shall reverse the denial and

20 pay the claim. If the insurer determines that the service was
21 not medically necessary, the insurer shall submit to the
22 hospital specific written clinical justification for the
23 determination. ~~The appeal may be by telephone, and the insurer's~~
24 ~~licensed physician must respond within a reasonable time, not to~~
25 ~~exceed 15 business days.~~
26 Section 2. Subsection (3) of section 641.3156, Florida
27 Statutes, is renumbered as subsection (4), and a new subsection
28 (3) is added to that section to read:
29 641.3156 Treatment authorization; payment of claims.—
30 (3) If a hospital claim or a portion of a hospital claim
31 of a contracted hospital is denied because the hospital, due to
32 an unintentional act of error or omission, failed to obtain the
33 necessary authorization, the hospital may appeal the denial to
34 the health maintenance organization's licensed physician who is
35 responsible for medical necessity reviews. The health
36 maintenance organization shall conduct and complete a
37 retrospective review of the medical necessity of the service
38 within 30 business days after the submitted appeal. If the
39 health maintenance organization determines that the service is
40 medically necessary, the health maintenance organization shall
41 reverse the denial and pay the claim. If the health maintenance
42 organization determines that the service is not medically
43 necessary, the health maintenance organization shall provide the
44 hospital with specific written clinical justification for the
45 determination.

Amendment No.2

COUNCIL/COMMITTEE ACTION

ADOPTED ___ (Y/N)
ADOPTED AS AMENDED ___ (Y/N)
ADOPTED W/O OBJECTION ___ (Y/N)
FAILED TO ADOPT ___ (Y/N)
WITHDRAWN ___ (Y/N)
OTHER ______

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1 Council/Committee hearing bill: Health Care Regulation Policy
2 Committee
3 Representative Patronis offered the following:
4
5 **Amendment (with title amendment)**
6 Between lines 61 and 62, insert:
7 Section 3. Section 627.6474, Florida Statutes, is amended
8 to read:
9 627.6474 Provider contracts.—
10 (1) A health insurer may ~~shall~~ not require a contracted
11 health care practitioner as defined in s. 456.001(4) to accept
12 the terms of other health care practitioner contracts with the
13 insurer or any other insurer, or health maintenance
14 organization, under common management and control with the
15 insurer, including Medicare and Medicaid practitioner contracts
16 and those authorized by s. 627.6471, s. 627.6472, s. 636.035, or
17 s. 641.315, except for a practitioner in a group practice as
18 defined in s. 456.053 who must accept the terms of a contract
19 negotiated for the practitioner by the group, as a condition of

Amendment No.2

20 continuation or renewal of the contract. Any contract provision
21 that violates this section is void. A violation of this section
22 is not subject to the criminal penalty specified in s. 624.15.
23 (2) A contract between a health insurer and a dentist
24 licensed under chapter 466 for the provision of services to
25 patients may not contain any provision that requires the dentist
26 to provide services to the insured under such contract at a fee
27 set by the health insurer unless such services are covered
28 services under the applicable contract. As used in this
29 subsection, the term "covered services" means services
30 reimbursable under the applicable contract, subject to such
31 contractual limitations on benefits, such as deductibles,
32 coinsurance and copayments, as may apply. This subsection
33 applies to all contracts entered into or renewed on or after
34 July 1, 2010.
35 Section 4. Subsection (13) is added to section 636.035,
36 Florida Statutes, to read:
37 636.035 Provider arrangements.—
38 (13) A contract between a prepaid limited health service
39 organization and a dentist licensed under chapter 466 for the
40 provision of services to subscribers of the prepaid limited
41 health service organization may not contain any provision that
42 requires the dentist to provide services to subscribers of the
43 prepaid limited health service organization at a fee set by the
44 prepaid limited health service organization unless such services
45 are covered services under the applicable contract. As used in
46 this subsection, the term "covered services" means services
47 reimbursable under the applicable contract, subject to such

48 contractual limitations on benefits, such as deductibles,
49 coinsurance and copayments, as may apply. This subsection
50 applies to all contracts entered into or renewed on or after
51 July 1, 2010.
52 Section 5. Subsection (11) is added to section 641.315,
53 Florida Statutes, to read:
54 641.315 Provider contracts.—
55 (11) A contract between a health maintenance organization
56 and a dentist licensed under chapter 466 for the provision of
57 services to subscribers of the health maintenance organization
58 may not contain any provision that requires the dentist to
59 provide services to subscribers of the health maintenance
60 organization at a fee set by the health maintenance organization
61 unless such services are covered services under the applicable
62 contract. As used in this subsection, the term "covered
63 services" means services reimbursable under the applicable
64 contract, subject to such contractual limitations on subscriber
65 benefits, such as deductibles, coinsurance and copayments, as
66 may apply. This subsection applies to all contracts entered into
67 or renewed on or after July 1, 2010.
68
69
70
71 ---
72 **T I T L E A M E N D M E N T**
73 Remove line 18 and insert:
74 the determination; amending s. 627.6474, F.S.; prohibiting
75 contracts between health insurers and dentists from containing

Amendment No.2

76 certain fee requirements set by the insurer under certain
77 circumstances; providing a definition; providing application;
78 amending s. 636.035, F.S.; prohibiting contracts between prepaid
79 limited health service organizations and dentists from
80 containing certain fee requirements set by the organization
81 under certain circumstances; providing a definition; providing
82 application; amending s. 641.315, F.S.; prohibiting contracts
83 between health maintenance organizations and dentists from
84 containing certain fee requirements set by the organization
85 under certain circumstances; providing a definition; providing
86 application; providing an effective date.

Amendment No.3

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Council/Committee hearing bill: Health Care Regulation Policy
2 Committee
3 Representative(s) Patronis offered the following:
4
5 **Amendment (with title amendment)**
6 Between lines 21 and 22, insert:
7 Section 1. Section 626.9541, Florida Statutes, is amended
8 to read:
9 626.9541 Unfair methods of competition and unfair or
10 deceptive acts or practices defined.—
11 (3) WELLNESS PROGRAMS.— An insurer issuing a group or
12 individual health benefit plan may offer a voluntary wellness or
13 health improvement program that allows for rewards or
14 incentives, including but not limited to, merchandise, gift
15 cards, debit cards, premium discounts or rebates, contributions
16 towards a member's health savings account, modifications to
17 copayment, deductible, or coinsurance amounts, or any
18 combination of these incentives, to encourage participation or
19 to reward for participation in the program. The health plan

Amendment No.3

20 member may be required to provide verification, such as a
21 statement from their physician, that a medical condition makes
22 it unreasonably difficult or medically inadvisable for the
23 individual to participate in the wellness program. Any reward
24 or incentive established under this section is not an insurance
25 benefit and does not violate this section. Nothing in this
26 subsection shall prohibit an insurer from offering incentives or
27 rewards to members for adherence to wellness or health
28 improvement programs if otherwise allowed by state or federal
29 law.
30
31 ---
32 **T I T L E A M E N D M E N T**
33 Remove line 2 and insert:
34 An act relating to health services claims; amending s. 626.9541,
35 F.S.; provides that an insurer offering a group or individual
36 health benefit plan may offer a wellness program; authorizes
37 rewards or incentives; provides that such rewards or incentives
38 are not insurance benefits; provides for verification of a
39 member's inability to participate for medical reasons; amending
40 s.

HB 1503

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1503 Health Care
SPONSOR(S): Flores
TIED BILLS: **IDEN./SIM. BILLS:** SB 2138

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee		Holt	Calamas
2)	Health Care Appropriations Committee			
3)	Health & Family Services Policy Council			
4)				
5)				

SUMMARY ANALYSIS

House Bill 1503 amends the Health Care Licensing Procedures Act and the various authorizing statutes of entities regulated by the Agency for Health Care Administration (AHCA) to reduce, streamline, and clarify regulations for those providers.

The bill makes various changes to the regulation of home health agencies. The bill provides a home health agency patient a bill of rights. Home health agency administrators are required to direct the operation of the home health agency and have qualified alternate administrators. The director of nursing must be available during the hours the home health agency is open. The bill specifies the duties of the director of nursing, registered nurse, licensed practical nurse, therapists and therapist's assistants in providing home health care and supervision. Home health aides must be competent to provide care to patients. Skilled services must be performed in compliance with state practice acts and the patient's plan of care. The plan of care is to be reviewed and updated according to specified time frames. The home health agency must provide one type of service directly and may provide other services through arrangements with others if they have a written contract.

The bill amends various licensure provisions, including those related to bankruptcy notifications, licensure renewal notices, billing complaints, accrediting organizations, licensure application document submissions, staffing in geriatric outpatient clinics, property statements, AHCA inspection staff, litigation notices, and health care clinic licensure exemptions.

The bill repeals obsolete or duplicative provisions in licensing and related statutes, including expired reports and regulations and provisions that exist in other sections of law, and resolves conflicts among and between provisions in the Health Care Licensing Procedures Act and various authorizing statutes for individual provider types. The bill makes various revisions to update terminology and conform current law to prior legislative changes.

The bill has a positive fiscal impact on AHCA. The bill will save an estimated $55,700 annually in certified mail costs for license renewal notices and up to $425,273 annually for staffing of AHCA's consumer call center. The bill also redirects revenue from certain traffic fines from AHCA to the Brain and Spinal Cord Trust Fund within the Department of Health. (See Fiscal Comments.)

The bill has an effective date of July 1, 2010, unless expressly provided otherwise.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Health Care Licensing Procedures Act

The Agency for Health Care Administration (AHCA) regulates over 41,000 health care providers under various regulatory programs. Regulated providers include:

- Laboratories authorized to perform testing under the Drug-Free Workplace Act (ss. 112.0455, 440.102, F.S.)
- Birth centers (Ch. 383, F.S.).
- Abortion clinics (Ch. 390, F.S.).
- Crisis stabilization units (Pts. I and IV of Ch. 394, F.S.).
- Short-term residential treatment facilities (Pt. I and IV of Ch. 394, F.S.).
- Residential treatment facilities (Pt. IV of Ch. 394, F.S.).
- Residential treatment centers for children and adolescents (Pt. IV of Ch. 394, F.S.).
- Hospitals (Part I of Ch. 395, F.S.).
- Ambulatory surgical centers (Pt. I of Ch. 395, F.S.).
- Mobile surgical facilities (Pt. I of Ch. 395, F.S.).
- Health care risk managers (Pt. I of Ch. 395, F.S.).
- Nursing homes (Pt. II of Ch. 400, F.S.).
- Assisted living facilities (Pt. I of Ch. 429, F.S.).
- Home health agencies (Pt. III of Ch. 400, F.S.).
- Nurse registries (Pt. III of Ch. 400, F.S.).
- Companion services or homemaker services providers (Pt. III of Ch. 400, F.S.).
- Adult day care centers (Pt. III of Ch. 429, F.S.).
- Hospices (Pt. IV of Ch. 400, F.S.).
- Adult family-care homes (Pt. II of Ch. 429, F.S.).
- Homes for special services (Pt. V of Ch. 400, F.S.).
- Transitional living facilities (Pt. V of Ch. 400, F.S.).
- Prescribed pediatric extended care centers (Pt. VI of Ch. 400, F.S.).
- Home medical equipment providers (Pt. VII of Ch. 400, F.S.).
- Intermediate care facilities for persons with developmental disabilities (Pt. VIII of Ch. 400, F.S.).
- Health care services pools (Pt. IX of Ch. 400, F.S.).
- Health care clinics (Pt. X of Ch. 400, F.S.).

- Clinical laboratories (Pt. I of Ch. 483, F.S.).
- Multiphasic health testing centers (Pt. II of Ch. 483, F.S.).
- Organ, tissue, and eye procurement organizations (Pt. V of Ch. 765, F.S.).

Providers are regulated under individual licensing statutes and the Health Care Licensing Procedures Act (Act) in Part II of Chapter 408, Florida Statutes. The Act provides uniform licensing procedures and standards applicable to most AHCA-regulated entities. The Act contains basic licensing standards for 29 provider types in areas such as licensure application requirements, ownership disclosure, staff background screening, inspections, and administrative sanctions, license renewal notices, and bankruptcy and eviction notices.

In addition to the Act, each provider type has an authorizing statute which includes unique provisions for licensure beyond the uniform criteria. Pursuant to s. 408.832, F.S., in the case of conflict between the Act and an individual authorizing statute, the Act prevails. There are several references in authorizing statutes, that conflict with or duplicate provisions in the Act, including references to the classification of deficiencies, penalties for an intentional or negligent act by a provider, provisional licenses, proof of financial ability to operate, inspection requirements and plans of corrections from providers. In 2009, the Legislature passed and the Governor signed into law SB 1986 (Ch. 2009-223 L.O.F), which made changes to part II of Chapter 408 that supersede components of the specific licensing statutes.

The bill repeals obsolete or duplicative provisions in licensing and related statutes, including expired reports and regulations and provisions that exist in other sections of law like the Act. The bill also makes changes to the Act to reduce, streamline, or clarify regulations for all providers regulated by AHCA.

The bill changes individual licensing statutes to reflect updates to the uniform standards in the Act. The bill makes corresponding changes to provider licensing statutes to reflect the changes made to the Act to eliminate conflicts and obsolete language.

The bill amends s. 400.811 related to inspections by AHCA, to clarify that AHCA inspection reports are not subject to challenge under Chapter 120, the Administrative Procedures Act, unless a sanction is imposed.

License Renewal Notices

Section 408.806, F.S., requires AHCA to notify licensees by mail or electronically when it is time to renew their licenses. AHCA mails renewal notices by to over 30,000 providers every two years. While the statute does not specify the manner of mailing notices, AHCA sends them by certified mail to verify receipt by the providers. The cost of certified mail is approximately $55,700 annually. According to AHCA, some certified mail is returned, as providers do not pick it up or the post office is unable to obtain necessary signatures for delivery. AHCA has also encountered situations in which licensees did not timely renew their licenses, and claimed that their lack of receipt of a renewal reminder was a reason for that failure.

The bill clarifies that renewal notices are courtesy reminders only and do not excuse the licensees from the requirement to file timely licensure applications. The revised language gives AHCA clear flexibility to use or not use certified mail to send courtesy renewal reminders.

Classification and Fines for Violations

Section 408.813, F.S., includes criteria for the classification of deficiencies for all providers licensed by AHCA. Some authorizing statutes also contain criteria for the classification of deficiencies, some of which do not match the provisions contained in the Act. The provisions in the Act legally supersede conflicting provisions in the authorizing statutes; however, the dual provisions are confusing, and some conflicts still exist. Additionally, authorizing statutes are inconsistent related to fines for unclassified deficiencies such as failure to maintain insurance or exceeding licensed bed capacity.

The bill modifies the classification of licensure violations related to nursing homes, home health agencies, intermediate care facilities for the developmentally disabled and adult family care homes to refer to the scope and severity in s. 408.813, F.S. Fine amounts for violations are unchanged. The bill adopts federal regulations by allowing a state fine to be imposed for a federal violation for intermediate care facilities for the developmentally disabled. The state fine for Class I, II and II violations are unchanged, but a new Class IV is added consistent with s. 408.813 with a fine not to exceed $500 for intermediate care facilities. The addition of the Class IV violation creates a lower category for minor violations by those facilities. This resolves conflicting or confusing differences between the Act and the authorizing statutes, and resolves inconsistencies between these three authorizing statutes.

In addition, the bill establishes uniform sanction authority for unclassified deficiencies of up to $500 per violation. Examples of unclassified deficiencies include failure to maintain insurance and other administrative requirements, exceeding licensed capacity, or violating a moratorium. Without fine authority, AHCA would be required to initiate revocation action for violations against those providers that do not have general fine authority. These violations may not warrant such a severe sanction.

Notice of Bankruptcy and Eviction

Currently, nursing homes are required to notify AHCA of bankruptcy filing pursuant to s. 400.141(1)(r), F.S. However, nursing homes are not required to notify AHCA of eviction, and there is no statutory requirement for other types of facility providers to notify AHCA if served with an eviction notice or bankruptcy. According to AHCA, recently it has been made aware of several eviction and bankruptcy orders affecting regulated facilities. If notice is not received early in the process, finding alternative resident placement can become difficult and create a hardship for clients.

The bill amends s. 408.806, F.S., to require providers' controlling interests to notify AHCA within 10 days after a court action to initiate bankruptcy foreclosure or eviction proceedings. This applies to any such action to which the controlling interest is a petitioner or defendant. According to AHCA, this allows it to monitor the facility to ensure patient protection and safe transfer, if needed. If the property upon which a licensed provider operates is encumbered by a mortgage or is leased, the bill requires the licensee to notify the mortgage holder or landlord that the property will provide services that require licensure and instruct the mortgage holder or landlord to notify AHCA if action is initiated against the licensee, such as eviction.

Licensure Denial and Revocation

An action by AHCA to deny or revoke a license is subject to challenge under the Administrative Procedures Act (Chapter 120). If a licensee challenges AHCA action, s. 408.815(2), F.S., allows the license to continue to exist and the provider to continue to operate during the pendency of the case. Once a final order is issued on the denial or revocation, if the original licensure expiration date has passed, there is no valid license and the provider must cease operations immediately. According to AHCA, this can be problematic for residents or clients who must immediately be moved to another facility or find another health care provider.

The bill amends s. 408.815, F.S., to authorize AHCA to extend a license expiration date up to 30 days beyond the final order date in the event of a licensure denial or revocation to allow for orderly transfer of residents or patients.

License Display

Section 408.804, F.S., makes it unlawful to provide or offer services that require licensure without having first obtained a license, and makes licenses valid only for the entities to which they are issued. Licensees are required to conspicuously display licenses for clients to see. The Act law does not currently address falsification or ill-usage of license documents.

The bill makes it a second degree misdemeanor to knowingly alter, deface or falsify a license, punishable by up to 60 days in jail and a fine up to $500. The bill makes it an administrative violation for a licensee to display an altered, defaced or falsified license. Such violations are subject to licensure revocation and a fine of up to $1,000 per day.

Hospital Licensure

Currently, Florida law allows AHCA to consider and use hospital accreditation by certain accrediting organizations for various purposes, including accepting accreditation surveys in lieu of AHCA survey, requiring accreditation for designation as certain specialty hospitals, and setting standards for quality improvement programs. Section 395.002, F.S., defines "accrediting organizations" as 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.

Complaint investigation procedures for hospitals exist in the hospital authorizing chapter as well as in the Act. Section 395.1046, F.S., provides special procedures for hospital complaints regarding emergency access issues. For example, AHCA must: investigate emergency access complaints even if the complaint is withdrawn; prepare an investigative report; and make a probable cause determination. According to AHCA, the federal process for emergency access complaints dictates that these complaints should not be handled any differently from other types of complaints, thereby creating two separate processes for emergency access complaints, one state and one federal.

The bill broadens the definition of "accrediting organizations" for hospitals and ambulatory surgery centers to include any nationally recognized accrediting organization which has standards comparable to AHCA's licensure standards, as determined by AHCA. This gives AHCA and providers greater flexibility to accept new or improving accrediting organizations, and reconsider existing ones based on current statutory and rule-based standards.

The bill repeals s. 395.1046, F.S., which modifies the procedures for investigations hospital emergency access complaints. Under the bill, AHCA would use existing hospital complaint investigation procedures used for all other types of complaints.

Home Health Agency Licensure

Currently, services provided by a home health agency must be covered by an agreement between the home health agency and the patient or the patient's legal representative. The agreement must specify the services being provided, rates or charges for services paid with private funds, and sources of payment.[1] The bill provides that the home health agency must provide a copy of the agreement to the patient or patient's representative.

Patient Rights

In addition, the bill creates new provisions requiring a home health agency to protect and promote the rights of each individual under its care. The home health agency is required to provide the patient a written notice of the patients rights prior to the initiation of treatment. The provisions are:

- The patient has the right to exercise their rights as a patient;
- The patient has the right to have their property treated with respect;
- The patient has the right to voice grievances regarding treatment, care, or lack of respect for personal property;
- The patient must be informed of the right to report complaints via the statewide toll-free telephone number;
- The patient has the right to be informed prior to receiving care and any changes in the plan of care; and

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[1] s. 400.487(1), F.S.

- The patient has the right to participate in the planning of care and they must be advised in advance.

The home health agency must investigate any complaint about patient care and failure to respect the patient's property and document both the existence and resolution of the complaint. The patient must be informed of the disciplines (such as registered nurse, home health aide, physical therapist) that will provide the care; notified in advance of the individuals who will provide treatment and care; and the frequency of visits.

Personnel

The bill amends s. 400.476, F.S., to provide additional requirements and limitations of staffing services for home health agencies.

The bill amends the responsibilities of a home health agency administrator. It requires that an alternate administrator meet the same qualifications as an administrator which includes not working for multiple unrelated home health agencies. It prohibits delegation of supervisory and administrative functions to another agency or organization.

The bill requires the director of nursing or a similarly qualified alternate to be available at all times during operating hours; to oversee the assignment of personnel and nursing services, home health aides and certified nursing assistants; and to participate in all activities related to the provision of professional services by the home health agency.

The bill provides that a home health agency's professional staff must comply with applicable state practice acts, accepted professional standards and principles, and the home health agency's policies and procedures. According to AHCA, by referencing the professional practice acts in state law, AHCA surveyors can cite for non-compliance, and follow up to see if a correction is made.[2]

The bill provides that a home health agency may not use a home health aide unless the individual has successfully completed a training and competency evaluation program to ensure they are adequately trained. All aides must be competent and cannot perform tasks for which they received an unsatisfactory evaluation except under direct supervision of a licensed practical nurse.

The bill amends s. 400.487, F.S., to require home health aides and certified nursing assistants to be supervised by a registered nurse. However, supervision may be provided by therapists if therapy services are only provided. The bill requires that a supervisory visit be made to the home of a patient at least once every 60 days while the home health aide or certified nursing is providing care to a patient. If a patient receiving skilled nursing or therapy services a nurse or therapist is required to visit at least once every two weeks, however, the visit does not have to be made while the aide or certified nursing assistant is providing care. The bill requires that home health aides and certified nursing assistants to receive written patient care instructions from their supervisors.

Provision of Services

The bill provides in s. 400.476, F.S., that a home health agency must provide at least one of the types of services directly. The services provided by individuals that are not direct employees and by other organizations under arrangements must have a written contract that specifies the services to be provided, procedures for scheduling visits, submitting notes, evaluating patients, and payment for services.

The bill specifies in s. 400.487, F.S., the services to be provided by a registered nurse, licensed practical nurse, home health aide, certified nursing assistant, therapist and therapist assistant are specified. All personnel serving patients must coordinate their efforts to provide care and show this communication in the patient's record. Verbal orders must be put in writing and plans of care are to be

[2] Agency for Health Care Administration 2010 Bill Analysis & Economic Impact Statement of House Bill 1503 (March 24, 2010).

reviewed every 60 days or more frequently if there is a significant change in the patient's condition. The bill specifies that drugs and treatments can only be provided as ordered by a physician, or advanced registered nurse practitioner or physician's assistant who works under the supervision of a physician. Flu and pneumonia vaccines may be administered to patients in accordance with home health agency policy that is developed in consultation with a physician.

The bill amends the definition of "admission" in s. 400.462, F.S., so that the evaluation of the patient does not have to occur when the patient gets home, but can be done while the patient is still at a hospital or rehabilitation facility. In addition, "home health services" is revised to include the provision of durable medical equipment. The bill provides a new definition for "primary home health agency" designating the agency that is responsible for the services provided as well as the plan of care since many home health agencies contract with other agencies for services.

Nursing Home Licensure

An application for nursing home licensure must include the following:

- A signed affidavit disclosing financial or ownership interest of a nursing home controlling interest in the last five years in any health or residential facility which has closed, filed bankruptcy, has a receiver appointed or an injunction placed against it, or been denied, suspended, or revoked by a regulatory agency. This information is also required in s. 400.111, F.S.
- A plan for quality assurance and risk management. This plan is also reviewed during onsite inspections by AHCA.
- The total number of beds including those certified for Medicaid and Medicaid. This information is also required by s. 408.806(1)(d), F.S.

The bill eliminates routine submission of documents at licensure by amending ss. 400.071, 400.111, 400.1183, 400.141, F.S. to substitute the requirement for nursing homes to routinely submit certain documents at the time of licensure with the ability for AHCA to request them if needed. The bill amends s. 400.0712, F.S., relating to nursing home licensure, removing duplicate language related to an inactive license which now exists in Chapter 408, Part II. The bill removes a requirement of a nursing home to notify AHCA of a change in the management company within 30 days. This provision now exists in Chapter 408, Part II.

Geriatric Outpatient Clinics

Under current law, nursing homes may establish a geriatric outpatient clinic as authorized in s. 400.021, F.S., to provide outpatient health care to persons 60 years of age or older. The clinic can be staffed by a registered nurse or a physician's assistant.

The bill expands the health care professionals that may staff a geriatric outpatient clinic in a nursing home by including licensed practical nurses under the direct supervision of registered nurses or advanced registered nurse practitioners.

Staffing Ratios

Nursing homes must comply with nursing staff-to-resident staffing ratios. Under s. 400.141(1)(o), F.S., if a nursing home fails to comply with minimum staffing requirements for two consecutive days, the facility must cease new admissions until the staffing ratio has been achieved for six consecutive days. Failure to self-impose this moratorium on admissions results in a Class II deficiency cited by AHCA. All other citations for a Class II deficiency represent current, ongoing non-compliance that AHCA determines has compromised a resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being. Use of the Class II deficiency for a failure to cease admissions is an inconsistent use of a "Class II" level compared to all other violations. No nursing homes were cited for this violation in 2009.

The bill modifies the penalty for nursing homes that fail to self impose a moratorium for insufficient staffing to a fine of $1,000 instead of a Class II deficiency.

Do Not Resuscitate Orders

Section 400.142, F.S., requires AHCA to develop rules relating to implementation of Do Not Resuscitate Orders for nursing home residents. According to AHCA, draft rules have been developed but are not final. Criteria for Do Not Resuscitate Orders are found in s. 401.45, F.S.

The bill removes the requirement for AHCA to promulgate rules related to the implementation of Do Not Resuscitate Orders for nursing home residents. The statutory requirements for such orders in s. 401.45 are clear and do not require rule implementation.

Inspections and Surveys

AHCA employs staff to inspect nursing homes, referred to as surveyors. Pursuant to s. 400.275, F.S., newly-hired nursing home surveyors must spend two days in a nursing home as part of basic training in a non-regulatory role. Federal regulations prescribe an extensive training process for nursing home inspection staff. Staff must pass the federal Surveyor Minimum Qualifications Test. Federal regulations prohibit an AHCA staff person who formerly worked in a nursing home from inspecting a nursing home within two years of employment with that home; state law requires a five year lapse.

The bill removes the requirement for new AHCA nursing home inspection staff to spend two days in a nursing home as part of basic training and aligns staff requirements with federal regulations. Agency nursing home staff must still be fully qualified under federal requirements for the Surveyor Minimum Qualifications Test.

Litigation Notices

Since 2001, nursing homes have been required by s. 400.147(10), F.S., to report civil notices of intent to litigate (required by s. 400.0233, F.S.) and civil complaints filed with clerks of courts by a resident or representative of a resident. This information has been used to produce the Semi-Annual Report on Nursing Homes required by s. 400.195, F.S. Information is reported in aggregate for all facilities.

The bill eliminates the requirement to report notices of intent to litigate and civil complaints.

Hospice Licensure

In 2009, the Legislature passed and the Governor signed into law SB 1986 (Ch. 2009-223 L.O.F). The new law requires any hospice initial or change of ownership applicant show anticipated provider revenue and expenditures, the basis for financing anticipated cash flow requirements and access to contingency financing, per s. 408.810(8), F.S. Current state law for hospice licensing, s. 400.606(1)(i), F.S., requires that an annual operating budget be submitted, which duplicates the financial information now required in the Act.

The hospice authorizing statutes (ss.400.606-400.609, F.S.) and federal regulations (42 CFR 418.98) require that hospices have inpatient beds for symptom control and pain management and for respite for caregivers. Inpatient beds may be in a hospital, skilled nursing facility or a freestanding inpatient facility operated by a hospice. Section 408.043, F.S., requires that there be a certificate of need for a hospice freestanding facility "primarily engaged in providing inpatient care and related services." This provision is repeated in the Act (s. 400.606(4), F.S.).

The bill removes the requirement for hospice licensure applicants to submit a projected annual operating budget. Since financial projections are already submitted as part of the proof of financial ability to operate as required in the Act, this removes duplicative requirements.

The bill amends both the Act and the hospice authorizing statute related to certificates of need for inpatient hospice facilities. The bill eliminates the modifier "primarily" to provide that any provision of inpatient hospice care, in any facility not already licensed as a health care facility (like a hospital or nursing home), requires a certificate of need. In effect, the bill provides that no exemptions to this requirement exist.

Home Medical Equipment Licensure

Licensure law, s. 400.931(2), F.S., allows a bond be posted as an alternative to submitted proof of financial ability to operate for a home medical equipment provider. In 2009, the Legislature passed and the Governor signed into law SB 1986 (Ch. 2009-223 L.O.F). The new law, s. 408.8065, F.S., requires that financial statements with evidence of funding to cover start up costs, working capital and contingencies be submitted.

The bill deletes the provisions of s. 400.931, F.S., related to the ability to submit a bond as an alternative to submitting proof of financial ability to operate. Due to the 2009 legislative changes, financial oversight is now addressed in the Act.

Health Care Clinic Licensure

Licensure for health care clinics includes mobile clinics and portable equipment providers. Exemptions from licensure exist for clinics that are wholly owned, directly or indirectly, by a publically traded corporation, among other exemptions.

Licensure law, s. 400.991(4), F.S., allows a bond be posted as an alternative to submitted proof of financial ability to operate for a home medical equipment provider. In 2009, the Legislature passed and the Governor signed into law SB 1986 (Ch. 2009-223 L.O.F). The new law, s. 408.8065, F.S., requires that financial statements with evidence of funding to cover start up costs, working capital and contingencies be submitted in.

The bill provides that portable service providers, such as mobile ultrasound providers, are subject to health care clinic licensure even though they do not deliver care at the clinic's location. The bill also expands an existing exemption from health care clinic licensure for clinics that are wholly owned, directly or indirectly, by a publically traded corporation to include pediatric cardiology or perinatology clinics.

Assisted Living Facility Licensure

Assisted Living Facilities (ALFs) are not currently required to submit resident population data to AHCA. However, there is a requirement to submit disaster/emergency information electronically via AHCA's Emergency Status System (ESS).[3] Submission of ESS data was a result of SB 1986 (Ch. 2009-223 L.O.F), and is being required at the time of licensure renewal. Currently, 42.1 percent (1197) of ALFs are currently enrolled in this system.

Section 429.23, F.S., requires each ALF to submit a monthly report on civil liability claims filed against the facility, and provides that the reports are not discoverable on civil or administrative actions.

Section 429. 35, F.S., requires AHCA to forward the results of biennial licensure surveys to various entities, including a local public library, the local ombudsman council, and the district Adult Services and Mental Health Program Office.

The bill repeals the requirement to monitor extended congregate care facilities, and replaces it with a requirement to monitor based upon citation of serious violations (Class I or Class II) in any ALF. The bill allows AHCA to charge a fee for monitoring visits.

[3] The Emergency Status System is a web-based system for reporting and tracking health care facility status before, during and after an emergency. See

The bill modifies AHCA's consultation duties, and requires AHCA to adopt rules for data submission by ALFs to AHCA related to numbers of residents receiving mental health or nursing services, resident funding sources and staffing. The bill requires facilities to electronically submit resident population data to AHCA on a semi-annual basis.

The bill also eliminates the requirement that ALFs report civil liability claims to AHCA, and allows AHCA to provide biennial survey results to the public electronically or via AHCA website.

Medicaid Long Term Care Waivers

Many of the Medicaid long term care waiver programs offer similar services and cover similar populations. According to AHCA, phasing out the Adult Day Health Care waiver, which is only available in a limited area of the state, will reduce administrative costs and create a system of care that is easier for Medicaid recipients to navigate. Individuals in this waiver will be given the opportunity to choose a comparable waiver program, and funding will be transferred to other waivers as recipients transfer to these other programs. The bill amends s. 409.906, F.S., which phases out the Medicaid Adult Day Health Waiver by December 31, 2010.

Multi-Phasic Health Testing Centers

Multi-phasic health testing centers (centers) are facilities which take human specimens for delivery to clinical laboratories for testing, and which may perform other basic human measurement functions. Centers are licensed and regulated under Part II of Chapter 483, Florida Statutes. Section 483.294, F.S., requires AHCA to inspect centers at least annually. The bill amends the inspection schedule, requiring AHCA to inspect centers biennially.

Brain and Spinal Cord Injury Trust Fund

Under current law, specified traffic fines may be used to provide an enhanced Medicaid rate to nursing homes that serve clients with brain and spinal cord injuries. According to AHCA, funds collected from these fines thus far have not been sufficient to support a Medicaid nursing home supplemental rate for an estimated 100 adult ventilator-dependent patients ($255.80 per day). As of July 2009, the Department of Revenue should have transferred a total of $39,294 to AHCA since May 2008.

The bill redirects the revenue to the Brain and Spinal Cord Injury Trust Fund within the Department of Health, to be used for Medicaid recipients who have sustained a spinal cord injury and who are technologically and respiratory dependent.

Pilot Projects

The Medicaid "Up-or-Out" Quality of Care Contract Management Program in s. 400.148, F.S., was created as a pilot program in 2001 to improve care in poor performing nursing homes and assisted living facilities by assigning trained medical personnel to facilities in select counties similar to Medicare models for managing the medical and supportive-care needs of long-term nursing home residents. The pilot was subject to appropriation; however, an appropriation was not allocated to this program and it was never implemented. According to AHCA, the criteria specified to identify poor performing facilities has been replaced by more comprehensive information for consumers to make informed choices for care.

The bill repeals the Medicaid Up or Out Pilot Quality of Care Contract Management Program.

AHCA Complaint Call Center

Currently s. 408.10, F.S., requires AHCA to operate a consumer call center. Operation of the AHCA call center is currently under contract with a private entity. According to AHCA, a Request for Proposal was advertised to consider new contractors; there was one bidder. The current contract has been extended for a six month period. Current annual budget of the contract is $1,050,482.40. The bill

provides AHCA the authority to provide staffing for this toll-free number through agency staff or other arrangements.

Reports

The semi-annual report on nursing homes in s. 400.195, F.S., was provided from December 2002 through June 2005 as a tool to provide information about litigation in Florida nursing homes. The report included demographic and regulatory information about nursing homes in Florida and aggregate numbers of notices of intent to litigate and civil complaints filed with the clerks of courts against Florida nursing homes. The reporting requirement ended June 2005 by law. The statutory obligation to publish this report has been met and by law expired on June 30, 2005.

The Consumer Directed Care Plus report was created as part of the new program, in s. 409.221(4)(k), F.S. for AHCA, Department of Elder Affairs, and Agency for Persons with Disabilities to provide an annual update of the review of the CDC program and recommendations for improvement. In March 2008, the CDC program was approved to be under the 1915(j) self directed option as a Medicaid state plan amendment instead of an 1115 Research and Demonstrative waiver. The 1915(j) state plan amendment requires annual and three (3) year comprehensive reporting to the federal Centers for Medicare and Medicaid Services (CMS). The report to CMS communicates current status of the CDC program, data on CDC enrollment, demographics, consumer satisfaction and cost effectiveness. This federal report is required by CMS to be available for public review.

The Comprehensive Review for Long Term Care Services program report was required to be submitted to the Legislature by July 1, 2005. However, the language requiring the report still exists in s. 409.912(15)(g), F.S.

The bill repeals these three report requirements.

Statutory Revisions

The bill updates the name of The Joint Commission, formerly known as the Joint Commission of the Accreditation of Healthcare Organizations, the Florida Society for Healthcare Risk Management and Patient Safety, formerly known as the Florida Society of Healthcare Risk Management, The Council on Accreditation, formerly known as the Council on Accreditation for Children and Family Services, and the federal Centers for Medicare and Medicaid Services formerly known as the federal Health Care Financing Administration.

The bill deletes definitions for and references to private review agents and utilization review in s. 395.002, F.S., to conform to repeals made in 2009 (SB 1986, ch. 2009-223 L.O.F.).

The bill makes technical corrections and repeals requested by the Division of Statutory Revision, such as repealing obsolete dates, amending cross-references, and updating the reference to an obsolete rule.

B. SECTION DIRECTORY:

Section 1. Amends s. 1.01, F.S., relating to definitions.
Section 2. Amends s. 112.0455, F.S., relating to drug-free workplace act.
Section 3. Amends s.154.11, F.S., relating to powers of board of trustees.
Section 4. Amends s. 318.21, F.S., relating to disposition of civil penalties by county courts.
Section 5. Repeals s. 383.325, F.S., relating to inspection reports.
Section 6. Amends s. 394.4787, F.S., relating to definitions.
Section 7. Amends s. 394.741, F.S., relating to accreditation requirements for providers of behavioral health care services.
Section 8. Amends s. 395.002, F.S., relating to definitions.
Section 9. Amends s. 395.003, F.S., relating to licensure, denial, suspension, and revocation.
Section 10. Amends s. 395.0193, F.S., relating to licensed facilities, peer review, disciplinary powers, and agency or partnership with physicians.

Section 11. Amends s. 395.1023, F.S., relating to child abuse and neglect cases, and duties.
Section 12. Amends s. 395.1041, F.S., relating to access to emergency services and care.
Section 13. Repeals s. 395.1046, F.S., relating to complaint investigation procedures.
Section 14. Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 15. Amends s. 395.10975, F.S., relating to Health Care Risk Manager Advisory Council.
Section 16. Amends s. 395.2050, F.S., relating to routine inquiry for organ and tissue donation, certification for procurement activities, and death records review.
Section 17. Amends s. 395.3036, F.S., relating to confidentiality of records and meetings of corporations that lease public hospitals or other public health care facilities.
Section 18. Repeals s. 395.3037, F.S., relating to definitions.
Section 19. Amends s. 395.3038, F.S., relating to state-listed primary stroke centers and comprehensive stroke centers, and notification of hospitals.
Section 20. Amends s. 395.602, F.S., relating to rural hospitals.
Section 21. Amends s. 400.021, F.S., relating to definitions.
Section 22. Amends s. 400.0239, F.S., relating to quality of long-term care facility improvement trust fund.
Section 23. Amends s. 400.063, F.S., relating to resident protection.
Section 24. Amends s. 400.071, F.S., relating to application for license.
Section 25. Amends s. 400.0712, F.S., relating to application for inactive license.
Section 26. Amends s. 400.111, F.S., relating to disclosure of controlling interest.
Section 27. Amends s. 400.1183, F.S., relating to resident grievance procedures,
Section 28. Amends s. 400.141, F.S., relating to administration and management of nursing homes facilities.
Section 29. Amends s. 400.142, F.S., relating to emergency medication kits, and orders not to resuscitate.
Section 30. Repeals s. 400.147, F.S., relating to internal risk management and quality assurance program.
Section 31. Repeals s. 400.148, F.S., relating to Medicaid "Up-or-Out" Quality of Care Contract Management Program.
Section 32. Amends s. 400.19, F.S., relating to rights of entry and inspection.
Section 33. Repeals s. 400.195, F.S., relating to agency reporting requirements.
Section 34. Amends s. 400.23, F.S., relating to rules, evaluation and deficiencies, and licensure status.
Section 35. Repeals s. 400.275, F.S., relating to agency duties.
Section 36. Amends s. 400.462, F.S., relating to definitions.
Section 37. Amends s. 400.476, F.S., relating to staffing requirements, notifications, and limitations on staffing services.
Section 38. Amends s. 400.484, F.S., relating to right of inspection, violations and fines.
Section 39. Amends s.400.487, F.S., relating to home health agreements; physician's, physician assistant's, and advanced registered nurse practitioner's treatment orders; patient assessment; establishment and review of plan of care; provision of services; and orders not to resuscitate.
Section 40. Amends s. 400.606, F.S., relating to license, application, renewal, conditional license or permit, and certificate of need.
Section 41. Amends s. 400.607, F.S., relating to denial, suspension, revocation of license; emergency actions; imposition of administrative fine; and grounds.
Section 42. Amends s. 400.925, F.S., relating to definitions.
Section 43. Amends s. 400.931, F.S., relating to application for license and fee.
Section 44. Amends s. 400.932, F.S., relating to administrative penalties.
Section 45. Amends s. 400.933, F.S., relating to licensure inspections and investigations.
Section 46. Amends s. 400.953, F.S., relating to background screening of home medical equipment provider personnel.
Section 47. Amends s. 400.967, F.S., relating to rules and classification of violations.
Section 48. Amends s. 400.969, F.S., relating to violation of part and penalties.
Section 49. Amends s. 400.9905, F.S., relating to definitions.
Section 50. Amends s. 400.991, F.S., relating to license requirements, background screenings, and prohibitions.

Section 51. Amends s. 400.9935, F.S., relating to clinic responsibilities.
Section 52. Amends s. 408.034, F.S., relating to duties and responsibilities of agency and rules.
Section 53. Amends s. 408.036, F.S., relating to projects subject to review and exemptions.
Section 54. Amends s. 408.043, F.S., relating to special provisions.
Section 55. Amends s. 408.05, F.S., relating to Florida Center for Health Information and Policy Analysis.
Section 56. Amends s. 408.061, F.S., relating to data collection, uniform systems of financial reporting, information relating to physician charges, confidential information, and immunity.
Section 57. Amends s. 408.10, F.S., relating to consumer complaints.
Section 58. Repeals s. 408.802, F.S., relating to applicability.
Section 59. Amends s. 408.804, F.S., relating to license required, and display.
Section 60. Amends s. 408.806, F.S., relating to license application process.
Section 61. Amends s. 408.810, F.S., relating to minimum licensure requirements.
Section 62. Amends s. 408.811, F.S., relating to right of inspection, copies, inspection reports, and plan for correction of deficiencies.
Section 63. Amends s. 408.813, F.S., relating to administrative fines, and violations.
Section 64. Amends s. 408.815, F.S., relating to license or application denial, and revocation.
Section 65. Amends s. 409.906, F.S., relating to optional Medicaid services.
Section 66. Repeals s. 409.221, F.S., relating to consumer-directed care program.
Section 67. Repeals s. 409.912, F.S., relating to cost-effective purchasing of health care.
Section 68. Amends s. 429.11, F.S., relating to initial application for license.
Section 69. Repeals s. 429.12, F.S., relating to sale or transfer of ownership of a facility.
Section 70. Amends s. 429.14, F.S., relating to administrative penalities.
Section 71. Amends s. 429.17, F.S., relating to expiration of license, renewal, and conditional license.
Section 72. Repeals s. 429.23, F.S., relating to internal risk management and quality assurance program; adverse incidents and reporting requirements.
Section 73. Amends s. 429.35, F.S., relating to maintenance of records, and reports.
Section 74. Amends s. 429.53, F.S., relating to consultation by the agency.
Section 75. Amends s. 429.65, F.S., relating to definitions.
Section 76. Amends s. 429.71, F.S., relating to classification of violations.
Section 77. Repeals s. 429.911, F.S., relating to denial, suspension, revocation of license; emergency action; administrative fines; investigations and inspections.
Section 78. Amends s. 429.915, F.S., relating to conditional license.
Section 79. Amends s. 430.80, F.S., relating to implementation of a teaching nursing home pilot project.
Section 80. Amends s. 440.13, F.S., relating to medical services and supplies, penalty for violations, and limitations.
Section 81. Amends s. 483.294, F.S., relating to inspection of centers.
Section 82. Amends s. 627.645, F.S., relating to denial of health insurance claims restricted.
Section 83. Amends s. 627.668, F.S., relating to optional coverage for mental and nervous disorders required, and exception.
Section 84. Amends s. 627.669, F.S., relating to optional coverage required for substance abuse impaired persons, and exception.
Section 85. Amends s. 627.736, F.S., relating to required personal injury protection benefits, exclusions, priority, and claims.
Section 86. Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of certificate.
Section 87. Amends s. 651.118, F.S., relating to the Agency for Health Care Administration, certificate of need, sheltered beds, and community beds.
Section 88. Amends s. 766.1015, F.S., relating to civil immunity for members of or consultants to certain boards, committees, or other entities.
Section 89. Provides that the bill takes effect July 1, 2010, unless expressly provided otherwise.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to AHCA as of January 26, 2010, 61 percent (940) of the 2,385 licensed home health agencies are also Medicare and/or Medicaid certified. Approximately one-third of these agencies are in the process of becoming certified.[4] Certified agencies are already required to meet the new requirements in this bill. Non-certified home health agencies may be impacted if they are not doing the following:[5]

- Supervisory visits for home health aides and certified nursing assistants
- Reviewing plans of care
- Investigating complaints from patients
- Preparing written contracts for individuals not directly employed and other agencies that are providing services under arrangements
- Having a director of nursing or alternate available during operating hours
- Having a registered nurse provide written instructions on patient care to home health aides and certified nursing assistants

D. FISCAL COMMENTS:

The bill is projected to save an estimated $55,700 annually in certified mail costs for reminder license renewal notices and up to $425,273 annually for staffing of AHCA's consumer call center.[6]

According to AHCA, state savings are derived by providing flexibility for staffing of the consumer call center. AHCA, proposes that the call center be brought in-house beginning FY 2010-2011. The net savings would be $354,273 in the first year and $425,273 annually thereafter.

Bringing operation of the call center in-house will increase the quality of complaint intake, improve efficiency and reduce costs to the state. Staff needed to operate the call center include: two Registered Nurse Specialists, two Health Facility Evaluator I positions, two Regulatory Specialist II positions, and four Regulatory Specialist I positions.

The bill also redirects revenue from certain traffic fines from AHCA to the Brain and Spinal Cord Trust Fund within the Department of Health.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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[4] Agency for Health Care Administration 2010 Bill Analysis & Economic Impact Statement of House Bill 1503 (March 24, 2010).
[5] *Id.*
[6] *Id.*

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to health care; amending s. 1.01, F.S.;
3 defining the term "Joint Commission"; amending s.
4 112.0455, F.S., relating to a prohibition against applying
5 the Drug-Free Workplace Act retroactively; conforming a
6 cross-reference; amending s. 154.11, F.S.; renaming the
7 Joint Commission on the Accreditation of Hospitals as the
8 "Joint Commission"; amending s. 318.21, F.S.; requiring
9 that certain fines received by the county court for
10 traffic infractions be remitted to the Department of
11 Revenue for deposit into the Brain and Spinal Cord Injury
12 Rehabilitation Trust Fund within the Department of Health
13 for use for Medicaid recipients who have spinal cord
14 injuries; repealing s. 383.325, F.S., relating to the
15 requirement of a licensed facility under s. 383.305, F.S.,
16 to maintain inspection reports; amending s. 394.4787,
17 F.S.; conforming a cross-reference; amending s. 394.741,
18 F.S.; renaming the Joint Commission on the Accreditation
19 of Healthcare Organizations as the "Joint Commission";
20 renaming the Council on Accreditation for Children and
21 Family Services as the "Council on Accreditation";
22 amending s. 395.002, F.S.; redefining the term
23 "accrediting organizations" as it relates to hospital
24 licensure and regulation; deleting the definitions for the
25 terms "initial denial determination," "private review
26 agent," and "utilization review plan" as they relate to
27 hospital licensure and regulation; amending s. 395.003,
28 F.S.; deleting a provision that prohibits the Agency for

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 Health Care Administration from authorizing emergency
30 departments that are located off the premises of a
31 licensed hospital; conforming a cross-reference; amending
32 s. 395.0193, F.S.; requiring the Division of Medical
33 Quality Assurance within the Department of Health to
34 conduct the reviews of the recordings of agendas and
35 minutes of licensed facilities; requiring the Division of
36 Medical Quality Assurance within the Department of Health
37 to report disciplinary actions rather than the Division of
38 Health Quality Assurance within the Agency for Health Care
39 Administration; amending s. 395.1023, F.S.; requiring a
40 licensed facility to adopt a protocol to designate a
41 physician in cases involving suspected child abuse at the
42 request of the Department of Children and Family Services
43 rather than the Department of Health; amending s.
44 395.1041, F.S.; deleting provisions that require the
45 Agency for Health Care Administration to request a
46 hospital to identify its services, notify each hospital of
47 the service capability to be included in the inventory,
48 and publish a final inventory; deleting obsolete
49 provisions; repealing s. 395.1046, F.S., relating to the
50 investigation of complaints regarding hospitals; amending
51 s. 395.1055, F.S.; requiring the agency to adopt rules
52 that ensure that licensed facility beds conform to certain
53 standards as specified by the agency, the Florida Building
54 Code, and the Florida Fire Prevention Code; amending s.
55 395.10972, F.S.; renaming the Florida Society of
56 Healthcare Risk Management as the "Florida Society for

57 Healthcare Risk Management and Patient Safety"; amending
58 s. 395.2050, F.S.; providing for an organ procurement
59 organization to be designated by the federal Centers for
60 Medicare and Medicaid Services rather than the federal
61 Health Care Financing Administration; amending s.
62 395.3036, F.S.; correcting a cross-reference; repealing s.
63 395.3037, F.S.; deleting definitions relating to obsolete
64 provisions governing primary and comprehensive stroke
65 centers; amending s. 395.3038, F.S.; renaming the Joint
66 Commission on the Accreditation of Healthcare
67 Organizations as the "Joint Commission"; amending s.
68 395.602, F.S.; redefining the term "rural hospital" as it
69 relates to hospital licensure and regulation; amending s.
70 400.021, F.S.; redefining the term "geriatric outpatient
71 clinic" as it relates to nursing homes; amending ss.
72 400.0239 and 400.063, F.S., relating to trust funds;
73 deleting obsolete provisions; amending s. 400.071, F.S.;
74 revising the requirements for an application for a license
75 to operate a nursing home facility; amending s. 400.0712,
76 F.S.; deleting the agency's authority to issue an inactive
77 license to a nursing home facility; amending s. 400.111,
78 F.S.; requiring the agency to request a licensee to submit
79 an affidavit disclosing financial or ownership interest
80 that a controlling interest has held in certain entities;
81 amending s. 400.1183, F.S.; requiring nursing home
82 facilities to maintain records of grievances for agency
83 inspection; deleting a requirement that a facility report
84 the number of grievances handled during the prior

85 licensure period; amending s. 400.141, F.S.; conforming a
86 cross-reference; deleting the requirement that a facility
87 submit to the agency information regarding a management
88 company with which it has entered into an agreement;
89 specifying a fine for a nursing facility's failure to
90 impose an admissions moratorium for not complying with
91 state minimum-staffing requirements; deleting the
92 requirement for a facility to report to the agency any
93 filing of bankruptcy protection, divestiture, or corporate
94 reorganization; amending s. 400.142, F.S.; deleting a
95 provision that requires the agency to adopt rules
96 regarding orders not to resuscitate; repealing s.
97 400.147(10), F.S., relating to a requirement that a
98 nursing home facility report any notice of a filing of a
99 claim for a violation of a resident's rights or a claim of
100 negligence; repealing s. 400.148, F.S., relating to the
101 Medicaid "Up-or-Out" Quality of Care Contract Management
102 Program; amending s. 400.19, F.S.; authorizing the agency
103 to verify the correction of certain deficiencies after an
104 unannounced inspection of a nursing home facility;
105 repealing s. 400.195, F.S., relating to agency reporting
106 requirements; amending s. 400.23, F.S.; renaming the
107 Children's Medical Services of the Department of Health as
108 the "Children's Medical Services Network"; deleting an
109 obsolete provision; amending s. 400.275, F.S.; deleting a
110 requirement that the agency ensure that a newly hired
111 nursing home surveyor is assigned full time to a licensed
112 nursing home to observe facility operations; amending s.

113 400.462, F.S.; revising definitions with regard to the
114 Home Health Services Act; defining the terms "primary home
115 health agency" and "temporary" with regard to the Home
116 Health Services Act; amending s. 400.476, F.S.; providing
117 requirements for an alternative administrator of a home
118 health agency; revising the duties of the administrator;
119 revising the requirements for a director of nursing for a
120 specified number of home health agencies; prohibiting a
121 home health agency from using an individual as a home
122 health aide unless the person has completed training and
123 an evaluation program; requiring a home health aide to
124 meet certain standards in order to be competent in
125 performing certain tasks; requiring a home health agency
126 and staff to comply with accepted professional standards;
127 providing certain requirements for a written contract
128 between certain personnel and the agency; requiring a home
129 health agency to provide certain services through its
130 employees; authorizing a home health agency to provide
131 additional services with another organization; providing
132 responsibilities of a home health agency when it provides
133 home health aide services through another organization;
134 requiring the home health agency to coordinate personnel
135 that provide home health services; requiring personnel to
136 communicate with the home health agency; amending s.
137 400.484, F.S.; redefining class I, II, III, and IV
138 deficiencies as class I, II, III, and IV violations;
139 amending s. 400.487, F.S.; requiring a home health agency
140 to provide a copy of the agreement between the agency and

141 a patient which specifies the home health services to be
142 provided; providing the rights that are protected by the
143 home health agency; requiring the home health agency to
144 furnish nursing services by or under the supervision of a
145 registered nurse; requiring the home health agency to
146 provide therapy services through a qualified therapist or
147 therapy assistant; providing the duties and qualifications
148 of a therapist and therapy assistant; requiring
149 supervision by a physical therapist or occupational
150 therapist of a physical therapist assistant or
151 occupational therapist assistant; providing duties of a
152 physical therapist assistant or occupational therapist
153 assistant; providing for speech therapy services to be
154 provided by a qualified speech pathologist or audiologist;
155 providing for a plan of care; providing that only the
156 staff of a home health agency may administer drugs and
157 treatments as ordered by certain health professionals;
158 providing requirements for verbal orders; providing duties
159 of a registered nurse, licensed practical nurse, home
160 health aide, and certified nursing assistant who work for
161 a home health agency; amending s. 400.606, F.S.; revising
162 the requirements for the plan for the delivery of home,
163 residential, and homelike inpatient hospice services for
164 terminally ill patients and their families; amending s.
165 400.607, F.S.; revising the grounds under which the agency
166 may take administrative action against a hospice; amending
167 s. 400.925, F.S.; renaming the Joint Commission on the
168 Accreditation of Healthcare Organizations as the "Joint

169 Commission" within the definition of the term "accrediting
170 organizations" as it relates to home medical equipment
171 providers; amending s. 400.931, F.S.; deleting the
172 requirement that an applicant for a license to be a home
173 medical equipment provider submit a surety bond to the
174 agency; amending s. 400.932, F.S.; revising the grounds
175 under which the agency may take administrative action
176 against a home medical equipment provider; amending s.
177 400.933, F.S.; prohibiting a home medical equipment
178 provider from submitting a survey or inspection of an
179 accrediting organization if the home medical equipment
180 provider's licensure is conditional or provisional;
181 amending s. 400.953, F.S.; deleting the requirement of a
182 general manager of a home medical equipment provider to
183 annually sign an affidavit regarding the background
184 screening of personnel; providing requirements for
185 submission of the affidavit; amending s. 400.967, F.S.;
186 redefining class I, II, III, and IV deficiencies as class
187 I, II, III, and IV violations as they relate to
188 intermediate care facilities for developmentally disabled
189 persons; amending s. 400.969, F.S.; revising the grounds
190 for an administrative or civil penalty; amending s.
191 400.9905, F.S.; redefining the term "portable service or
192 equipment provider" as it relates to the Health Care
193 Clinic Act; amending s. 400.991, F.S.; conforming a
194 provision to changes made by the act; revising application
195 requirements to show proof of financial ability to operate
196 a health care clinic; amending s. 400.9935, F.S.; renaming

197 the Joint Commission on the Accreditation of Healthcare
198 Organizations as the "Joint Commission" for purposes of
199 the Health Care Clinic Act; amending s. 408.034, F.S.;
200 prohibiting the agency from issuing a license to a health
201 care facility that applies for a license to operate an
202 intermediate care facility for developmentally disabled
203 persons under certain conditions; amending s. 408.036,
204 F.S., relating to certificates of need; conforming a
205 provision to changes made by the act; amending s. 408.043,
206 F.S.; requiring a freestanding facility or a part of the
207 facility that is the inpatient hospice care component of a
208 hospice to obtain a certificate of need; amending s.
209 408.05, F.S.; renaming the Joint Commission on the
210 Accreditation of Healthcare Organizations as the "Joint
211 Commission"; amending s. 408.061, F.S.; revising
212 requirements for the reporting of certified data elements
213 by health care facilities; amending s. 408.10, F.S.;
214 authorizing the agency to provide staffing for a toll-free
215 phone number for the purpose of handling consumer
216 complaints regarding a health care facility; repealing s.
217 408.802(11), F.S., relating to the applicability of the
218 Health Care Licensing Procedures Act to private review
219 agents; amending s. 408.804, F.S.; providing a criminal
220 penalty for altering, defacing, or falsifying a license
221 certificate of certain health care providers; providing
222 civil penalties for displaying an altered, defaced, or
223 falsified license certificate; amending s. 408.806, F.S.;
224 requiring the agency to provide a courtesy notice to a

225 licensee regarding the expiration of a licensee's license;
226 providing that failure of the agency to provide the
227 courtesy notice or failure of the licensee to receive the
228 notice is not an excuse for the licensee to timely renew
229 its license; providing that payment of the late fee is
230 required for a later application; amending s. 408.810,
231 F.S.; revising the requirements for obtaining and
232 maintaining a license for certain health care providers
233 and those who own a controlling interest in a health care
234 provider; amending s. 408.811, F.S.; providing that a
235 licensee's inspection report is not subject to
236 administrative challenge; amending s. 408.813, F.S.;
237 authorizing the agency to impose administrative fines for
238 unclassified violations; amending s. 408.815, F.S.;
239 authorizing the agency to extend the expiration date of a
240 license for the purpose of the safe and orderly discharge
241 of clients; authorizing the agency to impose conditions on
242 the extension; amending s. 409.906, F.S.; requiring the
243 agency, in consultation with the Department of Elderly
244 Affairs, to phase out the adult day health care waiver
245 program; requiring adult day health care waiver providers,
246 in consultation with resource centers for the aged to
247 assist in the transition of enrollees from the waiver
248 program; repealing s. 409.221(4)(k), F.S., relating to the
249 responsibility of the agency, the Department of Elderly
250 Affairs, the Department of Health, the Department of
251 Children and Family Services, and the Agency for Persons
252 with Disabilities to review and assess the implementation

253 of the consumer-directed care program and the agency's
254 responsibility to submit a report to the Legislature;
255 repealing s. 409.912(15)(e), (f), and (g), F.S., relating
256 to a requirement for the Agency for Health Care
257 Administration to submit a report to the Legislature
258 regarding the operations of the CARE program; amending s.
259 429.11, F.S.; deleting provisions relating to a
260 provisional license to operate as an assisted living
261 facility; repealing s. 429.12(2), F.S., relating to the
262 sale or transfer of ownership of an assisted living
263 facility; amending s. 429.14, F.S.; authorizing the agency
264 to provide electronically or through the agency's Internet
265 site information regarding the denial, suspension, or
266 revocation of a license to the Division of Hotels and
267 Restaurants of the Department of Business and Professional
268 Regulation; amending s. 429.17, F.S.; revising the
269 requirements for a conditional license to operate an
270 assisted living facility; repealing s. 429.23(5), F.S.,
271 relating to each assisted living facility's requirement to
272 submit a report to the agency regarding liability claims
273 filed against it; amending s. 429.35, F.S.; authorizing
274 the agency to provide electronically or through the
275 agency's Internet website information regarding the
276 results of an inspection to the local ombudsman council;
277 amending s. 429.53, F.S.; requiring the agency, rather
278 than the agency's area offices of licensure and
279 certification, to provide consultation to certain persons
280 and licensees regarding assisted living facilities;

281 redefining the term "consultation" as it relates to
282 assisted living facilities; amending s. 429.65, F.S.;
283 redefining the term "adult family-care home" as it relates
284 to the Adult Family-Care Home Act; amending s. 429.71,
285 F.S.; redefining class I, II, III, and IV deficiencies as
286 class I, II, III, and IV violations as they relate to
287 adult family-care homes; repealing s. 429.911, F.S.,
288 relating to the denial, suspension, or revocation of a
289 license to operate an adult day care center; amending s.
290 429.915, F.S.; revising requirements for a conditional
291 license to operate an adult day care center; amending s.
292 430.80, F.S.; conforming a cross-reference; renaming the
293 Joint Commission on the Accreditation of Healthcare
294 Organizations to the Joint Commission; amending s. 440.13,
295 F.S.; renaming the Joint Commission on the Accreditation
296 of Healthcare Organizations as the "Joint Commission";
297 amending s. 483.294, F.S.; requiring the agency to
298 biennially inspect the premises and operations of
299 multiphasic health testing centers; amending ss. 627.645,
300 627.668, and 627.669, F.S.; renaming the Joint Commission
301 on the Accreditation of Hospitals to the Joint Commission;
302 amending ss. 627.736 and 641.495 F.S.; renaming the Joint
303 Commission on the Accreditation of Healthcare
304 Organizations as the "Joint Commission"; amending s.
305 651.118, F.S.; conforming a cross-reference; amending s.
306 766.1015, F.S.; renaming the Joint Commission on the
307 Accreditation of Healthcare Organizations as the "Joint
308 Commission"; providing effective dates.

309

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

311

312 Section 1. Subsection (16) is added to section 1.01,
313 Florida Statutes, to read:
314 1.01 Definitions.—In construing these statutes and each
315 and every word, phrase, or part hereof, where the context will
316 permit:
317 (16) The term "Joint Commission" means the independent,
318 not-for-profit organization that evaluates and accredits
319 hospitals and health care organizations and programs in the
320 United States. The Joint Commission was formerly known as the
321 Joint Commission on Accreditation of Hospitals (JCAH) and the
322 Joint Commission on Accreditation of Healthcare Organizations
323 (JCAHO).
324 Section 2. Paragraphs (f) through (k) of subsection (10)
325 of section 112.0455, Florida Statutes, are redesignated as
326 paragraphs (e) through (j), present paragraph (e) of that
327 subsection is amended, and paragraph (e) of subsection (14) of
328 that section is amended to read:
329 112.0455 Drug-Free Workplace Act.—
330 (10) EMPLOYER PROTECTION.—
331 ~~(e) Nothing in this section shall be construed to operate~~
332 ~~retroactively, and nothing in this section shall abrogate the~~
333 ~~right of an employer under state law to conduct drug tests prior~~
334 ~~to January 1, 1990. A drug test conducted by an employer prior~~
335 ~~to January 1, 1990, is not subject to this section.~~ .
336 (14) DISCIPLINE REMEDIES.—

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337 (e) Upon resolving an appeal filed pursuant to paragraph
338 (c), and finding a violation of this section, the commission may
339 order the following relief:
340 1. Rescind the disciplinary action, expunge related
341 records from the personnel file of the employee or job applicant
342 and reinstate the employee.
343 2. Order compliance with paragraph (10)(f)~~(g)~~.
344 3. Award back pay and benefits.
345 4. Award the prevailing employee or job applicant the
346 necessary costs of the appeal, reasonable attorney's fees, and
347 expert witness fees.
348 Section 3. Paragraph (n) of subsection (1) of section
349 154.11, Florida Statutes, is amended to read:
350 154.11 Powers of board of trustees.—
351 (1) The board of trustees of each public health trust
352 shall be deemed to exercise a public and essential governmental
353 function of both the state and the county and in furtherance
354 thereof it shall, subject to limitation by the governing body of
355 the county in which such board is located, have all of the
356 powers necessary or convenient to carry out the operation and
357 governance of designated health care facilities, including, but
358 without limiting the generality of, the foregoing:
359 (n) To appoint originally the staff of physicians to
360 practice in any designated facility owned or operated by the
361 board and to approve the bylaws and rules to be adopted by the
362 medical staff of any designated facility owned and operated by
363 the board, such governing regulations to be in accordance with
364 the standards of the Joint Commission ~~on the Accreditation of~~

365 ~~Hospitals~~ which provide, among other things, for the method of
366 appointing additional staff members and for the removal of staff
367 members.
368 Section 4. Subsection (15) of section 318.21, Florida
369 Statutes, is amended to read:
370 318.21 Disposition of civil penalties by county courts.—
371 All civil penalties received by a county court pursuant to the
372 provisions of this chapter shall be distributed and paid monthly
373 as follows:
374 (15) Of the additional fine assessed under s. 318.18(3)(e)
375 for a violation of s. 316.1893, 50 percent of the moneys
376 received from the fines shall be remitted to the Department of
377 Revenue and deposited into Brain and Spinal Cord Injury
378 Rehabilitation Trust Fund within Department of Health and shall
379 be appropriated to the Department of Health ~~Agency for Health~~
380 ~~Care Administration~~ as general revenue to ~~provide an enhanced~~
381 ~~Medicaid payment to nursing homes that~~ serve Medicaid recipients
382 with ~~brain and~~ spinal cord injuries that are medically complex,
383 technologically dependent, and respiratory dependent. The
384 remaining 50 percent of the moneys received from the enhanced
385 fine imposed under s. 318.18(3)(e) shall be remitted to the
386 Department of Revenue and deposited into the Department of
387 Health Administrative Trust Fund to provide financial support to
388 certified trauma centers in the counties where enhanced penalty
389 zones are established to ensure the availability and
390 accessibility of trauma services. Funds deposited into the
391 Administrative Trust Fund under this subsection shall be
392 allocated as follows:

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393 (a) Fifty percent shall be allocated equally among all
394 Level I, Level II, and pediatric trauma centers in recognition
395 of readiness costs for maintaining trauma services.
396 (b) Fifty percent shall be allocated among Level I, Level
397 II, and pediatric trauma centers based on each center's relative
398 volume of trauma cases as reported in the Department of Health
399 Trauma Registry.
400 Section 5. Section 383.325, Florida Statutes, is repealed.
401 Section 6. Subsection (7) of section 394.4787, Florida
402 Statutes, is amended to read:
403 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788,
404 and 394.4789.—As used in this section and ss. 394.4786,
405 394.4788, and 394.4789:
406 (7) "Specialty psychiatric hospital" means a hospital
407 licensed by the agency pursuant to s. 395.002(26) ~~s. 395.002(28)~~
408 and part II of chapter 408 as a specialty psychiatric hospital.
409 Section 7. Subsection (2) of section 394.741, Florida
410 Statutes, is amended to read:
411 394.741 Accreditation requirements for providers of
412 behavioral health care services.—
413 (2) Notwithstanding any provision of law to the contrary,
414 accreditation shall be accepted by the agency and department in
415 lieu of the agency's and department's facility licensure onsite
416 review requirements and shall be accepted as a substitute for
417 the department's administrative and program monitoring
418 requirements, except as required by subsections (3) and (4),
419 for:
420 (a) Any organization from which the department purchases

421 behavioral health care services that is accredited by the Joint
422 Commission ~~on Accreditation of Healthcare Organizations~~ or the
423 Council on Accreditation ~~for Children and Family Services~~, or
424 has those services that are being purchased by the department
425 accredited by CARF—the Rehabilitation Accreditation Commission.
426 (b) Any mental health facility licensed by the agency or
427 any substance abuse component licensed by the department that is
428 accredited by the Joint Commission ~~on Accreditation of~~
429 ~~Healthcare Organizations~~, CARF—the Rehabilitation Accreditation
430 Commission, or the Council on Accreditation ~~of Children and~~
431 ~~Family Services~~.
432 (c) Any network of providers from which the department or
433 the agency purchases behavioral health care services accredited
434 by the Joint Commission ~~on Accreditation of Healthcare~~
435 ~~Organizations~~, CARF—the Rehabilitation Accreditation Commission,
436 the Council on Accreditation ~~of Children and Family Services~~, or
437 the National Committee for Quality Assurance. A provider
438 organization, which is part of an accredited network, is
439 afforded the same rights under this part.
440 Section 8. Section 395.002, Florida Statutes, is amended
441 to read:
442 395.002 Definitions.—As used in this chapter, the term:
443 (1) "Accrediting organizations" means nationally
444 recognized or approved accrediting organizations whose standards
445 incorporate comparable licensure requirements as determined by
446 the agency. ~~the Joint Commission on Accreditation of Healthcare~~
447 ~~Organizations, the American Osteopathic Association, the~~
448 ~~Commission on Accreditation of Rehabilitation Facilities, and~~

449 ~~the Accreditation Association for Ambulatory Health Care, Inc.~~
450 (2) "Agency" means the Agency for Health Care
451 Administration.
452 (3) "Ambulatory surgical center" or "mobile surgical
453 facility" means a facility the primary purpose of which is to
454 provide elective surgical care, in which the patient is admitted
455 to and discharged from such facility within the same working day
456 and is not permitted to stay overnight, and which is not part of
457 a hospital. However, a facility existing for the primary purpose
458 of performing terminations of pregnancy, an office maintained by
459 a physician for the practice of medicine, or an office
460 maintained for the practice of dentistry shall not be construed
461 to be an ambulatory surgical center, provided that any facility
462 or office which is certified or seeks certification as a
463 Medicare ambulatory surgical center shall be licensed as an
464 ambulatory surgical center pursuant to s. 395.003. Any structure
465 or vehicle in which a physician maintains an office and
466 practices surgery, and which can appear to the public to be a
467 mobile office because the structure or vehicle operates at more
468 than one address, shall be construed to be a mobile surgical
469 facility.
470 (4) "Biomedical waste" means any solid or liquid waste as
471 defined in s. 381.0098(2)(a).
472 (5) "Clinical privileges" means the privileges granted to
473 a physician or other licensed health care practitioner to render
474 patient care services in a hospital, but does not include the
475 privilege of admitting patients.
476 (6) "Department" means the Department of Health.

477 (7) "Director" means any member of the official board of
478 directors as reported in the organization's annual corporate
479 report to the Florida Department of State, or, if no such report
480 is made, any member of the operating board of directors. The
481 term excludes members of separate, restricted boards that serve
482 only in an advisory capacity to the operating board.
483 (8) "Emergency medical condition" means:
484 (a) A medical condition manifesting itself by acute
485 symptoms of sufficient severity, which may include severe pain,
486 such that the absence of immediate medical attention could
487 reasonably be expected to result in any of the following:
488 1. Serious jeopardy to patient health, including a
489 pregnant woman or fetus.
490 2. Serious impairment to bodily functions.
491 3. Serious dysfunction of any bodily organ or part.
492 (b) With respect to a pregnant woman:
493 1. That there is inadequate time to effect safe transfer
494 to another hospital prior to delivery;
495 2. That a transfer may pose a threat to the health and
496 safety of the patient or fetus; or
497 3. That there is evidence of the onset and persistence of
498 uterine contractions or rupture of the membranes.
499 (9) "Emergency services and care" means medical screening,
500 examination, and evaluation by a physician, or, to the extent
501 permitted by applicable law, by other appropriate personnel
502 under the supervision of a physician, to determine if an
503 emergency medical condition exists and, if it does, the care,
504 treatment, or surgery by a physician necessary to relieve or

505 eliminate the emergency medical condition, within the service
506 capability of the facility.
507 (10) "General hospital" means any facility which meets the
508 provisions of subsection (12) and which regularly makes its
509 facilities and services available to the general population.
510 (11) "Governmental unit" means the state or any county,
511 municipality, or other political subdivision, or any department,
512 division, board, or other agency of any of the foregoing.
513 (12) "Hospital" means any establishment that:
514 (a) Offers services more intensive than those required for
515 room, board, personal services, and general nursing care, and
516 offers facilities and beds for use beyond 24 hours by
517 individuals requiring diagnosis, treatment, or care for illness,
518 injury, deformity, infirmity, abnormality, disease, or
519 pregnancy; and
520 (b) Regularly makes available at least clinical laboratory
521 services, diagnostic X-ray services, and treatment facilities
522 for surgery or obstetrical care, or other definitive medical
523 treatment of similar extent, except that a critical access
524 hospital, as defined in s. 408.07, shall not be required to make
525 available treatment facilities for surgery, obstetrical care, or
526 similar services as long as it maintains its critical access
527 hospital designation and shall be required to make such
528 facilities available only if it ceases to be designated as a
529 critical access hospital.
530
531 However, the provisions of this chapter do not apply to any
532 institution conducted by or for the adherents of any well-

533 recognized church or religious denomination that depends
534 exclusively upon prayer or spiritual means to heal, care for, or
535 treat any person. For purposes of local zoning matters, the term
536 "hospital" includes a medical office building located on the
537 same premises as a hospital facility, provided the land on which
538 the medical office building is constructed is zoned for use as a
539 hospital; provided the premises were zoned for hospital purposes
540 on January 1, 1992.

541 (13) "Hospital bed" means a hospital accommodation which
542 is ready for immediate occupancy, or is capable of being made
543 ready for occupancy within 48 hours, excluding provision of
544 staffing, and which conforms to minimum space, equipment, and
545 furnishings standards as specified by rule of the agency for the
546 provision of services specified in this section to a single
547 patient.

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

552 (14) ~~(15)~~ "Intensive residential treatment programs for
553 children and adolescents" means a specialty hospital accredited
554 by an accrediting organization as defined in subsection (1)
555 which provides 24-hour care and which has the primary functions
556 of diagnosis and treatment of patients under the age of 18
557 having psychiatric disorders in order to restore such patients
558 to an optimal level of functioning.

559 (15) ~~(16)~~ "Licensed facility" means a hospital, ambulatory
560 surgical center, or mobile surgical facility licensed in

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561 accordance with this chapter.
562 (16) ~~(17)~~ "Lifesafety" means the control and prevention of
563 fire and other life-threatening conditions on a premises for the
564 purpose of preserving human life.
565 (17) ~~(18)~~ "Managing employee" means the administrator or
566 other similarly titled individual who is responsible for the
567 daily operation of the facility.
568 (18) ~~(19)~~ "Medical staff" means physicians licensed under
569 chapter 458 or chapter 459 with privileges in a licensed
570 facility, as well as other licensed health care practitioners
571 with clinical privileges as approved by a licensed facility's
572 governing board.
573 (19) ~~(20)~~ "Medically necessary transfer" means a transfer
574 made necessary because the patient is in immediate need of
575 treatment for an emergency medical condition for which the
576 facility lacks service capability or is at service capacity.
577 (20) ~~(21)~~ "Mobile surgical facility" is a mobile facility
578 in which licensed health care professionals provide elective
579 surgical care under contract with the Department of Corrections
580 or a private correctional facility operating pursuant to chapter
581 957 and in which inmate patients are admitted to and discharged
582 from said facility within the same working day and are not
583 permitted to stay overnight. However, mobile surgical facilities
584 may only provide health care services to the inmate patients of
585 the Department of Corrections, or inmate patients of a private
586 correctional facility operating pursuant to chapter 957, and not
587 to the general public.
588 (21) ~~(22)~~ "Person" means any individual, partnership,

589 corporation, association, or governmental unit.
590 <u>(22)</u>~~(23)~~ "Premises" means those buildings, beds, and
591 equipment located at the address of the licensed facility and
592 all other buildings, beds, and equipment for the provision of
593 hospital, ambulatory surgical, or mobile surgical care located
594 in such reasonable proximity to the address of the licensed
595 facility as to appear to the public to be under the dominion and
596 control of the licensee. For any licensee that is a teaching
597 hospital as defined in s. 408.07(45), reasonable proximity
598 includes any buildings, beds, services, programs, and equipment
599 under the dominion and control of the licensee that are located
600 at a site with a main address that is within 1 mile of the main
601 address of the licensed facility; and all such buildings, beds,
602 and equipment may, at the request of a licensee or applicant, be
603 included on the facility license as a single premises.
604 ~~(24) "Private review agent" means any person or entity~~
605 ~~which performs utilization review services for third-party~~
606 ~~payors on a contractual basis for outpatient or inpatient~~
607 ~~services. However, the term shall not include full-time~~
608 ~~employees, personnel, or staff of health insurers, health~~
609 ~~maintenance organizations, or hospitals, or wholly owned~~
610 ~~subsidiaries thereof or affiliates under common ownership, when~~
611 ~~performing utilization review for their respective hospitals,~~
612 ~~health maintenance organizations, or insureds of the same~~
613 ~~insurance group. For this purpose, health insurers, health~~
614 ~~maintenance organizations, and hospitals, or wholly owned~~
615 ~~subsidiaries thereof or affiliates under common ownership,~~
616 ~~include such entities engaged as administrators of self-~~

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617 ~~insurance as defined in s. 624.031.~~
618 (23)~~(25)~~ "Service capability" means all services offered
619 by the facility where identification of services offered is
620 evidenced by the appearance of the service in a patient's
621 medical record or itemized bill.
622 (24)~~(26)~~ "At service capacity" means the temporary
623 inability of a hospital to provide a service which is within the
624 service capability of the hospital, due to maximum use of the
625 service at the time of the request for the service.
626 (25)~~(27)~~ "Specialty bed" means a bed, other than a general
627 bed, designated on the face of the hospital license for a
628 dedicated use.
629 (26)~~(28)~~ "Specialty hospital" means any facility which
630 meets the provisions of subsection (12), and which regularly
631 makes available either:
632 (a) The range of medical services offered by general
633 hospitals, but restricted to a defined age or gender group of
634 the population;
635 (b) A restricted range of services appropriate to the
636 diagnosis, care, and treatment of patients with specific
637 categories of medical or psychiatric illnesses or disorders; or
638 (c) Intensive residential treatment programs for children
639 and adolescents as defined in subsection (14) ~~(15)~~.
640 (27)~~(29)~~ "Stabilized" means, with respect to an emergency
641 medical condition, that no material deterioration of the
642 condition is likely, within reasonable medical probability, to
643 result from the transfer of the patient from a hospital.
644 ~~(30) "Utilization review" means a system for reviewing the~~

645 ~~medical necessity or appropriateness in the allocation of health~~
646 ~~care resources of hospital services given or proposed to be~~
647 ~~given to a patient or group of patients.~~
648 ~~(31) "Utilization review plan" means a description of the~~
649 ~~policies and procedures governing utilization review activities~~
650 ~~performed by a private review agent.~~
651 (28) ~~(32)~~ "Validation inspection" means an inspection of
652 the premises of a licensed facility by the agency to assess
653 whether a review by an accrediting organization has adequately
654 evaluated the licensed facility according to minimum state
655 standards.
656 Section 9. Subsection (1) and paragraph (b) of subsection
657 (2) of section 395.003, Florida Statutes, are amended to read:
658 395.003 Licensure; denial, suspension, and revocation.—
659 (1)(a) The requirements of part II of chapter 408 apply to
660 the provision of services that require licensure pursuant to ss.
661 395.001-395.1065 and part II of chapter 408 and to entities
662 licensed by or applying for such licensure from the Agency for
663 Health Care Administration pursuant to ss. 395.001-395.1065. A
664 license issued by the agency is required in order to operate a
665 hospital, ambulatory surgical center, or mobile surgical
666 facility in this state.
667 (b)1. It is unlawful for a person to use or advertise to
668 the public, in any way or by any medium whatsoever, any facility
669 as a "hospital," "ambulatory surgical center," or "mobile
670 surgical facility" unless such facility has first secured a
671 license under the provisions of this part.
672 2. This part does not apply to veterinary hospitals or to

673 commercial business establishments using the word "hospital,"
674 "ambulatory surgical center," or "mobile surgical facility" as a
675 part of a trade name if no treatment of human beings is
676 performed on the premises of such establishments.
677 ~~(c) Until July 1, 2006, additional emergency departments~~
678 ~~located off the premises of licensed hospitals may not be~~
679 ~~authorized by the agency.~~
680 (2)
681 (b) The agency shall, at the request of a licensee that is
682 a teaching hospital as defined in s. 408.07(45), issue a single
683 license to a licensee for facilities that have been previously
684 licensed as separate premises, provided such separately licensed
685 facilities, taken together, constitute the same premises as
686 defined in s. 395.002(22) ~~(23)~~. Such license for the single
687 premises shall include all of the beds, services, and programs
688 that were previously included on the licenses for the separate
689 premises. The granting of a single license under this paragraph
690 shall not in any manner reduce the number of beds, services, or
691 programs operated by the licensee.
692 Section 10. Paragraph (e) of subsection (2) and subsection
693 (4) of section 395.0193, Florida Statutes, are amended to read:
694 395.0193 Licensed facilities; peer review; disciplinary
695 powers; agency or partnership with physicians.—
696 (2) Each licensed facility, as a condition of licensure,
697 shall provide for peer review of physicians who deliver health
698 care services at the facility. Each licensed facility shall
699 develop written, binding procedures by which such peer review
700 shall be conducted. Such procedures shall include:

701 (e) Recording of agendas and minutes which do not contain
702 confidential material, for review by the Division of Medical
703 Quality Assurance of the department ~~Health Quality Assurance of~~
704 ~~the agency~~.
705 (4) Pursuant to ss. 458.337 and 459.016, any disciplinary
706 actions taken under subsection (3) shall be reported in writing
707 to the Division of Medical Quality Assurance of the department
708 ~~Health Quality Assurance of the agency~~ within 30 working days
709 after its initial occurrence, regardless of the pendency of
710 appeals to the governing board of the hospital. The notification
711 shall identify the disciplined practitioner, the action taken,
712 and the reason for such action. All final disciplinary actions
713 taken under subsection (3), if different from those which were
714 reported to the department ~~agency~~ within 30 days after the
715 initial occurrence, shall be reported within 10 working days to
716 the Division of Medical Quality Assurance of the department
717 ~~Health Quality Assurance of the agency~~ in writing and shall
718 specify the disciplinary action taken and the specific grounds
719 therefor. The division shall review each report and determine
720 whether it potentially involved conduct by the licensee that is
721 subject to disciplinary action, in which case s. 456.073 shall
722 apply. The reports are not subject to inspection under s.
723 119.07(1) even if the division's investigation results in a
724 finding of probable cause.
725 Section 11. Section 395.1023, Florida Statutes, is amended
726 to read:
727 395.1023 Child abuse and neglect cases; duties.—Each
728 licensed facility shall adopt a protocol that, at a minimum,

729 requires the facility to:
730 (1) Incorporate a facility policy that every staff member
731 has an affirmative duty to report, pursuant to chapter 39, any
732 actual or suspected case of child abuse, abandonment, or
733 neglect; and
734 (2) In any case involving suspected child abuse,
735 abandonment, or neglect, designate, at the request of the
736 Department of Children and Family Services, a staff physician to
737 act as a liaison between the hospital and the Department of
738 Children and Family Services office which is investigating the
739 suspected abuse, abandonment, or neglect, and the child
740 protection team, as defined in s. 39.01, when the case is
741 referred to such a team.
742
743 Each general hospital and appropriate specialty hospital shall
744 comply with the provisions of this section and shall notify the
745 agency and the Department of Children and Family Services of its
746 compliance by sending a copy of its policy to the agency and the
747 Department of Children and Family Services as required by rule.
748 The failure by a general hospital or appropriate specialty
749 hospital to comply shall be punished by a fine not exceeding
750 $1,000, to be fixed, imposed, and collected by the agency. Each
751 day in violation is considered a separate offense.
752 Section 12. Subsection (2) and paragraph (d) of subsection
753 (3) of section 395.1041, Florida Statutes, are amended to read:
754 395.1041 Access to emergency services and care.—
755 (2) INVENTORY OF HOSPITAL EMERGENCY SERVICES.—The agency
756 shall establish and maintain an inventory of hospitals with

757 emergency services. The inventory shall list all services within
758 the service capability of the hospital, and such services shall
759 appear on the face of the hospital license. Each hospital having
760 emergency services shall notify the agency of its service
761 capability in the manner and form prescribed by the agency. The
762 agency shall use the inventory to assist emergency medical
763 services providers and others in locating appropriate emergency
764 medical care. The inventory shall also be made available to the
765 general public. ~~On or before August 1, 1992, the agency shall~~
766 ~~request that each hospital identify the services which are~~
767 ~~within its service capability. On or before November 1, 1992,~~
768 ~~the agency shall notify each hospital of the service capability~~
769 ~~to be included in the inventory. The hospital has 15 days from~~
770 ~~the date of receipt to respond to the notice. By December 1,~~
771 ~~1992, the agency shall publish a final inventory.~~ Each hospital
772 shall reaffirm its service capability when its license is
773 renewed and shall notify the agency of the addition of a new
774 service or the termination of a service prior to a change in its
775 service capability.
776 (3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF
777 FACILITY OR HEALTH CARE PERSONNEL.—
778 (d)1. Every hospital shall ensure the provision of
779 services within the service capability of the hospital, at all
780 times, either directly or indirectly through an arrangement with
781 another hospital, through an arrangement with one or more
782 physicians, or as otherwise made through prior arrangements. A
783 hospital may enter into an agreement with another hospital for
784 purposes of meeting its service capability requirement, and

785 appropriate compensation or other reasonable conditions may be
786 negotiated for these backup services.
787 2. If any arrangement requires the provision of emergency
788 medical transportation, such arrangement must be made in
789 consultation with the applicable provider and may not require
790 the emergency medical service provider to provide transportation
791 that is outside the routine service area of that provider or in
792 a manner that impairs the ability of the emergency medical
793 service provider to timely respond to prehospital emergency
794 calls.
795 3. A hospital shall not be required to ensure service
796 capability at all times as required in subparagraph 1. if, prior
797 to the receiving of any patient needing such service capability,
798 such hospital has demonstrated to the agency that it lacks the
799 ability to ensure such capability and it has exhausted all
800 reasonable efforts to ensure such capability through backup
801 arrangements. In reviewing a hospital's demonstration of lack of
802 ability to ensure service capability, the agency shall consider
803 factors relevant to the particular case, including the
804 following:
805 a. Number and proximity of hospitals with the same service
806 capability.
807 b. Number, type, credentials, and privileges of
808 specialists.
809 c. Frequency of procedures.
810 d. Size of hospital.
811 4. The agency shall publish ~~proposed~~ rules implementing a
812 reasonable exemption procedure ~~by November 1, 1992~~. ~~Subparagraph~~

813 ~~1. shall become effective upon the effective date of said rules~~
814 ~~or January 31, 1993, whichever is earlier. For a period not to~~
815 ~~exceed 1 year from the effective date of subparagraph 1., a~~
816 ~~hospital requesting an exemption shall be deemed to be exempt~~
817 ~~from offering the service until the agency initially acts to~~
818 ~~deny or grant the original request.~~ The agency has 45 days from
819 the date of receipt of the request to approve or deny the
820 request. ~~After the first year from the effective date of~~
821 ~~subparagraph 1.,~~ If the agency fails to initially act within the
822 time period, the hospital is deemed to be exempt from offering
823 the service until the agency initially acts to deny the request.
824 Section 13. Section 395.1046, Florida Statutes, is
825 repealed.
826 Section 14. Paragraph (e) of subsection (1) of section
827 395.1055, Florida Statutes, is amended to read:
828 395.1055 Rules and enforcement.—
829 (1) The agency shall adopt rules pursuant to ss.
830 120.536(1) and 120.54 to implement the provisions of this part,
831 which shall include reasonable and fair minimum standards for
832 ensuring that:
833 (e) Licensed facility beds conform to minimum space,
834 equipment, and furnishings standards as specified by the agency,
835 the Florida Building Code, and the Florida Fire Prevention Code
836 ~~department~~.
837 Section 15. Subsection (1) of section 395.10972, Florida
838 Statutes, is amended to read:
839 395.10972 Health Care Risk Manager Advisory Council.—The
840 Secretary of Health Care Administration may appoint a seven-

841 member advisory council to advise the agency on matters
842 pertaining to health care risk managers. The members of the
843 council shall serve at the pleasure of the secretary. The
844 council shall designate a chair. The council shall meet at the
845 call of the secretary or at those times as may be required by
846 rule of the agency. The members of the advisory council shall
847 receive no compensation for their services, but shall be
848 reimbursed for travel expenses as provided in s. 112.061. The
849 council shall consist of individuals representing the following
850 areas:
851 (1) Two shall be active health care risk managers,
852 including one risk manager who is recommended by and a member of
853 the Florida Society for ~~of~~ Healthcare Risk Management and
854 Patient Safety.
855 Section 16. Subsection (3) of section 395.2050, Florida
856 Statutes, is amended to read:
857 395.2050 Routine inquiry for organ and tissue donation;
858 certification for procurement activities; death records review.—
859 (3) Each organ procurement organization designated by the
860 federal Centers for Medicare and Medicaid Services ~~Health Care~~
861 ~~Financing Administration~~ and licensed by the state shall conduct
862 an annual death records review in the organ procurement
863 organization's affiliated donor hospitals. The organ procurement
864 organization shall enlist the services of every Florida licensed
865 tissue bank and eye bank affiliated with or providing service to
866 the donor hospital and operating in the same service area to
867 participate in the death records review.
868 Section 17. Subsection (2) of section 395.3036, Florida

869 Statutes, is amended to read:
870 395.3036 Confidentiality of records and meetings of
871 corporations that lease public hospitals or other public health
872 care facilities.—The records of a private corporation that
873 leases a public hospital or other public health care facility
874 are confidential and exempt from the provisions of s. 119.07(1)
875 and s. 24(a), Art. I of the State Constitution, and the meetings
876 of the governing board of a private corporation are exempt from
877 s. 286.011 and s. 24(b), Art. I of the State Constitution when
878 the public lessor complies with the public finance
879 accountability provisions of s. 155.40(5) with respect to the
880 transfer of any public funds to the private lessee and when the
881 private lessee meets at least three of the five following
882 criteria:
883 (2) The public lessor and the private lessee do not
884 commingle any of their funds in any account maintained by either
885 of them, other than the payment of the rent and administrative
886 fees or the transfer of funds pursuant to subsection (5) ~~(2)~~.
887 Section 18. Section 395.3037, Florida Statutes, is
888 repealed.
889 Section 19. Subsections (1), (4), and (5) of section
890 395.3038, Florida Statutes, are amended to read:
891 395.3038 State-listed primary stroke centers and
892 comprehensive stroke centers; notification of hospitals.—
893 (1) The agency shall make available on its website and to
894 the department a list of the name and address of each hospital
895 that meets the criteria for a primary stroke center and the name
896 and address of each hospital that meets the criteria for a

897 comprehensive stroke center. The list of primary and
898 comprehensive stroke centers shall include only those hospitals
899 that attest in an affidavit submitted to the agency that the
900 hospital meets the named criteria, or those hospitals that
901 attest in an affidavit submitted to the agency that the hospital
902 is certified as a primary or a comprehensive stroke center by
903 the Joint Commission ~~on Accreditation of Healthcare~~
904 ~~Organizations~~.
905 (4) The agency shall adopt by rule criteria for a primary
906 stroke center which are substantially similar to the
907 certification standards for primary stroke centers of the Joint
908 Commission ~~on Accreditation of Healthcare Organizations~~.
909 (5) The agency shall adopt by rule criteria for a
910 comprehensive stroke center. However, if the Joint Commission ~~on~~
911 ~~Accreditation of Healthcare Organizations~~ establishes criteria
912 for a comprehensive stroke center, the agency shall establish
913 criteria for a comprehensive stroke center which are
914 substantially similar to those criteria established by the Joint
915 Commission ~~on Accreditation of Healthcare Organizations~~.
916 Section 20. Subsection (2) of section 395.602, Florida
917 Statutes, is amended to read:
918 395.602 Rural hospitals.—
919 (2) DEFINITIONS.—As used in this part:
920 (e) "Rural hospital" means an acute care hospital licensed
921 under this chapter, having 100 or fewer licensed beds and an
922 emergency room, which is:
923 1. The sole provider within a county with a population
924 density of no greater than 100 persons per square mile;

925 2. An acute care hospital, in a county with a population
926 density of no greater than 100 persons per square mile, which is
927 at least 30 minutes of travel time, on normally traveled roads
928 under normal traffic conditions, from any other acute care
929 hospital within the same county;
930 3. A hospital supported by a tax district or subdistrict
931 whose boundaries encompass a population of 100 persons or fewer
932 per square mile;
933 ~~4. A hospital in a constitutional charter county with a~~
934 ~~population of over 1 million persons that has imposed a local~~
935 ~~option health service tax pursuant to law and in an area that~~
936 ~~was directly impacted by a catastrophic event on August 24,~~
937 ~~1992, for which the Governor of Florida declared a state of~~
938 ~~emergency pursuant to chapter 125, and has 120 beds or less that~~
939 ~~serves an agricultural community with an emergency room~~
940 ~~utilization of no less than 20,000 visits and a Medicaid~~
941 ~~inpatient utilization rate greater than 15 percent;~~
942 4.~~5.~~ A hospital with a service area that has a population
943 of 100 persons or fewer per square mile. As used in this
944 subparagraph, the term "service area" means the fewest number of
945 zip codes that account for 75 percent of the hospital's
946 discharges for the most recent 5-year period, based on
947 information available from the hospital inpatient discharge
948 database in the Florida Center for Health Information and Policy
949 Analysis at the Agency for Health Care Administration; or
950 5.~~6.~~ A hospital designated as a critical access hospital,
951 as defined in s. 408.07(15).
952

953 Population densities used in this paragraph must be based upon
954 the most recently completed United States census. A hospital
955 that received funds under s. 409.9116 for a quarter beginning no
956 later than July 1, 2002, is deemed to have been and shall
957 continue to be a rural hospital from that date through June 30,
958 2015, if the hospital continues to have 100 or fewer licensed
959 beds and an emergency room~~, or meets the criteria of~~
960 ~~subparagraph 4~~. An acute care hospital that has not previously
961 been designated as a rural hospital and that meets the criteria
962 of this paragraph shall be granted such designation upon
963 application, including supporting documentation to the Agency
964 for Health Care Administration.

965 Section 21. Subsection (8) of section 400.021, Florida
966 Statutes, is amended to read:

967 400.021 Definitions.—When used in this part, unless the
968 context otherwise requires, the term:

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

975 Section 22. Paragraph (g) of subsection (2) of section
976 400.0239, Florida Statutes, is amended to read:

977 400.0239 Quality of Long-Term Care Facility Improvement
978 Trust Fund.—

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

981 (g) Other initiatives authorized by the Centers for
982 Medicare and Medicaid Services for the use of federal civil
983 monetary penalties~~, including projects recommended through the~~
984 ~~Medicaid "Up-or-Out" Quality of Care Contract Management Program~~
985 ~~pursuant to s. 400.148~~.
986 Section 23. Subsection (2) of section 400.063, Florida
987 Statutes, is amended to read:
988 400.063 Resident protection.—
989 (2) The agency is authorized to establish for each
990 facility, subject to intervention by the agency, a separate bank
991 account for the deposit to the credit of the agency of any
992 moneys received from the Health Care Trust Fund or any other
993 moneys received for the maintenance and care of residents in the
994 facility, and the agency is authorized to disburse moneys from
995 such account to pay obligations incurred for the purposes of
996 this section. The agency is authorized to requisition moneys
997 from the Health Care Trust Fund in advance of an actual need for
998 cash on the basis of an estimate by the agency of moneys to be
999 spent under the authority of this section. Any bank account
1000 established under this section need not be approved in advance
1001 of its creation as required by s. 17.58, but shall be secured by
1002 depository insurance equal to or greater than the balance of
1003 such account or by the pledge of collateral security ~~in~~
1004 ~~conformance with criteria established in s. 18.11~~. The agency
1005 shall notify the Chief Financial Officer of any such account so
1006 established and shall make a quarterly accounting to the Chief
1007 Financial Officer for all moneys deposited in such account.
1008 Section 24. Subsections (1) and (5) of section 400.071,

1009 Florida Statutes, are amended to read:
1010 400.071 Application for license.—
1011 (1) In addition to the requirements of part II of chapter
1012 408, the application for a license shall be under oath and must
1013 contain the following:
1014 (a) The location of the facility for which a license is
1015 sought and an indication, as in the original application, that
1016 such location conforms to the local zoning ordinances.
1017 ~~(b) A signed affidavit disclosing any financial or~~
1018 ~~ownership interest that a controlling interest as defined in~~
1019 ~~part II of chapter 408 has held in the last 5 years in any~~
1020 ~~entity licensed by this state or any other state to provide~~
1021 ~~health or residential care which has closed voluntarily or~~
1022 ~~involuntarily; has filed for bankruptcy; has had a receiver~~
1023 ~~appointed; has had a license denied, suspended, or revoked; or~~
1024 ~~has had an injunction issued against it which was initiated by a~~
1025 ~~regulatory agency. The affidavit must disclose the reason any~~
1026 ~~such entity was closed, whether voluntarily or involuntarily.~~
1027 ~~(c) The total number of beds and the total number of~~
1028 ~~Medicare and Medicaid certified beds.~~
1029 (b) ~~(d)~~ Information relating to the applicant and employees
1030 which the agency requires by rule. The applicant must
1031 demonstrate that sufficient numbers of qualified staff, by
1032 training or experience, will be employed to properly care for
1033 the type and number of residents who will reside in the
1034 facility.
1035 (c) ~~(e)~~ Copies of any civil verdict or judgment involving
1036 the applicant rendered within the 10 years preceding the

1037 application, relating to medical negligence, violation of
1038 residents' rights, or wrongful death. As a condition of
1039 licensure, the licensee agrees to provide to the agency copies
1040 of any new verdict or judgment involving the applicant, relating
1041 to such matters, within 30 days after filing with the clerk of
1042 the court. The information required in this paragraph shall be
1043 maintained in the facility's licensure file and in an agency
1044 database which is available as a public record.
1045 (5) As a condition of licensure, each facility must
1046 establish ~~and submit with its application~~ a plan for quality
1047 assurance and for conducting risk management.
1048 Section 25. Section 400.0712, Florida Statutes, is amended
1049 to read:
1050 400.0712 Application for inactive license.—
1051 ~~(1) As specified in this section, the agency may issue an~~
1052 ~~inactive license to a nursing home facility for all or a portion~~
1053 ~~of its beds. Any request by a licensee that a nursing home or~~
1054 ~~portion of a nursing home become inactive must be submitted to~~
1055 ~~the agency in the approved format. The facility may not initiate~~
1056 ~~any suspension of services, notify residents, or initiate~~
1057 ~~inactivity before receiving approval from the agency; and a~~
1058 ~~licensee that violates this provision may not be issued an~~
1059 ~~inactive license.~~
1060 <u>(1)</u>~~(2)~~ <u>In addition to the authority granted in part II of</u>
1061 <u>chapter 408,</u> the agency may issue an inactive license to a
1062 nursing home that chooses to use an unoccupied contiguous
1063 portion of the facility for an alternative use to meet the needs
1064 of elderly persons through the use of less restrictive, less

1065 institutional services.
1066 (a) An inactive license issued under this subsection may
1067 be granted for a period not to exceed the current licensure
1068 expiration date but may be renewed by the agency at the time of
1069 licensure renewal.
1070 (b) A request to extend the inactive license must be
1071 submitted to the agency in the approved format and approved by
1072 the agency in writing.
1073 (c) Nursing homes that receive an inactive license to
1074 provide alternative services shall not receive preference for
1075 participation in the Assisted Living for the Elderly Medicaid
1076 waiver.
1077 (2) ~~(3)~~ The agency shall adopt rules pursuant to ss.
1078 120.536(1) and 120.54 necessary to administer ~~implement~~ this
1079 section.
1080 Section 26. Section 400.111, Florida Statutes, is amended
1081 to read:
1082 400.111 Disclosure of controlling interest.—In addition to
1083 the requirements of part II of chapter 408, when requested by
1084 the agency, the licensee shall submit a signed affidavit
1085 disclosing any financial or ownership interest that a
1086 controlling interest has held within the last 5 years in any
1087 entity licensed by the state or any other state to provide
1088 health or residential care which entity has closed voluntarily
1089 or involuntarily; has filed for bankruptcy; has had a receiver
1090 appointed; has had a license denied, suspended, or revoked; or
1091 has had an injunction issued against it which was initiated by a
1092 regulatory agency. The affidavit must disclose the reason such

1093 entity was closed, whether voluntarily or involuntarily.
1094 Section 27. Section 400.1183, Florida Statutes, is amended
1095 to read:
1096 400.1183 Resident grievance procedures.—
1097 (1) Every nursing home must have a grievance procedure
1098 available to its residents and their families. The grievance
1099 procedure must include:
1100 (a) An explanation of how to pursue redress of a
1101 grievance.
1102 (b) The names, job titles, and telephone numbers of the
1103 employees responsible for implementing the facility's grievance
1104 procedure. The list must include the address and the toll-free
1105 telephone numbers of the ombudsman and the agency.
1106 (c) A simple description of the process through which a
1107 resident may, at any time, contact the toll-free telephone
1108 hotline of the ombudsman or the agency to report the unresolved
1109 grievance.
1110 (d) A procedure for providing assistance to residents who
1111 cannot prepare a written grievance without help.
1112 (2) Each facility shall maintain records of all grievances
1113 for agency inspection ~~and shall report to the agency at the time~~
1114 ~~of relicensure the total number of grievances handled during the~~
1115 ~~prior licensure period, a categorization of the cases underlying~~
1116 ~~the grievances, and the final disposition of the grievances~~.
1117 (3) Each facility must respond to the grievance within a
1118 reasonable time after its submission.
1119 (4) The agency may investigate any grievance at any time.
1120 Section 28. Subsection (1) of section 400.141, Florida

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1121 Statutes, is amended to read:
1122 400.141 Administration and management of nursing home
1123 facilities.—
1124 (1) Every licensed facility shall comply with all
1125 applicable standards and rules of the agency and shall:
1126 (a) Be under the administrative direction and charge of a
1127 licensed administrator.
1128 (b) Appoint a medical director licensed pursuant to
1129 chapter 458 or chapter 459. The agency may establish by rule
1130 more specific criteria for the appointment of a medical
1131 director.
1132 (c) Have available the regular, consultative, and
1133 emergency services of physicians licensed by the state.
1134 (d) Provide for resident use of a community pharmacy as
1135 specified in s. 400.022(1)(q). Any other law to the contrary
1136 notwithstanding, a registered pharmacist licensed in Florida,
1137 that is under contract with a facility licensed under this
1138 chapter or chapter 429, shall repackage a nursing facility
1139 resident's bulk prescription medication which has been packaged
1140 by another pharmacist licensed in any state in the United States
1141 into a unit dose system compatible with the system used by the
1142 nursing facility, if the pharmacist is requested to offer such
1143 service. In order to be eligible for the repackaging, a resident
1144 or the resident's spouse must receive prescription medication
1145 benefits provided through a former employer as part of his or
1146 her retirement benefits, a qualified pension plan as specified
1147 in s. 4972 of the Internal Revenue Code, a federal retirement
1148 program as specified under 5 C.F.R. s. 831, or a long-term care

1149 policy as defined in s. 627.9404(1). A pharmacist who correctly
1150 repackages and relabels the medication and the nursing facility
1151 which correctly administers such repackaged medication under
1152 this paragraph may not be held liable in any civil or
1153 administrative action arising from the repackaging. In order to
1154 be eligible for the repackaging, a nursing facility resident for
1155 whom the medication is to be repackaged shall sign an informed
1156 consent form provided by the facility which includes an
1157 explanation of the repackaging process and which notifies the
1158 resident of the immunities from liability provided in this
1159 paragraph. A pharmacist who repackages and relabels prescription
1160 medications, as authorized under this paragraph, may charge a
1161 reasonable fee for costs resulting from the implementation of
1162 this provision.
1163 (e) Provide for the access of the facility residents to
1164 dental and other health-related services, recreational services,
1165 rehabilitative services, and social work services appropriate to
1166 their needs and conditions and not directly furnished by the
1167 licensee. When a geriatric outpatient nurse clinic is conducted
1168 in accordance with rules adopted by the agency, outpatients
1169 attending such clinic shall not be counted as part of the
1170 general resident population of the nursing home facility, nor
1171 shall the nursing staff of the geriatric outpatient clinic be
1172 counted as part of the nursing staff of the facility, until the
1173 outpatient clinic load exceeds 15 a day.
1174 (f) Be allowed and encouraged by the agency to provide
1175 other needed services under certain conditions. If the facility
1176 has a standard licensure status, and has had no class I or class

1177 II deficiencies during the past 2 years or has been awarded a
1178 Gold Seal under the program established in s. 400.235, it may be
1179 encouraged by the agency to provide services, including, but not
1180 limited to, respite and adult day services, which enable
1181 individuals to move in and out of the facility. A facility is
1182 not subject to any additional licensure requirements for
1183 providing these services. Respite care may be offered to persons
1184 in need of short-term or temporary nursing home services.
1185 Respite care must be provided in accordance with this part and
1186 rules adopted by the agency. However, the agency shall, by rule,
1187 adopt modified requirements for resident assessment, resident
1188 care plans, resident contracts, physician orders, and other
1189 provisions, as appropriate, for short-term or temporary nursing
1190 home services. The agency shall allow for shared programming and
1191 staff in a facility which meets minimum standards and offers
1192 services pursuant to this paragraph, but, if the facility is
1193 cited for deficiencies in patient care, may require additional
1194 staff and programs appropriate to the needs of service
1195 recipients. A person who receives respite care may not be
1196 counted as a resident of the facility for purposes of the
1197 facility's licensed capacity unless that person receives 24-hour
1198 respite care. A person receiving either respite care for 24
1199 hours or longer or adult day services must be included when
1200 calculating minimum staffing for the facility. Any costs and
1201 revenues generated by a nursing home facility from
1202 nonresidential programs or services shall be excluded from the
1203 calculations of Medicaid per diems for nursing home
1204 institutional care reimbursement.

1205 (g) If the facility has a standard license or is a Gold
1206 Seal facility, exceeds the minimum required hours of licensed
1207 nursing and certified nursing assistant direct care per resident
1208 per day, and is part of a continuing care facility licensed
1209 under chapter 651 or a retirement community that offers other
1210 services pursuant to part III of this chapter or part I or part
1211 III of chapter 429 on a single campus, be allowed to share
1212 programming and staff. At the time of inspection and in the
1213 semiannual report required pursuant to paragraph (n) ~~(o)~~, a
1214 continuing care facility or retirement community that uses this
1215 option must demonstrate through staffing records that minimum
1216 staffing requirements for the facility were met. Licensed nurses
1217 and certified nursing assistants who work in the nursing home
1218 facility may be used to provide services elsewhere on campus if
1219 the facility exceeds the minimum number of direct care hours
1220 required per resident per day and the total number of residents
1221 receiving direct care services from a licensed nurse or a
1222 certified nursing assistant does not cause the facility to
1223 violate the staffing ratios required under s. 400.23(3)(a).
1224 Compliance with the minimum staffing ratios shall be based on
1225 total number of residents receiving direct care services,
1226 regardless of where they reside on campus. If the facility
1227 receives a conditional license, it may not share staff until the
1228 conditional license status ends. This paragraph does not
1229 restrict the agency's authority under federal or state law to
1230 require additional staff if a facility is cited for deficiencies
1231 in care which are caused by an insufficient number of certified
1232 nursing assistants or licensed nurses. The agency may adopt

1233 rules for the documentation necessary to determine compliance
1234 with this provision.
1235 (h) Maintain the facility premises and equipment and
1236 conduct its operations in a safe and sanitary manner.
1237 (i) If the licensee furnishes food service, provide a
1238 wholesome and nourishing diet sufficient to meet generally
1239 accepted standards of proper nutrition for its residents and
1240 provide such therapeutic diets as may be prescribed by attending
1241 physicians. In making rules to implement this paragraph, the
1242 agency shall be guided by standards recommended by nationally
1243 recognized professional groups and associations with knowledge
1244 of dietetics.
1245 (j) Keep full records of resident admissions and
1246 discharges; medical and general health status, including medical
1247 records, personal and social history, and identity and address
1248 of next of kin or other persons who may have responsibility for
1249 the affairs of the residents; and individual resident care plans
1250 including, but not limited to, prescribed services, service
1251 frequency and duration, and service goals. The records shall be
1252 open to inspection by the agency.
1253 (k) Keep such fiscal records of its operations and
1254 conditions as may be necessary to provide information pursuant
1255 to this part.
1256 (l) Furnish copies of personnel records for employees
1257 affiliated with such facility, to any other facility licensed by
1258 this state requesting this information pursuant to this part.
1259 Such information contained in the records may include, but is
1260 not limited to, disciplinary matters and any reason for

1261 termination. Any facility releasing such records pursuant to
1262 this part shall be considered to be acting in good faith and may
1263 not be held liable for information contained in such records,
1264 absent a showing that the facility maliciously falsified such
1265 records.
1266 (m) Publicly display a poster provided by the agency
1267 containing the names, addresses, and telephone numbers for the
1268 state's abuse hotline, the State Long-Term Care Ombudsman, the
1269 Agency for Health Care Administration consumer hotline, the
1270 Advocacy Center for Persons with Disabilities, the Florida
1271 Statewide Advocacy Council, and the Medicaid Fraud Control Unit,
1272 with a clear description of the assistance to be expected from
1273 each.
1274 ~~(n) Submit to the agency the information specified in s.~~
1275 ~~400.071(1)(b) for a management company within 30 days after the~~
1276 ~~effective date of the management agreement.~~
1277 <u>(n)</u>~~(o)~~1. Submit semiannually to the agency, or more
1278 frequently if requested by the agency, information regarding
1279 facility staff-to-resident ratios, staff turnover, and staff
1280 stability, including information regarding certified nursing
1281 assistants, licensed nurses, the director of nursing, and the
1282 facility administrator. For purposes of this reporting:
1283 a. Staff-to-resident ratios must be reported in the
1284 categories specified in s. 400.23(3)(a) and applicable rules.
1285 The ratio must be reported as an average for the most recent
1286 calendar quarter.
1287 b. Staff turnover must be reported for the most recent 12-
1288 month period ending on the last workday of the most recent

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1289 calendar quarter prior to the date the information is submitted.
1290 The turnover rate must be computed quarterly, with the annual
1291 rate being the cumulative sum of the quarterly rates. The
1292 turnover rate is the total number of terminations or separations
1293 experienced during the quarter, excluding any employee
1294 terminated during a probationary period of 3 months or less,
1295 divided by the total number of staff employed at the end of the
1296 period for which the rate is computed, and expressed as a
1297 percentage.
1298 c. The formula for determining staff stability is the
1299 total number of employees that have been employed for more than
1300 12 months, divided by the total number of employees employed at
1301 the end of the most recent calendar quarter, and expressed as a
1302 percentage.
1303 d. A nursing facility that has failed to comply with state
1304 minimum-staffing requirements for 2 consecutive days is
1305 prohibited from accepting new admissions until the facility has
1306 achieved the minimum-staffing requirements for a period of 6
1307 consecutive days. For the purposes of this sub-subparagraph, any
1308 person who was a resident of the facility and was absent from
1309 the facility for the purpose of receiving medical care at a
1310 separate location or was on a leave of absence is not considered
1311 a new admission. The agency shall fine the nursing facility
1312 $1,000 if it fails ~~Failure~~ to impose such an admissions
1313 moratorium ~~constitutes a class II deficiency~~.
1314 e. A nursing facility which does not have a conditional
1315 license may be cited for failure to comply with the standards in
1316 s. 400.23(3)(a)1.a. only if it has failed to meet those

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1317 standards on 2 consecutive days or if it has failed to meet at
1318 least 97 percent of those standards on any one day.
1319 f. A facility which has a conditional license must be in
1320 compliance with the standards in s. 400.23(3)(a) at all times.
1321 2. This paragraph does not limit the agency's ability to
1322 impose a deficiency or take other actions if a facility does not
1323 have enough staff to meet the residents' needs.
1324 (o) ~~(p)~~ Notify a licensed physician when a resident
1325 exhibits signs of dementia or cognitive impairment or has a
1326 change of condition in order to rule out the presence of an
1327 underlying physiological condition that may be contributing to
1328 such dementia or impairment. The notification must occur within
1329 30 days after the acknowledgment of such signs by facility
1330 staff. If an underlying condition is determined to exist, the
1331 facility shall arrange, with the appropriate health care
1332 provider, the necessary care and services to treat the
1333 condition.
1334 (p) ~~(q)~~ If the facility implements a dining and hospitality
1335 attendant program, ensure that the program is developed and
1336 implemented under the supervision of the facility director of
1337 nursing. A licensed nurse, licensed speech or occupational
1338 therapist, or a registered dietitian must conduct training of
1339 dining and hospitality attendants. A person employed by a
1340 facility as a dining and hospitality attendant must perform
1341 tasks under the direct supervision of a licensed nurse.
1342 ~~(r) Report to the agency any filing for bankruptcy~~
1343 ~~protection by the facility or its parent corporation,~~
1344 ~~divestiture or spin-off of its assets, or corporate~~

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1345 ~~reorganization within 30 days after the completion of such~~
1346 ~~activity.~~
1347 <u>(q)</u>~~(s)~~ Maintain general and professional liability
1348 insurance coverage that is in force at all times. In lieu of
1349 general and professional liability insurance coverage, a state-
1350 designated teaching nursing home and its affiliated assisted
1351 living facilities created under s. 430.80 may demonstrate proof
1352 of financial responsibility as provided in s. 430.80(3)(h).
1353 <u>(r)</u>~~(t)~~ Maintain in the medical record for each resident a
1354 daily chart of certified nursing assistant services provided to
1355 the resident. The certified nursing assistant who is caring for
1356 the resident must complete this record by the end of his or her
1357 shift. This record must indicate assistance with activities of
1358 daily living, assistance with eating, and assistance with
1359 drinking, and must record each offering of nutrition and
1360 hydration for those residents whose plan of care or assessment
1361 indicates a risk for malnutrition or dehydration.
1362 <u>(s)</u>~~(u)~~ Before November 30 of each year, subject to the
1363 availability of an adequate supply of the necessary vaccine,
1364 provide for immunizations against influenza viruses to all its
1365 consenting residents in accordance with the recommendations of
1366 the United States Centers for Disease Control and Prevention,
1367 subject to exemptions for medical contraindications and
1368 religious or personal beliefs. Subject to these exemptions, any
1369 consenting person who becomes a resident of the facility after
1370 November 30 but before March 31 of the following year must be
1371 immunized within 5 working days after becoming a resident.
1372 Immunization shall not be provided to any resident who provides

1373 documentation that he or she has been immunized as required by
1374 this paragraph. This paragraph does not prohibit a resident from
1375 receiving the immunization from his or her personal physician if
1376 he or she so chooses. A resident who chooses to receive the
1377 immunization from his or her personal physician shall provide
1378 proof of immunization to the facility. The agency may adopt and
1379 enforce any rules necessary to comply with or administer
1380 ~~implement~~ this paragraph ~~subsection~~.
1381 (t) ~~(v)~~ Assess all residents for eligibility for
1382 pneumococcal polysaccharide vaccination (PPV) and vaccinate
1383 residents when indicated within 60 days after the effective date
1384 of this act in accordance with the recommendations of the United
1385 States Centers for Disease Control and Prevention, subject to
1386 exemptions for medical contraindications and religious or
1387 personal beliefs. Residents admitted after the effective date of
1388 this act shall be assessed within 5 working days of admission
1389 and, when indicated, vaccinated within 60 days in accordance
1390 with the recommendations of the United States Centers for
1391 Disease Control and Prevention, subject to exemptions for
1392 medical contraindications and religious or personal beliefs.
1393 Immunization shall not be provided to any resident who provides
1394 documentation that he or she has been immunized as required by
1395 this paragraph. This paragraph does not prohibit a resident from
1396 receiving the immunization from his or her personal physician if
1397 he or she so chooses. A resident who chooses to receive the
1398 immunization from his or her personal physician shall provide
1399 proof of immunization to the facility. The agency may adopt and
1400 enforce any rules necessary to comply with or administer

1401 ~~implement~~ this paragraph.

1402 <u>(u)</u> ~~(w)~~ Annually encourage and promote to its employees the
1403 benefits associated with immunizations against influenza viruses
1404 in accordance with the recommendations of the United States
1405 Centers for Disease Control and Prevention. The agency may adopt
1406 and enforce any rules necessary to comply with or <u>administer</u>
1407 ~~implement~~ this paragraph.

1408 Section 29. Subsection (3) of section 400.142, Florida
1409 Statutes, is amended to read:

1410 400.142 Emergency medication kits; orders not to
1411 resuscitate.—

1412 (3) Facility staff may withhold or withdraw
1413 cardiopulmonary resuscitation if presented with an order not to
1414 resuscitate executed pursuant to s. 401.45. ~~The agency shall~~
1415 ~~adopt rules providing for the implementation of such orders.~~
1416 Facility staff and facilities shall not be subject to criminal
1417 prosecution or civil liability, nor be considered to have
1418 engaged in negligent or unprofessional conduct, for withholding
1419 or withdrawing cardiopulmonary resuscitation pursuant to such an
1420 order and rules adopted by the agency. The absence of an order
1421 not to resuscitate executed pursuant to s. 401.45 does not
1422 preclude a physician from withholding or withdrawing
1423 cardiopulmonary resuscitation as otherwise permitted by law.

1424 Section 30. <u>Subsection (10) of section 400.147, Florida</u>
1425 <u>Statutes, is repealed.</u>

1426 Section 31. <u>Section 400.148, Florida Statutes, is</u>
1427 <u>repealed.</u>

1428 Section 32. Subsection (3) of section 400.19, Florida

1429 Statutes, is amended to read:
1430 400.19 Right of entry and inspection.—
1431 (3) The agency shall every 15 months conduct at least one
1432 unannounced inspection to determine compliance by the licensee
1433 with statutes, and with rules promulgated under the provisions
1434 of those statutes, governing minimum standards of construction,
1435 quality and adequacy of care, and rights of residents. The
1436 survey shall be conducted every 6 months for the next 2-year
1437 period if the facility has been cited for a class I deficiency,
1438 has been cited for two or more class II deficiencies arising
1439 from separate surveys or investigations within a 60-day period,
1440 or has had three or more substantiated complaints within a 6-
1441 month period, each resulting in at least one class I or class II
1442 deficiency. In addition to any other fees or fines in this part,
1443 the agency shall assess a fine for each facility that is subject
1444 to the 6-month survey cycle. The fine for the 2-year period
1445 shall be $6,000, one-half to be paid at the completion of each
1446 survey. The agency may adjust this fine by the change in the
1447 Consumer Price Index, based on the 12 months immediately
1448 preceding the increase, to cover the cost of the additional
1449 surveys. The agency shall verify through subsequent inspection
1450 that any deficiency identified during inspection is corrected.
1451 However, the agency may verify the correction of a class III or
1452 class IV deficiency ~~unrelated to resident rights or resident~~
1453 ~~care~~ without reinspecting the facility if adequate written
1454 documentation has been received from the facility, which
1455 provides assurance that the deficiency has been corrected. The
1456 giving or causing to be given of advance notice of such

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1457 unannounced inspections by an employee of the agency to any
1458 unauthorized person shall constitute cause for suspension of not
1459 fewer than 5 working days according to the provisions of chapter
1460 110.
1461 Section 33. Section 400.195, Florida Statutes, is
1462 repealed.
1463 Section 34. Subsection (5) of section 400.23, Florida
1464 Statutes, is amended to read:
1465 400.23 Rules; evaluation and deficiencies; licensure
1466 status.—
1467 (5) The agency, in collaboration with the Division of
1468 Children's Medical Services Network of the Department of Health,
1469 must~~, no later than December 31, 1993,~~ adopt rules for minimum
1470 standards of care for persons under 21 years of age who reside
1471 in nursing home facilities. The rules must include a methodology
1472 for reviewing a nursing home facility under ss. 408.031-408.045
1473 which serves only persons under 21 years of age. A facility may
1474 be exempt from these standards for specific persons between 18
1475 and 21 years of age, if the person's physician agrees that
1476 minimum standards of care based on age are not necessary.
1477 Section 35. Subsection (1) of section 400.275, Florida
1478 Statutes, is amended to read:
1479 400.275 Agency duties.—
1480 (1) ~~The agency shall ensure that each newly hired nursing~~
1481 ~~home surveyor, as a part of basic training, is assigned full-~~
1482 ~~time to a licensed nursing home for at least 2 days within a 7-~~
1483 ~~day period to observe facility operations outside of the survey~~
1484 ~~process before the surveyor begins survey responsibilities. Such~~

1485 ~~observations may not be the sole basis of a deficiency citation~~
1486 ~~against the facility.~~ The agency may not assign an individual to
1487 be a member of a survey team for purposes of a survey,
1488 evaluation, or consultation visit at a nursing home facility in
1489 which the surveyor was an employee within the preceding 5 years.
1490 Section 36. Subsections (2) and (14) of section 400.462,
1491 Florida Statutes, are amended, present subsections (27), (28),
1492 and (29) of that section are renumbered as subsections (28),
1493 (29), and (30), respectively, and new subsections (27) and (31)
1494 are added to that section, to read:
1495 400.462 Definitions.—As used in this part, the term:
1496 (2) "Admission" means a decision by the home health
1497 agency, during or after an evaluation visit with the patient ~~to~~
1498 ~~the patient's home~~, that there is reasonable expectation that
1499 the patient's medical, nursing, and social needs for skilled
1500 care can be adequately met by the agency in the patient's place
1501 of residence. Admission includes completion of an agreement with
1502 the patient or the patient's legal representative to provide
1503 home health services as required in s. 400.487(1).
1504 (14) "Home health services" means health and medical
1505 services and medical supplies furnished by an organization to an
1506 individual in the individual's home or place of residence. The
1507 term includes organizations that provide one or more of the
1508 following:
1509 (a) Nursing care.
1510 (b) Physical, occupational, respiratory, or speech
1511 therapy.
1512 (c) Home health aide services.

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1513 (d) Dietetics and nutrition practice and nutrition
1514 counseling.
1515 (e) Medical supplies and durable medical equipment,
1516 ~~restricted to drugs and biologicals~~ prescribed by a physician.
1517 (27) "Primary home health agency" means the agency that is
1518 responsible for the services furnished to patients and for
1519 implementation of the plan of care.
1520 (31) "Temporary" means short term, such as for employee
1521 absences, temporary skill shortages, seasonal workloads.
1522 Section 37. Section 400.476, Florida Statutes, is amended
1523 to read:
1524 400.476 Staffing requirements; notifications; limitations
1525 on staffing services.—
1526 (1) ADMINISTRATOR.—
1527 (a) An administrator may manage only one home health
1528 agency, except that an administrator may manage up to five home
1529 health agencies if all five home health agencies have identical
1530 controlling interests as defined in s. 408.803 and are located
1531 within one agency geographic service area or within an
1532 immediately contiguous county. If the home health agency is
1533 licensed under this chapter and is part of a retirement
1534 community that provides multiple levels of care, an employee of
1535 the retirement community may administer the home health agency
1536 and up to a maximum of four entities licensed under this chapter
1537 or chapter 429 which all have identical controlling interests as
1538 defined in s. 408.803. An administrator shall designate, in
1539 writing, for each licensed entity, a qualified alternate
1540 administrator to serve during the administrator's absence. An

1541 alternate administrator must meet the requirements in this
1542 paragraph and s. 400.462(1).
1543 (b) An administrator of a home health agency who is a
1544 licensed physician, physician assistant, or registered nurse
1545 licensed to practice in this state may also be the director of
1546 nursing for a home health agency. An administrator may serve as
1547 a director of nursing for up to the number of entities
1548 authorized in subsection (2) only if there are 10 or fewer full-
1549 time equivalent employees and contracted personnel in each home
1550 health agency.
1551 (c) The administrator shall organize and direct the
1552 agency's ongoing functions, maintain an ongoing liaison with the
1553 board members and the staff, employ qualified personnel and
1554 ensure adequate staff education and evaluations, ensures the
1555 accuracy of public informational materials and activities,
1556 implement an effective budgeting and accounting system, and
1557 ensures that the home health agency operates in compliance with
1558 this part and part II of chapter 408 and rules adopted for these
1559 laws.
1560 (d) The administrator shall clearly set forth in writing
1561 the organizational chart, services furnished, administrative
1562 control, and lines of authority for the delegation of
1563 responsibilities for patient care. These responsibilities must
1564 be readily identifiable. Administrative and supervisory
1565 functions may not be delegated to another agency or
1566 organization, and the primary home health agency shall monitor
1567 and control all services that are not furnished directly,
1568 including services provided through contracts.

1569 (2) DIRECTOR OF NURSING.—
1570 (a) A director of nursing may be the director of nursing
1571 for:
1572 1. Up to two licensed home health agencies if the agencies
1573 have identical controlling interests as defined in s. 408.803
1574 and are located within one agency geographic service area or
1575 within an immediately contiguous county; or
1576 2. Up to five licensed home health agencies if:
1577 a. All of the home health agencies have identical
1578 controlling interests as defined in s. 408.803;
1579 b. All of the home health agencies are located within one
1580 agency geographic service area or within an immediately
1581 contiguous county; ~~and~~
1582 c. Each home health agency has a registered nurse who
1583 meets the qualifications of a director of nursing and who has a
1584 written delegation from the director of nursing to serve as the
1585 director of nursing for that home health agency when the
1586 director of nursing is not present; and~~.~~
1587 d. This person, or similarly qualified alternate, is
1588 available at all times during operating hours and participates
1589 in all activities relevant to the professional services
1590 furnished, including, but not limited to, the oversight of
1591 nursing services, home health aides, and certified nursing
1592 assistants, and assignment of personnel.
1593
1594 If a home health agency licensed under this chapter is part of a
1595 retirement community that provides multiple levels of care, an
1596 employee of the retirement community may serve as the director

1597 of nursing of the home health agency and up to a maximum of four
1598 entities, other than home health agencies, licensed under this
1599 chapter or chapter 429 which all have identical controlling
1600 interests as defined in s. 408.803.
1601 (b) A home health agency that provides skilled nursing
1602 care may not operate for more than 30 calendar days without a
1603 director of nursing. A home health agency that provides skilled
1604 nursing care and the director of nursing of a home health agency
1605 must notify the agency within 10 business days after termination
1606 of the services of the director of nursing for the home health
1607 agency. A home health agency that provides skilled nursing care
1608 must notify the agency of the identity and qualifications of the
1609 new director of nursing within 10 days after the new director is
1610 hired. If a home health agency that provides skilled nursing
1611 care operates for more than 30 calendar days without a director
1612 of nursing, the home health agency commits a class II
1613 deficiency. In addition to the fine for a class II deficiency,
1614 the agency may issue a moratorium in accordance with s. 408.814
1615 or revoke the license. The agency shall fine a home health
1616 agency that fails to notify the agency as required in this
1617 paragraph $1,000 for the first violation and $2,000 for a repeat
1618 violation. The agency may not take administrative action against
1619 a home health agency if the director of nursing fails to notify
1620 the department upon termination of services as the director of
1621 nursing for the home health agency.
1622 (c) A home health agency that is not Medicare or Medicaid
1623 certified and does not provide skilled care or provides only
1624 physical, occupational, or speech therapy is not required to

1625 have a director of nursing and is exempt from paragraph (b).
1626 (3) TRAINING.—A home health agency shall ensure that each
1627 certified nursing assistant employed by or under contract with
1628 the home health agency and each home health aide employed by or
1629 under contract with the home health agency is adequately trained
1630 to perform the tasks of a home health aide in the home setting.
1631 (a) The home health agency may not use as a home health
1632 aide on a full-time, temporary, per diem, or other basis, any
1633 individual to provide services unless the individual has
1634 completed a training and competency evaluation program, or a
1635 competency evaluation program, as permitted in s. 400.497 which
1636 meets the minimum standards established by the agency in state
1637 rules.
1638 (b) A home health aide is not competent in any task for
1639 which he or she is evaluated as "unsatisfactory." The aide must
1640 perform any such task only under direct supervision by a
1641 licensed nurse until he or she receives training in the task and
1642 satisfactorily passes a subsequent evaluation in performing the
1643 task. A home health aide has not successfully passed a
1644 competency evaluation if the aide does not have a passing score
1645 on the test as specified by agency rule.
1646 (4) STAFFING.—Staffing services may be provided anywhere
1647 within the state.
1648 (5) PERSONNEL.—
1649 (a) The home health agency and its staff must comply with
1650 accepted professional standards and principles that apply to
1651 professionals, including, but not limited to, the state practice
1652 acts and the home health agency's policies and procedures.

1653 (b) If personnel under hourly or per-visit contracts are
1654 used by the home health agency, there must be a written contract
1655 between those personnel and the agency which specifies the
1656 following requirements:
1657 1. Acceptance for care only of patients by the primary
1658 home health agency.
1659 2. The services to be furnished.
1660 3. The necessity to conform to all applicable agency
1661 policies, including personnel qualifications.
1662 4. The responsibility for participating in developing
1663 plans of care.
1664 5. The manner in which services are controlled,
1665 coordinated, and evaluated by the primary home health agency.
1666 6. The procedures for submitting clinical and progress
1667 notes, scheduling of visits, and periodic patient evaluation.
1668 7. The procedures for payment for services furnished under
1669 the contract.
1670 (c) A home health agency shall directly provide at least
1671 one of the types of services through home health agency
1672 employees, but may provide additional services under
1673 arrangements with another agency or organization. Services
1674 furnished under such arrangements must have a written contract
1675 conforming with the requirements specified in paragraph (b).
1676 (d) If home health aide services are provided by an
1677 individual who is not employed directly by the home health
1678 agency, the services of the home health aide must be provided
1679 under arrangements as stated in paragraphs (b) and (c). If the
1680 home health agency chooses to provide home health aide services

1681 under arrangements with another organization, the
1682 responsibilities of the home health agency include, but are not
1683 limited to:
1684 1. Ensuring the overall quality of the care provided by
1685 the aide;
1686 2. Supervising the aide's services as described in s.
1687 400.487; and
1688 3. Ensuring that each home health aide providing services
1689 under arrangements with another organization has met the
1690 training requirements or competency evaluation requirements of
1691 s. 400.497.
1692 (e) The home health agency shall coordinate the efforts of
1693 all personnel furnishing services, and the personnel shall
1694 maintain communication with the home health agency to ensure
1695 that personnel efforts support the objectives outlined in the
1696 plan of care. The clinical record or minutes of case conferences
1697 shall ensure that effective interchange, reporting, and
1698 coordination of patient care occurs.
1699 Section 38. Section 400.484, Florida Statutes, is amended
1700 to read:
1701 400.484 Right of inspection; violations ~~deficiencies~~;
1702 fines.—
1703 (1) In addition to the requirements of s. 408.811, the
1704 agency may make such inspections and investigations as are
1705 necessary in order to determine the state of compliance with
1706 this part, part II of chapter 408, and applicable rules.
1707 (2) The agency shall impose fines for various classes of
1708 deficiencies in accordance with the following schedule:

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1709 (a) Class I violations are defined in s. 408.813. ~~A class~~
1710 ~~I deficiency is any act, omission, or practice that results in a~~
1711 ~~patient's death, disablement, or permanent injury, or places a~~
1712 ~~patient at imminent risk of death, disablement, or permanent~~
1713 ~~injury.~~ Upon finding a class I violation ~~deficiency~~, the agency
1714 shall impose an administrative fine in the amount of $15,000 for
1715 each occurrence and each day that the violation ~~deficiency~~
1716 exists.
1717 (b) Class II violations are defined in s. 408.813. ~~A class~~
1718 ~~II deficiency is any act, omission, or practice that has a~~
1719 ~~direct adverse effect on the health, safety, or security of a~~
1720 ~~patient.~~ Upon finding a class II violation ~~deficiency~~, the
1721 agency shall impose an administrative fine in the amount of
1722 $5,000 for each occurrence and each day that the violation
1723 ~~deficiency~~ exists.
1724 (c) Class III violations are defined in s. 408.813. ~~A~~
1725 ~~class III deficiency is any act, omission, or practice that has~~
1726 ~~an indirect, adverse effect on the health, safety, or security~~
1727 ~~of a patient.~~ Upon finding an uncorrected or repeated class III
1728 violation ~~deficiency~~, the agency shall impose an administrative
1729 fine not to exceed $1,000 for each occurrence and each day that
1730 the uncorrected or repeated violation ~~deficiency~~ exists.
1731 (d) Class IV violations are defined in s. 408.813. ~~A class~~
1732 ~~IV deficiency is any act, omission, or practice related to~~
1733 ~~required reports, forms, or documents which does not have the~~
1734 ~~potential of negatively affecting patients. These violations are~~
1735 ~~of a type that the agency determines do not threaten the health,~~
1736 ~~safety, or security of patients.~~ Upon finding an uncorrected or

1737 repeated class IV <u>violation</u> ~~deficiency~~, the agency shall impose
1738 an administrative fine not to exceed $500 for each occurrence
1739 and each day that the uncorrected or repeated <u>violation</u>
1740 ~~deficiency~~ exists.
1741 (3) In addition to any other penalties imposed pursuant to
1742 this section or part, the agency may assess costs related to an
1743 investigation that results in a successful prosecution,
1744 excluding costs associated with an attorney's time.
1745 Section 39. Section 400.487, Florida Statutes, is amended
1746 to read:
1747 400.487 Home health service agreements; physician's,
1748 physician assistant's, and advanced registered nurse
1749 practitioner's treatment orders; patient assessment;
1750 establishment and review of plan of care; provision of services;
1751 orders not to resuscitate.—
1752 (1) Services provided by a home health agency must be
1753 covered by an agreement between the home health agency and the
1754 patient or the patient's legal representative specifying the
1755 home health services to be provided, the rates or charges for
1756 services paid with private funds, and the sources of payment,
1757 which may include Medicare, Medicaid, private insurance,
1758 personal funds, or a combination thereof. <u>The home health agency</u>
1759 <u>shall provide a copy of the agreement to the patient or the</u>
1760 <u>patient's legal representative.</u> A home health agency providing
1761 skilled care must make an assessment of the patient's needs
1762 within 48 hours after the start of services.
1763 (2) When required by the provisions of chapter 464; part
1764 I, part III, or part V of chapter 468; or chapter 486, the

1765 attending physician, physician assistant, or advanced registered
1766 nurse practitioner, acting within his or her respective scope of
1767 practice, shall establish treatment orders for a patient who is
1768 to receive skilled care. The treatment orders must be signed by
1769 the physician, physician assistant, or advanced registered nurse
1770 practitioner before a claim for payment for the skilled services
1771 is submitted by the home health agency. If the claim is
1772 submitted to a managed care organization, the treatment orders
1773 must be signed within the time allowed under the provider
1774 agreement. The treatment orders shall be reviewed, as frequently
1775 as the patient's illness requires, by the physician, physician
1776 assistant, or advanced registered nurse practitioner in
1777 consultation with the home health agency.
1778 (3) A home health agency shall arrange for supervisory
1779 visits by a registered nurse to the home of a patient receiving
1780 home health aide services as specified in subsection (9) ~~in~~
1781 ~~accordance with the patient's direction, approval, and agreement~~
1782 ~~to pay the charge for the visits~~.
1783 (4) The home health agency shall protect and promote the
1784 rights of each individual under its care, including each of the
1785 following rights:
1786 (a) *Notice of rights.*—The home health agency shall provide
1787 the patient with a written notice of the patient's rights in
1788 advance of furnishing care to the patient or during the initial
1789 evaluation visit before the initiation of treatment. The home
1790 health agency must maintain documentation showing that it has
1791 complied with the requirements of this section.
1792 (b) *Exercise of rights and respect for property and*

1793 *person.*—

1794 1. The patient has the right to exercise his or her rights
1795 as a patient of the home health agency.

1796 2. The patient has the right to have his or her property
1797 treated with respect.

1798 3. The patient has the right to voice grievances regarding
1799 treatment or care that is or fails to be furnished, or regarding
1800 the lack of respect for property by anyone who is furnishing
1801 services on behalf of the home health agency, and not be
1802 subjected to discrimination or reprisal for doing so.

1803 4. The home health agency must investigate complaints made
1804 by a patient or the patient's family or guardian regarding
1805 treatment or care that is or fails to be furnished, or regarding
1806 the lack of respect for the patient's property by anyone
1807 furnishing services on behalf of the home health agency. The
1808 home health agency shall document the existence of the complaint
1809 and its resolution.

1810 5. The patient and his or her immediate family or
1811 representative must be informed of the right to report
1812 complaints via the statewide toll-free telephone number to the
1813 agency as required in s. 408.810.

1814 (c) *Right to be informed and to participate in planning*
1815 *care and treatment.*—

1816 1. The patient has the right to be informed, in advance,
1817 about the care to be furnished and of any changes in the care to
1818 be furnished. The home health agency shall advise the patient in
1819 advance of which disciplines will furnish care and the frequency
1820 of visits proposed to be furnished. The home health agency must

1821 advise the patient in advance of any change in the plan of care
1822 before the change is made.
1823 2. The patient has the right to participate in the
1824 planning of the care. The home health agency must advise the
1825 patient in advance of the right to participate in planning the
1826 care or treatment and in planning changes in the care or
1827 treatment. ~~Each patient has the right to be informed of and to~~
1828 ~~participate in the planning of his or her care.~~ Each patient
1829 must be provided, upon request, a copy of the plan of care
1830 established and maintained for that patient by the home health
1831 agency.
1832 (5) When nursing services are ordered, the home health
1833 agency to which a patient has been admitted for care must
1834 provide the initial admission visit, all service evaluation
1835 visits, and the discharge visit by a direct employee. Services
1836 provided by others under contractual arrangements to a home
1837 health agency must be monitored and managed by the admitting
1838 home health agency. The admitting home health agency is fully
1839 responsible for ensuring that all care provided through its
1840 employees or contract staff is delivered in accordance with this
1841 part and applicable rules.
1842 (6) The skilled care services provided by a home health
1843 agency, directly or under contract, must be supervised and
1844 coordinated in accordance with the plan of care. The home health
1845 agency shall furnish skilled nursing services by or under the
1846 supervision of a registered nurse and in accordance with the
1847 plan of care. Any therapy services offered directly or under
1848 arrangement by the home health agency must be provided by a

1849 qualified therapist or by a qualified therapy assistant under
1850 the supervision of a qualified therapist and in accordance with
1851 the plan of care.
1852 (a) *Duties and qualifications.*—A qualified therapist shall
1853 assist the physician in evaluating the level of function, help
1854 develop or revise the plan of care, prepare clinical and
1855 progress notes, advise and consult with the family and other
1856 agency personnel, and participate in in-service programs. The
1857 therapist or therapy assistant must meet the qualifications in
1858 the state practice acts and related applicable rules.
1859 (b) *Physical therapy assistants and occupational therapy*
1860 *assistants.*—Services provided by a physical therapy assistant or
1861 occupational therapy assistant must be under the supervision of
1862 a qualified physical therapist or occupational therapist as
1863 required in chapter 486 and part III of chapter 468,
1864 respectively, and related applicable rules. A physical therapy
1865 assistant or occupational therapy assistant shall perform
1866 services planned, delegated, and supervised by the therapist,
1867 assist in preparing clinical notes and progress reports,
1868 participate in educating the patient and his or her family, and
1869 participate in in-service programs.
1870 (c) *Speech therapy services.*—Speech therapy services shall
1871 be furnished only by or under supervision of a qualified speech
1872 pathologist or audiologist as required in part I of chapter 468
1873 and related applicable rules.
1874 (d) *Care follows a written plan of care.*—The plan of care
1875 shall be reviewed by the physician or health professional who
1876 provided the treatment orders pursuant to subsection (2) and

1877 home health agency personnel as often as the severity of the
1878 patient's condition requires, but at least once every 60 days or
1879 more when there is a beneficiary-elected transfer, a significant
1880 change in condition resulting in a change in the case-mix
1881 assignment, or a discharge and return to the same home health
1882 agency during the 60-day episode. Professional staff of a home
1883 health agency shall promptly alert the physician or other health
1884 professional who provided the treatment orders of any change
1885 that suggests a need to alter the plan of care.
1886 (e) *Administration of drugs and treatment.*—Only
1887 professional staff of a home health agency may administer drugs
1888 and treatments as ordered by the physician or health
1889 professional pursuant to subsection (2), with the exception of
1890 influenza and pneumococcal polysaccharide vaccines, which may be
1891 administered according to the policy of the home health agency
1892 developed in consultation with a physician and after an
1893 assessment for contraindications. The physician or health
1894 professional, as provided in subsection (2), shall put any
1895 verbal order in writing and sign and date it with the date of
1896 receipt by the registered nurse or qualified therapist who is
1897 responsible for furnishing or supervising the ordered service. A
1898 verbal order may be accepted only by personnel who are
1899 authorized to do so by applicable state laws, rules, and
1900 internal policies of the home health agency.
1901 (7) A registered nurse shall conduct the initial
1902 evaluation visit, regularly reevaluate the patient's nursing
1903 needs, initiate the plan of care and necessary revisions,
1904 furnish those services requiring substantial and specialized

1905 nursing skill, initiate appropriate preventive and
1906 rehabilitative nursing procedures, prepare clinical and progress
1907 notes, coordinate services, inform the physician and other
1908 personnel of changes in the patient's condition and needs,
1909 counsel the patient and his or her family in meeting nursing and
1910 related needs, participate in in-service programs, and supervise
1911 and teach other nursing personnel.
1912 (8) A licensed practical nurse shall furnish services in
1913 accordance with agency policies, prepare clinical and progress
1914 notes, assist the physician and registered nurse in performing
1915 specialized procedures, prepare equipment and materials for
1916 treatments observing aseptic technique as required, and assist
1917 the patient in learning appropriate self-care techniques.
1918 (9) A home health aide and certified nursing assistant
1919 shall provide services that are ordered by the physician in the
1920 plan of care and that the aide or assistant is permitted to
1921 perform under state law. The duties of a home health aide or
1922 certified nursing assistant include the provision of hands-on
1923 personal care, performance of simple procedures as an extension
1924 of therapy or nursing services, assistance in ambulation or
1925 exercises, and assistance in administering medications that are
1926 ordinarily self-administered and are specified in agency rules.
1927 Any services by a home health aide which are offered by a home
1928 health agency must be provided by a qualified home health aide
1929 or certified nursing assistant.
1930 (a) *Assignment and duties.*—A home health aide or certified
1931 nursing assistant shall be assigned to a specific patient by a
1932 registered nurse. Written patient care instructions for the home

1933 health aide and certified nursing assistant must be prepared by
1934 the registered nurse or other appropriate professional who is
1935 responsible for the supervision of the home health aide and
1936 certified nursing assistant as stated in this section.
1937 (b) *Supervision.*—If a patient receives skilled nursing
1938 care, the registered nurse shall perform the supervisory visit.
1939 If the patient is not receiving skilled nursing care but is
1940 receiving physical therapy, occupational therapy, or speech-
1941 language pathology services, the appropriate therapist may
1942 provide the supervision. A registered nurse or other
1943 professional must make an onsite visit to the patient's home at
1944 least once every 2 weeks. The visit is not required while the
1945 aide is providing care.
1946 (c) *Supervising visits.*—If home health aide services are
1947 provided to a patient who is not receiving skilled nursing care,
1948 physical or occupational therapy, or speech-language pathology
1949 services, a registered nurse must make a supervisory visit to
1950 the patient's home at least once every 60 days. The registered
1951 nurse shall ensure that the aide is properly caring for the
1952 patient and each supervisory visit must occur while the home
1953 health aide is providing patient care.
1954 (10) ~~(7)~~ Home health agency personnel may withhold or
1955 withdraw cardiopulmonary resuscitation if presented with an
1956 order not to resuscitate executed pursuant to s. 401.45. The
1957 agency shall adopt rules providing for the implementation of
1958 such orders. Home health personnel and agencies shall not be
1959 subject to criminal prosecution or civil liability, nor be
1960 considered to have engaged in negligent or unprofessional

1961 conduct, for withholding or withdrawing cardiopulmonary
1962 resuscitation pursuant to such an order and rules adopted by the
1963 agency.
1964 Section 40. Subsections (1) and (4) of section 400.606,
1965 Florida Statutes, are amended to read:
1966 400.606 License; application; renewal; conditional license
1967 or permit; certificate of need.—
1968 (1) In addition to the requirements of part II of chapter
1969 408, the initial application and change of ownership application
1970 must be accompanied by a plan for the delivery of home,
1971 residential, and homelike inpatient hospice services to
1972 terminally ill persons and their families. Such plan must
1973 contain, but need not be limited to:
1974 (a) The estimated average number of terminally ill persons
1975 to be served monthly.
1976 (b) The geographic area in which hospice services will be
1977 available.
1978 (c) A listing of services which are or will be provided,
1979 either directly by the applicant or through contractual
1980 arrangements with existing providers.
1981 (d) Provisions for the implementation of hospice home care
1982 within 3 months after licensure.
1983 (e) Provisions for the implementation of hospice homelike
1984 inpatient care within 12 months after licensure.
1985 (f) The number and disciplines of professional staff to be
1986 employed.
1987 (g) The name and qualifications of any existing or
1988 potential contractee.

1989 (h) A plan for attracting and training volunteers.
1990 ~~(i) The projected annual operating cost of the hospice.~~
1991
1992 If the applicant is an existing licensed health care provider,
1993 the application must be accompanied by a copy of the most recent
1994 profit-loss statement and, if applicable, the most recent
1995 licensure inspection report.
1996 (4) A freestanding hospice facility that is ~~primarily~~
1997 engaged in providing inpatient and related services and that is
1998 not otherwise licensed as a health care facility shall be
1999 required to obtain a certificate of need. However, a
2000 freestanding hospice facility with six or fewer beds shall not
2001 be required to comply with institutional standards such as, but
2002 not limited to, standards requiring sprinkler systems, emergency
2003 electrical systems, or special lavatory devices.
2004 Section 41. Subsection (2) of section 400.607, Florida
2005 Statutes, is amended to read:
2006 400.607 Denial, suspension, revocation of license;
2007 emergency actions; imposition of administrative fine; grounds.—
2008 (2) A violation of the provisions of this part, part II of
2009 chapter 408, or applicable rules ~~Any of the following actions~~ by
2010 a licensed hospice or any of its employees shall be grounds for
2011 administrative action by the agency against a hospice.~~:~~
2012 ~~(a) A violation of the provisions of this part, part II of~~
2013 ~~chapter 408, or applicable rules.~~
2014 ~~(b) An intentional or negligent act materially affecting~~
2015 ~~the health or safety of a patient.~~
2016 Section 42. Subsection (1) of section 400.925, Florida

2017 Statutes, is amended to read:
2018 400.925 Definitions.—As used in this part, the term:
2019 (1) "Accrediting organizations" means the Joint Commission
2020 ~~on Accreditation of Healthcare Organizations~~ or other national
2021 accreditation agencies whose standards for accreditation are
2022 comparable to those required by this part for licensure.
2023 Section 43. Section 400.931, Florida Statutes, is amended
2024 to read:
2025 400.931 Application for license; fee~~; provisional license;~~
2026 ~~temporary permit~~.—
2027 (1) In addition to the requirements of part II of chapter
2028 408, the applicant must file with the application satisfactory
2029 proof that the home medical equipment provider is in compliance
2030 with this part and applicable rules, including:
2031 (a) A report, by category, of the equipment to be
2032 provided, indicating those offered either directly by the
2033 applicant or through contractual arrangements with existing
2034 providers. Categories of equipment include:
2035 1. Respiratory modalities.
2036 2. Ambulation aids.
2037 3. Mobility aids.
2038 4. Sickroom setup.
2039 5. Disposables.
2040 (b) A report, by category, of the services to be provided,
2041 indicating those offered either directly by the applicant or
2042 through contractual arrangements with existing providers.
2043 Categories of services include:
2044 1. Intake.

2045 2. Equipment selection.
2046 3. Delivery.
2047 4. Setup and installation.
2048 5. Patient training.
2049 6. Ongoing service and maintenance.
2050 7. Retrieval.
2051 (c) A listing of those with whom the applicant contracts,
2052 both the providers the applicant uses to provide equipment or
2053 services to its consumers and the providers for whom the
2054 applicant provides services or equipment.
2055 ~~(2) As an alternative to submitting proof of financial~~
2056 ~~ability to operate as required in s. 408.810(8), the applicant~~
2057 ~~may submit a $50,000 surety bond to the agency.~~
2058 (2) ~~(3)~~ As specified in part II of chapter 408, the home
2059 medical equipment provider must also obtain and maintain
2060 professional and commercial liability insurance. Proof of
2061 liability insurance, as defined in s. 624.605, must be submitted
2062 with the application. The agency shall set the required amounts
2063 of liability insurance by rule, but the required amount must not
2064 be less than $250,000 per claim. In the case of contracted
2065 services, it is required that the contractor have liability
2066 insurance not less than $250,000 per claim.
2067 (3) ~~(4)~~ When a change of the general manager of a home
2068 medical equipment provider occurs, the licensee must notify the
2069 agency of the change within 45 days.
2070 (4) ~~(5)~~ In accordance with s. 408.805, an applicant or a
2071 licensee shall pay a fee for each license application submitted
2072 under this part, part II of chapter 408, and applicable rules.

2073 The amount of the fee shall be established by rule and may not
2074 exceed $300 per biennium. The agency shall set the fees in an
2075 amount that is sufficient to cover its costs in carrying out its
2076 responsibilities under this part. However, state, county, or
2077 municipal governments applying for licenses under this part are
2078 exempt from the payment of license fees.
2079 (5)~~(6)~~ An applicant for initial licensure, renewal, or
2080 change of ownership shall also pay an inspection fee not to
2081 exceed $400, which shall be paid by all applicants except those
2082 not subject to licensure inspection by the agency as described
2083 in s. 400.933.
2084 Section 44. Subsection (2) of section 400.932, Florida
2085 Statutes, is amended to read:
2086 400.932 Administrative penalties.—
2087 (2) A violation of this part, part II of chapter 408, or
2088 applicable rules ~~Any of the following actions~~ by an employee of
2089 a home medical equipment provider are grounds for administrative
2090 action or penalties by the agency.~~:~~
2091 ~~(a) Violation of this part, part II of chapter 408, or~~
2092 ~~applicable rules.~~
2093 ~~(b) An intentional, reckless, or negligent act that~~
2094 ~~materially affects the health or safety of a patient.~~
2095 Section 45. Subsection (2) of section 400.933, Florida
2096 Statutes, is amended to read:
2097 400.933 Licensure inspections and investigations.—
2098 (2) The agency shall accept, in lieu of its own periodic
2099 inspections for licensure, submission of the following:
2100 (a) The survey or inspection of an accrediting

2101 organization, provided the accreditation of the licensed home
2102 medical equipment provider is not conditional or provisional and
2103 provided the licensed home medical equipment provider authorizes
2104 release of, and the agency receives the report of, the
2105 accrediting organization; or
2106 (b) A copy of a valid medical oxygen retail establishment
2107 permit issued by the Department of Health, pursuant to chapter
2108 499.
2109 Section 46. Subsection (2) of section 400.953, Florida
2110 Statutes, is amended to read:
2111 400.953 Background screening of home medical equipment
2112 provider personnel.—The agency shall require employment
2113 screening as provided in chapter 435, using the level 1
2114 standards for screening set forth in that chapter, for home
2115 medical equipment provider personnel.
2116 (2) The general manager of each home medical equipment
2117 provider must sign an affidavit ~~annually~~, under penalty of
2118 perjury, stating that all home medical equipment provider
2119 personnel hired on or after July 1, 1999, who enter the home of
2120 a patient in the capacity of their employment have been screened
2121 and that its remaining personnel have worked for the home
2122 medical equipment provider continuously since before July 1,
2123 1999. This attestation must be submitted in accordance with s.
2124 408.809(6).
2125 Section 47. Section 400.967, Florida Statutes, is amended
2126 to read:
2127 400.967 Rules and classification of violations
2128 ~~deficiencies~~.—

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

2129 (1) It is the intent of the Legislature that rules adopted
2130 and enforced under this part and part II of chapter 408 include
2131 criteria by which a reasonable and consistent quality of
2132 resident care may be ensured, the results of such resident care
2133 can be demonstrated, and safe and sanitary facilities can be
2134 provided.
2135 (2) Pursuant to the intention of the Legislature, the
2136 agency, in consultation with the Agency for Persons with
2137 Disabilities and the Department of Elderly Affairs, shall adopt
2138 and enforce rules to administer this part and part II of chapter
2139 408, which shall include reasonable and fair criteria governing:
2140 (a) The location and construction of the facility;
2141 including fire and life safety, plumbing, heating, cooling,
2142 lighting, ventilation, and other housing conditions that will
2143 ensure the health, safety, and comfort of residents. The agency
2144 shall establish standards for facilities and equipment to
2145 increase the extent to which new facilities and a new wing or
2146 floor added to an existing facility after July 1, 2000, are
2147 structurally capable of serving as shelters only for residents,
2148 staff, and families of residents and staff, and equipped to be
2149 self-supporting during and immediately following disasters. The
2150 Agency for Health Care Administration shall work with facilities
2151 licensed under this part and report to the Governor and the
2152 Legislature by April 1, 2000, its recommendations for cost-
2153 effective renovation standards to be applied to existing
2154 facilities. In making such rules, the agency shall be guided by
2155 criteria recommended by nationally recognized, reputable
2156 professional groups and associations having knowledge concerning

2157 such subject matters. The agency shall update or revise such
2158 criteria as the need arises. All facilities must comply with
2159 those lifesafety code requirements and building code standards
2160 applicable at the time of approval of their construction plans.
2161 The agency may require alterations to a building if it
2162 determines that an existing condition constitutes a distinct
2163 hazard to life, health, or safety. The agency shall adopt fair
2164 and reasonable rules setting forth conditions under which
2165 existing facilities undergoing additions, alterations,
2166 conversions, renovations, or repairs are required to comply with
2167 the most recent updated or revised standards.

2168 (b) The number and qualifications of all personnel,
2169 including management, medical nursing, and other personnel,
2170 having responsibility for any part of the care given to
2171 residents.

2172 (c) All sanitary conditions within the facility and its
2173 surroundings, including water supply, sewage disposal, food
2174 handling, and general hygiene, which will ensure the health and
2175 comfort of residents.

2176 (d) The equipment essential to the health and welfare of
2177 the residents.

2178 (e) A uniform accounting system.

2179 (f) The care, treatment, and maintenance of residents and
2180 measurement of the quality and adequacy thereof.

2181 (g) The preparation and annual update of a comprehensive
2182 emergency management plan. The agency shall adopt rules
2183 establishing minimum criteria for the plan after consultation
2184 with the Department of Community Affairs. At a minimum, the

2185 rules must provide for plan components that address emergency
2186 evacuation transportation; adequate sheltering arrangements;
2187 postdisaster activities, including emergency power, food, and
2188 water; postdisaster transportation; supplies; staffing;
2189 emergency equipment; individual identification of residents and
2190 transfer of records; and responding to family inquiries. The
2191 comprehensive emergency management plan is subject to review and
2192 approval by the local emergency management agency. During its
2193 review, the local emergency management agency shall ensure that
2194 the following agencies, at a minimum, are given the opportunity
2195 to review the plan: the Department of Elderly Affairs, the
2196 Agency for Persons with Disabilities, the Agency for Health Care
2197 Administration, and the Department of Community Affairs. Also,
2198 appropriate volunteer organizations must be given the
2199 opportunity to review the plan. The local emergency management
2200 agency shall complete its review within 60 days and either
2201 approve the plan or advise the facility of necessary revisions.
2202 (h) The use of restraint and seclusion. Such rules must be
2203 consistent with recognized best practices; prohibit inherently
2204 dangerous restraint or seclusion procedures; establish
2205 limitations on the use and duration of restraint and seclusion;
2206 establish measures to ensure the safety of clients and staff
2207 during an incident of restraint or seclusion; establish
2208 procedures for staff to follow before, during, and after
2209 incidents of restraint or seclusion, including individualized
2210 plans for the use of restraints or seclusion in emergency
2211 situations; establish professional qualifications of and
2212 training for staff who may order or be engaged in the use of

2213 restraint or seclusion; establish requirements for facility data
2214 collection and reporting relating to the use of restraint and
2215 seclusion; and establish procedures relating to the
2216 documentation of the use of restraint or seclusion in the
2217 client's facility or program record.
2218 (3) The agency shall adopt rules to provide that, when the
2219 criteria established under this part and part II of chapter 408
2220 are not met, such violations ~~deficiencies~~ shall be classified
2221 according to the nature of the violation ~~deficiency~~. The agency
2222 shall indicate the classification on the face of the notice of
2223 violations ~~deficiencies~~ as follows:
2224 (a) Class I violations ~~deficiencies~~ are defined in s.
2225 408.813. ~~those which the agency determines present an imminent~~
2226 ~~danger to the residents or guests of the facility or a~~
2227 ~~substantial probability that death or serious physical harm~~
2228 ~~would result therefrom. The condition or practice constituting a~~
2229 ~~class I violation must be abated or eliminated immediately,~~
2230 ~~unless a fixed period of time, as determined by the agency, is~~
2231 ~~required for correction.~~ A class I violation ~~deficiency~~ is
2232 subject to a civil penalty in an amount not less than $5,000 and
2233 not exceeding $10,000 for each violation ~~deficiency~~. A fine may
2234 be levied notwithstanding the correction of the violation
2235 ~~deficiency~~.
2236 (b) Class II violations ~~deficiencies~~ are defined in s.
2237 408.813. ~~those which the agency determines have a direct or~~
2238 ~~immediate relationship to the health, safety, or security of the~~
2239 ~~facility residents, other than class I deficiencies.~~ A class II
2240 violation ~~deficiency~~ is subject to a civil penalty in an amount

2241 not less than $1,000 and not exceeding $5,000 for each
2242 deficiency. A citation for a class II violation ~~deficiency~~ shall
2243 specify the time within which the violation ~~deficiency~~ must be
2244 corrected. If a class II violation ~~deficiency~~ is corrected
2245 within the time specified, no civil penalty shall be imposed,
2246 unless it is a repeated offense.
2247 (c) Class III violations ~~deficiencies~~ are defined in s.
2248 408.813. ~~those which the agency determines to have an indirect~~
2249 ~~or potential relationship to the health, safety, or security of~~
2250 ~~the facility residents, other than class I or class II~~
2251 ~~deficiencies.~~ A class III violation ~~deficiency~~ is subject to a
2252 civil penalty of not less than $500 and not exceeding $1,000 for
2253 each violation ~~deficiency~~. A citation for a class III violation
2254 ~~deficiency~~ shall specify the time within which the violation
2255 ~~deficiency~~ must be corrected. If a class III violation
2256 ~~deficiency~~ is corrected within the time specified, no civil
2257 penalty shall be imposed, unless it is a repeated offense.
2258 (d) Class IV violations are defined in s. 408.813.
2259 (4) The agency shall approve or disapprove the plans and
2260 specifications within 60 days after receipt of the final plans
2261 and specifications. The agency may be granted one 15-day
2262 extension for the review period, if the secretary of the agency
2263 so approves. If the agency fails to act within the specified
2264 time, it is deemed to have approved the plans and
2265 specifications. When the agency disapproves plans and
2266 specifications, it must set forth in writing the reasons for
2267 disapproval. Conferences and consultations may be provided as
2268 necessary.

2269 (5) The agency may charge an initial fee of $2,000 for
2270 review of plans and construction on all projects, no part of
2271 which is refundable. The agency may also collect a fee, not to
2272 exceed 1 percent of the estimated construction cost or the
2273 actual cost of review, whichever is less, for the portion of the
2274 review which encompasses initial review through the initial
2275 revised construction document review. The agency may collect its
2276 actual costs on all subsequent portions of the review and
2277 construction inspections. Initial fee payment must accompany the
2278 initial submission of plans and specifications. Any subsequent
2279 payment that is due is payable upon receipt of the invoice from
2280 the agency. Notwithstanding any other provision of law, all
2281 money received by the agency under this section shall be deemed
2282 to be trust funds, to be held and applied solely for the
2283 operations required under this section.
2284 Section 48. Subsection (1) of section 400.969, Florida
2285 Statutes, is amended to read:
2286 400.969 Violation of part; penalties.—
2287 (1) In addition to the requirements of part II of chapter
2288 408, and except as provided in s. 400.967(3), a violation of any
2289 provision of federal certification required pursuant to
2290 400.960(8), this part, part II of chapter 408, or applicable
2291 rules is punishable by payment of an administrative or civil
2292 penalty not to exceed $5,000.
2293 Section 49. Subsection (7) of section 400.9905, Florida
2294 Statutes, is amended to read:
2295 400.9905 Definitions.—
2296 (7) "Portable service or equipment provider" means an

2297 entity that contracts with or employs persons to provide
2298 portable service or equipment to multiple locations which
2299 ~~performing treatment or diagnostic testing of individuals, that~~
2300 bills third-party payors for those services, and that otherwise
2301 meets the definition of a clinic in subsection (4).
2302 Section 50. Subsections (1) and (4) of section 400.991,
2303 Florida Statutes, are amended to read:
2304 400.991 License requirements; background screenings;
2305 prohibitions.—
2306 (1)(a) The requirements of part II of chapter 408 apply to
2307 the provision of services that require licensure pursuant to
2308 this part and part II of chapter 408 and to entities licensed by
2309 or applying for such licensure from the agency pursuant to this
2310 part. A license issued by the agency is required in order to
2311 operate a clinic in this state. Each clinic location shall be
2312 licensed separately regardless of whether the clinic is operated
2313 under the same business name or management as another clinic.
2314 (b) Each mobile clinic must obtain a separate health care
2315 clinic license and must provide to the agency, at least
2316 quarterly, its projected street location to enable the agency to
2317 locate and inspect such clinic. A portable equipment and health
2318 services provider must obtain a health care clinic license for a
2319 single administrative office and is not required to submit
2320 quarterly projected street locations.
2321 (4) In addition to the requirements of part II of chapter
2322 408, the applicant must file with the application satisfactory
2323 proof that the clinic is in compliance with this part and
2324 applicable rules, including:

2325 (a) A listing of services to be provided either directly
2326 by the applicant or through contractual arrangements with
2327 existing providers;
2328 (b) The number and discipline of each professional staff
2329 member to be employed; and
2330 (c) Proof of financial ability to operate as required
2331 under ss. 408.810(8) and 408.8065 ~~s. 408.810(8)~~. ~~As an~~
2332 ~~alternative to submitting proof of financial ability to operate~~
2333 ~~as required under s. 408.810(8), the applicant may file a surety~~
2334 ~~bond of at least $500,000 which guarantees that the clinic will~~
2335 ~~act in full conformity with all legal requirements for operating~~
2336 ~~a clinic, payable to the agency. The agency may adopt rules to~~
2337 ~~specify related requirements for such surety bond.~~
2338 Section 51. Paragraph (g) of subsection (1) and paragraph
2339 (a) of subsection (7) of section 400.9935, Florida Statutes, are
2340 amended to read:
2341 400.9935 Clinic responsibilities.—
2342 (1) Each clinic shall appoint a medical director or clinic
2343 director who shall agree in writing to accept legal
2344 responsibility for the following activities on behalf of the
2345 clinic. The medical director or the clinic director shall:
2346 (g) Conduct systematic reviews of clinic billings to
2347 ensure that the billings are not fraudulent or unlawful. Upon
2348 discovery of an unlawful charge, the medical director or clinic
2349 director shall take immediate corrective action. If the clinic
2350 performs only the technical component of magnetic resonance
2351 imaging, static radiographs, computed tomography, or positron
2352 emission tomography, and provides the professional

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2353 interpretation of such services, in a fixed facility that is
2354 accredited by the Joint Commission ~~on Accreditation of~~
2355 ~~Healthcare Organizations~~ or the Accreditation Association for
2356 Ambulatory Health Care, and the American College of Radiology;
2357 and if, in the preceding quarter, the percentage of scans
2358 performed by that clinic which was billed to all personal injury
2359 protection insurance carriers was less than 15 percent, the
2360 chief financial officer of the clinic may, in a written
2361 acknowledgment provided to the agency, assume the responsibility
2362 for the conduct of the systematic reviews of clinic billings to
2363 ensure that the billings are not fraudulent or unlawful.
2364 (7)(a) Each clinic engaged in magnetic resonance imaging
2365 services must be accredited by the Joint Commission ~~on~~
2366 ~~Accreditation of Healthcare Organizations~~, the American College
2367 of Radiology, or the Accreditation Association for Ambulatory
2368 Health Care, within 1 year after licensure. A clinic that is
2369 accredited by the American College of Radiology or is within the
2370 original 1-year period after licensure and replaces its core
2371 magnetic resonance imaging equipment shall be given 1 year after
2372 the date on which the equipment is replaced to attain
2373 accreditation. However, a clinic may request a single, 6-month
2374 extension if it provides evidence to the agency establishing
2375 that, for good cause shown, such clinic cannot be accredited
2376 within 1 year after licensure, and that such accreditation will
2377 be completed within the 6-month extension. After obtaining
2378 accreditation as required by this subsection, each such clinic
2379 must maintain accreditation as a condition of renewal of its
2380 license. A clinic that files a change of ownership application

2381 must comply with the original accreditation timeframe
2382 requirements of the transferor. The agency shall deny a change
2383 of ownership application if the clinic is not in compliance with
2384 the accreditation requirements. When a clinic adds, replaces, or
2385 modifies magnetic resonance imaging equipment and the
2386 accreditation agency requires new accreditation, the clinic must
2387 be accredited within 1 year after the date of the addition,
2388 replacement, or modification but may request a single, 6-month
2389 extension if the clinic provides evidence of good cause to the
2390 agency.
2391 Section 52. Subsection (2) of section 408.034, Florida
2392 Statutes, is amended to read:
2393 408.034 Duties and responsibilities of agency; rules.—
2394 (2) In the exercise of its authority to issue licenses to
2395 health care facilities and health service providers, as provided
2396 under chapters 393 and 395 and parts II, ~~and~~ IV, and VIII of
2397 chapter 400, the agency may not issue a license to any health
2398 care facility or health service provider that fails to receive a
2399 certificate of need or an exemption for the licensed facility or
2400 service.
2401 Section 53. Paragraph (d) of subsection (1) of section
2402 408.036, Florida Statutes, is amended to read:
2403 408.036 Projects subject to review; exemptions.—
2404 (1) APPLICABILITY.—Unless exempt under subsection (3), all
2405 health-care-related projects, as described in paragraphs (a)-
2406 (g), are subject to review and must file an application for a
2407 certificate of need with the agency. The agency is exclusively
2408 responsible for determining whether a health-care-related

2409 project is subject to review under ss. 408.031-408.045.
2410 (d) The establishment of a hospice or hospice inpatient
2411 facility~~, except as provided in s. 408.043~~.
2412 Section 54. Subsection (2) of section 408.043, Florida
2413 Statutes, is amended to read:
2414 408.043 Special provisions.—
2415 (2) HOSPICES.—When an application is made for a
2416 certificate of need to establish or to expand a hospice, the
2417 need for such hospice shall be determined on the basis of the
2418 need for and availability of hospice services in the community.
2419 The formula on which the certificate of need is based shall
2420 discourage regional monopolies and promote competition. The
2421 inpatient hospice care component of a hospice which is a
2422 freestanding facility, or a part of a facility~~, which is~~
2423 ~~primarily engaged in providing inpatient care and related~~
2424 ~~services~~ and is not licensed as a health care facility shall
2425 also be required to obtain a certificate of need. Provision of
2426 hospice care by any current provider of health care is a
2427 significant change in service and therefore requires a
2428 certificate of need for such services.
2429 Section 55. Paragraph (k) of subsection (3) of section
2430 408.05, Florida Statutes, is amended to read:
2431 408.05 Florida Center for Health Information and Policy
2432 Analysis.—
2433 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to
2434 produce comparable and uniform health information and statistics
2435 for the development of policy recommendations, the agency shall
2436 perform the following functions:

2437 (k) Develop, in conjunction with the State Consumer Health
2438 Information and Policy Advisory Council, and implement a long-
2439 range plan for making available health care quality measures and
2440 financial data that will allow consumers to compare health care
2441 services. The health care quality measures and financial data
2442 the agency must make available shall include, but is not limited
2443 to, pharmaceuticals, physicians, health care facilities, and
2444 health plans and managed care entities. The agency shall submit
2445 the initial plan to the Governor, the President of the Senate,
2446 and the Speaker of the House of Representatives by January 1,
2447 2006, and shall update the plan and report on the status of its
2448 implementation annually thereafter. The agency shall also make
2449 the plan and status report available to the public on its
2450 Internet website. As part of the plan, the agency shall identify
2451 the process and timeframes for implementation, any barriers to
2452 implementation, and recommendations of changes in the law that
2453 may be enacted by the Legislature to eliminate the barriers. As
2454 preliminary elements of the plan, the agency shall:
2455 1. Make available patient-safety indicators, inpatient
2456 quality indicators, and performance outcome and patient charge
2457 data collected from health care facilities pursuant to s.
2458 408.061(1)(a) and (2). The terms "patient-safety indicators" and
2459 "inpatient quality indicators" shall be as defined by the
2460 Centers for Medicare and Medicaid Services, the National Quality
2461 Forum, the Joint Commission ~~on Accreditation of Healthcare~~
2462 ~~Organizations~~, the Agency for Healthcare Research and Quality,
2463 the Centers for Disease Control and Prevention, or a similar
2464 national entity that establishes standards to measure the

2465 performance of health care providers, or by other states. The
2466 agency shall determine which conditions, procedures, health care
2467 quality measures, and patient charge data to disclose based upon
2468 input from the council. When determining which conditions and
2469 procedures are to be disclosed, the council and the agency shall
2470 consider variation in costs, variation in outcomes, and
2471 magnitude of variations and other relevant information. When
2472 determining which health care quality measures to disclose, the
2473 agency:
2474 a. Shall consider such factors as volume of cases; average
2475 patient charges; average length of stay; complication rates;
2476 mortality rates; and infection rates, among others, which shall
2477 be adjusted for case mix and severity, if applicable.
2478 b. May consider such additional measures that are adopted
2479 by the Centers for Medicare and Medicaid Studies, National
2480 Quality Forum, the Joint Commission ~~on Accreditation of~~
2481 ~~Healthcare Organizations~~, the Agency for Healthcare Research and
2482 Quality, Centers for Disease Control and Prevention, or a
2483 similar national entity that establishes standards to measure
2484 the performance of health care providers, or by other states.
2485
2486 When determining which patient charge data to disclose, the
2487 agency shall include such measures as the average of
2488 undiscounted charges on frequently performed procedures and
2489 preventive diagnostic procedures, the range of procedure charges
2490 from highest to lowest, average net revenue per adjusted patient
2491 day, average cost per adjusted patient day, and average cost per
2492 admission, among others.

2493 2. Make available performance measures, benefit design,
2494 and premium cost data from health plans licensed pursuant to
2495 chapter 627 or chapter 641. The agency shall determine which
2496 health care quality measures and member and subscriber cost data
2497 to disclose, based upon input from the council. When determining
2498 which data to disclose, the agency shall consider information
2499 that may be required by either individual or group purchasers to
2500 assess the value of the product, which may include membership
2501 satisfaction, quality of care, current enrollment or membership,
2502 coverage areas, accreditation status, premium costs, plan costs,
2503 premium increases, range of benefits, copayments and
2504 deductibles, accuracy and speed of claims payment, credentials
2505 of physicians, number of providers, names of network providers,
2506 and hospitals in the network. Health plans shall make available
2507 to the agency any such data or information that is not currently
2508 reported to the agency or the office.
2509 3. Determine the method and format for public disclosure
2510 of data reported pursuant to this paragraph. The agency shall
2511 make its determination based upon input from the State Consumer
2512 Health Information and Policy Advisory Council. At a minimum,
2513 the data shall be made available on the agency's Internet
2514 website in a manner that allows consumers to conduct an
2515 interactive search that allows them to view and compare the
2516 information for specific providers. The website must include
2517 such additional information as is determined necessary to ensure
2518 that the website enhances informed decisionmaking among
2519 consumers and health care purchasers, which shall include, at a
2520 minimum, appropriate guidance on how to use the data and an

2521 explanation of why the data may vary from provider to provider.
2522 The data specified in subparagraph 1. shall be released no later
2523 than January 1, 2006, for the reporting of infection rates, and
2524 no later than October 1, 2005, for mortality rates and
2525 complication rates. The data specified in subparagraph 2. shall
2526 be released no later than October 1, 2006.
2527 4. Publish on its website undiscounted charges for no
2528 fewer than 150 of the most commonly performed adult and
2529 pediatric procedures, including outpatient, inpatient,
2530 diagnostic, and preventative procedures.
2531 Section 56. Paragraph (a) of subsection (1) of section
2532 408.061, Florida Statutes, is amended to read:
2533 408.061 Data collection; uniform systems of financial
2534 reporting; information relating to physician charges;
2535 confidential information; immunity.—
2536 (1) The agency shall require the submission by health care
2537 facilities, health care providers, and health insurers of data
2538 necessary to carry out the agency's duties. Specifications for
2539 data to be collected under this section shall be developed by
2540 the agency with the assistance of technical advisory panels
2541 including representatives of affected entities, consumers,
2542 purchasers, and such other interested parties as may be
2543 determined by the agency.
2544 (a) Data submitted by health care facilities, including
2545 the facilities as defined in chapter 395, shall include, but are
2546 not limited to: case-mix data, patient admission and discharge
2547 data, hospital emergency department data which shall include the
2548 number of patients treated in the emergency department of a

2549 licensed hospital reported by patient acuity level, data on
2550 hospital-acquired infections as specified by rule, data on
2551 complications as specified by rule, data on readmissions as
2552 specified by rule, with patient and provider-specific
2553 identifiers included, actual charge data by diagnostic groups,
2554 financial data, accounting data, operating expenses, expenses
2555 incurred for rendering services to patients who cannot or do not
2556 pay, interest charges, depreciation expenses based on the
2557 expected useful life of the property and equipment involved, and
2558 demographic data. The agency shall adopt nationally recognized
2559 risk adjustment methodologies or software consistent with the
2560 standards of the Agency for Healthcare Research and Quality and
2561 as selected by the agency for all data submitted as required by
2562 this section. Data may be obtained from documents such as, but
2563 not limited to: leases, contracts, debt instruments, itemized
2564 patient bills, medical record abstracts, and related diagnostic
2565 information. Reported data elements shall be reported
2566 electronically and ~~in accordance with rule 59E-7.012, Florida~~
2567 ~~Administrative Code. Data submitted shall be~~ certified by the
2568 chief executive officer or an appropriate and duly authorized
2569 representative or employee of the licensed facility that the
2570 information submitted is true and accurate.
2571 Section 57. Subsection (1) of section 408.10, Florida
2572 Statutes, is amended to read:
2573 408.10 Consumer complaints.—The agency shall:
2574 (1) Publish and make available to the public a toll-free
2575 telephone number for the purpose of handling consumer complaints
2576 and shall serve as a liaison between consumer entities and other

2577 private entities and governmental entities for the disposition
2578 of problems identified by consumers of health care. The agency
2579 may provide staffing for this toll-free number through agency
2580 staff or other arrangements.
2581 Section 58. Subsection (11) of section 408.802, Florida
2582 Statutes, is repealed.
2583 Section 59. Effective October 1, 2010, subsection (3) is
2584 added to section 408.804, Florida Statutes, to read:
2585 408.804 License required; display.—
2586 (3) Any person who knowingly alters, defaces, or falsifies
2587 any license certificate issued by the agency, or causes or
2588 procures any person to commit such an offense, commits a
2589 misdemeanor of the second degree, punishable as provided in s.
2590 775.082 or s. 775.083. Any licensee or provider who displays an
2591 altered, defaced, or falsified license certificate is subject to
2592 the penalties set forth in s. 408.815 and an administrative fine
2593 of $1,000 for each day of illegal display.
2594 Section 60. Paragraph (d) of subsection (2) of section
2595 408.806, Florida Statutes, is amended to read:
2596 408.806 License application process.—
2597 (2)(d) The agency shall notify the licensee by mail or
2598 electronically at least 90 days before the expiration of a
2599 license that a renewal license is necessary to continue
2600 operation. The licensee's failure to timely file submit a
2601 renewal application and license application fee with the agency
2602 shall result in a $50 per day late fee charged to the licensee
2603 by the agency; however, the aggregate amount of the late fee may
2604 not exceed 50 percent of the licensure fee or $500, whichever is

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2605 less. The agency shall provide a courtesy notice to the licensee
2606 by United States mail, electronically, or by any other manner at
2607 its address of record at least 90 days before the expiration of
2608 a license informing the licensee of the expiration of the
2609 license. Any failure of the agency to provide the courtesy
2610 notice or any failure of the licensee to receive the courtesy
2611 notice does not excuse the licensee from the legal obligation to
2612 timely file the renewal application and license application fee
2613 with the agency and does not mitigate the late fee. Payment of
2614 the late fee is required in order for any late application to be
2615 complete, and failure to pay the late fee is an omission from
2616 the application. ~~If an application is received after the~~
2617 ~~required filing date and exhibits a hand-canceled postmark~~
2618 ~~obtained from a United States post office dated on or before the~~
2619 ~~required filing date, no fine will be levied.~~
2620 Section 61. Subsections (6) and (9) of section 408.810,
2621 Florida Statutes, are amended to read:
2622 408.810 Minimum licensure requirements.—In addition to the
2623 licensure requirements specified in this part, authorizing
2624 statutes, and applicable rules, each applicant and licensee must
2625 comply with the requirements of this section in order to obtain
2626 and maintain a license.
2627 (6)(a) An applicant must provide the agency with proof of
2628 the applicant's legal right to occupy the property before a
2629 license may be issued. Proof may include, but need not be
2630 limited to, copies of warranty deeds, lease or rental
2631 agreements, contracts for deeds, quitclaim deeds, or other such
2632 documentation.

2633 (b) If the property is encumbered by a mortgage or is
2634 leased, an applicant must provide the agency with proof that the
2635 mortgagor or landlord has received written notice of the
2636 applicant's intent as mortgagee or tenant to provide services
2637 that require licensure and instructions that the agency be
2638 served by certified mail with copies of any actions initiated by
2639 the mortgagor or landlord against applicant.
2640 (9) A controlling interest may not withhold from the
2641 agency any evidence of financial instability, including, but not
2642 limited to, checks returned due to insufficient funds,
2643 delinquent accounts, nonpayment of withholding taxes, unpaid
2644 utility expenses, nonpayment for essential services, or adverse
2645 court action concerning the financial viability of the provider
2646 or any other provider licensed under this part that is under the
2647 control of the controlling interest. A controlling interest
2648 shall notify the agency within 10 days after a court action,
2649 including, but not limited to, the initiation of bankruptcy
2650 proceedings, foreclosure, or eviction proceedings, in which the
2651 controlling interest is a petitioner or defendant. Any person
2652 who violates this subsection commits a misdemeanor of the second
2653 degree, punishable as provided in s. 775.082 or s. 775.083. Each
2654 day of continuing violation is a separate offense.
2655 Section 62. Paragraph (a) of subsection (6) of section
2656 408.811, Florida Statutes, is amended to read:
2657 408.811 Right of inspection; copies; inspection reports;
2658 plan for correction of deficiencies.—
2659 (6)(a) Each licensee shall maintain as public information,
2660 available upon request, records of all inspection reports

2661 pertaining to that provider that have been filed by the agency
2662 unless those reports are exempt from or contain information that
2663 is exempt from s. 119.07(1) and s. 24(a), Art. I of the State
2664 Constitution or is otherwise made confidential by law. Effective
2665 October 1, 2006, copies of such reports shall be retained in the
2666 records of the provider for at least 3 years following the date
2667 the reports are filed and issued, regardless of a change of
2668 ownership. The inspection report is not subject to challenge
2669 under s. 120.569 or s. 120.57.
2670 Section 63. Subsection (2) of section 408.813, Florida
2671 Statutes, is amended to read:
2672 408.813 Administrative fines; violations.—As a penalty for
2673 any violation of this part, authorizing statutes, or applicable
2674 rules, the agency may impose an administrative fine.
2675 (2)(a) Violations of this part, authorizing statutes, or
2676 applicable rules shall be classified according to the nature of
2677 the violation and the gravity of its probable effect on clients.
2678 The scope of a violation may be cited as an isolated, patterned,
2679 or widespread deficiency. An isolated deficiency is a deficiency
2680 affecting one or a very limited number of clients, or involving
2681 one or a very limited number of staff, or a situation that
2682 occurred only occasionally or in a very limited number of
2683 locations. A patterned deficiency is a deficiency in which more
2684 than a very limited number of clients are affected, or more than
2685 a very limited number of staff are involved, or the situation
2686 has occurred in several locations, or the same client or clients
2687 have been affected by repeated occurrences of the same deficient
2688 practice but the effect of the deficient practice is not found

2689 to be pervasive throughout the provider. A widespread deficiency
2690 is a deficiency in which the problems causing the deficiency are
2691 pervasive in the provider or represent systemic failure that has
2692 affected or has the potential to affect a large portion of the
2693 provider's clients. This subsection does not affect the
2694 legislative determination of the amount of a fine imposed under
2695 authorizing statutes. Violations shall be classified on the
2696 written notice as follows:

2697 1. ~~(a)~~ Class "I" violations are those conditions or
2698 occurrences related to the operation and maintenance of a
2699 provider or to the care of clients which the agency determines
2700 present an imminent danger to the clients of the provider or a
2701 substantial probability that death or serious physical or
2702 emotional harm would result therefrom. The condition or practice
2703 constituting a class I violation shall be abated or eliminated
2704 within 24 hours, unless a fixed period, as determined by the
2705 agency, is required for correction. The agency shall impose an
2706 administrative fine as provided by law for a cited class I
2707 violation. A fine shall be levied notwithstanding the correction
2708 of the violation.

2709 2. ~~(b)~~ Class "II" violations are those conditions or
2710 occurrences related to the operation and maintenance of a
2711 provider or to the care of clients which the agency determines
2712 directly threaten the physical or emotional health, safety, or
2713 security of the clients, other than class I violations. The
2714 agency shall impose an administrative fine as provided by law
2715 for a cited class II violation. A fine shall be levied
2716 notwithstanding the correction of the violation.

2717 3.~~(c)~~ Class "III" violations are those conditions or
2718 occurrences related to the operation and maintenance of a
2719 provider or to the care of clients which the agency determines
2720 indirectly or potentially threaten the physical or emotional
2721 health, safety, or security of clients, other than class I or
2722 class II violations. The agency shall impose an administrative
2723 fine as provided in this section for a cited class III
2724 violation. A citation for a class III violation must specify the
2725 time within which the violation is required to be corrected. If
2726 a class III violation is corrected within the time specified, a
2727 fine may not be imposed.

2728 4.~~(d)~~ Class "IV" violations are those conditions or
2729 occurrences related to the operation and maintenance of a
2730 provider or to required reports, forms, or documents that do not
2731 have the potential of negatively affecting clients. These
2732 violations are of a type that the agency determines do not
2733 threaten the health, safety, or security of clients. The agency
2734 shall impose an administrative fine as provided in this section
2735 for a cited class IV violation. A citation for a class IV
2736 violation must specify the time within which the violation is
2737 required to be corrected. If a class IV violation is corrected
2738 within the time specified, a fine may not be imposed.

2739 (b) The agency may impose an administrative fine for
2740 violations that do not qualify as class I, class II, class III,
2741 or class IV violations. The amount of the fine may not exceed
2742 $500 for each violation. Unclassified violations may include:

2743 1. Violating any term or condition of a license.

2744 2. Violating any provision of this part, authorizing

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2745 statutes, or applicable rules.
2746 3. Exceeding licensed capacity without authorization.
2747 4. Providing services beyond the scope of the license.
2748 5. Violating a moratorium.
2749 Section 64. Subsection (5) is added to section 408.815,
2750 Florida Statutes, to read:
2751 408.815 License or application denial; revocation.—
2752 (5) In order to ensure the health, safety, and welfare of
2753 clients where a license has been denied, revoked, or is set to
2754 terminate, the agency may extend the license expiration date for
2755 up to 60 days after denial, revocation, or termination the sole
2756 purpose of allowing the safe and orderly discharge of clients.
2757 The agency may impose conditions on the extension, including,
2758 but not limited to, prohibiting or limiting admissions,
2759 expediting discharge planning, submitting required status
2760 reports, and mandatory monitoring by the agency or third
2761 parties. The agency may terminate the extension or modify the
2762 conditions at any time at its discretion. Upon the discharge of
2763 the final client, the extension shall immediately terminate and
2764 the provider shall cease operation and promptly surrender its
2765 license certificate to the agency. During the extension, the
2766 provider must continue to meet all other requirements of this
2767 part, authorizing statutes, and applicable rules. This authority
2768 is in addition to any other authority granted to the agency
2769 under chapter 120, this part, and the authorizing statutes, but
2770 does not create any right or entitlement to an extension of a
2771 license expiration date.
2772 Section 65. Paragraph (d) is added to subsection (13) of

2773 section 409.906, Florida Statutes, to read:
2774 409.906 Optional Medicaid services.—Subject to specific
2775 appropriations, the agency may make payments for services which
2776 are optional to the state under Title XIX of the Social Security
2777 Act and are furnished by Medicaid providers to recipients who
2778 are determined to be eligible on the dates on which the services
2779 were provided. Any optional service that is provided shall be
2780 provided only when medically necessary and in accordance with
2781 state and federal law. Optional services rendered by providers
2782 in mobile units to Medicaid recipients may be restricted or
2783 prohibited by the agency. Nothing in this section shall be
2784 construed to prevent or limit the agency from adjusting fees,
2785 reimbursement rates, lengths of stay, number of visits, or
2786 number of services, or making any other adjustments necessary to
2787 comply with the availability of moneys and any limitations or
2788 directions provided for in the General Appropriations Act or
2789 chapter 216. If necessary to safeguard the state's systems of
2790 providing services to elderly and disabled persons and subject
2791 to the notice and review provisions of s. 216.177, the Governor
2792 may direct the Agency for Health Care Administration to amend
2793 the Medicaid state plan to delete the optional Medicaid service
2794 known as "Intermediate Care Facilities for the Developmentally
2795 Disabled." Optional services may include:
2796 (13) HOME AND COMMUNITY-BASED SERVICES.—
2797 (d) The agency, in consultation with the Department of
2798 Elderly Affairs, shall phase out the adult day health care
2799 waiver program and transfer existing waiver enrollees to other
2800 appropriate home and community-based service programs. Effective

2801 July 1, 2010, the adult day health care waiver program shall
2802 cease to enroll new members. Existing enrollees in the adult day
2803 health care program shall receive counseling regarding available
2804 options and shall be offered an alternative home and community-
2805 based services program based on eligibility and personal choice.
2806 Each enrollee in the waiver program shall continue to receive
2807 home and community-based services without interruption in the
2808 enrollee's program of choice. The providers of the adult day
2809 health care waiver program, in consultation with the resource
2810 centers for the aged, shall assist in the transition of
2811 enrollees and cease provision of adult day health care waiver
2812 services by December 31, 2010. The agency may seek federal
2813 waiver approval to administer this change.
2814 Section 66. Paragraph (k) of subsection (4) of section
2815 409.221, Florida Statutes, is repealed.
2816 Section 67. Paragraphs (e), (f), and (g) of subsection
2817 (15) of section 409.912, Florida Statutes, are repealed.
2818 Section 68. Section 429.11, Florida Statutes, is amended
2819 to read:
2820 429.11 Initial application for license~~; provisional~~
2821 ~~license~~.—
2822 (1) Each applicant for licensure must comply with all
2823 provisions of part II of chapter 408 and must:
2824 (a) Identify all other homes or facilities, including the
2825 addresses and the license or licenses under which they operate,
2826 if applicable, which are currently operated by the applicant or
2827 administrator and which provide housing, meals, and personal
2828 services to residents.

2829 (b) Provide the location of the facility for which a
2830 license is sought and documentation, signed by the appropriate
2831 local government official, which states that the applicant has
2832 met local zoning requirements.
2833 (c) Provide the name, address, date of birth, social
2834 security number, education, and experience of the administrator,
2835 if different from the applicant.
2836 (2) The applicant shall provide proof of liability
2837 insurance as defined in s. 624.605.
2838 (3) If the applicant is a community residential home, the
2839 applicant must provide proof that it has met the requirements
2840 specified in chapter 419.
2841 (4) The applicant must furnish proof that the facility has
2842 received a satisfactory firesafety inspection. The local
2843 authority having jurisdiction or the State Fire Marshal must
2844 conduct the inspection within 30 days after written request by
2845 the applicant.
2846 (5) The applicant must furnish documentation of a
2847 satisfactory sanitation inspection of the facility by the county
2848 health department.
2849 ~~(6) In addition to the license categories available in s.~~
2850 ~~408.808, a provisional license may be issued to an applicant~~
2851 ~~making initial application for licensure or making application~~
2852 ~~for a change of ownership. A provisional license shall be~~
2853 ~~limited in duration to a specific period of time not to exceed 6~~
2854 ~~months, as determined by the agency.~~
2855 <u>(6)</u> ~~(7)~~ A county or municipality may not issue an
2856 occupational license that is being obtained for the purpose of

2857 operating a facility regulated under this part without first
2858 ascertaining that the applicant has been licensed to operate
2859 such facility at the specified location or locations by the
2860 agency. The agency shall furnish to local agencies responsible
2861 for issuing occupational licenses sufficient instruction for
2862 making such determinations.
2863 Section 69. Subsection (2) of section 429.12, Florida
2864 Statutes, is repealed.
2865 Section 70. Subsections (5) and (6) of section 429.14,
2866 Florida Statutes, are amended to read:
2867 429.14 Administrative penalties.—
2868 (5) An action taken by the agency to suspend, deny, or
2869 revoke a facility's license under this part or part II of
2870 chapter 408, in which the agency claims that the facility owner
2871 or an employee of the facility has threatened the health,
2872 safety, or welfare of a resident of the facility shall be heard
2873 by the Division of Administrative Hearings of the Department of
2874 Management Services within 120 days after receipt of the
2875 facility's request for a hearing, unless that time limitation is
2876 waived by both parties. The administrative law judge must render
2877 a decision within 30 days after receipt of a proposed
2878 recommended order.
2879 (6) The agency shall provide to the Division of Hotels and
2880 Restaurants of the Department of Business and Professional
2881 Regulation, on a monthly basis, a list of those assisted living
2882 facilities that have had their licenses denied, suspended, or
2883 revoked or that are involved in an appellate proceeding pursuant
2884 to s. 120.60 related to the denial, suspension, or revocation of

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2885 a license. This information may be provided electronically or
2886 through the agency's Internet website.
2887 Section 71. Subsection (4) of section 429.17, Florida
2888 Statutes, is amended to read:
2889 429.17 Expiration of license; renewal; conditional
2890 license.—
2891 (4) In addition to the license categories available in s.
2892 408.808, a conditional license may be issued to an applicant for
2893 license renewal if the applicant fails to meet all standards and
2894 requirements for licensure. A conditional license issued under
2895 this subsection shall be limited in duration to a specific
2896 period of time not to exceed 6 months, as determined by the
2897 agency~~, and shall be accompanied by an agency-approved plan of~~
2898 ~~correction~~.
2899 Section 72. Subsection (5) of section 429.23, Florida
2900 Statutes, is repealed.
2901 Section 73. Subsection (2) of section 429.35, Florida
2902 Statutes, is amended to read:
2903 429.35 Maintenance of records; reports.—
2904 (2) Within 60 days after the date of the biennial
2905 inspection visit required under s. 408.811 or within 30 days
2906 after the date of any interim visit, the agency shall forward
2907 the results of the inspection to the local ombudsman council in
2908 whose planning and service area, as defined in part II of
2909 chapter 400, the facility is located; to at least one public
2910 library or, in the absence of a public library, the county seat
2911 in the county in which the inspected assisted living facility is
2912 located; and, when appropriate, to the district Adult Services

2913 and Mental Health Program Offices. This information may be
2914 provided electronically or through the agency's Internet site.
2915 Section 74. Section 429.53, Florida Statutes, is amended
2916 to read:
2917 429.53 Consultation by the agency.—
2918 (1) The ~~area offices of licensure and certification of the~~
2919 agency shall provide consultation to the following upon request:
2920 (a) A licensee of a facility.
2921 (b) A person interested in obtaining a license to operate
2922 a facility under this part.
2923 (2) As used in this section, "consultation" includes:
2924 (a) An explanation of the requirements of this part and
2925 rules adopted pursuant thereto;
2926 (b) An explanation of the license application and renewal
2927 procedures; and
2928 ~~(c) The provision of a checklist of general local and~~
2929 ~~state approvals required prior to constructing or developing a~~
2930 ~~facility and a listing of the types of agencies responsible for~~
2931 ~~such approvals;~~
2932 ~~(d) An explanation of benefits and financial assistance~~
2933 ~~available to a recipient of supplemental security income~~
2934 ~~residing in a facility;~~
2935 (c) ~~(e)~~ Any other information that ~~which~~ the agency deems
2936 necessary to promote compliance with the requirements of this
2937 part. ~~; and~~
2938 ~~(f) A preconstruction review of a facility to ensure~~
2939 ~~compliance with agency rules and this part.~~
2940 (3) The agency may charge a fee commensurate with the cost

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2941 of providing consultation under this section.
2942 Section 75. Subsections (2) and (11) of section 429.65,
2943 Florida Statutes, are amended to read:
2944 429.65 Definitions.—As used in this part, the term:
2945 (2) "Adult family-care home" means a full-time, family-
2946 type living arrangement, in a private home, under which up to
2947 two individuals ~~a person~~ who reside in the home and own or rent
2948 ~~owns or rents~~ the home provide ~~provides~~ room, board, and
2949 personal care, on a 24-hour basis, for no more than five
2950 disabled adults or frail elders who are not relatives. The
2951 following family-type living arrangements are not required to be
2952 licensed as an adult family-care home:
2953 (a) An arrangement whereby the person who resides in the
2954 home and owns or rents the home provides room, board, and
2955 personal services for not more than two adults who do not
2956 receive optional state supplementation under s. 409.212. The
2957 person who provides the housing, meals, and personal care must
2958 own or rent the home and reside therein.
2959 (b) An arrangement whereby the person who owns or rents
2960 the home provides room, board, and personal services only to his
2961 or her relatives.
2962 (c) An establishment that is licensed as an assisted
2963 living facility under this chapter.
2964 (11) "Provider" means one or two individuals ~~a person~~ who
2965 are ~~is~~ licensed to operate an adult family-care home.
2966 Section 76. Section 429.71, Florida Statutes, is amended
2967 to read:
2968 429.71 Classification of violations ~~deficiencies~~;

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2969 administrative fines.—
2970 (1) In addition to the requirements of part II of chapter
2971 408 and in addition to any other liability or penalty provided
2972 by law, the agency may impose an administrative fine on a
2973 provider according to the following classification:
2974 (a) Class I violations are defined in s. 408.813. ~~those~~
2975 ~~conditions or practices related to the operation and maintenance~~
2976 ~~of an adult family-care home or to the care of residents which~~
2977 ~~the agency determines present an imminent danger to the~~
2978 ~~residents or guests of the facility or a substantial probability~~
2979 ~~that death or serious physical or emotional harm would result~~
2980 ~~therefrom. The condition or practice that constitutes a class I~~
2981 ~~violation must be abated or eliminated within 24 hours, unless a~~
2982 ~~fixed period, as determined by the agency, is required for~~
2983 ~~correction.~~ A class I violation ~~deficiency~~ is subject to an
2984 administrative fine in an amount not less than $500 and not
2985 exceeding $1,000 for each violation. A fine may be levied
2986 notwithstanding the correction of the violation ~~deficiency~~.
2987 (b) Class II violations are defined in s. 408.813. ~~those~~
2988 ~~conditions or practices related to the operation and maintenance~~
2989 ~~of an adult family-care home or to the care of residents which~~
2990 ~~the agency determines directly threaten the physical or~~
2991 ~~emotional health, safety, or security of the residents, other~~
2992 ~~than class I violations.~~ A class II violation is subject to an
2993 administrative fine in an amount not less than $250 and not
2994 exceeding $500 for each violation. ~~A citation for a class II~~
2995 ~~violation must specify the time within which the violation is~~
2996 ~~required to be corrected. If a class II violation is corrected~~

2997 ~~within the time specified, no civil penalty shall be imposed,~~
2998 ~~unless it is a repeated offense.~~
2999 (c) Class III violations are defined in s. 408.813. ~~those~~
3000 ~~conditions or practices related to the operation and maintenance~~
3001 ~~of an adult family-care home or to the care of residents which~~
3002 ~~the agency determines indirectly or potentially threaten the~~
3003 ~~physical or emotional health, safety, or security of residents,~~
3004 ~~other than class I or class II violations.~~ A class III violation
3005 is subject to an administrative fine in an amount not less than
3006 $100 and not exceeding $250 for each violation. ~~A citation for a~~
3007 ~~class III violation shall specify the time within which the~~
3008 ~~violation is required to be corrected. If a class III violation~~
3009 ~~is corrected within the time specified, no civil penalty shall~~
3010 ~~be imposed, unless it is a repeated offense.~~
3011 (d) Class IV violations are defined in s. 408.813. ~~those~~
3012 ~~conditions or occurrences related to the operation and~~
3013 ~~maintenance of an adult family-care home, or related to the~~
3014 ~~required reports, forms, or documents, which do not have the~~
3015 ~~potential of negatively affecting the residents. A provider that~~
3016 ~~does not correct~~ A class IV violation ~~within the time limit~~
3017 ~~specified by the agency~~ is subject to an administrative fine in
3018 an amount not less than $50 and not exceeding $100 for each
3019 violation. ~~Any class IV violation that is corrected during the~~
3020 ~~time the agency survey is conducted will be identified as an~~
3021 ~~agency finding and not as a violation.~~
3022 (2) The agency may impose an administrative fine for
3023 violations which do not qualify as class I, class II, class III,
3024 or class IV violations. The amount of the fine may ~~shall~~ not

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

3025 exceed $250 for each violation or $2,000 in the aggregate.
3026 Unclassified violations may include:
3027 (a) Violating any term or condition of a license.
3028 (b) Violating any provision of this part, part II of
3029 chapter 408, or applicable rules.
3030 (c) Failure to follow the criteria and procedures provided
3031 under part I of chapter 394 relating to the transportation,
3032 voluntary admission, and involuntary examination of adult
3033 family-care home residents.
3034 (d) Exceeding licensed capacity.
3035 (e) Providing services beyond the scope of the license.
3036 (f) Violating a moratorium.
3037 (3) Each day during which a violation occurs constitutes a
3038 separate offense.
3039 (4) In determining whether a penalty is to be imposed, and
3040 in fixing the amount of any penalty to be imposed, the agency
3041 must consider:
3042 (a) The gravity of the violation.
3043 (b) Actions taken by the provider to correct a violation.
3044 (c) Any previous violation by the provider.
3045 (d) The financial benefit to the provider of committing or
3046 continuing the violation.
3047 ~~(5) As an alternative to or in conjunction with an~~
3048 ~~administrative action against a provider, the agency may request~~
3049 ~~a plan of corrective action that demonstrates a good faith~~
3050 ~~effort to remedy each violation by a specific date, subject to~~
3051 ~~the approval of the agency.~~
3052 Section 77. Section 429.911, Florida Statutes, is

3053 repealed.

3054 Section 78. Section 429.915, Florida Statutes, is amended
3055 to read:

3056 429.915 Conditional license.—In addition to the license
3057 categories available in part II of chapter 408, the agency may
3058 issue a conditional license to an applicant for license renewal
3059 or change of ownership if the applicant fails to meet all
3060 standards and requirements for licensure. A conditional license
3061 issued under this subsection must be limited to a specific
3062 period not exceeding 6 months, as determined by the agency~~, and~~
3063 ~~must be accompanied by an approved plan of correction~~.

3064 Section 79. Subsection (3) of section 430.80, Florida
3065 Statutes, is amended to read:

3066 430.80 Implementation of a teaching nursing home pilot
3067 project.—

3068 (3) To be designated as a teaching nursing home, a nursing
3069 home licensee must, at a minimum:

3070 (a) Provide a comprehensive program of integrated senior
3071 services that include institutional services and community-based
3072 services;

3073 (b) Participate in a nationally recognized accreditation
3074 program and hold a valid accreditation, such as the
3075 accreditation awarded by the Joint Commission ~~on Accreditation~~
3076 ~~of Healthcare Organizations~~;

3077 (c) Have been in business in this state for a minimum of
3078 10 consecutive years;

3079 (d) Demonstrate an active program in multidisciplinary
3080 education and research that relates to gerontology;

3081 (e) Have a formalized contractual relationship with at
3082 least one accredited health profession education program located
3083 in this state;
3084 (f) Have a formalized contractual relationship with an
3085 accredited hospital that is designated by law as a teaching
3086 hospital; and
3087 (g) Have senior staff members who hold formal faculty
3088 appointments at universities, which must include at least one
3089 accredited health profession education program.
3090 (h) Maintain insurance coverage pursuant to s.
3091 400.141(1)(q) ~~s. 400.141(1)(s)~~ or proof of financial
3092 responsibility in a minimum amount of $750,000. Such proof of
3093 financial responsibility may include:
3094 1. Maintaining an escrow account consisting of cash or
3095 assets eligible for deposit in accordance with s. 625.52; or
3096 2. Obtaining and maintaining pursuant to chapter 675 an
3097 unexpired, irrevocable, nontransferable and nonassignable letter
3098 of credit issued by any bank or savings association organized
3099 and existing under the laws of this state or any bank or savings
3100 association organized under the laws of the United States that
3101 has its principal place of business in this state or has a
3102 branch office which is authorized to receive deposits in this
3103 state. The letter of credit shall be used to satisfy the
3104 obligation of the facility to the claimant upon presentment of a
3105 final judgment indicating liability and awarding damages to be
3106 paid by the facility or upon presentment of a settlement
3107 agreement signed by all parties to the agreement when such final
3108 judgment or settlement is a result of a liability claim against

3109 the facility.

3110 Section 80. Paragraph (a) of subsection (2) of section
3111 440.13, Florida Statutes, is amended to read:

3112 440.13 Medical services and supplies; penalty for
3113 violations; limitations.—

3114 (2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—

3115 (a) Subject to the limitations specified elsewhere in this
3116 chapter, the employer shall furnish to the employee such
3117 medically necessary remedial treatment, care, and attendance for
3118 such period as the nature of the injury or the process of
3119 recovery may require, which is in accordance with established
3120 practice parameters and protocols of treatment as provided for
3121 in this chapter, including medicines, medical supplies, durable
3122 medical equipment, orthoses, prostheses, and other medically
3123 necessary apparatus. Remedial treatment, care, and attendance,
3124 including work-hardening programs or pain-management programs
3125 accredited by the Commission on Accreditation of Rehabilitation
3126 Facilities or the Joint Commission ~~on the Accreditation of~~
3127 ~~Health Organizations~~ or pain-management programs affiliated with
3128 medical schools, shall be considered as covered treatment only
3129 when such care is given based on a referral by a physician as
3130 defined in this chapter. Medically necessary treatment, care,
3131 and attendance does not include chiropractic services in excess
3132 of 24 treatments or rendered 12 weeks beyond the date of the
3133 initial chiropractic treatment, whichever comes first, unless
3134 the carrier authorizes additional treatment or the employee is
3135 catastrophically injured.

3136

3137 Failure of the carrier to timely comply with this subsection
3138 shall be a violation of this chapter and the carrier shall be
3139 subject to penalties as provided for in s. 440.525.
3140 Section 81. Section 483.294, Florida Statutes, is amended
3141 to read:
3142 483.294 Inspection of centers.—In accordance with s.
3143 408.811, the agency shall biennially~~, at least once annually,~~
3144 inspect the premises and operations of all centers subject to
3145 licensure under this part.
3146 Section 82. Subsection (1) of section 627.645, Florida
3147 Statutes, is amended to read:
3148 627.645 Denial of health insurance claims restricted.—
3149 (1) A ~~No~~ claim for payment under a health insurance policy
3150 or self-insured program of health benefits for treatment, care,
3151 or services in a licensed hospital which is accredited by the
3152 Joint Commission ~~on the Accreditation of Hospitals~~, the American
3153 Osteopathic Association, or the Commission on the Accreditation
3154 of Rehabilitative Facilities may not ~~shall~~ be denied because
3155 such hospital lacks major surgical facilities and is primarily
3156 of a rehabilitative nature, if such rehabilitation is
3157 specifically for treatment of physical disability.
3158 Section 83. Paragraph (c) of subsection (2) of section
3159 627.668, Florida Statutes, is amended to read:
3160 627.668 Optional coverage for mental and nervous disorders
3161 required; exception.—
3162 (2) Under group policies or contracts, inpatient hospital
3163 benefits, partial hospitalization benefits, and outpatient
3164 benefits consisting of durational limits, dollar amounts,

3165 deductibles, and coinsurance factors shall not be less favorable
3166 than for physical illness generally, except that:
3167 (c) Partial hospitalization benefits shall be provided
3168 under the direction of a licensed physician. For purposes of
3169 this part, the term "partial hospitalization services" is
3170 defined as those services offered by a program accredited by the
3171 Joint Commission ~~on Accreditation of Hospitals (JCAH)~~ or in
3172 compliance with equivalent standards. Alcohol rehabilitation
3173 programs accredited by the Joint Commission ~~on Accreditation of~~
3174 ~~Hospitals~~ or approved by the state and licensed drug abuse
3175 rehabilitation programs shall also be qualified providers under
3176 this section. In any benefit year, if partial hospitalization
3177 services or a combination of inpatient and partial
3178 hospitalization are utilized, the total benefits paid for all
3179 such services shall not exceed the cost of 30 days of inpatient
3180 hospitalization for psychiatric services, including physician
3181 fees, which prevail in the community in which the partial
3182 hospitalization services are rendered. If partial
3183 hospitalization services benefits are provided beyond the limits
3184 set forth in this paragraph, the durational limits, dollar
3185 amounts, and coinsurance factors thereof need not be the same as
3186 those applicable to physical illness generally.
3187 Section 84. Subsection (3) of section 627.669, Florida
3188 Statutes, is amended to read:
3189 627.669 Optional coverage required for substance abuse
3190 impaired persons; exception.—
3191 (3) The benefits provided under this section shall be
3192 applicable only if treatment is provided by, or under the

3193 supervision of, or is prescribed by, a licensed physician or
3194 licensed psychologist and if services are provided in a program
3195 accredited by the Joint Commission ~~on Accreditation of Hospitals~~
3196 or approved by the state.
3197 Section 85. Paragraph (a) of subsection (1) of section
3198 627.736, Florida Statutes, is amended to read:
3199 627.736 Required personal injury protection benefits;
3200 exclusions; priority; claims.—
3201 (1) REQUIRED BENEFITS.—Every insurance policy complying
3202 with the security requirements of s. 627.733 shall provide
3203 personal injury protection to the named insured, relatives
3204 residing in the same household, persons operating the insured
3205 motor vehicle, passengers in such motor vehicle, and other
3206 persons struck by such motor vehicle and suffering bodily injury
3207 while not an occupant of a self-propelled vehicle, subject to
3208 the provisions of subsection (2) and paragraph (4)(e), to a
3209 limit of $10,000 for loss sustained by any such person as a
3210 result of bodily injury, sickness, disease, or death arising out
3211 of the ownership, maintenance, or use of a motor vehicle as
3212 follows:
3213 (a) Medical benefits.—Eighty percent of all reasonable
3214 expenses for medically necessary medical, surgical, X-ray,
3215 dental, and rehabilitative services, including prosthetic
3216 devices, and medically necessary ambulance, hospital, and
3217 nursing services. However, the medical benefits shall provide
3218 reimbursement only for such services and care that are lawfully
3219 provided, supervised, ordered, or prescribed by a physician
3220 licensed under chapter 458 or chapter 459, a dentist licensed

3221 under chapter 466, or a chiropractic physician licensed under
3222 chapter 460 or that are provided by any of the following persons
3223 or entities:
3224 1. A hospital or ambulatory surgical center licensed under
3225 chapter 395.
3226 2. A person or entity licensed under ss. 401.2101-401.45
3227 that provides emergency transportation and treatment.
3228 3. An entity wholly owned by one or more physicians
3229 licensed under chapter 458 or chapter 459, chiropractic
3230 physicians licensed under chapter 460, or dentists licensed
3231 under chapter 466 or by such practitioner or practitioners and
3232 the spouse, parent, child, or sibling of that practitioner or
3233 those practitioners.
3234 4. An entity wholly owned, directly or indirectly, by a
3235 hospital or hospitals.
3236 5. A health care clinic licensed under ss. 400.990-400.995
3237 that is:
3238 a. Accredited by the Joint Commission ~~on Accreditation of~~
3239 ~~Healthcare Organizations~~, the American Osteopathic Association,
3240 the Commission on Accreditation of Rehabilitation Facilities, or
3241 the Accreditation Association for Ambulatory Health Care, Inc.;
3242 or
3243 b. A health care clinic that:
3244 (I) Has a medical director licensed under chapter 458,
3245 chapter 459, or chapter 460;
3246 (II) Has been continuously licensed for more than 3 years
3247 or is a publicly traded corporation that issues securities
3248 traded on an exchange registered with the United States

3249 Securities and Exchange Commission as a national securities
3250 exchange; and
3251 (III) Provides at least four of the following medical
3252 specialties:
3253 (A) General medicine.
3254 (B) Radiography.
3255 (C) Orthopedic medicine.
3256 (D) Physical medicine.
3257 (E) Physical therapy.
3258 (F) Physical rehabilitation.
3259 (G) Prescribing or dispensing outpatient prescription
3260 medication.
3261 (H) Laboratory services.
3262
3263 The Financial Services Commission shall adopt by rule the form
3264 that must be used by an insurer and a health care provider
3265 specified in subparagraph 3., subparagraph 4., or subparagraph
3266 5. to document that the health care provider meets the criteria
3267 of this paragraph, which rule must include a requirement for a
3268 sworn statement or affidavit.
3269
3270 Only insurers writing motor vehicle liability insurance in this
3271 state may provide the required benefits of this section, and no
3272 such insurer shall require the purchase of any other motor
3273 vehicle coverage other than the purchase of property damage
3274 liability coverage as required by s. 627.7275 as a condition for
3275 providing such required benefits. Insurers may not require that
3276 property damage liability insurance in an amount greater than

3277 $10,000 be purchased in conjunction with personal injury
3278 protection. Such insurers shall make benefits and required
3279 property damage liability insurance coverage available through
3280 normal marketing channels. Any insurer writing motor vehicle
3281 liability insurance in this state who fails to comply with such
3282 availability requirement as a general business practice shall be
3283 deemed to have violated part IX of chapter 626, and such
3284 violation shall constitute an unfair method of competition or an
3285 unfair or deceptive act or practice involving the business of
3286 insurance; and any such insurer committing such violation shall
3287 be subject to the penalties afforded in such part, as well as
3288 those which may be afforded elsewhere in the insurance code.
3289 Section 86. Subsection (12) of section 641.495, Florida
3290 Statutes, is amended to read:
3291 641.495 Requirements for issuance and maintenance of
3292 certificate.—
3293 (12) The provisions of part I of chapter 395 do not apply
3294 to a health maintenance organization that, on or before January
3295 1, 1991, provides not more than 10 outpatient holding beds for
3296 short-term and hospice-type patients in an ambulatory care
3297 facility for its members, provided that such health maintenance
3298 organization maintains current accreditation by the Joint
3299 Commission ~~on Accreditation of Health Care Organizations~~, the
3300 Accreditation Association for Ambulatory Health Care, or the
3301 National Committee for Quality Assurance.
3302 Section 87. Subsection (13) of section 651.118, Florida
3303 Statutes, is amended to read:
3304 651.118 Agency for Health Care Administration;

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

3305 certificates of need; sheltered beds; community beds.—
3306 (13) Residents, as defined in this chapter, are not
3307 considered new admissions for the purpose of s. 400.141(1)(n)1.d
3308 ~~s. 400.141(1)(o)1.d~~.
3309 Section 88. Subsection (2) of section 766.1015, Florida
3310 Statutes, is amended to read:
3311 766.1015 Civil immunity for members of or consultants to
3312 certain boards, committees, or other entities.—
3313 (2) Such committee, board, group, commission, or other
3314 entity must be established in accordance with state law or in
3315 accordance with requirements of the Joint Commission ~~on~~
3316 ~~Accreditation of Healthcare Organizations~~, established and duly
3317 constituted by one or more public or licensed private hospitals
3318 or behavioral health agencies, or established by a governmental
3319 agency. To be protected by this section, the act, decision,
3320 omission, or utterance may not be made or done in bad faith or
3321 with malicious intent.
3322 Section 89. Except as otherwise expressly provided in this
3323 act, this act shall take effect July 1, 2010.

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	____

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1 Council/Committee hearing bill: Health Care Regulation Policy
2 Committee
3 Representative(s) Flores offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Paragraph (e) of subsection (10) of section
8 112.0455, Florida Statutes, is repealed.
9 Section 2. Section 383.325, Florida Statutes, is repealed.
10 Section 3. Section 395.1046, Florida Statutes, is
11 repealed.
12 Section 4. Section 395.3037, Florida Statutes, is
13 repealed.
14 Section 5. Paragraph (g) of subsection (2) of section
15 400.0239, Florida Statutes, is amended to read:
16 400.0239 Quality of Long-Term Care Facility Improvement
17 Trust Fund.—
18 (2) Expenditures from the trust fund shall be allowable
19 for direct support of the following:

20 (g) Other initiatives authorized by the Centers for
21 Medicare and Medicaid Services for the use of federal civil
22 monetary penalties~~, including projects recommended through the~~
23 ~~Medicaid "Up-or-Out" Quality of Care Contract Management Program~~
24 ~~pursuant to s. 400.148~~.
25 Section 6. <u>Subsection (10) of section 400.147, Florida</u>
26 <u>Statutes, is repealed.</u>
27 Section 7. <u>Section 400.148, Florida Statutes, is repealed.</u>
28 Section 8. <u>Section 400.195, Florida Statutes, is repealed.</u>
29 Section 9. Section 400.476, Florida Statutes, is amended
30 to read:
31 400.476 Staffing requirements; notifications; limitations
32 on staffing services.—
33 (1) ADMINISTRATOR.—
34 (a) An administrator may manage only one home health
35 agency, except that an administrator may manage up to five home
36 health agencies if all five home health agencies have identical
37 controlling interests as defined in s. 408.803 and are located
38 within one agency geographic service area or within an
39 immediately contiguous county. If the home health agency is
40 licensed under this chapter and is part of a retirement
41 community that provides multiple levels of care, an employee of
42 the retirement community may administer the home health agency
43 and up to a maximum of four entities licensed under this chapter
44 or chapter 429 which all have identical controlling interests as
45 defined in s. 408.803. An administrator shall designate, in
46 writing, for each licensed entity, a qualified alternate
47 administrator to serve during the administrator's absence. <u>An</u>

48 alternate administrator must meet the requirements in this
49 paragraph and s. 400.462(1).
50 (b) An administrator of a home health agency who is a
51 licensed physician, physician assistant, or registered nurse
52 licensed to practice in this state may also be the director of
53 nursing for a home health agency. An administrator may serve as
54 a director of nursing for up to the number of entities
55 authorized in subsection (2) only if there are 10 or fewer full-
56 time equivalent employees and contracted personnel in each home
57 health agency.
58 (c) The administrator shall organize and direct the
59 agency's ongoing functions, maintain an ongoing liaison with the
60 board members and the staff, employ qualified personnel and
61 ensure adequate staff education and evaluations, ensure the
62 accuracy of public informational materials and activities,
63 implement an effective budgeting and accounting system, and
64 ensure that the home health agency operates in compliance with
65 this part and part II of chapter 408 and rules adopted for these
66 laws.
67 (d) The administrator shall clearly set forth in writing
68 the organizational chart, services furnished, administrative
69 control, and lines of authority for the delegation of
70 responsibilities for patient care. These responsibilities must
71 be readily identifiable. Administrative and supervisory
72 functions may not be delegated to another agency or
73 organization, and the primary home health agency shall monitor
74 and control all services that are not furnished directly,
75 including services provided through contracts.

76 (2) DIRECTOR OF NURSING.—
77 (a) A director of nursing may be the director of nursing
78 for:
79 1. Up to two licensed home health agencies if the agencies
80 have identical controlling interests as defined in s. 408.803
81 and are located within one agency geographic service area or
82 within an immediately contiguous county; or
83 2. Up to five licensed home health agencies if:
84 a. All of the home health agencies have identical
85 controlling interests as defined in s. 408.803;
86 b. All of the home health agencies are located within one
87 agency geographic service area or within an immediately
88 contiguous county; ~~and~~
89 c. Each home health agency has a registered nurse who
90 meets the qualifications of a director of nursing and who has a
91 written delegation from the director of nursing to serve as the
92 director of nursing for that home health agency when the
93 director of nursing is not present; and~~.~~
94 d. This person, or similarly qualified alternate, is
95 available at all times during operating hours and participates
96 in all activities relevant to the professional services
97 furnished, including, but not limited to, the oversight of
98 nursing services, home health aides, and certified nursing
99 assistants, and assignment of personnel.
100
101 If a home health agency licensed under this chapter is part of a
102 retirement community that provides multiple levels of care, an
103 employee of the retirement community may serve as the director

104 of nursing of the home health agency and up to a maximum of four
105 entities, other than home health agencies, licensed under this
106 chapter or chapter 429 which all have identical controlling
107 interests as defined in s. 408.803.
108 (b) A home health agency that provides skilled nursing
109 care may not operate for more than 30 calendar days without a
110 director of nursing. A home health agency that provides skilled
111 nursing care and the director of nursing of a home health agency
112 must notify the agency within 10 business days after termination
113 of the services of the director of nursing for the home health
114 agency. A home health agency that provides skilled nursing care
115 must notify the agency of the identity and qualifications of the
116 new director of nursing within 10 days after the new director is
117 hired. If a home health agency that provides skilled nursing
118 care operates for more than 30 calendar days without a director
119 of nursing, the home health agency commits a class II
120 deficiency. In addition to the fine for a class II deficiency,
121 the agency may issue a moratorium in accordance with s. 408.814
122 or revoke the license. The agency shall fine a home health
123 agency that fails to notify the agency as required in this
124 paragraph $1,000 for the first violation and $2,000 for a repeat
125 violation. The agency may not take administrative action against
126 a home health agency if the director of nursing fails to notify
127 the department upon termination of services as the director of
128 nursing for the home health agency.
129 (c) A home health agency that is not Medicare or Medicaid
130 certified and does not provide skilled care or provides only

131 physical, occupational, or speech therapy is not required to
132 have a director of nursing and is exempt from paragraph (b).
133 (3) TRAINING.—A home health agency shall ensure that each
134 certified nursing assistant employed by or under contract with
135 the home health agency and each home health aide employed by or
136 under contract with the home health agency is adequately trained
137 to perform the tasks of a home health aide in the home setting.
138 (a) The home health agency may not use as a home health
139 aide on a full-time, temporary, per diem, or other basis, any
140 individual to provide services unless the individual has
141 completed a training and competency evaluation program, or a
142 competency evaluation program, as permitted in s. 400.497, which
143 meets the minimum standards established by the agency in state
144 rules.
145 (b) A home health aide is not competent in any task for
146 which he or she is evaluated as "unsatisfactory." The aide must
147 perform any such task only under direct supervision by a
148 licensed nurse until he or she receives training in the task and
149 satisfactorily passes a subsequent evaluation in performing the
150 task. A home health aide has not successfully passed a
151 competency evaluation if the aide does not have a passing score
152 on the test as specified by agency rule.
153 (4) STAFFING.—Staffing services may be provided anywhere
154 within the state.
155 (5) PERSONNEL.—
156 (a) The home health agency and its staff must comply with
157 accepted professional standards and principles that apply to

158 professionals, including, but not limited to, the state practice
159 acts and the home health agency's policies and procedures.
160 (b) If personnel under hourly or per-visit contracts are
161 used by the home health agency, there must be a written contract
162 between those personnel and the agency which specifies the
163 following requirements:
164 1. Acceptance for care only of patients by the primary
165 home health agency.
166 2. The services to be furnished.
167 3. The necessity to conform to all applicable agency
168 policies, including personnel qualifications.
169 4. The responsibility for participating in developing
170 plans of care.
171 5. The manner in which services are controlled,
172 coordinated, and evaluated by the primary home health agency.
173 6. The procedures for submitting clinical and progress
174 notes, scheduling of visits, and periodic patient evaluation.
175 7. The procedures for payment for services furnished under
176 the contract.
177 (c) A home health agency shall directly provide at least
178 one of the types of services through home health agency
179 employees, but may provide additional services under
180 arrangements with another agency or organization. Services
181 furnished under such arrangements must have a written contract
182 conforming to the requirements specified in paragraph (b).
183 (d) If home health aide services are provided by an
184 individual who is not employed directly by the home health
185 agency, the services of the home health aide must be provided

186 under arrangements as stated in paragraphs (b) and (c). If the
187 home health agency chooses to provide home health aide services
188 under arrangements with another organization, the
189 responsibilities of the home health agency include, but are not
190 limited to:
191 1. Ensuring the overall quality of the care provided by
192 the aide;
193 2. Supervising the aide's services as described in s.
194 400.487; and
195 3. Ensuring that each home health aide providing services
196 under arrangements with another organization has met the
197 training requirements or competency evaluation requirements of
198 s. 400.497.
199 (e) The home health agency shall coordinate the efforts of
200 all personnel furnishing services, and the personnel shall
201 maintain communication with the home health agency to ensure
202 that personnel efforts support the objectives outlined in the
203 plan of care. The clinical record or minutes of case conferences
204 shall ensure that effective interchange, reporting, and
205 coordination of patient care occurs.
206 Section 10. Section 400.487, Florida Statutes, is amended
207 to read:
208 400.487 Home health service agreements; physician's,
209 physician assistant's, and advanced registered nurse
210 practitioner's treatment orders; patient assessment;
211 establishment and review of plan of care; provision of services;
212 orders not to resuscitate.—

213 (1) Services provided by a home health agency must be
214 covered by an agreement between the home health agency and the
215 patient or the patient's legal representative specifying the
216 home health services to be provided, the rates or charges for
217 services paid with private funds, and the sources of payment,
218 which may include Medicare, Medicaid, private insurance,
219 personal funds, or a combination thereof. The home health agency
220 shall provide a copy of the agreement to the patient or the
221 patient's legal representative. A home health agency providing
222 skilled care must make an assessment of the patient's needs
223 within 48 hours after the start of services.
224 (2) When required by the provisions of chapter 464; part
225 I, part III, or part V of chapter 468; or chapter 486, the
226 attending physician, physician assistant, or advanced registered
227 nurse practitioner, acting within his or her respective scope of
228 practice, shall establish treatment orders for a patient who is
229 to receive skilled care. The treatment orders must be signed by
230 the physician, physician assistant, or advanced registered nurse
231 practitioner before a claim for payment for the skilled services
232 is submitted by the home health agency. If the claim is
233 submitted to a managed care organization, the treatment orders
234 must be signed within the time allowed under the provider
235 agreement. The treatment orders shall be reviewed, as frequently
236 as the patient's illness requires, by the physician, physician
237 assistant, or advanced registered nurse practitioner in
238 consultation with the home health agency.
239 (3) A home health agency shall arrange for supervisory
240 visits by a registered nurse to the home of a patient receiving

241 home health aide services as specified in subsection (9) ~~in~~
242 ~~accordance with the patient's direction, approval, and agreement~~
243 ~~to pay the charge for the visits~~.
244 (4) The home health agency shall protect and promote the
245 rights of each individual under its care, including each of the
246 following rights:
247 (a) *Notice of rights.*—The home health agency shall provide
248 the patient with a written notice of the patient's rights in
249 advance of furnishing care to the patient or during the initial
250 evaluation visit before the initiation of treatment. The home
251 health agency must maintain documentation showing that it has
252 complied with the requirements of this section.
253 (b) *Exercise of rights and respect for property and*
254 *person.*—
255 1. The patient has the right to exercise his or her rights
256 as a patient of the home health agency.
257 2. The patient has the right to have his or her property
258 treated with respect.
259 3. The patient has the right to voice grievances regarding
260 treatment or care that is or fails to be furnished, or regarding
261 the lack of respect for property by anyone who is furnishing
262 services on behalf of the home health agency, and not be
263 subjected to discrimination or reprisal for doing so.
264 4. The home health agency must investigate complaints made
265 by a patient or the patient's family or guardian regarding
266 treatment or care that is or fails to be furnished, or regarding
267 the lack of respect for the patient's property by anyone
268 furnishing services on behalf of the home health agency. The

269 home health agency shall document the existence of the complaint
270 and its resolution.
271 5. The patient and his or her immediate family or
272 representative must be informed of the right to report
273 complaints via the statewide toll-free telephone number to the
274 agency as required in s. 408.810.
275 (c) *Right to be informed and to participate in planning*
276 *care and treatment.*—
277 1. The patient has the right to be informed, in advance,
278 about the care to be furnished and of any changes in the care to
279 be furnished. The home health agency shall advise the patient in
280 advance of which disciplines will furnish care and the frequency
281 of visits proposed to be furnished. The home health agency must
282 advise the patient in advance of any change in the plan of care
283 before the change is made.
284 2. The patient has the right to participate in the
285 planning of the care. The home health agency must advise the
286 patient in advance of the right to participate in planning the
287 care or treatment and in planning changes in the care or
288 treatment. ~~Each patient has the right to be informed of and to~~
289 ~~participate in the planning of his or her care.~~ Each patient
290 must be provided, upon request, a copy of the plan of care
291 established and maintained for that patient by the home health
292 agency.
293 (5) When nursing services are ordered, the home health
294 agency to which a patient has been admitted for care must
295 provide the initial admission visit, all service evaluation
296 visits, and the discharge visit by a direct employee. Services

297 provided by others under contractual arrangements to a home
298 health agency must be monitored and managed by the admitting
299 home health agency. The admitting home health agency is fully
300 responsible for ensuring that all care provided through its
301 employees or contract staff is delivered in accordance with this
302 part and applicable rules.
303 (6) The skilled care services provided by a home health
304 agency, directly or under contract, must be supervised and
305 coordinated in accordance with the plan of care. The home health
306 agency shall furnish skilled nursing services by or under the
307 supervision of a registered nurse and in accordance with the
308 plan of care. Any therapy services offered directly or under
309 arrangement by the home health agency must be provided by a
310 qualified therapist or by a qualified therapy assistant under
311 the supervision of a qualified therapist and in accordance with
312 the plan of care.
313 (a) *Duties and qualifications.*—A qualified therapist shall
314 assist the physician in evaluating the level of function, help
315 develop or revise the plan of care, prepare clinical and
316 progress notes, advise and consult with the family and other
317 agency personnel, and participate in in-service programs. The
318 therapist or therapy assistant must meet the qualifications in
319 the state practice acts and related applicable rules.
320 (b) *Physical therapy assistants and occupational therapy*
321 *assistants.*—Services provided by a physical therapy assistant or
322 occupational therapy assistant must be under the supervision of
323 a qualified physical therapist or occupational therapist as
324 required in chapter 486 and part III of chapter 468,

325 respectively, and related applicable rules. A physical therapy
326 assistant or occupational therapy assistant shall perform
327 services planned, delegated, and supervised by the therapist,
328 assist in preparing clinical notes and progress reports,
329 participate in educating the patient and his or her family, and
330 participate in in-service programs.
331 (c) *Speech therapy services.*—Speech therapy services shall
332 be furnished only by or under supervision of a qualified speech
333 pathologist or audiologist as required in part I of chapter 468
334 and related applicable rules.
335 (d) *Care follows a written plan of care.*—The plan of care
336 shall be reviewed by the physician or health professional who
337 provided the treatment orders pursuant to subsection (2) and
338 home health agency personnel as often as the severity of the
339 patient's condition requires, but at least once every 60 days or
340 more when there is a patient-elected transfer, a significant
341 change in condition, or a discharge and return to the same home
342 health agency during the 60-day episode. Professional staff of a
343 home health agency shall promptly alert the physician or other
344 health professional who provided the treatment orders of any
345 change that suggests a need to alter the plan of care.
346 (e) *Administration of drugs and treatment.*—Only
347 professional staff of a home health agency may administer drugs
348 and treatments as ordered by the physician or health
349 professional pursuant to subsection (2), with the exception of
350 influenza and pneumococcal polysaccharide vaccines, which may be
351 administered according to the policy of the home health agency
352 developed in consultation with a physician and after an

353 assessment for contraindications. Verbal orders shall be in
354 writing and signed and dated with the date of receipt by the
355 registered nurse or qualified therapist who is responsible for
356 furnishing or supervising the ordered service. A verbal order
357 may be accepted only by personnel who are authorized to do so by
358 applicable state laws, rules, and internal policies of the home
359 health agency.

360 (7) A registered nurse shall conduct the initial
361 evaluation visit, regularly reevaluate the patient's nursing
362 needs, initiate the plan of care and necessary revisions,
363 furnish those services requiring substantial and specialized
364 nursing skill, initiate appropriate preventive and
365 rehabilitative nursing procedures, prepare clinical and progress
366 notes, coordinate services, inform the physician and other
367 personnel of changes in the patient's condition and needs,
368 counsel the patient and his or her family in meeting nursing and
369 related needs, participate in in-service programs, and supervise
370 and teach other nursing personnel, unless the home health agency
371 providing the home health aide services is not Medicare-
372 certified or Medicaid-certified and does not provide skilled
373 care.

374 (8) A licensed practical nurse shall furnish services in
375 accordance with agency policies, prepare clinical and progress
376 notes, assist the physician and registered nurse in performing
377 specialized procedures, prepare equipment and materials for
378 treatments observing aseptic technique as required, and assist
379 the patient in learning appropriate self-care techniques.

380 (9) A home health aide and certified nursing assistant
381 shall provide services that are in the service provision plan
382 provided in s. 400.491 and other services that the home health
383 aide or certified nursing assistant is permitted to perform
384 under state law. The duties of a home health aide or certified
385 nursing assistant include the provision of hands-on personal
386 care, performance of simple procedures as an extension of
387 therapy or nursing services, assistance in ambulation or
388 exercises, and assistance in administering medications that are
389 ordinarily self-administered and are specified in agency rules.
390 Any services by a home health aide which are offered by a home
391 health agency must be provided by a qualified home health aide
392 or certified nursing assistant.
393 (a) *Assignment and duties.*—A home health aide or certified
394 nursing assistant shall be assigned to a specific patient by a
395 registered nurse, unless the home health agency providing the
396 home health aide services is not Medicare-certified or Medicaid-
397 certified and does not provide skilled care. Written patient
398 care instructions for the home health aide and certified nursing
399 assistant must be prepared by the registered nurse or other
400 appropriate professional who is responsible for the supervision
401 of the home health aide and certified nursing assistant as
402 stated in this section.
403 (b) *Supervision.*—If a patient receives skilled nursing
404 care, the registered nurse shall perform the supervisory visit.
405 If the patient is not receiving skilled nursing care but is
406 receiving physical therapy, occupational therapy, or speech-
407 language pathology services, the appropriate therapist may

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408 provide the supervision. A registered nurse or other
409 professional must make an onsite visit to the patient's home at
410 least once every 2 weeks. The visit is not required while the
411 aide is providing care.
412 (c) *Supervising visits.*—If home health aide services are
413 provided to a patient who is not receiving skilled nursing care,
414 physical or occupational therapy, or speech-language pathology
415 services, a registered nurse must make a supervisory visit to
416 the patient's home at least once every 60 days, unless the home
417 health agency providing the home health aide services is not
418 Medicare or Medicaid certified and does not provide skilled
419 care, either directly or through contracts. The registered nurse
420 shall ensure that the aide is properly caring for the patient
421 and each supervisory visit must occur while the home health aide
422 is providing patient care. In addition to the requirements in
423 this subsection, a home health agency shall arrange for
424 additional supervisory visits by a registered nurse to the home
425 of a patient receiving home health aide services in accordance
426 with the patient's direction, approval, and agreement to pay the
427 charge for the visits.
428 (10)~~(7)~~ Home health agency personnel may withhold or
429 withdraw cardiopulmonary resuscitation if presented with an
430 order not to resuscitate executed pursuant to s. 401.45. The
431 agency shall adopt rules providing for the implementation of
432 such orders. Home health personnel and agencies shall not be
433 subject to criminal prosecution or civil liability, nor be
434 considered to have engaged in negligent or unprofessional
435 conduct, for withholding or withdrawing cardiopulmonary

436 resuscitation pursuant to such an order and rules adopted by the
437 agency.
438 Section 11. Subsection (11) of section 408.802, Florida
439 Statutes, is repealed.
440 Section 12. Paragraphs (e), (f), and (g) of subsection
441 (15) of section 409.912, Florida Statutes, are repealed.
442 Section 13. Subsection (2) of section 429.12, Florida
443 Statutes, is repealed.
444 Section 14. Subsection (5) of section 429.23, Florida
445 Statutes, is repealed.
446 Section 15. Paragraph (a) of subsection (2) of section
447 429.911, Florida Statutes, is repealed.
448 Section 16. This act shall take effect July 1, 2010.
449
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451
452 ---
453 **T I T L E A M E N D M E N T**
454 Remove the entire title and insert:
455 A bill to be entitled
456 An act relating to health care; repealing s.
457 112.0455(10)(e), F.S., relating to a prohibition against
458 applying the Drug-Free Workplace Act retroactively;
459 repealing s. 383.325, F.S., relating to the requirement of
460 a licensed facility under s. 383.305, F.S., to maintain
461 inspection reports; repealing s. 395.1046, F.S., relating
462 to the investigation of complaints regarding hospitals;
463 repealing s. 395.3037, F.S.; deleting definitions relating

464 to obsolete provisions governing primary and comprehensive
465 stroke centers; amending s. 400.0239, F.S.; deleting an
466 obsolete provision; repealing s. 400.147(10), F.S.,
467 relating to a requirement that a nursing home facility
468 report any notice of a filing of a claim for a violation
469 of a resident's rights or a claim of negligence; repealing
470 s. 400.148, F.S., relating to the Medicaid "Up-or-Out"
471 Quality of Care Contract Management Program; repealing s.
472 400.195, F.S., relating to reporting requirements for the
473 Agency for Health Care Administration; amending s.
474 400.476, F.S.; providing requirements for an alternative
475 administrator of a home health agency; revising the duties
476 of the administrator; revising the requirements for a
477 director of nursing for a specified number of home health
478 agencies; prohibiting a home health agency from using an
479 individual as a home health aide unless the person has
480 completed training and an evaluation program; requiring a
481 home health aide to meet certain standards in order to be
482 competent in performing certain tasks; requiring a home
483 health agency and staff to comply with accepted
484 professional standards; providing certain requirements for
485 a written contract between certain personnel and the
486 agency; requiring a home health agency to provide certain
487 services through its employees; authorizing a home health
488 agency to provide additional services with another
489 organization; providing responsibilities of a home health
490 agency when it provides home health aide services through
491 another organization; requiring the home health agency to

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492 coordinate personnel who provide home health services;
493 requiring personnel to communicate with the home health
494 agency; amending s. 400.487, F.S.; requiring a home health
495 agency to provide a copy of the agreement between the
496 agency and a patient which specifies the home health
497 services to be provided; providing the rights that are
498 protected by the home health agency; requiring the home
499 health agency to furnish nursing services by or under the
500 supervision of a registered nurse; requiring the home
501 health agency to provide therapy services through a
502 qualified therapist or therapy assistant; providing the
503 duties and qualifications of a therapist and therapy
504 assistant; requiring supervision by a physical therapist
505 or occupational therapist of a physical therapist
506 assistant or occupational therapist assistant; providing
507 duties of a physical therapist assistant or occupational
508 therapist assistant; providing for speech therapy services
509 to be provided by a qualified speech pathologist or
510 audiologist; providing for a plan of care; providing that
511 only the staff of a home health agency may administer
512 drugs and treatments as ordered by certain health
513 professionals; providing requirements for verbal orders;
514 providing duties of a registered nurse, licensed practical
515 nurse, home health aide, and certified nursing assistant
516 who work for a home health agency; providing for
517 supervisory visits of services provided by a home health
518 agency; repealing s. 408.802(11), F.S., relating to the
519 applicability of the Health Care Licensing Procedures Act

520 to private review agents; repealing s. 409.912(15)(e),
521 (f), and (g), F.S., relating to a requirement for the
522 Agency for Health Care Administration to submit a report
523 to the Legislature regarding the operations of the CARE
524 program; repealing s. 429.12(2), F.S., relating to the
525 sale or transfer of ownership of an assisted living
526 facility; repealing s. 429.23(5), F.S., relating to each
527 assisted living facility's requirement to submit a report
528 to the agency regarding liability claims filed against it;
529 repealing s. 429.911(2)(a), F.S., relating to grounds for
530 which the agency may take action against the owner of an
531 adult day care center or its operator or employee;
532 providing an effective date.
533

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COUNCIL/COMMITTEE ACTION

ADOPTED ___ (Y/N)
ADOPTED AS AMENDED ___ (Y/N)
ADOPTED W/O OBJECTION ___ (Y/N)
FAILED TO ADOPT ___ (Y/N)
WITHDRAWN ___ (Y/N)
OTHER ______

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1 Council/Committee hearing bill: Health Care Regulation Policy
2 Committee
3 Representative Horner offered the following:
4
5 **Amendment (with title amendment)**
6 Between lines 447 and 448, insert:
7 Section 16. Dental workforce survey.—
8 (1) Beginning in 2012, each person who applies for
9 licensure renewal as a dentist or dental hygienist under chapter
10 466, Florida Statutes, must, in conjunction with the renewal of
11 such license under procedures and forms adopted by the Board of
12 Dentistry and in addition to any other information that may be
13 required from the applicant, furnish the following information
14 to the Department of Health, working in conjunction with the
15 board, in a dental workforce survey:
16 (a) Licensee information, including, but not limited to:
17 1. The name of the dental school or dental hygiene program
18 that the dentist or dental hygienist graduated from and the year
19 of graduation.

20 2. The year that the dentist or dental hygienist began
21 practicing or working in this state.
22 3. The geographic location of the dentist's or dental
23 hygienist's practice or address within the state.
24 4. For a dentist in private practice:
25 a. The number of full-time dental hygienists employed by
26 the dentist during the reporting period.
27 b. The number of full-time dental assistants employed by
28 the dentist during the reporting period.
29 c. The average number of patients treated per week by the
30 dentist during the reporting period.
31 d. The settings where the dental care was delivered.
32 5. Anticipated plans of the dentist to change the status
33 of his or her license or practice.
34 6. The dentist's areas of specialty or certification.
35 7. The year that the dentist completed a specialty program
36 recognized by the American Dental Association.
37 8. For a hygienist:
38 a. The average number of patients treated per week by the
39 hygienist during the reporting period.
40 b. The settings where the dental care was delivered.
41 9. The dentist's memberships in professional
42 organizations.
43 10. The number of pro bono hours provided by the dentist
44 or dental hygienist during the last biennium.
45 (b) Information concerning the availability and trends
46 relating to critically needed services, including, but not

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47 limited to, the following types of care provided by the dentist
48 or dental hygienist:
49 1. Dental care to children having special needs.
50 2. Geriatric dental care.
51 3. Dental services in emergency departments.
52 4. Medicaid services.
53 5. Other critically needed specialty areas, as determined
54 by the advisory body.
55 (2) In addition to the completed survey, the dentist or
56 dental hygienist must submit a statement that the information
57 provided is true and accurate to the best of his or her
58 knowledge and belief.
59 (3) Beginning in 2012, renewal of a license by a dentist
60 or dental hygienist licensed under chapter 466, Florida
61 Statutes, is not contingent upon the completion and submission
62 of the dental workforce survey; however, for any subsequent
63 license renewal, the board may not renew the license of any
64 dentist or dental hygienist until the survey required under this
65 section is completed and submitted by the licensee.
66 (4)(a) Beginning in 2012, the Board of Dentistry shall
67 issue a nondisciplinary citation to any dentist or dental
68 hygienist licensed under chapter 466, Florida Statutes, who
69 fails to complete the survey within 90 days after the renewal of
70 his or her license to practice as a dentist or dental hygienist.
71 (b) The citation must notify a dentist or dental hygienist
72 who fails to complete the survey required by this section that
73 his or her license will not be renewed for any subsequent

74 license renewal unless the dentist or dental hygienist completes
75 the survey.
76 (c) In conjunction with issuing the license renewal notice
77 required by s. 456.038, Florida Statutes, the board shall notify
78 each dentist or dental hygienist licensed under chapter 466,
79 Florida Statutes, who fails to complete the survey that the
80 survey must be completed before the subsequent license renewal.
81 Section 90. (1) The Department of Health shall serve as
82 the coordinating body for the purpose of collecting and
83 regularly updating and disseminating dental workforce data. The
84 department shall work with multiple stakeholders, including the
85 Florida Dental Association and the Florida Dental Hygiene
86 Association, to assess and share with all communities of
87 interest all data collected in a timely fashion.
88 (2) The Department of Health shall maintain a current
89 database to serve as a statewide source of data concerning the
90 dental workforce. The department, in conjunction with the board,
91 shall also:
92 (a) Develop strategies to maximize federal and state
93 programs that provide incentives for dentists to practice in
94 shortage areas that are federally designated. Strategies shall
95 include programs such as the Florida Health Services Corps
96 established under s. 381.0302, Florida Statutes.
97 (b) Work in conjunction with an advisory body to address
98 matters relating to the state's dental workforce. The advisory
99 body shall provide input on developing questions for the dentist
100 workforce survey. An advisory body shall include, but need not
101 be limited to, the State Surgeon General or his or her designee,

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102 the dean of each dental school accredited in the United States
103 and based in this state or his or her designee, a representative
104 from the Florida Dental Association, a representative from the
105 Florida Dental Hygiene Association, a representative from the
106 Florida Board of Dentistry, and a dentist from each of the
107 dental specialties recognized by the American Dental
108 Association's Commission on Dental Accreditation. Members of the
109 advisory body shall serve without compensation.
110 (c) Act as a clearinghouse for collecting and
111 disseminating information concerning the dental workforce.
112 (3) The Department of Health and the Board of Dentistry
113 shall adopt rules necessary to administer this section.
114 Section 91. It is the intent of the Legislature that the
115 Department of Health and the Board of Dentistry implement the
116 provisions of this act within existing resources.
117 Section 92. Paragraph (t) of subsection (2) of section
118 499.01, Florida Statutes, is amended to read:
119 499.01 Permits.—
120 (2) The following permits are established:
121 (t) Health care clinic establishment permit.—Effective
122 January 1, 2009, a health care clinic establishment permit is
123 required for the purchase of a prescription drug by a place of
124 business at one general physical location that provides health
125 care or veterinary services, which is owned and operated by a
126 business entity that has been issued a federal employer tax
127 identification number. For the purpose of this paragraph, the
128 term "qualifying practitioner" means a licensed health care
129 practitioner defined in s. 456.001, or a veterinarian licensed

130 under chapter 474, who is authorized under the appropriate
131 practice act to prescribe and administer a prescription drug.
132 1. An establishment must provide, as part of the
133 application required under s. 499.012, designation of a
134 qualifying practitioner who will be responsible for complying
135 with all legal and regulatory requirements related to the
136 purchase, recordkeeping, storage, and handling of the
137 prescription drugs. In addition, the designated qualifying
138 practitioner shall be the practitioner whose name, establishment
139 address, and license number is used on all distribution
140 documents for prescription drugs purchased or returned by the
141 health care clinic establishment. Upon initial appointment of a
142 qualifying practitioner, the qualifying practitioner and the
143 health care clinic establishment shall notify the department on
144 a form furnished by the department within 10 days after such
145 employment. In addition, the qualifying practitioner and health
146 care clinic establishment shall notify the department within 10
147 days after any subsequent change.
148 2. The health care clinic establishment must employ a
149 qualifying practitioner at each establishment.
150 3. In addition to the remedies and penalties provided in
151 this part, a violation of this chapter by the health care clinic
152 establishment or qualifying practitioner constitutes grounds for
153 discipline of the qualifying practitioner by the appropriate
154 regulatory board.
155 4. The purchase of prescription drugs by the health care
156 clinic establishment is prohibited during any period of time
157 when the establishment does not comply with this paragraph.

158 5. A health care clinic establishment permit is not a
159 pharmacy permit or otherwise subject to chapter 465. A health
160 care clinic establishment that meets the criteria of a modified
161 Class II institutional pharmacy under s. 465.019 is not eligible
162 to be permitted under this paragraph.
163 6. This paragraph does not apply to the purchase of a
164 prescription drug by a licensed practitioner under his or her
165 license. A professional corporation or limited liability company
166 composed of dentists and operating as authorized in s. 466.0285
167 may pay for prescription drugs obtained by a practitioner
168 licensed under chapter 466, and the licensed practitioner is
169 deemed the purchaser and owner of the prescription drugs.
170 Section 93. Paragraph (a) of subsection (6) of section
171 624.91, Florida Statutes, is amended to read:
172 624.91 The Florida Healthy Kids Corporation Act.—
173 (6) BOARD OF DIRECTORS.—
174 (a) The Florida Healthy Kids Corporation shall operate
175 subject to the supervision and approval of a board of directors
176 chaired by the Chief Financial Officer or her or his designee,
177 and composed of 12 ~~11~~ other members selected for 3-year terms of
178 office as follows:
179 1. The Secretary of Health Care Administration, or his or
180 her designee.
181 2. One member appointed by the Commissioner of Education
182 from the Office of School Health Programs of the Florida
183 Department of Education.

184 3. One member appointed by the Chief Financial Officer
185 from among three members nominated by the Florida Pediatric
186 Society.
187 4. One member, appointed by the Governor, who represents
188 the Children's Medical Services Program.
189 5. One member appointed by the Chief Financial Officer
190 from among three members nominated by the Florida Hospital
191 Association.
192 6. One member, appointed by the Governor, who is an expert
193 on child health policy.
194 7. One member, appointed by the Chief Financial Officer,
195 from among three members nominated by the Florida Academy of
196 Family Physicians.
197 8. One member, appointed by the Governor, who represents
198 the state Medicaid program.
199 9. One member, appointed by the Chief Financial Officer,
200 from among three members nominated by the Florida Association of
201 Counties.
202 10. The State Health Officer or her or his designee.
203 11. The Secretary of Children and Family Services, or his
204 or her designee.
205 12. One member, appointed by the Governor, from among
206 three members nominated by the Florida Dental Association.
207
208
209 ---
210 **T I T L E A M E N D M E N T**
211 Remove line 531 and insert:

212 adult day care center or its operator or employee;
213 requiring persons who apply for licensure renewal as a
214 dentist or dental hygienist to furnish certain information
215 to the Department of Health in a dental workforce survey;
216 requiring the Board of Dentistry to issue a
217 nondisciplinary citation and a notice for failure to
218 complete the survey within a specified time; providing
219 notification requirements for the citation; requiring the
220 department to serve as the coordinating body for the
221 purpose of collecting, disseminating, and updating dental
222 workforce data; requiring the department to maintain a
223 database regarding the state's dental workforce; requiring
224 the department to develop strategies to maximize federal
225 and state programs and to work with an advisory body to
226 address matters relating to the state's dental workforce;
227 providing membership of the advisory body; providing for
228 members of the advisory body to serve without
229 compensation; requiring the department to act as a
230 clearinghouse for collecting and disseminating information
231 regarding the dental workforce; requiring the department
232 and the board to adopt rules; providing legislative intent
233 regarding implementation of the act within existing
234 resources; amending s. 499.01, F.S.; authorizing certain
235 business entities to pay for prescription drugs obtained
236 by practitioners licensed under ch. 466, F.S.; amending s.
237 624.91, F.S.; revising the membership of the board of
238 directors of the Florida Healthy Kids Corporation to
239 include a member nominated by the Florida Dental

240 Association and appointed by the Governor; providing an
241 effective date.