Journal of the Senate

Number 19 **Wednesday, March 31, 1993**

CALL TO ORDER

The Senate was called to order by the President at 9:00 a.m. A quorum present—39:

Mr. President	Diaz-Balart	Jenne	Scott
Bankhead	Dudley	Jennings	Siegel
Beard	Dyer	Johnson	Silver
Boczar	Foley	Jones	Sullivan
Brown-Waite	Forman	Kirkpatrick	Thomas
Burt	Grant	Kiser	Turner
Casas	Gutman	Kurth	Weinstein
Childers	Harden	McKay	Wexler
Crist	Hargrett	Meadows	Williams
Dantzler	Holzendorf	Myers	

Excused: Senator Grogan until 3:40 p.m.; Senators Dudley, Crist, Williams and Kirkpatrick from 4:00 to 5:00 p.m.

PRAYER

The following prayer was offered by Joe Brown, Secretary of the Senate:

We ask your blessings, O Lord, on those who must live by the laws we make. Bless those who interpret and enforce the laws.

But most of all we ask an unequally large share of your blessings on those who make the laws. Amen.

PLEDGE

Senate Page, Gautier Kitchen, of Tallahassee led the Senate in the pledge of allegiance to the flag of the United States of America.

CONSIDERATION OF RESOLUTIONS

On motion by Senator Bankhead, by two-thirds vote **SR 2362** was withdrawn from the Committee on Rules and Calendar.

On motion by Senator Bankhead—

SR 2362—A resolution honoring the Florida Jaycees for their Hurricane Andrew relief efforts.

WHEREAS, the Florida Junior Chamber of Commerce, also known as the Florida Jaycees, is an organization that provides young people the opportunity to develop personal and leadership skills through local community service and organizational involvement while expanding the Jaycee movement, and

WHEREAS, on August 24, 1992, Hurricane Andrew struck the South Florida coastline, leaving a horrible path of destruction along its way, and

WHEREAS, during the first few days after the disaster, the Florida Jaycees distributed more than 6.5 million pounds of food, and

WHEREAS, two warehouses for supplies and an office to monitor relief efforts were established to receive donations arriving from Jaycees across America, and

WHEREAS, many chapters and state Jaycee organizations transported supplies themselves, and

WHEREAS, some local chapters arrived with truckloads of water, blankets, and medical supplies hours after the storm, and

WHEREAS, the Jaycees unloaded, sorted, packaged, and distributed well over 350 truckloads of miscellaneous food, sanitary products, baby food, and clothing items, and

WHEREAS, Jaycee manhours spent on this project in their warehouse locations alone are estimated at approximately 160,000, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida:

That the Florida Senate recognizes the Florida Jaycees' heroic efforts on behalf of Florida residents whose lives were disrupted by Hurricane Andrew and commends the organization for spending well over 160,000 manhours in relief efforts.

BE IT FURTHER RESOLVED that a copy of this resolution, with the Seal of the Senate affixed, be presented to the Florida Jaycees as a tangible token of the gratitude of the Florida Senate.

—was taken up out of order by unanimous consent, read the second time in full and adopted.

On motion by Senator McKay, the rules were waived by unanimous consent and the following resolution was introduced out of order:

By Senator McKay—

SR 2422—A resolution commending the Manatee High School football team for its 1992 football season.

WHEREAS, the Manatee High School Hurricane football team in Bradenton, under the direction of head coach Joe Kinnan and his excellent staff, won the 1992 class 5-A state football championship in a 44-14 victory over Fort Lauderdale Dillard at Florida Field on December 19, 1992, and

WHEREAS, the victory gave the Hurricanes and Coach Kinnan their fourth state championship since 1983, and

WHEREAS, the Hurricanes ended the 1992 season ranked seventh in the state and twenty-second in the nation, and

WHEREAS, in achieving this enviable record the Hurricanes conducted themselves in an exemplary manner, typifying the virtues that athletic programs strive to develop in young men, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida:

That the Florida Senate commends the Manatee High School football team, Head Coach Joe Kinnan, and the entire coaching staff for their outstanding accomplishments in bringing honor and recognition to Manatee High School, to the City of Bradenton, and to Manatee County.

BE IT FURTHER RESOLVED that a copy of this resolution, with the Seal of the Senate affixed, be presented to the Manatee High School football team and to Coach Joe Kinnan as a tangible token of the sentiments of the Florida Senate.

On motion by Senator McKay, **SR 2422** was read by title and was read the second time in full and adopted.

On motion by Senator Kurth, by two-thirds vote **SR 958** was withdrawn from the Committee on Rules and Calendar.

On motion by Senator Kurth—

SR 958—A resolution expressing sorrow over the loss of Deputy Corporal Richard Raczkoski of the Indian River County Sheriff's Department.

WHEREAS, the law enforcement officers of the state perform vital duties for the citizens of the state and face the danger of physical harm and even death in the performance of these duties, and

WHEREAS, it is fitting and appropriate that the Senate of the State of Florida honor these courageous men for their contributions to our state, and

WHEREAS, Deputy Corporal Richard Raczkoski of the Indian River County Sheriff's Department was killed in the line of duty on September 23, 1986, at a convenience store on 82nd Avenue and Route 60 in Vero Beach, Florida, and

WHEREAS, officers such as Deputy Corporal Richard Raczkoski risk their lives every day to protect and serve the public, and

WHEREAS, the loss of Deputy Corporal Richard Raczkoski should not be forgotten with the passage of time, but should be remembered by all who knew him, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida:

That the Florida Senate joins the officers of the Indian River County Sheriff's Department and the people of Indian River County in mourning the loss of Deputy Corporal Richard Raczkoski.

BE IT FURTHER RESOLVED that a copy of this resolution, with the Seal of the Senate affixed, be presented to the Indian River County Sheriff's Department as a tangible token of the sentiments of the Florida Senate.

—was taken up out of order by unanimous consent, read the second time in full and adopted.

On motion by Senator Burt, the rules were waived by unanimous consent and the following resolution was introduced out of order:

By Senator Burt—

SR 2424—A resolution recognizing Joan P. Kowal, Ed.D.

WHEREAS, Joan P. Kowal, Ed.D., superintendent of the School District of Volusia County since August 1991, has dedicated her professional efforts to personalizing learning and instruction and seeks and expects success in all staff and students, and

WHEREAS, Joan Kowal believes that the most important aspect of schooling is what happens between teachers and individual students and that this belief must be central to all efforts to support quality instruction, and

WHEREAS, Joan Kowal has been recognized by the Volusia Council of Government for outstanding service to the community, by the Florida Music Educators Association as Superintendent of the Year, and by the Executive Educator as one of North America's 100 best and brightest school executives and has been highlighted in this national publication, and

WHEREAS, Joan Kowal was elected president of the Women's Caucus of the American Association of School Administrators, was one of 100 superintendents selected to participate in the First Annual Congress for Exemplary Superintendents, serves on the Board of Directors of Volusia Visions which promotes the social welfare of the community and instructs the public on subjects beneficial to the community, and is a leader in Mission United of Daytona Beach which encourages and supports cultural diversity within the community, and

WHEREAS, Joan Kowal has many professional affiliations which include the American Association of School Administrators, American Association of University Women, Association for Individually Guided Education, Association for Supervision and Curriculum Development, Delta Kappa Gamma, Florida Association of District School Superintendents, and Institute Director of I/D/E/A Fellows Program, and

WHEREAS, Joan Kowal has been active in numerous civic and community activities, including the Daytona Beach Chamber of Commerce Board of Directors, Humana Hospital of Daytona Beach Board of Trustees, Mission United of Daytona Beach, Rotary International, United Way, Volusia County Business Development Corporation, Volusia County Children's Services Council, and Private Industry Council, and

WHEREAS, Joan Kowal has proven herself to be an invaluable asset to the School District of Volusia County, a faithful member of the community, and a dedicated teacher and educational leader with an undying love for children and lifelong learning, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida:

That the Florida Senate recognizes Joan P. Kowal, Ed.D., as an outstanding educational and community leader in the State of Florida.

BE IT FURTHER RESOLVED that a copy of this resolution, with the Seal of the Senate affixed, be presented to Joan P. Kowal as a tangible token of the sentiments of the Florida Senate.

On motion by Senator Burt, **SR 2424** was read by title and was read the second time in full and adopted.

MOTIONS RELATING TO COMMITTEE REFERENCE

On motions by Senator Jennings, by two-thirds vote **SB 240, SCR 366, SCR 1456, SB 2148, CS for SB 1498** and **SB 742** were withdrawn from the Committee on Rules and Calendar.

On motions by Senator Scott, by two-thirds vote **CS for HB 279, CS for SB's 722, 1284 and 1952, CS for SB 940, CS for SB 1184, CS for SB 1384, CS for SB 1450, CS for SB 1600** and **CS for SB 2158** were withdrawn from the Committee on Appropriations.

On motions by Senator Scott, by two-thirds vote **Senate Bills 944, 1154, 1840, 1970, 1976, 1992, 2078, CS for SB 788, CS for SB 994, CS for SB 1002, CS for SB 1434, CS for SB 1500, CS for SB 1742, CS for SB 2086, CS for SB 1598, HB 403, CS for HB 401, CS for SB 904** and **CS for SB 1962** were withdrawn from the Committee on Appropriations.

On motions by Senator Kiser, by two-thirds vote **Senate Bills 1520, 2152, 270, CS for SB 1998** and **CS for SB 1618** were withdrawn from the Committee on Finance, Taxation and Claims.

MOTION

On motion by Senator McKay, the House was requested to return **HB 1037**.

SPECIAL ORDER

Consideration of **CS for SB 152** was deferred.

CS for SB 194—A bill to be entitled An act relating to legal expense insurance; amending s. 642.015, F.S.; defining the term "gross written premiums" for purposes of legal expense insurance; amending s. 642.021, F.S.; revising requirements for obtaining a certificate of authority; creating s. 642.0261, F.S.; prescribing net worth requirements for applicants for a certificate of authority; creating s. 642.0262, F.S.; prescribing net worth requirements for maintenance of a certificate of authority; creating s. 642.0301, F.S.; prescribing fees; repealing s. 21, ch. 83-278, Laws of Florida, which section provided for the repeal of ch. 642, F.S., and its review pursuant to the Regulatory Sunset Act; reviving and readopting ss. 642.016, 642.022, 642.024, F.S., their repeal and review under the Regulatory Sunset Act notwithstanding; providing an effective date.

—was read the second time by title. On motion by Senator Grant, by two-thirds vote **CS for SB 194** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—34 Nays—None

Reconsideration

On motion by Senator Grant, the Senate reconsidered the vote by which **CS for SB 194** passed.

On motions by Senator Grant, by two-thirds vote **HB 1773** was withdrawn from the Committees on Commerce; Finance, Taxation and Claims; and Appropriations.

On motions by Senator Grant, by two-thirds vote—

HB 1773—A bill to be entitled An act relating to legal expense insurance; amending s. 642.015, F.S.; defining the term "gross written premiums" for purposes of legal expense insurance; amending s. 642.021, F.S.; revising requirements for obtaining a certificate of authority; creating s. 642.0261, F.S.; prescribing net worth requirements for applicants for a certificate of authority; creating s. 642.0262, F.S.; prescribing net worth

requirements for maintenance of a certificate of authority; requiring certain legal expense insurance corporations to increase required net worth by specified amounts; creating s. 642.0301, F.S.; providing a schedule of fees; saving chapter 642, F.S., from Sunset repeal; providing an effective date.

—a companion measure, was substituted for **CS for SB 194** and read the second time by title. On motion by Senator Grant, by two-thirds vote **HB 1773** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—33 Nays—None

CS for SB 202—A bill to be entitled An act relating to insurance; creating the Prepaid Limited Health Service Organization Act of Florida; providing for regulation of prepaid limited health service organizations and contracts by the Department of Insurance; providing definitions; specifying applicability of other laws; requiring incorporation; providing that such organizations are not authorized to transact any other insurance business; requiring and providing for application for certificate of authority; providing for issuance or denial of certificate; providing standards for continued eligibility; providing for issuance of provisional certificate of authority; requiring contracts in English, with translations provided in certain circumstances; specifying content of contracts; regulating rates and charges; prohibiting discrimination; specifying validity of noncomplying contracts; providing for construction of contract; providing for delivery; requiring notice of cancellation; specifying what payments are acceptable; prohibiting the advertising use of certain words; regulating contracts between organizations and providers, managers, and administrators; providing for complaints; specifying examination and investigation authority of the department; providing for determination of acceptable assets and investments; requiring reports; requiring licensed agents; requiring minimum surplus; providing for insolvency protection; requiring fidelity bonds; providing for suspension or revocation of certificate of authority; providing for administrative penalties; providing civil remedies; providing for injunctions; requiring payment of judgments within a specified time; providing for rehabilitation, conservation, and liquidation; providing fees; defining unfair methods, acts, and practices; providing for appeals; providing for confidentiality; providing for review and repeal; regulating acquisitions; imposing taxes on prepaid limited health service organization contracts; providing for deposit of such taxes; providing for rules; amending s. 624.5092, F.S.; providing for administration of taxes; amending s. 641.407, F.S.; increasing certain minimum surplus amounts; repealing ch. 637, F.S., relating to optometric, pharmaceutical, and dental service plan corporations, and ch. 638, F.S., relating to ambulance service contracts; providing for review and repeal; repealing s. 624.523(1)(l), F.S., to conform; providing an effective date.

—was read the second time by title. On motion by Senator Grant, by two-thirds vote **CS for SB 202** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

Reconsideration

On motion by Senator Grant, the Senate reconsidered the vote by which **CS for SB 202** passed.

On motions by Senator Grant, by two-thirds vote **CS for HB 1965** was withdrawn from the Committees on Commerce; Finance, Taxation and Claims; and Appropriations.

On motions by Senator Grant, by two-thirds vote—

CS for HB 1965—A bill to be entitled An act relating to insurance; creating the Prepaid Limited Health Service Organization Act of Florida; providing for regulation of prepaid limited health service organizations and contracts by the Department of Insurance; providing definitions; specifying applicability of other laws; requiring incorporation; providing that such organizations are not authorized to transact any other insurance business; requiring and providing for application for certificate of authority; providing for issuance or denial of certificate; providing standards for continued eligibility; providing for issuance of provisional certificate of authority; requiring contracts in English, with translations provided in certain circumstances; specifying content of contracts; regulating rates and charges; prohibiting discrimination; specifying validity of noncomplying contracts; providing for construction of contract; providing for delivery; requiring notice of cancellation; specifying what payments are acceptable; prohibiting the advertising use of certain words; regulating contracts between organizations and providers, managers, and administrators; providing for complaints; specifying examination and investigation authority of the department; providing for determination of acceptable assets and investments; requiring reports; requiring licensed agents; requiring minimum surplus; providing for insolvency protection; requiring fidelity bonds; providing for suspension or revocation of certificate of authority; providing for administrative penalties; providing civil remedies; providing for injunctions; requiring payment of judgments within a specified time; providing for rehabilitation, conservation, and liquidation; providing fees; defining unfair methods, acts, and practices; providing for appeals; providing for confidentiality; providing for review and repeal; regulating acquisitions; imposing taxes on prepaid limited health service organization contracts; providing for deposit of such taxes; providing for rules; amending s. 624.5092, F.S.; providing for administration of taxes; amending s. 641.407, F.S.; increasing certain minimum surplus amounts; repealing ch. 637, F.S., relating to optometric, pharmaceutical, and dental service plan corporations, and ch. 638, F.S., relating to ambulance service contracts; providing for review and repeal; repealing s. 624.523(1)(l), F.S., to conform; providing an effective date.

—a companion measure, was substituted for **CS for SB 202** and read the second time by title. On motion by Senator Grant, by two-thirds vote **CS for HB 1965** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

On motions by Senator McKay, by two-thirds vote—

CS for HB 2069—A bill to be entitled An act relating to adult day care centers; amending s. 400.55, F.S.; modifying purpose of pt. IV of ch. 400, F.S.; amending ss. 400.551, 400.552, 400.556, 400.557, 400.5575, 400.558, 400.559, 400.56, and 400.562, F.S.; conforming definitions and language to transfer of responsibilities from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; expanding definition of "basic services"; amending s. 400.553, F.S.; revising exemptions from regulation under pt. IV of ch. 400, F.S.; authorizing provision of certain services by an adult congregate living facility, nursing home facility, or hospital; requiring monitoring by the agency; amending s. 400.554, F.S.; providing for biennial rather than annual license fee; providing an additional fee; deleting license fee exemption for centers operated by local governments; amending s. 400.555, F.S.; providing additional license application requirements; amending s. 400 5565, F.S.; clarifying authority to impose fines; conditioning license renewal on payment of outstanding fines; saving pt. IV of ch. 400, F.S., from Sunset repeal; providing for future review and repeal; providing an effective date.

—a companion measure, was substituted for **CS for SB 306** and by two-thirds vote read the second time by title.

Senator McKay moved the following amendment:

Amendment 1 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Section 400.55, Florida Statutes, is amended to read:

400.55 Purpose.—The purpose of this part is to develop, establish, and enforce basic standards for adult day care centers in order to assure that *a program of therapeutic social and health activities and services is provided to adults who have functional impairments, in a protective environment that provides as noninstitutional an atmosphere as possible* ~~a protective environment and preventive, remedial, and restorative services are provided~~.

Section 2. Section 400.551, Florida Statutes, is amended to read:

400.551 Definitions.—*As* ~~When~~ used in this part, *the term* ~~unless the context otherwise requires~~:

(1) "Adult day care center;" *or* ~~hereinafter referred to as~~ "center;" means any building, ~~or~~ buildings, or *part of a building* ~~other place~~, whether operated for profit or not, *in* which *is provided* ~~undertakes~~ through its ownership or management ~~to provide~~, for a part of *a* ~~the 24-hour~~ day, basic services to three or more *persons who are 18 years of age or older, who are* ~~adults,~~ not related to the *owner or operator* ~~owner/operator~~ by blood or marriage, *and* who require such services.

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

(3)~~(2)~~ "Basic services" ~~shall~~ include, but *are* not ~~be~~ limited to, providing a protective setting *that is as noninstitutional as possible; therapeutic programs of*~~,~~ social *and health* activities *and services;*~~,~~ leisure ~~time~~ activities~~,~~ self-care training~~,~~ rest~~,~~ nutritional services*; and respite care*~~, and, when possible, speech and physical therapy~~.

(4)~~(3)~~ "Department" means the Department of Health and Rehabilitative Services.

(5) "Multiple or repeated violations" means 2 or more violations that present an imminent danger to the health, safety, or welfare of participants or 10 or more violations within a 5-year period that threaten the health, safety, or welfare of the participants.

(6)~~(4)~~ *"Operator"* ~~"Owner/operator"~~ means *the person having* ~~any individual who has~~ general administrative charge of an adult day care center.

(7) "Owner" means the owner of an adult day care center.

(8) "Participant" means a recipient of basic services or of supportive and optional services provided by an adult day care center.

~~(5) "Participant and program data" shall include, but not be limited to, number of participants, frequency of participation, distance traveled, hours of operation, number of referrals from a center to other programs, facilities or institutions, and incidence of illness.~~

(9)~~(6)~~ "Supportive and optional services" include, but are not limited to, *speech, occupational, and physical therapy;* direct transportation*;* ~~services,~~ legal consultation~~,~~ consumer education~~,~~ and referrals for followup services.

Section 3. Section 400.552, Florida Statutes, is amended to read:

400.552 *Applicability* ~~Centers to be licensed~~.—*Any facility that comes within the definition of an* ~~For the administration of this part, facilities to be licensed by the department shall include all~~ adult day care *center* ~~centers as defined in this part~~ which *is* ~~are~~ not ~~otherwise~~ exempt *under* ~~as provided in~~ s. 400.553 *must be licensed by the agency as an adult day care center.*

Section 4. Section 400.553, Florida Statutes, is amended to read:

400.553 Exemptions*; monitoring of adult day care center programs colocated with adult congregate living facilities or licensed nursing home facilities.*—

(1) The following *are* ~~shall be~~ exempt from the provisions of this part:

(a)~~(1)~~ Any facility, institution, or other place *that is* operated by the Federal Government or any agency thereof.

~~(2) Any federally funded congregate meals program.~~

~~(3) Any adult congregate living facility licensed by the state.~~

~~(4) Any nursing home facility licensed by the state.~~

(b)~~(5)~~ Any freestanding inpatient hospice facility *that is* licensed by the state *and* which provides day care services to hospice patients only.

(2) A licensed adult congregate living facility, a licensed hospital, or a licensed nursing home facility may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents. Such a facility need not be licensed as an adult day care center; however, the agency must monitor the facility during the regular inspection and at least biennially to ensure adequate space and sufficient staff. If an adult congregate living facility, a hospital, or a nursing home holds itself out to the public as an adult day care center, it must be licensed as such and meet all standards prescribed by statute and rule.

Section 5. Section 400.554, Florida Statutes, is amended to read:

400.554 License *requirement* ~~required~~; fee; exemption; display.—

(1) It is unlawful to operate *an adult day care* ~~or maintain a~~ center without first obtaining from the *agency* ~~department~~ a license authorizing such operation. The *agency* ~~department~~ is responsible for licensing adult day care centers in accordance with ~~the provisions of~~ this part.

(2) Separate licenses *are* ~~shall be~~ required for centers *operated* ~~maintained~~ on separate premises, even though operated under the same management. Separate licenses *are* ~~shall~~ not ~~be~~ required for separate buildings on the same *premises* ~~grounds~~.

(3) The *biennial* ~~annual~~ license fee required of a center shall be determined by the department, but *may* ~~shall~~ not exceed *$150* ~~$75~~.

(4) County-operated or municipally operated centers applying for licensure under this part *are* ~~shall be~~ exempt from the payment of license fees.

(5) The license *for a center* shall be displayed in a conspicuous place inside the center.

(6) A license *is* ~~shall be~~ valid only in the possession of the individual, firm, partnership, association, or corporation to *which* ~~whom~~ it is issued and *is* ~~shall~~ not ~~be~~ subject to sale, assignment, or other transfer, voluntary or involuntary; nor *is* ~~shall~~ a license ~~be~~ valid for any premises other than *the premises* ~~that~~ for which originally issued.

Section 6. Section 400.555, Florida Statutes, is amended to read:

400.555 Application for license.—

(1) *An* application for *a* license *to operate an adult day care center must* ~~shall~~ be made to the *agency* ~~department~~ on forms furnished by *the agency* ~~it~~ and *must* ~~shall~~ be accompanied by the appropriate license fee unless the applicant is exempt from payment of the fee as provided in s. 400.554(4).

(2) The applicant for licensure *must* ~~shall~~ furnish*:*

(a) A description of the physical and mental capabilities and needs of the participants to be served and the availability, frequency, and intensity of basic services and of supportive and optional services to be provided;

(b) Satisfactory proof of financial ability to operate and conduct the center in accordance with the requirements of this part*, which must include, in the case of an initial application, a 1-year operating plan and proof of a 3-month operating reserve fund; and.*

(c)~~(3) The applicant for licensure shall furnish~~ Proof of adequate liability insurance coverage.

Section 7. Section 400.556, Florida Statutes, is amended to read:

400.556 Denial, suspension, revocation of license; *administrative fines; investigations and inspections* ~~grounds~~.—

(1) The *agency* ~~department~~ may deny, revoke, or suspend a license *under this part* or *may* impose an administrative fine *against the owner of an adult day care center or its operator or employee* in the manner provided in chapter 120.

(2) *Each* ~~Either~~ of the following actions by *the owner of an adult day care* ~~a~~ center or *by* its *operator or* employee *is a ground* ~~shall be grounds~~ for action by the *agency* ~~department~~ against *the owner of the* ~~a~~ center or its *operator or* employee:

(a) An intentional or negligent act materially affecting the health or safety of *center* participants ~~in the center~~.

(b) A violation of ~~the provisions of~~ this part or of any *standard* ~~standards~~ or *rule under this part* ~~rules promulgated hereunder~~.

(c) A confirmed report of adult abuse, neglect, or exploitation, as defined in s. 415.102, or of child abuse or neglect, as defined in s. 415.503, which report has been upheld following a hearing held pursuant to chapter 120 or a waiver of such hearing.

(d) Multiple or repeated violations of this part or of any standard or rule adopted under this part.

(3) The *agency is* ~~department shall be~~ responsible for all investigations and inspections conducted pursuant to ~~the provisions of~~ this part.

Section 8. Section 400.5565, Florida Statutes, is amended to read:

400.5565 Administrative fines*; interest.*—

(1)(a) If the *agency* ~~department~~ determines that *an adult day care* ~~a~~ center is not *operated* in compliance with *this part or with* rules adopted under this part, ~~including the operation of a center without a license~~ the

agency ~~department~~, notwithstanding any other administrative action it takes, shall make a reasonable attempt to discuss *with the owner* each violation and recommended corrective action ~~with the owner of the center~~ prior to *providing the owner with* written notification ~~thereof~~. The *agency* ~~department~~ may request *the submission of* a corrective action plan *for* ~~from~~ the center which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the *agency* ~~department~~.

(b) *The owner of* a center or *its operator or* employee found in violation of *this part or of* rules adopted under this part may be fined by the *agency* ~~department~~. A fine may not exceed $500 for each violation. In no event, however, may such *fines* ~~fine~~ in the aggregate exceed $5,000.

(c) The failure to correct a violation by the date set by the *agency* ~~department~~, or the failure to comply with an approved corrective action plan, is a separate violation for each day such failure continues, unless the *agency* ~~department~~ approves an extension to a specific date.

(d) If *the owner of* a center *or its operator or employee appeals an agency* ~~desires to appeal any departmental~~ action under this section and the fine is upheld, the violator shall pay the fine, plus interest at the legal rate ~~as~~ specified in s. 687.01, for each day *that the fine remains unpaid after* ~~beyond~~ the date set by the *agency* ~~department~~ for payment of the fine.

(2) In determining *whether to impose* ~~if~~ a fine ~~is to be imposed~~ and in fixing the amount of any fine, the *agency* ~~department~~ shall consider the following factors:

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

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

(c) Any previous violations.

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

Section 9. Section 400.557, Florida Statutes, is amended to read:

400.557 Expiration of license; renewal; conditional license *or* ~~as~~ permit.—

(1) A license issued for the operation of *an adult day care* ~~a~~ center, unless sooner suspended or revoked, *expires 2 years after* ~~shall expire 1 year from~~ the date of issuance. *The agency shall notify a licensee by certified mail, return receipt requested, at least 120 days before the expiration date that license renewal is required to continue operation.* At least *90* ~~60~~ days prior to the expiration date, an application for renewal *must* ~~shall~~ be submitted to the *agency* ~~department~~. *A license* ~~Licenses~~ shall be renewed, upon the filing of an application on forms furnished by the *agency* ~~department~~, if the applicant has first met the requirements *of* ~~established under~~ this part and *of the* ~~all~~ rules *adopted under this part* ~~promulgated hereunder~~. The *applicant must* ~~center shall~~ file with the application satisfactory proof of financial ability to operate ~~and conduct~~ the *center* ~~facility~~ in accordance with the requirements of this part *and in accordance with the needs of the participants to be served.*

(2) *A licensee* ~~Licensees~~ against whom a revocation or suspension proceeding is pending at the time *for* ~~of~~ license renewal may be issued a conditional license effective until final disposition by the *agency* ~~department~~ of *the proceeding* ~~such proceedings~~. If judicial relief is sought from the final disposition, the court having jurisdiction may issue a conditional permit *effective* for the duration of the judicial proceeding.

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

Section 10. Section 400.5575, Florida Statutes, is amended to read:

400.5575 Disposition of fees and administrative fines.—Fees and fines received by the *agency* ~~department~~ under this part shall be deposited in the *Health Care* ~~Aging and Adult Licensure~~ Trust Fund *established pursuant to s. 455.2205.* These funds may be used to offset the costs of the licensure program, including the costs of conducting background investigations, verifying information submitted, and ~~defraying the costs of~~ processing applications.

Section 11. Section 400.558, Florida Statutes, is amended to read:

400.558 *Injunctive relief* ~~Injunction proceedings authorized~~.—

(1) The *agency* ~~department~~ may institute *an action for injunctive relief* ~~injunction proceedings~~ in a court of competent jurisdiction to:

(a) Enforce the provisions of this part or any standard, rule, or order issued or entered into pursuant *to this part* ~~thereto~~; or

(b) Terminate the operation of *an adult day care* ~~a~~ center *for* ~~where any of the following exist~~:

1. Failure to take preventive or corrective measures in accordance with *an* ~~any~~ order of the *agency;* ~~department.~~

2. Failure to abide by *a* ~~any~~ final order of the *agency; or* ~~department once it has become effective and binding.~~

3. Violation of any provision of this part or of any rule or standard *adopted* ~~promulgated~~ pursuant *to this part* ~~thereto~~, which violation constitutes an emergency requiring immediate action.

(2) *The court may grant* ~~Such injunctive relief may be a~~ temporary or permanent *injunctive relief* ~~injunction~~.

Section 12. Section 400.559, Florida Statutes, is amended to read:

400.559 Closing *or change of owner or operator* of center.—

(1) *Before operation of an adult day care* ~~Whenever a~~ center *may be* voluntarily *discontinued* ~~discontinues operation~~, *the operator must* ~~it shall~~ inform the *agency* ~~department~~ in writing at least *60* ~~30~~ days prior to the discontinuance of operation. The *operator must* ~~center shall~~ also, at such time, inform each participant of the fact and the proposed *date* ~~time~~ of such discontinuance.

(2) Immediately upon discontinuance of the operation of a center, the *owner or operator* ~~owner/operator~~ shall surrender the license *for the center* ~~therefor~~ to the *agency,* ~~department~~ and the license shall be canceled *by the agency.*

(3) If a center has a change of ownership, the new owner shall apply to the agency for a new license at least 60 days before the date of the change of ownership.

(4) If a center has a change of operator, the new operator shall notify the agency in writing within 30 days after the change of operator.

Section 13. Section 400.56, Florida Statutes, is amended to read:

400.56 Right of entry and inspection.—Any duly designated officer or employee of the *agency or* department *has* ~~shall have~~ the right to enter ~~upon and into~~ the premises of any *adult day care* center licensed pursuant to this part, at any reasonable time, in order to determine the state of compliance with ~~the provisions of~~ this part and *the* ~~of~~ rules or standards in force pursuant *to this part* ~~thereto~~. The right of entry and inspection ~~shall~~ also *extends* ~~extend~~ to any premises *that* ~~which~~ the *agency* ~~department~~ has reason to believe are being operated ~~or maintained~~ as a center without a license, but no ~~such~~ entry or inspection of any *unlicensed* premises *may* ~~shall~~ be made without the permission of the *owner or operator* ~~owner/operator in charge thereof~~ unless a warrant is first obtained from the circuit court authorizing *entry or inspection* ~~same~~. Any application for a center license or *license* renewal made pursuant to this part *constitutes* ~~shall constitute~~ permission for, and complete acquiescence in, any entry or inspection of the premises for which the license is sought in order to facilitate verification of the information submitted on or in connection with the application.

Section 14. Section 400.562, Florida Statutes, is amended to read:

400.562 Rules establishing standards.—

(1) ~~Pursuant to the intention of the Legislature to provide safe and sanitary facilities and healthful programs,~~ The Department *of Health and Rehabilitative Services* ~~within 1 year of July 1, 1978,~~ shall *adopt* ~~promulgate and publish~~ rules to implement the provisions of this part. *The rules must,* ~~which shall~~ include reasonable and fair standards. Any conflict between these standards and those that may be set forth in local, county, or *municipal* ~~city~~ ordinances shall be resolved in favor of those having statewide effect. Such standards *must* ~~shall~~ relate to:

(a) The maintenance of *adult day care* centers *with respect*~~, not in conflict with the provisions of chapter 553, and based upon the size of the structure and number of participants, relating~~ to plumbing, heating, lighting, ventilation, and other building conditions, including adequate meeting space, *to* ~~which will~~ ensure the health, safety, and comfort of participants and protection from fire hazard. *Such standards may not conflict with chapter 553 and must be based upon the size of the structure and the number of participants.*

(b) The number and qualifications of all personnel *employed by adult day care centers who have responsibilities* ~~having responsibility~~ for the care of participants.

(c) All sanitary conditions within *adult day care centers* ~~the center~~ and *their* ~~its~~ surroundings, including water supply, sewage disposal, food handling, and general hygiene, and maintenance *of sanitary conditions* ~~thereof~~, *to* ~~which will~~ ensure the health and comfort of participants.

(d) ~~Programs and~~ Basic services *provided by adult day care centers* ~~promoting and maintaining the health of participants and encouraging leisure and recreational activities, interaction, and communication among participants~~.

(e) ~~Transportation and other~~ Supportive and optional services *provided by adult day care centers.*

(f) Data and information relative to participants and programs *of adult day care centers, including, but not limited to, the physical and mental capabilities and needs of the participants, the availability, frequency, and intensity of basic services and of supportive and optional services provided, the frequency of participation, the distances traveled by participants, the hours of operation, the number of referrals to other centers or elsewhere, and the incidence of illness.*

(2) *The department may not enforce a standard adopted by rule* ~~Enforcement of standards pursuant to the promulgation of rules~~ under this part ~~shall not take effect~~ until 6 months *after adopting that rule* ~~following the promulgation of such rules~~.

(3) Pursuant to s. 119.07, the agency may charge a fee for furnishing a copy of this part, or of the rules adopted under this part, to any person upon request for the copy.

(4) Pursuant to rules adopted by the agency, the agency may conduct an abbreviated biennial inspection of key quality-of-care standards, in lieu of a full inspection, of a center that has a record of good performance. However, the agency must conduct a full inspection of a center that has had one or more confirmed complaints within the licensure period immediately preceding the inspection or which has a serious problem identified during the abbreviated inspection. The agency shall develop the key quality-of-care standards and rules, taking into consideration the comments and recommendations of the Department of Elderly Affairs and of provider groups.

Section 15. Section 400.563, Florida Statutes, is amended to read:

400.563 Construction and renovation; requirements.—The requirements for the construction and the renovation of a center *must* ~~shall~~ comply with the provisions of chapter 553 which pertain to building construction standards, including plumbing, electrical code, glass, manufactured buildings, accessibility *by* ~~for the~~ physically *handicapped persons* ~~disabled~~, and the state minimum building *codes* ~~code~~.

Section 16. Section 400.564, Florida Statutes, is amended to read:

400.564 Prohibited acts; penalty for violation.—

(1)*(a)* It is unlawful for any person or public body to offer or advertise to the public, in any way, by any medium whatever, *adult day care center* basic services ~~as defined in this part,~~ without *having a* ~~obtaining a valid current~~ license *under this part.*

(b) It is unlawful for any holder of a license issued *under* ~~pursuant to the provisions of~~ this part to advertise or hold out to the public that it holds a license for *an adult day care* a center other than *the one* ~~that~~ for which it actually holds a license.

(2) Any person *that violates paragraph (a) or paragraph (b)* ~~convicted of violating the provisions~~ of subsection (1) is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083. Each day of continuing violation *is* ~~shall be~~ considered a separate offense.

Section 17. Notwithstanding the provisions of section 11.61, Florida Statutes, or section 83 of chapter 83-181, Laws of Florida, sections 400.55, 400.551, 400.552, 400.553, 400.554, 400.555, 400.556, 400.5565, 400.557, 400.5575, 400.558, 400.559, 400.56, 400.562, 400.563, and 400.564, Florida Statutes, shall not expire or stand repealed October 1, 1993, as scheduled by those laws, but those sections, as amended by this act, are revived and readopted.

Section 18. This act shall take effect July 1, 1993.

And the title is amended as follows:

Strike everything before the enacting clause and insert: A bill to be entitled An act relating to adult day care centers; amending s. 400.55, F.S.; revising the purpose of pt. IV, ch. 400, F.S.; amending s. 400.551, F.S.; adding and revising definitions for purposes of pt. IV, ch. 400, F.S.; amending s. 400.552, F.S.; transferring responsibility for licensure from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; amending s. 400.553, F.S.; revising the exemptions from licensure and regulation; amending s. 400.554, F.S.; requiring biennial licensure; amending s. 400.555, F.S.; requiring additional information from licensure applicants; amending s. 400.556, F.S.; adding grounds for action against the owner of a center or its operator or employee; amending s. 400.5565, F.S.; specifying that the owner of a center, or its operator or employee, found in violation of this part or the rules adopted under this part is subject to an administrative fine; amending s. 400.557, F.S.; requiring biennial renewal of licenses; requiring additional information of applicants for renewal; providing for issuance of a conditional license; amending s. 400.5575, F.S.; providing for the deposit of fees and fines; providing for the use of these moneys; amending s. 400.558, F.S.; transferring responsibility relating to injunctive proceedings from the department to the agency; amending s. 400.559, F.S.; requiring notice of change of owner or operator; amending s. 400.56, F.S.; providing right of entry and inspection to the agency; amending s. 400.562, F.S.; requiring the Department of Health and Rehabilitative Services to adopt rules; describing information that may form the basis for rules establishing standards; authorizing a fee for copies of statutes or rules; providing for abbreviated biennial inspections; amending s. 400.563, F.S; updating cross-references with respect to construction and renovation requirements; amending s. 400.564, F.S., relating to prohibited acts, to delete an unnecessary cross-reference and otherwise clarify the section; reviving and readopting ss. 400.55-400.564, F.S., as amended, notwithstanding their scheduled repeal October 1, 1993; providing an effective date.

On motion by Senator McKay, further consideration of **CS for HB 2069** with pending **Amendment 1** was deferred.

Consideration of **CS for SB 2000, CS for CS for SB 146, CS for CS for SB 164** and **CS for SB 298** was deferred.

SB 258—A bill to be entitled An act relating to educational enhancement; providing for the issuance of Florida educational license plates by the Department of Highway Safety and Motor Vehicles; prescribing duties of the department with respect to such license plates; prescribing fees for such plates; prescribing uses of the proceeds from such license plates in enhancing educational programs; providing for automatic deauthorization of the plates in certain circumstances; providing an effective date.

—was read the second time by title.

The Committee on Transportation recommended the following amendment which was moved by Senator Jennings and adopted:

Amendment 1—On page 4, between lines 3 and 4, insert:

Section 2. The license plate created by this act shall be developed and issued by the department as soon as practicable, but no later than January 1, 1994.

(Renumber subsequent section.)

The Committee on Finance, Taxation and Claims recommended the following amendment which was moved by Senator Jennings and adopted:

Amendment 2—On page 1, strike all of lines 19-21 and insert: provided in this section and shall issue one to the owner or lessee of any motor vehicle, except a vehicle registered under the International Registration Plan or a commercial truck required to display two license plates pursuant to s. 320.0706, upon application and payment

On motion by Senator Jennings, by two-thirds vote **SB 258** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—39 Nays—None

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Consideration of **SB 304, CS for SB 144, CS for CS for SB 156** and **CS for CS for SB 402** was deferred.

HB 2007—A bill to be entitled An act relating to legislative and public records; creating s. 11.043, F.S.; specifying records of the legislative branch that are exempt from public disclosure; providing that certain records become public after a specified period; repealing s. 11.045(4)(b), F.S., which provides for confidentiality of persons' identities in advisory opinions relating to lobbyists; amending s. 11.26, F.S., relating to legislative employees, to conform; creating s. 14.27, F.S.; providing an exemption from public records and public meeting requirements for records relating to Board of Executive Clemency investigations and meetings between board members; amending s. 119.011, F.S.; including the Commission on Ethics and the Public Service Commission within the meaning of "agency" for purposes of ch. 119, F.S., relating to public records; reenacting ss. 119.012, 119.083(1)(a), and 281.301, F.S., relating to records associated with payment of dues and membership contributions by agencies, copyright of data processing software created by agencies, and information relating to security systems in the possession of agencies, to incorporate the amendment to s. 119.011, F.S., in references thereto; amending s. 119.07, F.S.; providing an exemption from public records requirements for records relating to allegations of employment discrimination, certain information relating to agency officers, employees, and applicants for employment and their spouses and dependents, certain agency correspondence, and certain medical information relating to agency officers and employees; amending s. 943.03, F.S.; providing an exemption from public records requirements for records relating to certain investigations by the Department of Law Enforcement at the direction of the Governor; providing for review and repeal; providing an effective date.

—was read the second time by title.

The Committee on Rules and Calendar recommended the following amendment which was moved by Senator Jennings:

Amendment 1—On page 2, strike everything after the enacting clause and insert:

Section 1. Section 11.043, Florida Statutes, is created to read:

11.043 Legislative Records; intent of legislature and exemption from public disclosure.—

(1) It is the policy of this legislature that every person has the right to inspect records of the Senate and the House of Representatives received in connection with the official business of the legislature as provided for by the constitution of this state. To that end, public records shall be open to personal inspection at reasonable times except when specific public necessity justifies that public records be exempt from such inspection.

(2) The following public records are exempt from public disclosure:

(a) Records which, while in the custody of an agency as defined in s. 119.011 are by law confidential or exempt from the provisions of s. 119.07(1), are shared with or disclosed to the legislative branch pursuant to the legislature's oversight function or revenue estimating function;

(b) Records obtained by the legislative branch pursuant to its oversight function or revenue estimating function which if obtained by an agency as defined in s. 119.011, would be by law confidential or exempt from the provisions of s. 119.07(1);

(c) Records prepared, used or kept pursuant to executive sessions which shall become subject to public disclosure 10 years after the date on which the executive session was held;

(d) Records of former legislative investigating committees whose records are sealed or confidential as of June 30, 1993. However, such records shall become subject to public disclosure on December 31, 2028;

(e) Formal complaints about a member or officer of the Legislature or about a lobbyist and the records relating to the complaint, until the complaint is dismissed, a determination as to probable cause has been made, a determination that there are sufficient grounds for review has been made, or the respondent has requested in writing that the President of the Senate or the Speaker of the House of Representatives make public the complaint or other records relating to the complaint, whichever occurs first;

(f) Requests by members for an advisory opinion concerning the application of the rules of either house pertaining to ethics, unless the member requesting the opinion authorizes in writing the release of such information. All advisory opinions shall be open to inspection except that the identity of the member shall not be disclosed in the opinion unless the member requesting the opinion authorizes in writing the release of such information;

(g) Requests for, and drafts of, bills, amendments, reapportionment plans, and redistricting plans, including supporting documentation; and

(h) Working papers of employees, officers or members, relating to their official or legislative oversight responsibilities.

(3) For purposes of this section, "public record" means all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, or other material, regardless of physical form or characteristics, made or received pursuant to law or ordinance or in connection with the transaction of official business by the legislative branch.

(4) Each house of the legislature may adopt rules governing the maintenance, control, destruction, disposal and disposition of records made public by this section.

Section 2. Section (2) of section 119.011, Florida Statutes, is amended to read:

119.011 Definitions.—For the purpose of this chapter:

(2) "Agency" means any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law *including for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel,* and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency.

Section 3. This act shall take effect June 30, 1993.

Senator Jennings moved the following amendments to **Amendment 1** which were adopted:

Amendment 1A—On page 2, strike all of lines 10-13 and insert:

(d) With respect to records of former legislative investigating committees whose records are sealed or confidential as of June 30, 1993, such records are subject to public disclosure, except that the names of persons testifying before such committees shall remain confidential.

Amendment 1B (with Title Amendment)—On page 3, between lines 27 and 28, insert:

Section 3. Section 14.27, Florida Statutes, is created to read:

14.27 Executive clemency.—All records developed or received by any state entity relating to a Board of Executive Clemency investigation shall be exempt from the provisions of s. 119.07(1). Except for clemency hearings before the Board of Executive Clemency, the provisions of s. 286.011 shall not apply to meetings of Board members or their staff. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 1, line 24, after the semicolon (;) insert: creating s. 14.27, F.S.; providing an exemption from public records and public meeting requirements for records relating to Board of Executive Clemency investigations and meetings between board members;

Amendment 1C (with Title Amendment)—On page 3, between lines 27 and 28, insert:

Section 3. Subsection (2) of section 943.03, Florida Statutes, 1992 Supplement, is amended to read:

943.03 Department of Law Enforcement.—

(2) Upon specific direction by the Governor in writing to the executive director, the department shall investigate the misconduct, in connection with their official duties, of public officials and employees and of members of public corporations and authorities subject to suspension or removal by the Governor. *All records related to such investigation, including any correspondence from the Governor, are confidential and exempt from the provisions of s. 119.07(1) until such time as the investigation is completed or ceases to be active. For purposes of this subsection, an investigation is considered "active" while the investigation is being conducted by the department with a reasonable, good faith belief that it may lead to the filing of criminal proceedings or gubernatorial action. An investigation does not cease to be active if the department is proceeding with reasonable dispatch and there is a good faith belief that gubernatorial action may be initiated or action initiated by the department or other administrative or law enforcement agency. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.*

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 1, line 24, after the semicolon (;) insert: amending s. 943.03, F.S.; providing an exemption from public records requirements for records relating to certain investigations by the Department of Law Enforcement at the direction of the Governor; providing for review and repeal;

Senators Weinstein, Sullivan, Boczar, Holzendorf, Beard, Forman, Johnson and Grant offered the following amendment to **Amendment 1** which was moved by Senator Weinstein and adopted:

Amendment 1D—On page 3, between lines 6 and 7, insert:

(i) Correspondence received by or sent from a member of the Legislature.

(j) Working papers relating to constituent casework.

Amendment 1 as amended was adopted.

Senator Jennings moved the following amendment which was adopted:

Amendment 2—In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to legislative and public records; creating s. 11.043, F.S.; providing legislative intent; specifying public records that are exempt from public disclosure; providing definition of public record; authorizing each house of the Legislature to adopt rules governing disposition of public records; amending s. 119.011, F.S.; amending definition of agency for purposes of ch. 119, F.S., to include the Commission on Ethics, the Public Service Commission, Office of Public Counsel; providing an effective date.

On motion by Senator Jennings, by two-thirds vote **HB 2007** as amended was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

SENATOR CHILDERS PRESIDING

On motions by Senator Gutman, by two-thirds vote **HB 1987** was withdrawn from the Committees on Health Care; Health and Rehabilitative Services; and Finance, Taxation and Claims.

On motion by Senator Gutman—

HB 1987—A bill to be entitled An act relating to home health services; amending s. 400.461, F.S.; deleting the statement that the Home Health Services Act does not supersede federal law; amending s. 400.462, F.S.; revising definitions; defining "certified nursing assistant," "companion" or "sitter," and "homemaker"; amending s. 400.464, F.S.; providing for licensure of home health agencies by the Agency for Health Care Administration, rather than the Department of Health and Rehabilitative Services; requiring separate licensure for related offices; specifying unlawful acts by unlicensed persons; providing a penalty; creating s. 400.465, F.S.; providing exemptions; amending s. 400.471, F.S.; revising requirements for licensure application; requiring proof of financial liability and liability insurance; providing for license renewal; providing for change of ownership; providing a fee; providing an exemption; requiring display of license; providing for conditional license; amending s. 400.474, F.S.; authorizing injunction proceedings; renumbering and amending s. 400.478, F.S.; providing for registration of attendant care providers by the agency; restricting application; deleting provision relating to employee recruitment; amending s. 400.484, F.S.; conforming references; amending s. 400.487, F.S.; providing for patient assessment and information; increasing frequency of patient evaluation; authorizing evaluation by additional types of practitioners; providing requirement for direct and indirect provision of services; authorizing supervised self-administration of medication; amending s. 400.491, F.S.; revising requirements for maintenance of patient records; amending s. 400.497, F.S.; revising minimum standards; providing for agency rules; deleting provisions relating to personnel screening; amending s. 400.506, F.S.; providing for licensure of nurse registries by the agency; specifying maximum licensure fee; increasing a penalty; authorizing referral of certified nursing assistants to private residences; creating s. 400.512, F.S.; providing for screening of home health agency, nurse registry, and attendant personnel; amending ss. 415.107 and 415.51, F.S.; conforming statutory references; deleting obsolete language and references; repealing s. 400.467, F.S., relating to licensure; repealing s. 400.477, F.S., relating to license expiration and renewal; repealing s. 400.479, F.S., relating to disposition of fees; repealing s. 400.481, F.S., relating to injunction proceedings; repealing s. 400.501, F.S., relating to prohibited acts; providing an appropriation; saving pt. III of ch. 400, F.S., from Sunset repeal; providing for review and repeal; providing an effective date.

—a companion measure, was substituted for **CS for SB 144** and read the second time by title.

Senator Gutman moved the following amendment:

Amendment 1 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Section 400.461, Florida Statutes, is amended to read:

400.461 Short title; purpose.—

(1) This *part, consisting of sections 400.461-400.515,* ~~act shall be known and~~ may be cited as the "Home Health Services Act."

(2) The purpose of this *part* ~~act~~ is to provide for the licensure of every home health agency and to provide for the development, establishment, and enforcement of basic standards *that* ~~which~~ will ensure the safe and adequate care of persons receiving health services in their own homes. ~~The provisions of this part do not supersede applicable federal laws or regulations.~~

Section 2. Section 400.462, Florida Statutes, is amended to read:

400.462 Definitions.—*As* ~~When~~ used in this part, ~~unless the context otherwise requires,~~ the term:

(1) "Certified nursing assistant" means any person who has been issued a certificate after fulfilling the requirements of s. 400.211.

(2) "Companion" or "sitter" means a person who cares for an elderly, handicapped, or convalescent individual and accompanies such individual on trips and outings and may prepare and serve meals to such individual.

(3)~~(1)~~ "Department" means the Department of Health and Rehabilitative Services.

(4)~~(2)~~ "Home health agency" ~~hereinafter referred to as "agency,"~~ means *an* ~~any public agency or private~~ organization *that,* ~~or a subdivision of such an agency or organization, whether operated for profit or not, which~~ provides home health services *and staffing services for health care facilities.*

(5)~~(3)~~ "Home health agency personnel" means persons who are employed by or under contract with a home health agency and enter the home or place of residence of patients at any time in the course of their employment or contract.

(6)~~(4)~~ "Home health services~~,~~" ~~hereinafter referred to as "services,"~~ means health and medical services and medical supplies furnished to an individual by ~~a~~ home health agency *personnel* or by others under arrangements with the agency, on a visiting basis, in *the individual's home or* ~~a~~ place of residence ~~used as an individual's home~~. *The term includes* ~~such services may include~~, but *is* ~~are~~ not limited to, the following:

(a) ~~Part-time or intermittent~~ Nursing care.

(b) Physical, occupational, *respiratory,* or speech therapy.

~~(c) Medical social services.~~

(c)~~(d)~~ Home health aide services.

(d)~~(e)~~ Nutritional guidance.

(e)~~(f)~~ Medical supplies, restricted to drugs and biologicals prescribed by a physician.

~~However, the furnishing of only home dialysis services, supplies, or equipment, or personal care services provided by a community care for the elderly lead agency pursuant to s. 410.0241, or personal care services provided by a community care for disabled adults program pursuant to s. 410.604, shall not be deemed a home health service under any of the provisions of this part. This personal care exemption does not apply to any agency or provider other than community care for the elderly lead agencies or community care for disabled adults programs which directly provide only personal care services to their clients, and do not provide other home health services. In addition, any licensed agency that performs home health services may also provide staffing services to health care facilities.~~

(7) "Homemaker" means a person who performs household chores that include housekeeping, meal planning and preparation, shopping assistance, and routine household activities for an elderly, handicapped, or convalescent individual.

(8)~~(5)~~ "Nurse registry" means any person *that procures, offers, promises, or attempts*~~, partnership, agency, firm, organization, corporation, or business entity operating for the purpose of procuring, offering, promising, or attempting~~ to secure health-care-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, *sitters, companions, or homemakers* ~~or persons enumerated in s. 400.478(1)~~, who are compensated by fees as independent contractors, including, but not limited to, ~~both~~ contracts for the provision of services to patients ~~at the homes or places of residence of the patients~~ and contracts *to provide private duty or* ~~for~~ *staffing* ~~the provision of~~ services *to* ~~including private duty and/or supplemental staffing at~~ health care facilities licensed under chapter 395 or *this chapter* ~~under parts I, II, IV, or V of chapter 400~~.

(9)~~(6)~~ "Patient" means any person who receives home health services in his home or place of residence ~~in accordance with this part~~.

(10)~~(7)~~ "Screening" means the assessment of the background of home health agency personnel, *nurse registry personnel, and persons registered under s. 400.509* and includes employment history checks, checks of references, records checks of the department's central abuse registry *and tracking system* under chapter 415, and statewide criminal records correspondence checks through the Department of Law Enforcement. ~~Employment history checks and checks of references shall be assessed by the director for each employee and by the department for all directors.~~

(11)~~(8)~~ "Staffing services" means services provided to a health care facility on a temporary basis by licensed health care personnel, including certified nursing assistants ~~and nurses' aides~~.

Section 3. Section 400.464, Florida Statutes, is amended to read:

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

(1) Any ~~agency providing~~ home health *agency must* ~~services as defined in this act shall~~ be licensed by the *Agency for Health Care Administration* ~~department~~ to operate in this state. *A license issued to a home health agency, unless sooner suspended or revoked, expires 1 year after its date of issuance.* However, any *home health* agency *that is* ~~or organization~~ operated by ~~an agency of~~ the Federal Government *is* ~~shall be~~ exempt from ~~the provisions of~~ this *part* ~~act~~.

(2) If the licensed home health agency operates related offices, each related office outside the county where the main office is located must be separately licensed. The counties where the related offices are operating must be specified on the license in the main office.

(3) The furnishing of only home dialysis services, supplies, or equipment, or personal care services as provided by a community-care-for-the-elderly lead agency under s. 410.0241, or personal care services provided through a community-care-for-disabled-adults program under s. 410.604, is exempt from this part. The personal care services exemptions apply only to community-care-for-the-elderly lead agencies and community-care-for-disabled-adults programs that directly provide only personal care services to their clients and do not provide other home health services.

(4) Any program offered through a county public health unit that makes home visits for the purpose of providing only environmental assessments, case management, health education, or personal care services is exempt from this part.

(5)(a) It is unlawful for any person to offer or advertise home health services to the public unless he has a valid license under this part. It is unlawful for any holder of a license issued under this part to advertise or indicate to the public that it holds a home health agency license other than the one it has been issued.

(b) A person that violates paragraph (a) is subject to an injunctive proceeding under s. 400.515.

(6)~~(2)~~ Any infusion therapy provider shall be licensed as a home health agency.

~~(a)~~ Any infusion therapy provider currently authorized to receive Medicare reimbursement under a DME - Part B Provider number for the provision of infusion therapy ~~and dialysis equipment and supplies~~ shall be licensed as a noncertified home health agency. Such a provider shall continue to receive that specified Medicare reimbursement without being certified so long as the reimbursement is limited to those items authorized pursuant to the DME - Part B Provider Agreement and the agency is licensed in compliance with the other provisions of this part.

~~(b) Any infusion therapy provider which is in operation on January 1, 1992, shall be given a reasonable time, not to exceed 6 months, within which to comply with licensure requirements.~~

Section 4. Section 400.471, Florida Statutes, is amended to read:

400.471 Application for license*; fee; provisional license; temporary permit.*—

(1) Application for *an initial* license *or for renewal of an existing license must* ~~shall~~ be made under oath~~,~~ to the *Agency for Health Care Administration* ~~department~~ on forms furnished by it and *must* ~~shall~~ be accompanied by the appropriate license fee *as provided in subsection (4). The agency must take final action on an initial licensure application within 60 days after receipt of all required documentation.*

(2) The applicant *must* ~~shall~~ file with the application satisfactory proof that the *home health* agency is in compliance with this *part* ~~act~~ and *applicable* ~~any~~ rules*, including:*

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

(b) The number and discipline of professional staff to be employed; and

(c) Proof of financial ability to operate.

(3) An applicant for initial licensure must demonstrate financial ability to operate by submitting a balance sheet and income and expense statement for the first 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses. The applicant shall have demonstrated financial ability to operate if the assets, credit, and projected revenues meet or exceed projected liabilities and expenses. All documents required under this paragraph must be prepared in accordance with generally accepted accounting principles and signed by a certified public accountant. ~~and minimum standards promulgated hereunder and proof of financial ability to operate and conduct the agency in accordance with the requirements of this act.~~

(4) The home health agency must also obtain and maintain liability insurance. Proof of liability insurance, as defined in s. 624.605, must be submitted with the application. The Agency for Health Care Administration shall set the required amounts of liability insurance by rule, but the required amount must not be less than $250,000 per claim.

(5) Sixty days before the expiration date, an application for renewal must be submitted to the Agency for Health Care Administration under oath on forms furnished by it, and a license must be renewed if the applicant has met the requirements established under this part and applicable rules. The home health agency must file with the application satisfactory proof that it is in compliance with this part and applicable rules. The home health agency must submit satisfactory proof of its financial ability to comply with the requirements of this part.

(6) When transferring the ownership of a home health agency, the transferee must submit an application for a license at least 60 days before the effective date of the transfer. If the home health agency is being leased, a copy of the lease agreement must be filed with the application.

(7) The license fee and annual renewal fee required of a home health agency is nonrefundable. The Agency for Health Care Administration shall set the fees in an amount that is sufficient to cover its costs in carrying out its responsibilities under this part, but not to exceed $1,000. However, state, county, or municipal governments applying for licenses under this part are exempt from the payment of license fees. All fees collected under this part must be deposited in the Health Care Trust Fund for the administration of this part.

(8) The license must be displayed in a conspicuous place in the administrative office of the home health agency and is valid only while in the possession of the person to which it is issued. The license may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily, and is valid only for the home health agency and location for which originally issued.

(9) A home health agency against whom a revocation or suspension proceeding is pending at the time of license renewal may be issued a provisional license effective until final disposition by the Agency for Health Care Administration of such proceedings. If judicial relief is sought from the final disposition, the court that has jurisdiction may issue a temporary permit for the duration of the judicial proceeding.

(10)~~(3)~~ The department shall not issue a license designated as certified to a home health agency which fails to receive a certificate of need under the provisions of *ss. 408.031-408.045* ~~ss. 381.701-381.715~~.

Section 5. Section 400.474, Florida Statutes, is amended to read:

400.474 Denial, suspension, revocation of license; *injunction;* grounds.—

(1) The *Agency for Health Care Administration* ~~department~~ may deny, revoke, or suspend a license, or impose an administrative fine in the manner provided in chapter 120, *or initiate injunctive proceedings under s. 400.515.*

(2) Any of the following actions by *a home health* ~~an~~ agency or its employee *is* ~~shall be~~ grounds for *disciplinary* action by the *Agency for Health Care Administration* ~~department against an agency~~:

(a) Violation of ~~provisions of~~ this *part* ~~act~~ or of *applicable rules* ~~any minimum standards or rules promulgated hereunder~~.

(b) An intentional, *reckless,* or negligent act *that* materially *affects* ~~affecting~~ the health or safety of a patient.

Section 6. Section 400.478, Florida Statutes, is transferred, renumbered as section 400.509, Florida Statutes, and amended to read:

400.509 ~~400.478~~ Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.—

(1) Any person *that* ~~or agency which~~ provides domestic maid services, sitter services, companion services, or homemaker services and does not provide a home health service~~, as defined in s. 400.462(4),~~ to a person *is* ~~in a place of residence used as a person's home shall be~~ exempt from licensure under this part. However, any person *that* ~~or agency which~~ provides~~, under definitions established in rule by the department~~, sitter services for adults, companion services, or homemaker services *must* ~~shall~~ register with the *Agency for Health Care Administration* ~~department pursuant to this section~~.

(2) Registration *consists* ~~shall consist~~ of annually filing with the *Agency for Health Care Administration* ~~department~~, under oath, on forms provided ~~upon request~~ by *it* ~~the department~~, the following information:

(a) The name, address, date of birth, and social security number of the individual, or the name and address of the *person* ~~agency~~, providing the service.

(b) If the registrant is a firm or partnership, the name, address, date of birth, and social security number of every member ~~thereof~~.

(c) If the registrant is a corporation or association, its name and address, the name, address, date of birth, and social security number of each of its directors and officers, and the name and address of each person having at least a 10-percent interest in the corporation *or association.*

(d) The name, address, date of birth, and social security number of each person employed or under contract.

(3) The *Agency for Health Care Administration* ~~department~~ shall charge a registration fee of $25 to be submitted with the information required under subsection (2).

(4) Each registrant *must* ~~shall~~ establish the employment history of persons employed or under contract having contact at any time with patients in their homes by:

(a) Requiring persons employed or under contract to submit an employment history to the registrant; and

(b) Verifying the employment history, unless through diligent efforts such verification is not possible. *The Agency for Health Care Administration shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.*

There *is* ~~shall be~~ no monetary liability on the part of, and no cause of action for damages *arises* ~~shall arise~~ against, a former employer of a prospective employee of or prospective independent contractor with a registrant who reasonably and in good faith communicates his honest opinions about the former employee's job performance. ~~The provisions of~~ This subsection *does* ~~do~~ not affect the official immunity of an officer or employee of a public corporation.

(5) On or before the first day on which services are provided to a patient, any *registrant* ~~person or agency registered~~ under this part must inform the patient and his immediate family, if appropriate, of the right to report abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse registry must be provided to patients in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free . . . (phone number) . . .." Registrants must establish appropriate policies and procedures for providing such notice to patients.

(6) The provisions of *s. 400.512* ~~s. 400.497~~ regarding screening apply to any person or *business entity* ~~agency~~ registered ~~or employed~~ under this section ~~by a registrant~~ on or after October 1, 1989.

(7) Upon verification that all requirements for registration have been met, the *Agency for Health Care Administration* ~~department~~ shall issue a certificate of registration valid for no more than 1 year.

~~(8) An agency that provides staffing services may not require an employee to recruit new employees for the agency from persons employed at a health care facility to which the agency employee is assigned, and a health care facility may not recruit new employees from agency employees who provide staffing services to the facility.~~

(8)~~(9)~~ The *Agency for Health Care Administration* ~~department~~ may deny, suspend, or revoke the registration of a person *that* ~~or agency which~~:

(a) Fails to comply with this section or *applicable* rules ~~established thereto~~.

(b) *Commits* ~~Causes~~ an intentional, *reckless,* or negligent act *that* ~~which~~ materially affects the health or safety of a person receiving services.

(9)~~(10)~~ The *Agency for Health Care Administration* ~~department~~ may institute injunctive proceedings *under s. 400.515* ~~in a court of competent jurisdiction when violation of the provisions of this section or any rules promulgated thereunder constitutes an emergency affecting the immediate health and safety of a person receiving services~~.

(10)~~(11)~~ *A* ~~Any~~ person *that* ~~or agency who~~ offers or advertises to the public *a*~~, in any way by any medium whatever, that he provides any~~ service for which registration is required *must* ~~under this section shall~~ include in *its advertisement* ~~such advertising~~ the registration number issued by the *Agency for Health Care Administration* ~~department~~.

(11)~~(12)~~ It is unlawful for *a* ~~any~~ person ~~or agency~~ to offer or advertise to the public~~, in any way by any medium whatever,~~ services, as defined by rule, ~~pursuant to this section~~ without obtaining a ~~valid~~ certificate of registration from the *Agency for Health Care Administration* ~~department~~. It is unlawful for any holder of a certificate of registration to advertise or hold out to the public that he holds a certificate of registration for other than that for which he actually holds a certificate of registration. Any person *who violates* ~~found guilty of violating~~ this subsection *is subject to injunctive proceedings under s. 400.515* ~~shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083. Each day of continuing violation shall be considered a separate offense~~.

(12)~~(13)~~ Any duly authorized officer or employee of the *Agency for Health Care Administration has* ~~department shall have~~ the right to make such inspections and investigations as are necessary in order to respond to complaints or to determine the state of compliance with ~~the provisions of~~ this section and *applicable* ~~the~~ rules ~~adopted thereto~~.

(a) If, in responding to a complaint, an officer or employee of the *Agency for Health Care Administration* ~~department~~ has reason to believe that a crime has been committed, he shall notify the appropriate law enforcement agency.

(b) If, in responding to a complaint, an officer or employee of the *Agency for Health Care Administration* ~~department~~ has reason to believe that abuse, neglect, or exploitation has occurred, according to the definitions in *chapter 415* ~~s. 415.102~~, he shall file a report under *chapter 415* ~~the provisions of s. 415.103~~.

(13)~~(14)~~ The *Agency for Health Care Administration* ~~department~~ shall adopt rules to *administer* ~~implement the provisions of~~ this section ~~within 90 days after October 1, 1988~~.

Section 7. Section 400.481, Florida Statutes, is transferred, renumbered as section 400.515, Florida Statutes, and amended to read:

400.515 ~~400.481~~ Injunction proceedings ~~authorized~~.—The *Agency for Health Care Administration* ~~department~~ may institute injunction proceedings in a court of competent jurisdiction when violation of ~~the provisions of~~ this *part* ~~act~~ or of *applicable rules* ~~any minimum standards or rules promulgated hereunder~~ constitutes an emergency affecting the immediate health and safety of a patient *or client*.

Section 8. Section 400.484, Florida Statutes, is amended to read:

400.484 Right of inspection.—Any duly authorized officer or employee of the *Agency for Health Care Administration may* ~~department shall have the right to~~ make such inspections and investigations as are necessary in order to determine the state of compliance with ~~the provisions of~~ this *part* ~~act~~ and *with applicable* ~~of~~ rules ~~or standards in force pursuant thereto~~. The right of inspection *extends* ~~shall also extend~~ to any *business that* ~~agency which~~ the *Agency for Health Care Administration* ~~department~~ has reason to believe is being operated as *a home health* ~~an~~ agency without a license, but ~~no~~ such inspection of any *such business may not* ~~agency shall~~ be made without the permission of the owner or person in charge ~~thereof~~ unless a warrant is first obtained from a circuit court ~~authorizing same~~. Any application for *a license issued under this part or for license renewal constitutes* ~~an agency license or renewal thereof made pursuant to this act shall constitute~~ permission for *an appropriate* ~~any~~ inspection ~~of the agency for which the license is sought, in order~~ to *verify* ~~facilitate verification of~~ the information submitted on or in connection with the application.

Section 9. Section 400.487, Florida Statutes, is amended to read:

400.487 *Patient assessment;* establishment and review of plan of *care; provision of services* ~~treatment~~.—

(1) The home health agency providing care and treatment must make an assessment of the patient's needs within 48 hours after the start of services.

(2)~~(1)~~ *The attending physician for* a ~~plan of care shall be established for each~~ patient receiving care or treatment provided by a licensed nurse or by a physical, occupational, or speech therapist *must establish a plan of care for the patient on behalf of the home health agency that provides services to the patient*~~, by the physician who is responsible for the care of the patient~~. The original plan of treatment *must* ~~shall~~ be signed by the physician and reviewed, *at least every 62 days or more frequently if the patient's illness requires,* by the physician in consultation with *home health* agency personnel *that provide* ~~involved in providing~~ services to the patient~~, at such intervals as the severity of the patient's illness requires, but in any instance, at least every 2 months~~.

(2) *Each patient has the right to be informed of and to participate in the planning of his care.* Each patient *must* ~~shall~~ be provided, upon request ~~and prior notification of the physician responsible for the care of the patient~~, a copy of the plan of *care* ~~treatment~~ established and maintained for that patient by the home health agency.

(3) Home health services that are provided to a patient *must* ~~shall~~ be evaluated in the patient's home by a physician licensed under chapter 458, ~~or~~ chapter 459, *or chapter 460* or by a registered nurse licensed under chapter 464 as frequently as necessary to assure safe and adequate care, but not less frequently than once every *62* ~~90~~ days.

(4) A home health agency must provide at least one home health service to patients for whom it has agreed to provide care. Services provided by others under contractual arrangements to a home health agency's patients must be monitored and controlled by the home health agency.

(5) The services provided by a home health agency, directly or under contract, must be supervised and coordinated in accordance with the plan of care.

Section 10. Section 400.491, Florida Statutes, is amended to read:

400.491 Clinical records.—The home health agency *must* ~~shall~~ maintain for each patient a clinical record *that* ~~which~~ includes the services the *home health* agency provides directly and those provided through arrangement with another *health care provider, except for those services provided by persons referred under s. 400.509* ~~agency~~. Such records *must* ~~shall~~ contain pertinent past and current medical, nursing, social and other therapeutic information, the plan of treatment, and other such information as is necessary for the safe and adequate care of the patient. When home health services are terminated, the record *must* ~~shall~~ show the date and reason for termination. *Such records are considered patient records under s. 400.241, and must be maintained by the home health agency for 5 years following termination of services. If a patient transfers to another home health agency, a copy of his record must be provided to the other home health agency upon request.*

Section 11. Section 400.495, Florida Statutes, is amended to read:

400.495 Notice of toll-free telephone number for central abuse registry.—On or before the first day home health services are provided to a patient, any home health agency *or nurse registry* licensed under this part must inform the patient and his immediate family, if appropriate, of the right to report abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse registry must be provided to patients in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free . . . (phone number) . . .." *The Agency for Health Care Administration shall adopt rules that provide for 90 days' advance notice of a change in the toll-free telephone number and that outline due process procedures, as provided under chapter 120, for home health agency personnel and nurse registry personnel who are reported to the central abuse registry.* Home health agencies *and nurse registries* shall establish appropriate policies and procedures for providing such notice to patients.

Section 12. Section 400.497, Florida Statutes, is amended to read:

400.497 Rules establishing minimum standards~~; screening of home health agency personnel~~.—

~~(1) Pursuant to the intent of the Legislature to provide safe and adequate home health services,~~ The *Agency for Health Care Administration* ~~department~~ shall adopt, publish, and enforce rules to implement ~~the provisions of~~ this *part, including, as applicable, ss. 400.506 and 400.509,* ~~act~~ which *must* ~~shall~~ *provide* ~~include~~ reasonable and fair minimum standards *relating* ~~in relation~~ to:

(1)~~(a)~~ Scope of *home health* services to be provided.

(2)~~(b)~~ The qualifications and minimum training requirements of all *home health* agency personnel.

(3)~~(c)~~ Procedures for maintaining a record of the employment history of all home health agency personnel ~~employed by or under contract with a home health agency~~. *A home health agency must* ~~Agencies shall~~ require *its personnel* ~~persons employed or under contract~~ to submit an employment history to the *home health* agency, and *it must* ~~agencies shall~~ verify the employment history unless through diligent efforts such verification is not possible. *The Agency for Health Care Administration shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made. The administrator of a home health agency must review the employment history and references of home health agency personnel and applicants for employment. The Agency for Health Care Administration must review the employment history and references of each administrator of a home health agency.* There *is* ~~shall be~~ no monetary liability on the part of, and no cause of action for damages *arises* ~~shall arise~~ against, a former employer of a prospective employee of or prospective independent contractor with a licensed home health agency who reasonably and in good faith communicates his honest opinions about the former employee's job performance. ~~The provisions of~~ This subsection *does* ~~do~~ not affect the official immunity of an officer or employee of a public corporation.

(4) Licensure application and renewal.

(5) The administration of the home health agency.

(6)~~(d)~~ Procedures for administering drugs and biologicals.

(7)~~(e)~~ *Procedures for maintaining patient records* ~~The desirability and practicality of accepting patients for services.~~

(8)~~(f)~~ Ensuring that the *home health* services provided by a home health agency are in accordance with the plan of treatment established for each patient.

(9)~~(g)~~ Geographic service areas ~~as defined by county boundaries for non-Medicare agencies and Department of Health and Rehabilitative Services district boundaries for Medicare certified agencies.~~

(10) Standards for contractual arrangements for the provision of home health services by providers not employed by the home health agency providing for the patient's care and treatment.

~~(2) The department shall establish minimum standards as to good moral character, based on screening, for home health agency personnel. Effective October 1, 1989, all such standards shall apply to nonlicensed home health agency personnel and licensed home health agency personnel whose licensing requirements do not include, at a minimum, records checks of the department's central abuse registry under chapter 415 and statewide criminal records correspondence checks through the Department of Law Enforcement.~~

~~(a) Such minimum standards for screening shall ensure that nonlicensed or applicable licensed home health agency personnel who, at any time, enter the home of a patient in the capacity of their employment have not been found guilty, regardless of adjudication, of any of the following offenses:~~

~~1. A forcible felony as defined in chapter 776.~~

~~2. A violation of chapter 812, relating to theft, robbery, and related crimes.~~

~~3. A violation of chapter 817, relating to fraudulent practices.~~

~~4. A felony violation of chapter 893, relating to drug abuse prevention and control.~~

~~5. A violation of chapter 800, relating to lewdness and indecent exposure.~~

~~6. A violation of chapter 784, relating to assault, battery, and culpable negligence.~~

~~7. A violation of chapter 827, relating to child abuse.~~

~~8. A violation of chapter 415, relating to protection from abuse, neglect, and exploitation.~~

~~(b) Standards for screening shall also ensure that the person:~~

~~1. Has not been judicially determined to have committed abuse or neglect against a child as defined in s. 39.01(2) and (37);~~

~~2. Does not have a confirmed report of abuse, neglect, or exploitation as defined in s. 415.102(5) or abuse or neglect as defined in s. 415.503(6) which has been uncontested or upheld under the procedures of s. 415.103 or s. 415.504; and~~

~~3. Has not committed an act which constitutes domestic violence as defined in s. 741.30.~~

~~(c)1. For the following, the department may grant to any person an exemption from disqualification from employment under this section:~~

~~a. A felony, other than a specified felony, prohibited under any of the foregoing chapters cited in paragraph (a) committed more than 3 years previously. For the purposes of this sub-subparagraph, "specified felony" means any felony in the chapters enumerated in subparagraphs (a)1., 4., 5., 7., and 8.;~~

~~b. Misdemeanors prohibited or referenced under any of the foregoing Florida Statutes cited in this subsection;~~

~~c. Offenses which were a felony when committed but are now a misdemeanor;~~

~~d. Judicial determinations of abuse or neglect under chapter 39;~~

~~e. Confirmed reports of abuse, neglect, or exploitation under chapter 415 which have been uncontested or have been upheld under the procedures provided in s. 415.103 or s. 415.504; or~~

~~f. Commissions of domestic violence.~~

~~2. In order to grant an exemption to a person, the department must have clear and convincing evidence to support a reasonable belief that the person is of good character so as to justify an exemption. The person shall bear the burden of setting forth sufficient evidence of rehabilitation, including, but not limited to, the circumstances surrounding the incident, the time period that has elapsed since the incident, the nature of the harm occasioned to the victim, and the history of the person since the incident or such other circumstances that shall by the aforementioned standards indicate that the person will not present a danger to the safety or well being of patients. The decision of the department regarding an exemption may be contested through a hearing under chapter 120.~~

~~(d) The disqualification from employment provided in paragraph (a) shall not be removed from any person found guilty of, regardless of adjudication, any felony covered by paragraph (a) solely by reason of any pardon, executive clemency, or restoration of civil rights.~~

~~(e) The department shall ensure that nonlicensed and applicable licensed home health agency personnel meet the minimum standards for good moral character as contained in this section.~~

~~1. As a condition for relicensure pursuant to s. 400.477, each home health agency must submit to the department a list of nonlicensed and applicable licensed home health agency personnel for whom a written assurance of compliance was provided by the department. The list shall identify those personnel who were employed by the agency prior to October 1, 1989, those personnel who have worked continuously for the agency since being screened and approved, and those personnel who have recently begun working for the agency and are awaiting the results of the required screening and the date of the submission of those names for screening. The department shall by rule determine the frequency with which home health agencies must submit such lists of personnel and the frequency of requests to the Department of Law Enforcement to run statewide criminal records correspondence checks for such nonlicensed and applicable licensed home health agency personnel except for those personnel awaiting the results of initial screening for employment by the agency. The department shall review the records of the agency personnel with respect to the crimes contained in this section and shall notify the agency of its findings. When disposition information is missing on a criminal record, it shall be the responsibility of the person being screened, upon request of the department, to obtain and supply within 30 days the missing disposition information to the department. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information shall result in automatic disqualification.~~

~~2. The administrator of each home health agency must sign an affidavit annually, under penalty of perjury, stating that all new nonlicensed and applicable licensed agency personnel hired on or after October 1, 1989, have been screened and that the agency's remaining personnel have worked for the agency continuously since before October 1, 1989.~~

~~(f) As a prerequisite to operating a new home health agency:~~

~~1. The administrator must submit to the department his name and any other information necessary to conduct a complete screening according to this section;~~

~~2. The department shall submit the information to the Department of Law Enforcement for state processing; and~~

~~3. The department shall review the record of the administrator with respect to the crimes contained in this section and shall notify the owner of its findings. If disposition information is missing on a criminal record, it is the responsibility of the administrator, upon request of the department, to obtain and supply within 30 days the missing disposition information to the department. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information shall result in automatic disqualification.~~

~~(g) The home health agency must automatically terminate the employment of any of its nonlicensed or applicable licensed personnel who are found to be in noncompliance with the minimum standards for good moral character as contained in this section.~~

~~(h) In compliance with the intent of this subsection, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, a licensed home health agency that, upon notice by the department of a confirmed report of abuse, neglect, or exploitation pursuant to subparagraph (b)1., terminates the employee against whom the report was issued, whether or not the employee has filed for an exemption with the department pursuant to sub-subparagraph (c)1.c. and whether or not the time for filing has expired.~~

~~(i) On or after October 1, 1989, nonlicensed and applicable licensed home health agency personnel must, within 5 working days after starting to work at a home health agency, submit to the agency for submission, within 48 hours, to the department a complete set of information necessary to conduct a screening according to the provisions of this section. In addition, new nonlicensed or applicable licensed personnel must sign an affidavit stating whether he meets the minimum standards for good moral character as contained in this section. The department shall submit the information to the Department of Law Enforcement for state processing. The department shall review the record of the person being screened with respect to the crimes contained in this section and shall notify the agency of its findings. If disposition information is missing on a criminal record, it is the responsibility of the person being screened, upon request of the department, to obtain and supply within 30 days the missing disposition information to the department. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information shall result in automatic disqualification.~~

~~1. Under the penalty of perjury, such nonlicensed and applicable licensed home health agency personnel shall attest to compliance with the minimum standards for good moral character as contained in this section.~~

~~2. Nonlicensed and applicable licensed home health agency personnel hired on or after October 1, 1989, shall be placed on probationary status pending a determination of compliance with minimum standards for good moral character.~~

~~3. The department, upon request of an agency, shall provide written assurance of compliance with this section for new personnel who have been screened for the agency at which they previously worked. However, if the person has been unemployed for more than 6 months, screening shall be required.~~

~~(j) The costs of processing the statewide correspondence criminal records checks shall be borne by the home health agency or the personnel being screened, at the discretion of the agency administrator.~~

~~(k) If the department has reasonable cause to believe that grounds for denial or termination of employment exist, it must notify, in writing, the agency personnel affected, stating the specific record which indicates noncompliance with the standards in this section. The procedures established for hearing under chapter 120 shall be available to the agency and the agency personnel affected in order to present evidence relating either to the accuracy of the basis of exclusion or to the denial of an exemption from disqualification.~~

~~(l) The department or home health agencies may not use the criminal records, juvenile records, or abuse registry information of a person for any purpose other than determining if that person meets minimum standards of good moral character for home health agency personnel and administrators. The criminal records, juvenile records, or abuse registry information obtained by the department or a home health agency for such purpose are exempt from s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.~~

~~(m) It is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:~~

~~1. Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for voluntary or paid employment a material fact used in making a determination as to such person's qualifications to be an administrator or employee of a home health agency;~~

~~2. Operate or attempt to operate a home health agency with personnel who are in noncompliance with the minimum standards for good moral character as contained in this section; or~~

~~3. Use information from the criminal records or central abuse registry obtained under this section for any purpose other than screening that person for employment as specified in this section or release such information to any other person for any purpose other than screening for employment as specified in this section.~~

~~4. It is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, for any person willfully, knowingly, or intentionally to use information from the juvenile records of a person obtained under this section for any purpose other than screening for employment as specified in this section or to release information from such records to any other person for any purpose other than screening for employment as specified in this section.~~

Section 13. Section 400.506, Florida Statutes, is amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(1) A nurse registry is exempt from the licensing requirements of a home health agency, but must be licensed as a nurse registry ~~pursuant to this section~~.

(2) Application for license *must* ~~shall~~ be made to the *Agency for Health Care Administration* ~~department~~ on forms furnished by it and *must* ~~shall~~ be accompanied by the appropriate licensure fee, as established by rule and not to exceed the cost of *regulation under* ~~properly carrying out the provisions of~~ this part. The licensure fee *for nurse registries may not exceed $1,000 and must* ~~shall~~ be *deposited in the Health Care Trust Fund* ~~limited to $25 for those nurse registries which handle only licensed nurses and assess fixed membership dues from independent contractors that are not based on the number, length, and type of referral. The applicant must file with the application satisfactory proof of compliance with this section and any rules adopted under this section, evidence that the registry operates as an agent and represents only independent contractors, and proof of financial ability to operate and conduct the nurse registry in accordance with the requirements of this section.~~

(3) The *Agency for Health Care Administration* ~~department~~ may deny, revoke, or suspend a license or impose an administrative fine in the manner provided in chapter 120 against a nurse registry that:

(a) Fails to comply with this section or *applicable* rules ~~adopted pursuant to this section~~.

(b) *Commits* ~~Causes~~ an intentional, *reckless,* or negligent act *that* ~~which~~ materially affects the health or safety of a person receiving services.

(4) A license issued for the operation of a nurse registry, unless sooner suspended or revoked, *expires* ~~shall expire~~ 1 year after *its* ~~the~~ date of issuance. Sixty days *before* ~~prior to~~ the expiration date, an application for renewal must be submitted to the *Agency for Health Care Administration* ~~department~~ on forms furnished by *it. The Agency for Health Care Administration shall renew the license* ~~the department, and licenses shall be renewed~~ if the applicant has ~~first~~ met the requirements *of* ~~established under~~ this section and *applicable* ~~all~~ rules ~~adopted under this section~~. A nurse registry against which a revocation or suspension proceeding is pending at the time of license renewal may be issued a conditional license effective until final disposition by the *Agency for Health Care*

Administration ~~department~~ of such proceedings. If judicial relief is sought from the final disposition, the court having jurisdiction may issue a conditional license for the duration of the judicial proceeding.

(5) The *Agency for Health Care Administration* ~~department~~ may institute injunctive proceedings *under s. 400.515* ~~in a court of competent jurisdiction when violation of this section or any rules adopted under this section constitutes an emergency affecting the immediate health and safety of a person contracting with an applicant of a nurse registry~~.

(6) *A* ~~Any~~ person~~, partnership, agency, firm, organization, corporation, or business entity~~ that offers or advertises to the public~~, in any way by any medium whatever,~~ that it provides any service for which licensure is required under this section must include in such *advertisement* ~~advertising~~ the license number issued *to it* by the *Agency for Health Care Administration* ~~department~~.

(7) It is unlawful for *a* ~~any~~ person~~, partnership, agency, firm, organization, corporation, or business entity~~ to offer or advertise to the public~~, in any way by any medium whatever,~~ services as defined by rule ~~pursuant to this section~~ without obtaining a valid license from the *Agency for Health Care Administration* ~~department~~. It is unlawful for any holder of a license to advertise or hold out to the public that he holds a license for other than that for which he actually holds a license. A person who violates this subsection *is subject to injunctive proceedings under s. 400.515* ~~commits a misdemeanor of the second degree, punishable as provided in s. 775.083. Each day of continuing violation constitutes a separate offense~~.

(8) Any duly authorized officer or employee of the *Agency for Health Care Administration* ~~department~~ may make such inspections and investigations as are necessary ~~in order~~ to respond to complaints or to determine the state of compliance with this section and *applicable* ~~the~~ rules ~~adopted pursuant to this section~~.

(a) If, in responding to a complaint, an agent or employee of the *Agency for Health Care Administration* ~~department~~ has reason to believe that a crime has been committed, he shall notify the appropriate law enforcement agency.

(b) If, in responding to a complaint, an agent or employee of the *Agency for Health Care Administration* ~~department~~ has reason to believe that abuse, neglect, or exploitation has occurred, according to the definitions in *chapter 415* ~~s. 415.102~~, he shall file a report under *chapter 415* ~~the provisions of s. 415.103~~.

(9)*(a)* A nurse registry may ~~not~~ refer for contract in private residences ~~any persons other than~~ registered nurses and licensed practical nurses registered and licensed *under* ~~pursuant to~~ chapter 464, *certified nursing assistants certified under s. 400.211,* and *sitters, companions, or homemakers* ~~those persons enumerated in s. 400.478(1)~~ for the purposes of providing those services authorized *under s. 400.509(1)* ~~pursuant to s. 400.478(1)~~.

(b) A certified nursing assistant may be referred for a contract to provide care to a patient in his home only if that patient is under a physician's care. A certified nursing assistant referred for contract in a private residence shall be limited to assisting a patient with bathing, dressing, toileting, grooming, eating, physical transfer, and those normal daily routines the patient could perform for himself were he physically capable. A certified nursing assistant may not provide medical or other health care services that require specialized training and that may be performed only by licensed health care professionals. The nurse registry shall obtain the name and address of the attending physician and send written notification to the physician within 48 hours after a contract is concluded that a certified nursing assistant will be providing care for that patient.

(c) A registered nurse shall make monthly visits to the patient's home to assess the patient's condition and quality of care being provided by the certified nursing assistant. Any condition which in the professional judgment of the nurse requires further medical attention shall be reported to the attending physician and the nurse registry. The assessment shall become a part of the patient's file with the nurse registry and may be reviewed by the Agency for Health Care Administration during their survey procedure.

(d) ~~Furthermore,~~ In order to refer for contract in private residences *a certified nursing assistant or* any person *specified* ~~enumerated~~ in *s. 400.509(1)* ~~s. 400.478(1)~~, the nurse registry and such person registered with the nurse registry ~~on or after October 1, 1990,~~ must also be registered *under s. 400.509* ~~pursuant to s. 400.478~~. Any person registered as an independent contractor with a nurse registry for the purpose of providing services authorized *under s. 400.509(1)* ~~pursuant to s. 400.478(1)~~ on or before October 1, 1990, is exempt from registration under *s. 400.509* ~~s. 400.478~~ so long as such person remains continuously registered with that nurse registry.

(10) A person who is referred by a nurse registry for contract in private residences and who is not a nurse licensed under chapter 464 may perform only those services or care to clients that the person has been certified to perform or trained to perform as required by law or rules of the Agency for Health Care Administration or the Department of Professional Regulation. Providing services beyond the scope authorized under this subsection constitutes the unauthorized practice of medicine or a violation of the Nurse Practice Act and is punishable as provided under chapter 464, chapter 458, or chapter 459.

(11)~~(10)~~ Each nurse registry *must* ~~shall~~ require every applicant for contract to complete an application form providing the following information:

(a) The name, address, date of birth, and social security number of the applicant.

(b) The educational background and employment history of the applicant.

(c) The number and date of the applicable license or certification.

(d) When appropriate, information concerning the renewal of the applicable license, registration, or certification.

(12)~~(11)~~ Each nurse registry *must* ~~shall~~ comply with the procedures set forth in *s. 400.497(3)* ~~s. 400.497(1)(c)~~ for maintaining records of the employment history of all persons referred for contract and *is* ~~shall be~~ subject to the standards and conditions set forth in *s. 400.512* ~~s. 400.497(2)~~. However, an initial screening may not be required for persons who have been continuously registered with the nurse registry since September 30, 1990.

(13)~~(12)~~ The nurse registry *must* ~~shall~~ maintain the application on file, and that file *must* ~~shall~~ be open to the inspection of the *Agency for Health Care Administration* ~~department~~. The nurse registry *must* ~~shall~~ maintain on file the name and address of the *client* ~~person~~ to whom the *nurse or other nurse registry personnel* ~~applicant~~ is sent for contract and the amount of the fee received by the nurse registry. A nurse registry *must* ~~shall~~ maintain the *file that includes the* application and other applicable documentation for ~~a period of~~ 3 years after the date of the last *file* entry *of client-related information* ~~thereon~~.

(14)~~(13)~~ All persons referred for contract in private residences by a nurse registry *must* ~~shall~~ comply with the following requirements for a plan of treatment:

(a) When, in accordance with the privileges and restrictions imposed upon a nurse *under* ~~pursuant to~~ chapter 464, the delivery of care to a patient is under the direction or supervision of a physician or when a physician is responsible for the medical care of the patient, a medical plan of treatment must be established for each patient receiving care or treatment provided by a licensed nurse in the home. The original medical plan of treatment must be *timely* signed by the physician ~~in a timely manner~~ and reviewed by *him* ~~the physician~~ in consultation with the licensed nurse at least every 2 months. Any additional order or change in orders must be obtained from the physician and reduced to writing and *timely* signed by the physician ~~in a timely manner~~. The delivery of care *under* ~~pursuant to~~ a medical plan of treatment must be substantiated by the appropriate nursing notes or documentation made by the nurse in compliance with nursing practices established under chapter 464.

(b) Whenever a medical plan of treatment is established for a patient, the initial medical plan of treatment, any amendment to the plan, additional order or change in orders, and copy of nursing notes must be filed in the office of the nurse registry.

(15)~~(14)~~ The nurse registry *must* ~~shall~~ comply with the notice requirements of s. 400.495, relating to abuse reporting.

(16) The Agency for Health Care Administration shall adopt rules to implement this section.

Section 14. Section 400.512, Florida Statutes, is created to read:

400.512 Screening of home health agency personnel, nurse registry personnel, and sitters, companions, and homemakers.—The Agency for Health Care Administration shall establish minimum standards of good moral character for home health agency personnel, persons referred for employment by nurse registries, and persons employed by sitter, companion, or homemaker services registered under s. 400.509.

(1) The minimum standards must ensure that all persons who, at any time, enter the home of a patient in the capacity of their employment have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

(a) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(b) Section 782.04, relating to murder.

(c) Section 782.07, relating to manslaughter.

(d) Section 782.071, relating to vehicular homicide.

(e) Section 782.09, relating to killing of an unborn child by injury to the mother.

(f) Section 784.011, relating to assault, if the victim of the offense was a minor.

(g) Section 784.021, relating to aggravated assault.

(h) Section 784.03, relating to battery, if the victim of the offense was a minor.

(i) Section 784.045, relating to aggravated battery.

(j) Section 787.01, relating to kidnapping.

(k) Section 787.02, relating to false imprisonment.

(l) Section 794.011, relating to sexual battery.

(m) Section 794.041, relating to prohibited acts of persons in familial or custodial authority.

(n) Chapter 796, relating to prostitution.

(o) Section 798.02, relating to lewd and lascivious behavior.

(p) Chapter 800, relating to lewdness and indecent exposure.

(q) Section 806.01, relating to arson.

(r) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(s) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(t) Section 826.04, relating to incest.

(u) Section 827.03, relating to aggravated child abuse.

(v) Section 827.04, relating to child abuse.

(w) Section 827.05, relating to negligent treatment of children.

(x) Section 827.071, relating to sexual performance by a child.

(y) Chapter 847, relating to obscene literature.

(z) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(2) Standards must also ensure that the person:

(a) Has not been judicially determined to have committed abuse or neglect against a child as defined in s. 39.01(2) and (37).

(b) Does not have a confirmed report of abuse, neglect, or exploitation as defined in s. 415.102(5), or abuse or neglect as defined in s. 415.503(6), which has been uncontested or upheld under s. 415.103 or s. 415.504.

(c) Has not committed an act that constitutes domestic violence as defined in s. 741.30.

(3)(a) The Agency for Health Care Administration may grant to any person an exemption from disqualification from employment under this section for:

1. A felony prohibited under any of the statutes cited in subsection (1) or under similar statutes of other jurisdictions;

2. Misdemeanors prohibited or referenced under any of the statutes cited in this section;

3. Offenses that were felonies when committed;

4. Judicial determinations of abuse or neglect under chapter 39;

5. Confirmed reports of abuse, neglect, or exploitation under chapter 415 that have been uncontested or have been upheld under the procedures provided in s. 415.103 or s. 415.504; or

6. Commissions of domestic violence.

(b) To exempt a person, the Agency for Health Care Administration must have clear and convincing evidence to support a reasonable belief that the person is of good moral character, has been rehabilitated, and poses no danger to the health or safety of patients. The person has the burden of setting forth sufficient evidence of rehabilitation, including, but not limited to, the circumstances surrounding the incident, the time period that has elapsed since the incident, the nature of the harm occasioned to the victim, and the history of the person since the incident or such other circumstances that under applicable rules indicates that the person will not present a danger to the safety or well-being of patients. The decision of the Agency for Health Care Administration regarding an exemption may be contested through a hearing under chapter 120.

(4) The disqualification from employment provided in subsection (1) may not be removed from any person found guilty of, regardless of adjudication, any felony covered by subsection (1) solely by reason of any pardon, executive clemency, or restoration of civil rights.

(5)(a) A person employed by home health agencies or by sitter, companion, or homemaker services registered under s. 400.509 shall, within 5 working days after starting to work, submit to the home health agency or registrant, a complete set of information necessary to conduct a screening under this section. The person must sign an affidavit stating whether the person meets the minimum standards for good moral character under this section. The home health agency or registrant shall submit the information to the Department of Law Enforcement and to the department's central abuse registry and tracking system for processing. If disposition information is missing on a criminal record, it is the responsibility of the person being screened to obtain and supply within 30 days the missing information. Failure to supply the missing information or to show reasonable efforts to obtain such information will result in automatic disqualification for employment.

1. Home health agency personnel or persons employed by sitter, companion, or homemakers services registered under s. 400.509, hired on or after October 1, 1989, must be placed on probationary status pending a determination of compliance with minimum standards for good moral character.

2. The home health agency or registrant must automatically terminate the employment of any of its personnel found to be in noncompliance with the minimum standards for good moral character under this section unless such person has obtained an exemption under subsection (3).

3. The administrator of each home health agency or sitter, companion, or homemaker service registered under s. 400.509 must sign an affidavit annually, under penalty of perjury, stating that all personnel hired on or after October 1, 1989, have been screened and that its remaining personnel have worked for the home health agency or registrant continuously since before October 1, 1989.

(b) Persons to be referred for employment as independent contractors by nurse registries, including persons seeking employment as sitters, companions, or homemakers, must submit to the nurse registry a complete set of information necessary to conduct a screening under this section. Each such person must sign an affidavit stating whether he meets the minimum standards for good moral character under this section. The nurse registry shall submit the information to the Department of Law

Enforcement and to the department's central abuse registry and tracking system for processing. If disposition information is missing on a criminal record, it is the responsibility of the person being screened to obtain and supply within 30 days the missing information. Failure to supply the missing information or to show reasonable efforts to obtain such information will result in automatic disqualification for employment. An initial screening shall not be required for a person who has been continuously registered with the nurse registry since September 30, 1990.

1. The nurse registry may not refer for employment any person found not in compliance with the minimum standards for good moral character as contained in this section unless such person has obtained an exemption under subsection (3).

2. The administrator of a nurse registry must sign an affidavit annually, under penlty of perjury, stating that all persons referred for employment, except those persons who have been continuously registered with the nurse registry since September 30, 1990, have been screened.

(6) As a prerequisite to operating as a home health agency, or sitter, companion, or homemaker service under s. 400.509, the administrator must submit to the Agency for Health Care Administration his name and any other information necessary to conduct a complete screening according to this section. The Agency for Health Care Administration shall submit the information to the Department of Law Enforcement and the department's abuse registry and tracking system for state processing. The Agency for Health Care Administration shall review the record of the administrator with respect to the offenses specified in this section and shall notify the owner of its findings. If disposition information is missing on a criminal record, the administrator, upon request of the Agency for Health Care Administration, must obtain and supply within 30 days the missing disposition information to the Agency for Health Care Administration. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information will result in automatic disqualification.

(7) Proof of compliance with the screening requirements of ss. 39.076, 110.1127, 393.0655, 394.457, 396.0425, 397.0715, 402.305, 402.313, or 409.175 or this part shall be accepted in lieu of the requirements of this section provided that such person has been continuously employed in the same type of occupation for which he is seeking employment with the nurse registry without a breach in service that exceeds 180 days. Proof of compliance with the screening requirements of this section shall be provided upon request to the person screened by the home health agencies, nurse registries, or sitter, companion, or homemaker services registered under s. 400.509.

(8) There is no monetary liability on the part of, and no cause of action for damages arises against, a licensed home health agency, or sitter, companion, or homemaker service registered under s. 400.509, that, upon notice of a confirmed report of abuse, neglect, or exploitation under paragraph (2)(b), terminates the employee against whom the report was issued, whether or not the employee has filed for an exemption with the Agency for Health Care Administration under subparagraph (3)(a)5. and whether or not the time for filing has expired.

(9) The costs of processing the statewide correspondence criminal records checks and the search of the department's central abuse registry and tracking system must be borne by the home health agency, the nurse registry, or sitter, companion, or homemaker service registered under s. 400.509, or by the person being screened, at the discretion of the home health agency, nurse registry, or s. 400 509 registrant.

(10) The Agency for Health Care Administration, the home health agency, nurse registry, or sitter, companion, or homemaker service registered under s. 400.509, may not use the criminal records, juvenile records, or central abuse registry information of a person for any purpose other than determining whether that person meets minimum standards of good moral character for home health agency personnel. The criminal records, juvenile records, or central abuse registry information obtained by the Agency for Health Care Administration, home health agency, nurse registry, or sitter, companion, or homemaker service for such purpose are exempt from s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(11)(a) It is a misdemeanor of the first degree, punishable under s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:

1. Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for voluntary or paid employment a material fact used in making a determination as to such person's qualifications to be an employee under this section;

2. Operate or attempt to operate an entity licensed or registered under this part with persons who do not meet the minimum standards for good moral character as contained in this section; or

3. Use information from the criminal records or central abuse registry obtained under this section for any purpose other than screening that person for employment as specified in this section or release such information to any other person for any purpose other than screening for employment under this section.

(b) It is a felony of the third degree, punishable under s. 775.082, s. 775.083, or s. 775.084, for any person willfully, knowingly, or intentionally to use information from the juvenile records of a person obtained under this section for any purpose other than screening for employment under this section.

Section 15. Paragraph (a) of subsection (5) of section 415.107, Florida Statutes, 1992 Supplement, is amended to read:

415.107 Confidentiality of reports and records in cases of abuse, neglect, or exploitation of aged persons or disabled adults.—

(5)(a) The department, upon receipt of the applicable fee, shall search its central abuse registry and tracking system records pursuant to the requirements of ss. 39.076, 110.1127, 393.0655, 394.457, 396.0425, 397.0715, *400.506, 400.509, 400.512* ~~400.478, 400.497~~, 402.305(1), 402.3055, 402.313, 409.175, *and* 409.176~~, and 464.008~~ for the existence of a confirmed report made on the personnel as defined in the foregoing provisions. ~~The search shall also include indicated reports prior to July 1, 1987. Reports prior to 1978 shall not be included. If the search reveals an indicated or closed report prior to July 1, 1987, the department shall review the report to determine whether the indicated or closed report shall be classified as "proposed confirmed" according to the definitions in s. 415.102. If the report is classified as "proposed confirmed," the department shall notify the individual according to the provisions in s. 415.103(3)(d)1.b.~~ The department shall report the existence of any confirmed report and advise the authorized licensing agency, applicant for licensure, or other authorized agency or person of the results of the search and the date of the report. Prior to a search being conducted, the department or its designee shall notify such person that an inquiry will be made. The department shall notify each person for whom a search is conducted of the results of the search upon request.

Section 16. Subsection (4) of section 415.51, Florida Statutes, 1992 Supplement, is amended to read:

415.51 Confidentiality of reports and records in cases of child abuse or neglect.—

(4) The department shall, upon receipt of the applicable fee, search its central abuse registry and tracking system records pursuant to the requirements of ss. 39.076, 110.1127, 242.335, 393.0655, 394 457, 396.0425, 397.0715, *400.506, 400.509, 400.512* ~~400.478, 400.497~~, 402.305(1), 402.3055, 402.313, 409.175, *and* 409.176~~, and 464.008~~ for the existence of a confirmed report made on the personnel as defined in the foregoing provisions. ~~The search shall also include indicated reports prior to July 1, 1987. Reports prior to 1978 shall not be included. If the search reveals an indicated or closed report prior to July 1, 1987, the department shall review the report to determine whether the indicated report shall be classified as "proposed confirmed" according to the definitions in s. 415.503. If the report is classified as "proposed confirmed," the department shall notify the individual according to the provisions of s. 415.504(4)(d)1.b.~~ The department shall report the existence of any confirmed report of abuse and advise the authorized licensing agency, applicant for license, or other authorized agency or person of the results of the search and the date of the report. In the case of judicial determination of abuse, the department shall report the procedure for inspection of court records as set forth in s. 39.411(3). The department may not release any information on unfounded reports. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14. Prior to a search being conducted, the department or its designee shall notify such person that an inquiry will be made. The department shall notify each person for whom a search is conducted of the results of the search upon request.

Section 17. Section 400.518, Florida Statutes, is created to read:

400.518 Prohibited referrals to home health agencies.—

(1) A physician licensed under chapter 458 or chapter 459 must comply with s. 455.236.

(2) A hospital or an ambulatory surgical center that has a financial interest in a home health agency is prohibited from requiring any physician on its staff to refer a patient to the home health agency.

(3)(a) A violation of this section is punishable by an administrative fine not to exceed $15,000. The proceeds of such fines must be deposited into the Health Care Trust Fund.

(b) A physician who violates this section is subject to disciplinary action by the appropriate board under s. 458.331(2) or s. 459.015(2). A hospital or ambulatory surgical center that violates this section is subject to the rules adopted by the agency under s. 395.0185(2).

Section 18. Effective July 1, 1995, subsection (2) of section 408.034, Florida Statutes, 1992 Supplement, is amended to read:

408.034 Duties and responsibilities of department; rules.—

(2) In the exercise of its authority to issue licenses to health care facilities and health service providers, as provided under chapters 393 *and*, ~~,~~ 395~~,~~ and *parts I and V of chapter* 400, ~~and to hospices,~~ the department shall not issue a license to any health care facility, health service provider, hospice, or part of a health care facility which fails to receive a certificate of need for the licensed facility or service.

Section 19. Effective July 1, 1995, subsections (1) and (3) of section 408.036, Florida Statutes, 1992 Supplement, are amended to read:

408.036 Projects subject to review.—

(1) APPLICABILITY.—Unless exempt *under* ~~pursuant to~~ subsection (3), all health-care-related projects, as described in paragraphs (a)-(n), are subject to review and must file an application for a certificate of need with the department. The department is exclusively responsible for determining whether a health-care-related project is subject to review under *ss. 408.031-408.045* ~~ss. 381.701-381.715~~.

(a) The addition of beds by new construction or alteration.

(b) The new construction or establishment of additional health care facilities.

(c) A capital expenditure of $1 million or more by or on behalf of a health care facility or hospice for a purpose directly related to the furnishing of health services at such facility; provided that a certificate of need *is* ~~shall~~ not ~~be~~ required for an expenditure to provide an outpatient health service, or to acquire equipment or refinance debt, for which a certificate of need is not otherwise required *under* ~~pursuant to~~ this subsection. The department shall, by rule, adjust the capital expenditure threshold annually using an appropriate inflation index.

(d) The conversion from one type of health care facility to another, including the conversion from one level of care to another, in a skilled or intermediate nursing facility, if *the* ~~such~~ conversion effects a change in the level of care of 10 beds or 10 percent of total bed capacity of *the* ~~such~~ skilled or intermediate nursing facility within a 2-year period. If *the* ~~such~~ nursing facility is certified for both skilled and intermediate nursing care, the provisions of this paragraph do not apply.

(e) Any change in licensed bed capacity.

(f) The establishment of a ~~home health agency or~~ hospice, or the direct provision of such services by a health care facility or health maintenance organization for those other than the subscribers of the health maintenance organization.

(g) An acquisition by or on behalf of a health care facility or health maintenance organization, by any means, which acquisition would have required review if the acquisition had been by purchase, including an acquisition at less than fair market value if the fair market value is greater than the capital expenditure threshold.

(h) The establishment of inpatient institutional health services by a health care facility, or a substantial change in such services, or the obligation of capital expenditures for the offering of, or a substantial change in, any such services which entails a capital expenditure in any amount, or an annual operating cost of $500,000 or more. The department shall, by rule, adjust the annual operating cost threshold annually using an appropriate inflation index.

(i) The acquisition by any means of an existing health care facility by any person, unless *the* ~~such~~ person provides the department with at least 30 days' written notice of the proposed acquisition, which notice is to include the services to be offered and the bed capacity of the facility, and unless the department does not determine, within 30 days *after* ~~of~~ receipt of such *notice* ~~letter of intent~~, that the services to be provided and the bed capacity of the facility will be changed.

(j) The acquisition, by any means, of major medical equipment by a health maintenance organization or health care facility to the extent that the health maintenance organization or health care facility is not exempt *under* ~~pursuant to~~ s. 381.713(1).

(k) An increase in the cost of a project for which a certificate of need has been issued when *the* ~~such~~ increase in cost exceeds the limits set forth in paragraph (c), paragraph (h), or *s. 408.032* ~~s. 381.702~~, or 10 percent of the originally approved cost of the project, whichever is less, except that *a* ~~no~~ cost overrun review is *not* necessary when the cost overrun is less than $10,000.

(l) A change in the number of psychiatric or rehabilitation beds.

(m) The establishment of tertiary health services.

(n) A transfer of a certificate of need, in which case an expedited review *must* ~~shall~~ be conducted according to rule and in accordance with *s. 408.042* ~~s. 381.712~~.

(3) EXEMPTIONS.—Upon request, supported by such documentation as the department *requires* ~~may require~~, the department shall grant an exemption from the provisions of subsection (1):

(a) For any expenditure by or on behalf of a health care facility for any part of the physical plant which is not to be directly *used* ~~utilized~~ for providing health services or housing health care providers. This exemption *applies* ~~shall apply~~ to expenditures for parking facilities, meeting rooms, cafeterias, administrative data processing facilities, research buildings, landscaping, and similar projects, but *does* ~~shall~~ not apply to expenditures for office facilities for health care providers.

(b) For any expenditure to eliminate or prevent safety hazards as defined by federal, state, or local codes.

(c) For any expenditure to replace any part of a facility or equipment which is destroyed as a result of fire, civil disturbance, or storm or any other act of God.

(d) For any expenditure to acquire major medical equipment *that* ~~which~~ is a substantially identical replacement for existing equipment being taken out of service.

(e) For the initiation or expansion of obstetric services after July 1, 1988.

(f) For any expenditure to replace or renovate any part of a licensed nursing facility, provided that the number of licensed beds will not increase and, in the case of a replacement facility, the project site is the same as the facility being replaced.

(g) For providing respite care services. *As used in this paragraph, the term* "respite care" means short-term care in a licensed health care facility which is personal or custodial in nature and is provided by reason of chronic illness, physical infirmity, or advanced age for the purpose of temporarily relieving family members of the burden of providing care and attendance in the home. In providing respite care, the health care facility *must be* ~~shall become~~ the primary caregiver. An individual may be admitted to a respite care program in a hospital without regard to inpatient requirements relating to admitting order and attendance of a member of a medical staff.

(h) For hospice ~~or home health~~ services provided by a rural hospital, as defined in s. 395.602, or for swing beds in such rural hospital in a number that does not exceed one-half of its licensed beds.

A request for exemption *under* ~~pursuant to~~ this subsection may be made at any time and is not subject to the batching requirements of this section.

Section 20. The Legislature shall review prior to July 1, 1995, the repeal of the requirement for a home health agency to obtain a certificate of need as a prerequisite to qualifying for Medicare certification.

Section 21. Sections 400.467, 400.477, 400.479, and 400.501, and subsection (10) of section 408.032, Florida Statutes, are repealed.

Section 22. Notwithstanding section 83 of chapter 83-181, Laws of Florida, section 3 of chapter 87-123, Laws of Florida, section 9 of chapter 88-219, Laws of Florida, and section 4 of chapter 90-101, Laws of Florida, sections 400.461, 400.462, 400.464, 400.471, 400.474, 400.478, 400.481, 400.484, 400.487, 400.491, 400.494, 400.495, 400.497, and 400.506, Florida Statutes, as amended, are revived and readopted.

Section 23. Except as otherwise provided in this act, this act shall take effect October 1, 1993.

And the title is amended as follows:

In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to health services; reassigning certain oversight functions from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; amending s. 400.461, F.S.; amending the short title and purpose of the "Home Health Services Act"; deleting the statement that the act does not supersede federal law; amending s. 400.462, F.S.; providing definitions; amending s. 400.464, F.S.; revising provisions for licensure of home health agencies; requiring licensure for related offices located outside the county where the main home health agency office is located; providing exemptions; deleting certain provisions relating to dialysis equipment and supplies; deleting certain obsolete provisions relating to providers of infusion therapy; providing unlawful acts; providing for injunctive proceedings; deleting criminal offense and penalty; amending s. 400.471, F.S.; revising requirements for licensure application; providing a fee; requiring proof of financial ability and providing for demonstration of financial ability; requiring a minimum amount of liability insurance; providing procedures for licensure relating to a change of ownership; requiring display of a license; providing restrictions; providing for a provisional license and a temporary permit when certain legal actions are pending; correcting a cross-reference; amending s. 400.474, F.S.; adding certain grounds for administrative action; transferring, renumbering, and amending s. 400.478, F.S.; amending provisions for a certificate of registration for certain exempt providers; amending provisions for the regulation of registrants; transferring, renumbering, and amending s. 400.481, F.S.; revising provisions authorizing injunctions; amending s. 400.484, F.S.; revising provisions relating to the right of inspection; adding clarifying language; amending s. 400.487, F.S.; amending provisions relating to establishing and reviewing plans of care; providing for patient assessment within 48 hours of the start of services; requiring review of the plan of care and the home evaluation of the delivery of services at least every 62 days; providing requirements relating to the provision of services by a home health agency; deleting the requirement of prior physician notification that a patient has requested a copy of his plan of treatment; amending s. 400.491, F.S.; amending provisions relating to clinical records; requiring retention of patient records for 5 years and providing for copies of records; amending s. 400.495, F.S.; requiring the Agency for Health Care Administration to adopt rules regarding notification to home health agencies and nurse registries of a change in the toll-free telephone number of the central-abuse registry and rules that provide for due process for home health agency personnel and nurse registry personnel who are reported to the registry; amending s. 400.497, F.S.; amending provisions relating to rules establishing minimum standards for home health agency personnel; specifying content of rules; deleting transferred provisions relating to screening such personnel; amending s. 400.506, F.S.; amending provisions for the licensure of nurse registries; raising the maximum nurse registry licensure fee; providing for temporary licenses, rather than conditional licenses, in specified circumstances; providing that certain acts constitute the unauthorized practice of medicine or violate the Nurse Practice Act; providing penalties; conforming cross-references; creating s. 400.512, F.S.; providing for screening of home health personnel, sitters, companions, homemakers, and persons referred by nurse registries; providing procedures; providing penalties; amending ss. 415.107, 415.51, F.S.; conforming statutory references; deleting obsolete language and references; creating s. 400.518, F.S.; requiring certain physicians to comply with s. 455.236, F.S.; prohibiting hospitals and ambulatory surgical centers from encouraging referrals to a home health agency in which they have a financial interest; providing penalties; amending ss. 408.034, 408.036, F.S.; removing home health agencies from certificate-of-need requirements effective July 1, 1995; correcting cross-references; providing for legislative review of the repeal of certain requirements relating to certificate of need prior to July 1, 1995; repealing s. 400.467, F.S., relating to licensure; repealing s. 400.477, F.S., relating to license expiration and renewal; repealing s. 400.479, F.S., relating to the disposition of fees; repealing s. 400.501, F.S., relating to prohibited acts; repealing s. 408.032(10), F.S., relating to defining the term "home health agency" for purposes of certificate-of-need requirements; reviving and readopting ss. 400.461, 400.462, 400.464, 400.471, 400.474, 400.478, 400.481, 400.484, 400.487, 400.491, 400.494, 400.495, 400.497, 400.506, F.S.; providing an effective date.

Senator Gutman moved the following amendment to **Amendment 1** which was adopted:

Amendment 1A (with Title Amendment)—On page 49, between lines 24 and 25, insert:

Section 21. The Agency for Health Care Administration is authorized 3 full-time equivalent positions and $106,524 from the Health Care Trust Fund to implement section 400.512, Florida Statutes.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 53, line 25, after the semicolon (;) insert: providing an appropriation;

Amendment 1 as amended was adopted.

On motion by Senator Gutman, by two-thirds vote **HB 1987** as amended was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

On motions by Senator Gutman, by two-thirds vote **HB 2071** was withdrawn from the Committees on Health Care and Appropriations.

On motion by Senator Gutman—

HB 2071—A bill to be entitled An act relating to health care; amending s. 483.021, F.S.; providing legislative intent; amending s. 483.031, F.S.; revising exemptions; creating s. 483.035, F.S.; providing for licensure and operation of exclusive use clinical laboratories; amending s. 483.041, F.S.; providing definitions; amending s. 483.051, F.S.; providing powers and duties of the Agency for Health Care Administration; providing for biennial licensure; revising requirements for clinical laboratory construction and safety conditions; requiring policy and procedure manuals; requiring standards for patient test management; providing for alternate site testing; amending s. 483.061, F.S.; revising inspection requirements; amending s. 483.091, F.S.; requiring application for new license after change in laboratory ownership; amending s. 483.101, F.S.; providing for applicants to be given copies of rules; creating s. 483.106, F.S.; providing for certificates of exemption; authorizing waived tests; amending s. 483.172, F.S.; revising licensure fees; specifying a biennial certificate-of-exemption fee; amending s. 483.221, F.S.; increasing administrative fine; amending s. 483.809, F.S.; providing for alternate site testing; amending s. 483.823, F.S.; providing for hospital or clinical laboratory training programs for laboratory technicians; authorizing the agency to establish a technical advisory panel; amending s. 483.800, F.S.; expanding legislative purpose and policy provisions; amending s. 483.801, F.S.; deleting exemption for specified laboratories; amending s. 483.811, F.S.; directing the Board of Clinical Laboratory Personnel to approve certain laboratory technician training programs; amending ss. 483.111, 483.181, 483.191, 483.201, 483.23, 483.245, and 483.25, F.S.; conforming language; repealing s. 455.238, F.S., relating to prohibition against markup on charges by health care providers; providing an appropriation; saving pt. I of ch. 483, F.S., from Sunset repeal; providing for future review and repeal; providing an effective date.

—a companion measure, was substituted for **CS for CS for SB 156** and read the second time by title.

Senator Gutman moved the following amendment which was adopted:

Amendment 1 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Section 483.021, Florida Statutes, 1992 Supplement, is amended to read:

483.021 Declaration of policy and statement of purpose.—The purpose of this part is to protect the public ~~health, safety, and welfare of the people of this state~~ from the hazards of improper performance by clinical

laboratories. Clinical laboratories provide essential services to practitioners of the healing arts by furnishing vital information *that* ~~which~~ is essential to a determination of the nature, cause, and extent of the condition involved. Unreliable and inaccurate reports *can* ~~may~~ cause unnecessary anxiety, suffering, financial burdens, and even contribute directly to death. The protection of public and individual health requires licensure of clinical laboratories and the meeting of certain minimum standards, as well as certain other necessary safeguards as authorized by this part. *The Legislature intends that, in keeping with federal law and regulations, clinical laboratories, regardless of location, size, or type, meet appropriate standards.*

Section 2. Section 483.031, Florida Statutes, 1992 Supplement, is amended to read:

483.031 Application of *part* ~~chapter~~; exemptions.—This part applies to all clinical laboratories within this state, except:

(1) *A* clinical *laboratory* ~~laboratories~~ operated by the United States Government.

(2) A clinical laboratory *that performs only waived tests and has received a certificate of exemption from the agency under s. 483.106.* ~~operated by five or less duly licensed practitioners of the healing arts exclusively in connection with the diagnosis and treatment of their own patients. However, if any referred work is received in the clinical laboratory or if any clinical laboratory work is done for patients referred by another practitioner, all provisions of this part shall apply. This exemption does not apply to a clinical laboratory operated by a practitioner of the healing arts who holds himself and the facilities of his laboratory out as available for the performance of diagnostic tests for other practitioners or their patients.~~

(3) *A clinical laboratory* ~~Laboratories~~ operated and maintained exclusively for research and teaching purposes *that do not involve*~~, involving no~~ patient or public health service ~~whatsoever~~.

Section 3. Section 483.035, Florida Statutes, is created to read:

483.035 Exclusive use clinical laboratories.—

(1) A clinical laboratory operated by a practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, or chapter 466, exclusively in connection with the diagnosis and treatment of his own patients, must be licensed under this part and must comply with the provisions of this part, except that the agency shall adopt rules for staffing, proficiency testing, and construction standards relating to the licensure and operation of the laboratory based upon and not exceeding the same standards contained in the federal Clinical Laboratory Improvement Amendments of 1988 and the federal regulations adopted thereunder.

(2) Subsection (1) does not apply to a clinical laboratory operated by a practitioner who holds the facilities of the laboratory out as available for the performance of diagnostic tests for other practitioners or their patients. All provisions of this part apply to a clinical laboratory that receives any referred work or performs any work for patients referred by another practitioner.

Section 4. Section 483.041, Florida Statutes, 1992 Supplement, is amended to read:

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

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

(2)~~(1)~~ "Clinical laboratory" means a laboratory where examinations are performed on materials or specimens taken from the human body to provide information or materials for use in the diagnosis, prevention, or treatment of a disease or the assessment of a medical condition.

(3)~~(2)~~ "Clinical laboratory proficiency testing program" means a program approved by the *agency* ~~department~~ for evaluating the performance of clinical laboratories.

(4)~~(3)~~ "Collection station" or "branch office" means a facility operated by a clinical laboratory where materials or specimens are withdrawn or collected from patients or assembled after being withdrawn or collected from patients elsewhere, for subsequent delivery to another location for examination.

~~(4) "Department" means the Department of Health and Rehabilitative Services.~~

(5) "Hospital laboratory" means a laboratory located in a hospital licensed *under* ~~pursuant to~~ chapter 395 that provides services solely to that hospital and that is owned by the hospital and governed by the hospital medical staff or *governing board* ~~management~~.

(6) "Licensed practitioner ~~of the healing arts~~" means a physician licensed *under* ~~pursuant to~~ chapter 458, chapter 459, ~~or~~ chapter 460 *or chapter 461*; a dentist licensed *under* ~~pursuant to~~ chapter 466; ~~or~~ a person licensed *under* ~~pursuant to chapter 461 or~~ chapter 462*; or an advanced registered nurse practitioner licensed under chapter 464.*

(7) "Person" means the State of Florida or any individual, firm, partnership, association, corporation, county, municipality, political subdivision, or other entity, whether organized for profit or not.

(8) "Validation inspection" means an inspection of a clinical laboratory by the agency to assess whether a review by an accrediting organization has adequately evaluated the clinical laboratory according to state standards.

(9) "Waived test" means a test that the federal Health Care Financing Administration has determined qualifies for a certificate of waiver under the federal Clinical Laboratory Improvement Amendments of 1988, and the federal rules adopted thereunder.

Section 5. Section 483.051, Florida Statutes, 1992 Supplement, is amended to read:

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

(1) LICENSING; QUALIFICATIONS.—The *agency* ~~department~~ shall provide for *biennial* ~~annual~~ licensure of all clinical laboratories meeting the requirements of this part and shall prescribe the qualifications necessary for such licensure. *A license issued for operating a clinical laboratory, unless sooner suspended or revoked, expires on the date set forth by the agency on the face of the license.* ~~The license of any clinical laboratory which fails to pay a required fee or otherwise fails to qualify within 60 days of the date of expiration of its license shall be automatically canceled without notice or further proceedings.~~

(2) STANDARDS OF PERFORMANCE IN THE EXAMINATION OF SPECIMENS.—The *agency* ~~department~~ shall ~~operate a clinical laboratory proficiency testing program and shall~~ prescribe*:*

(a) Overall standards of performance that comply with the federal Clinical Laboratory Improvement Amendments of 1988, and the federal rules adopted thereunder, for a comprehensive quality assurance program. The purpose of the quality assurance program is to monitor and evaluate the ongoing and overall quality of a laboratory's total testing process.

(b) Standards of performance in the examination of specimens *for clinical laboratory proficiency testing programs using external quality control procedures.* As part of *a* ~~the~~ clinical laboratory proficiency testing program, clinical laboratory personnel may be required to analyze test samples and report on the results of such analyses. The *agency* ~~department~~ may accept proficiency testing reports of ~~agencies and~~ organizations approved by the *agency* ~~department, and shall accept such reports for proficiency testing of blood banks,~~ if the *agency finds* ~~department determines~~ that the standards of such ~~agencies and~~ organizations are equal to or exceed those of the *agency* ~~department~~. *The agency shall establish, by rule, criteria for satisfactory performance for a clinical laboratory that participates in an approved proficiency testing program.*

(3) SHIPMENT OF SPECIMENS.—The *agency* ~~department~~ may prescribe requirements for *collecting, transporting* ~~collection, transportation~~, handling, and *storing* ~~storage of~~ specimens shipped by common carrier from clinical laboratories or collection stations. Each specimen *must* ~~shall~~ be sent to a laboratory for analysis as rapidly as possible, but no later than 12 hours after collection *unless appropriate measures are taken to preserve the specimen*, except that the 12-hour requirement does not apply to blood banks or to plasmapheresis centers in shipping samples. Specimens may be sent to any *out-of-state* clinical laboratory ~~outside the state~~ for examination if *the* ~~such out-of-state~~ laboratory *holds a current license issued by the agency* ~~would meet the requirements of this part, as determined by the department~~. When the specimen has been

referred for examination to another laboratory, the report *must include* ~~shall bear or be accompanied by~~ a clear statement that such findings were obtained in *another* ~~such other~~ laboratory and *must* ~~shall~~ specify its name and location.

(4) CONSTRUCTION OF CLINICAL LABORATORIES.—*A clinical laboratory must comply with all applicable local, county, state, and federal* ~~The department may establish~~ standards for the construction, renovation, maintenance, and repair of clinical laboratories, including standards for plumbing, heating, lighting, ventilation, electrical services, and similar conditions which standards will ensure the conduct and operation of the laboratory in a manner *that* ~~which~~ will protect the public health.

(5) SAFETY AND SANITARY CONDITIONS WITHIN A CLINICAL LABORATORY AND ITS SURROUNDINGS.—The *agency* ~~department~~ shall establish standards relating to safety and sanitary conditions within a clinical laboratory and its surroundings, including standards for water supply; sewage; the handling of specimens; *identification, segregation, and separation of biohazardous* ~~disposal of needles, syringes, and laboratory~~ wastes *as required by s. 381.0098*; storage of chemicals; workspace; firesafety; and general measures *that* ~~which~~ will *protect* ~~ensure the protection of~~ the public health. *The agency shall determine compliance by a clinical laboratory with the requirements of s 381 0098 by verifying that the laboratory has obtained all required permits.*

(6) EQUIPMENT.—The *agency* ~~department~~ shall establish minimum standards for clinical laboratory equipment essential to its proper operation, its calibration, and its adequacy for testing procedures.

(7) POLICY AND PROCEDURE MANUAL.—The agency shall require that each clinical laboratory adopt and maintain a written policy and procedure manual that must address, but is not limited to:

(a) The performance of all analytical methods used by the clinical laboratory, including specimen collection and preservation.

(b) Instrument calibration.

(c) Quality control systems, measures, and remedial actions.

(d) Equipment performance evaluations.

(e) Test performance.

(f) Maintenance and filing of required records and reports.

(g) Channels of communication.

(h) Space, equipment, and supply requirements.

The policy and procedure manual must be readily available to laboratory personnel and must be followed by laboratory personnel.

(8) STANDARDS FOR PATIENT TEST MANAGEMENT.—The agency shall adopt rules that prescribe standards for patient test management, including requirements for record retention and patient test reporting.

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

Section 6. Section 483.061, Florida Statutes, is amended to read:

483 061 Inspection of clinical laboratories.—

(1) The *agency shall ensure* ~~department is responsible for ensuring~~ that each clinical laboratory, collection station, and branch office subject to this part is inspected *when deemed* ~~as often as reasonably~~ necessary *by the agency*, but at least *every 2 years* ~~once annually~~, for the purpose of evaluating the premises, operation, supervision, and procedures of *the* ~~such~~ facility to ensure compliance with this part. The *agency* ~~department~~ may conduct or cause to be conducted *the following* announced or unannounced inspections at any reasonable time:~~.~~

(a) An inspection conducted at the direction of the federal Health Care Financing Administration.

(b) A licensure inspection.

(c) A validation inspection.

(d) A complaint investigation, including a full licensure investigation with a review of all licensure standards as outlined in rule. Complaints received by the agency from individuals, organizations, or other sources are subject to review and investigation by the agency. If a complaint has been filed against a laboratory or if a laboratory has a substantial licensure deficiency, the agency may inspect the laboratory annually or as the agency considers necessary.

However, for laboratories operated under s. 483.035, biennial licensure inspections shall be scheduled so as to cause the least disruption to the practitioner's scheduled patients.

(2) The right of entry and inspection *is* ~~also shall be~~ extended to any premises *that* ~~which~~ is ~~being~~ maintained as a laboratory without a license, but ~~no~~ such entry or inspection *may not* ~~shall~~ be made without the permission of the owner or person in charge *of the laboratory* ~~thereof~~, unless an inspection warrant as defined in s. 933.20 is first obtained.

(3) The agency shall inspect an out-of-state clinical laboratory under this section at the expense of the out-of-state clinical laboratory to determine whether the laboratory meets the requirements of this part.

(4)~~(2)~~ The *agency shall accept, in lieu of its own periodic inspections for licensure, the survey of or inspection by* ~~department may contract with~~ private accrediting organizations *that* ~~to~~ perform inspections of clinical laboratories accredited by such organizations, including postinspection activities required by the *agency* ~~department~~.

(a) The agency shall ~~department may, and in the case of blood banks the department shall,~~ accept ~~on an alternate year basis~~ inspections performed by such organizations if the accreditation is not provisional, if such organizations perform postinspection activities required by the *agency* ~~department~~ and provide the *agency* ~~department~~ with all necessary inspection and postinspection reports and information necessary for enforcement, ~~and~~ if such organizations apply standards equal to or exceeding standards established *and approved* by the *agency, and if such accrediting organizations are approved by the federal Health Care Financing Administration to perform such inspections* ~~department~~.

(b) The agency may conduct complaint investigations made against laboratories inspected by accrediting organizations.

(c) The agency may conduct sample validation inspections of laboratories inspected by accrediting organizations to evaluate the accreditation process used by an accrediting organization.

(d) The agency may conduct a full inspection if an accrediting survey has not been conducted within the previous 24 months, and the laboratory must pay the appropriate inspection fee under s. 483.172.

(e) The agency shall develop, and adopt, by rule, criteria for accepting inspection and postinspection reports of accrediting organizations in lieu of conducting a state licensure inspection.

Section 7. Section 483.091, Florida Statutes, is amended to read:

483.091 Clinical laboratory license.—*A* ~~No~~ person *may not* ~~shall~~ conduct, maintain, or operate a clinical laboratory in this state, except a laboratory that is exempt under s. 483.031, unless *the clinical laboratory has obtained* a license ~~therefor has been obtained~~ from the *agency* ~~department~~. *A clinical laboratory may not send a specimen drawn within this state to any clinical laboratory outside the state for examination unless*

the out-of-state laboratory has obtained a license from the agency. A license *is* ~~shall be~~ valid only for the person or persons to whom it is issued and *may* ~~shall~~ not be *sold, assigned, or transferred, voluntarily or involuntarily, and is not* ~~the subject of sale, assignment, or transfer, voluntary or involuntary, nor shall a license be~~ valid for any premises other than those for which *the license is* issued. However, a new license may be secured for the new location *before* ~~prior to~~ the actual change, if the contemplated change *complies* ~~is in compliance~~ with ~~the provisions of~~ this part and the rules *adopted under this part* ~~promulgated hereunder~~. *Application for a new clinical laboratory license must be made 60 days before a change in the ownership of the clinical laboratory.*

Section 8. Section 483.101, Florida Statutes, is amended to read:

483.101 Application for clinical laboratory license.—An application for a clinical laboratory license *must* ~~shall~~ be made under oath by the owner or operator of the clinical laboratory or by the public official responsible for *operating* ~~the operation of~~ a state, *municipal* ~~city~~, or county clinical laboratory or institution that contains a clinical laboratory, upon forms provided by the *agency* ~~department~~. A license *must* ~~shall~~ be issued authorizing the performance of one or more clinical laboratory procedures or one or more *tests on each specialty or subspecialty* ~~categories of such procedures~~. *A* separate *license is* ~~licenses are~~ required of all laboratories maintained on separate premises even *if the* ~~though such~~ laboratories are operated under the same management. *Upon receipt of a request for an application for a clinical laboratory license, the agency shall provide to the applicant a copy of the rules relating to licensure and operations applicable to the laboratory for which licensure is sought.*

Section 9. Section 483.106, Florida Statutes, is created to read:

483.106 Application for a certificate of exemption.—An application for a certificate of exemption must be made under oath by the owner or operator of a clinical laboratory that performs only waived tests as defined in s. 483.041. A certificate of exemption authorizes a clinical laboratory to perform waived tests. Laboratories maintained on separate premises and operated under the same management may apply for a single certificate of exemption or multiple certificates of exemption. The agency shall, by rule, specify the process for biennially issuing certificates of exemption. Sections 483.011, 483.021, 483.031, 483.041, 483.172, 483.23, and 483.25 apply to a clinical laboratory that obtains a certificate of exemption under this section.

Section 10. Section 483.111, Florida Statutes, is amended to read:

483.111 Limitations on licensure.—A license *may* ~~shall~~ be issued to a clinical laboratory to perform only those clinical laboratory procedures and tests that are within the specialties or subspecialties in which the clinical laboratory personnel are qualified. A license *may* ~~shall~~ not be issued unless the *agency* ~~department~~ determines that the clinical laboratory is adequately staffed and equipped to operate in conformity with the requirements of this part and the rules *adopted under this part* ~~promulgated hereunder~~.

Section 11. Section 483.172, Florida Statutes, 1992 Supplement, is amended to read:

483.172 License fees.—

(1) The *agency* ~~department~~ shall collect fees for all licenses issued under this part. ~~The fee schedule for fiscal year 1983-1984 shall be the minimum fees provided herein, and such schedule shall remain in effect until the effective date of a fee schedule adopted by rule by the department pursuant to this part. The fee schedule for licensure of clinical laboratories shall be increased annually in substantially equal increments to produce, by fiscal year 1985-1986, an overall fee schedule in which fees from licensure of clinical laboratories are sufficient to carry out the responsibilities of the department for regulation of clinical laboratories.~~ Each fee *is* ~~shall be~~ due at the time of application and *must be* ~~shall be~~ payable to the *agency* ~~department~~ to be deposited in *the Health Care* a Trust Fund administered by the *agency* ~~department and used only for the purposes of this chapter~~.

(2) The biennial license fee schedule is as follows:

(a) If a laboratory performs not more than 2,000 tests annually, the fee is $400.

(b) If a laboratory performs not more than 3 categories of procedures with a total annual volume of more than 2,000 but no more than 10,000 tests, the license fee is $965.

(c) If a laboratory performs at least 4 categories of procedures with a total annual volume of not more than 10,000 tests, the license fee is $1,294.

(d) If a laboratory performs not more than 3 categories of procedures with a total annual volume of more than 10,000 but not more than 25,000 tests, the license fee is $1,592.

(e) If a laboratory performs at least 4 categories of procedures with a total annual volume of more than 10,000 but not more than 25,000 tests, the license fee is $2,103.

(f) If a laboratory performs a total of more than 25,000 but not more than 50,000 tests annually, the license fee is $2,364.

(g) If a laboratory performs a total of more than 50,000 but not more than 75,000 tests annually, the license fee is $2,625.

(h) If a laboratory performs a total of more than 75,000 but not more than 100,000 tests annually, the license fee is $2,886.

(i) If a laboratory performs a total of more than 100,000 but not more than 500,000 tests annually, the license fee is $3,397.

(j) If a laboratory performs a total of more than 500,000 but not more than 1 million tests annually, the license fee is $3,658.

(k) If a laboratory performs a total of more than 1 million tests annually, the license fee is $3,919.

(3) The agency shall assess a biennial fee of $100 for a certificate of exemption and a $100 license fee for facilities surveyed by an approved accrediting organization.

(4) Upon the effective date of this subsection and until the agency is granted state exemption status by the Health Care Financing Administration, laboratories that are licensed under the Clinical Laboratory Improvement Amendments of 1988 may not be assessed the fees specified in subsections (2) and (3) by the agency. During that period, a fee must be assessed to those laboratories to cover the cost of state activities beyond those required under the Clinical Laboratory Improvement Amendments of 1988 This fee is $100 biennially. ~~For licensure as a clinical laboratory, the annual fee shall be not less than $210 or more than $1,200. No separate licensure fee shall be paid by any branch office, mobile donor unit, or transfusion service operated by a blood bank when the principal location of the blood bank is licensed under this part. For late filing of an application for renewal, there shall be a fee of $100. If any licensure period in which the department accepts an equivalent inspection of a blood bank pursuant to s. 483.061, such blood bank shall pay only a fee of $50.~~

Section 12. Section 483.181, Florida Statutes, is amended to read:

483.181 Acceptance, collection, identification, and examination of specimens.—

(1) A clinical laboratory *may* ~~shall~~ examine human specimens at the request only of a *licensed* practitioner ~~of the healing arts~~ or other person authorized by law to use the findings of clinical laboratory examinations.

(2) The results of a test *must* ~~shall~~ be reported directly to the licensed practitioner or other authorized person who requested it. *The* ~~Such~~ report *must include* ~~shall state~~ the name and address of the clinical laboratory in which the test was actually performed, *unless the* ~~except when such~~ test was performed in a hospital laboratory and *the* ~~such~~ report becomes an integral part of the hospital record.

(3) The results of clinical laboratory tests performed by a clinical laboratory complying with this part and performed *before* ~~prior to~~ a patient's admission to a facility licensed *under* ~~pursuant to~~ chapter 395 *must* ~~shall~~ be accepted in lieu of clinical laboratory tests required upon a patient's admission to *the* ~~such~~ facility and in lieu of tests *that* ~~which~~ may be ordered for patients of *the* ~~such~~ facility, *except that the facility may not be required to accept transfusion compatibility test results.* The *agency* ~~department by rule~~ shall establish, *by rule,* standards for *accepting* ~~the acceptance of such~~ laboratory *test results* ~~tests~~ to specify acceptable timeframes for such laboratory tests to assure that *the* ~~such~~ timeframes do not adversely affect the accuracy of *the* ~~such~~ test.

(4) All specimens accepted by a clinical laboratory *must* ~~shall~~ be tested on the premises, except that specimens for infrequently performed tests may be forwarded for examination to another clinical laboratory

approved under this part. This *subsection does not prohibit referring* ~~shall not be construed as prohibiting the referral of~~ specimens to a clinical laboratory excepted under s. 483.031. However, the clinical laboratory director of the referring clinical laboratory *must* ~~shall~~ assume complete responsibility.

Section 13. Section 483.191, Florida Statutes, is amended to read:

483.191 Branch offices, representation of other laboratories.—*A* ~~No~~ person *may not* ~~shall~~ represent or maintain an office or specimen collection station or other facility for the representation of any clinical laboratory situated in this state or any other state which makes examinations in connection with the diagnosis and control of diseases unless the clinical laboratory *meets* ~~so represented shall meet~~ or *exceeds* ~~exceed~~ the *minimum* ~~minimal~~ standards *of* ~~promulgated by~~ the *agency* ~~Department of Health and Rehabilitative Services pursuant to this part~~ and the rules *adopted under this part* ~~promulgated hereunder~~.

Section 14. Section 483.201, Florida Statutes, is amended to read:

483.201 Grounds for disciplinary action against clinical laboratories.—The following acts constitute grounds for which a disciplinary action specified in s. 483.221 may be taken against a clinical laboratory:

(1) Making a fraudulent statement on an application for a clinical laboratory license or any other document required by the *agency* ~~department~~.

(2) Permitting unauthorized persons to perform technical procedures or to issue reports.

(3) Demonstrating incompetence or making consistent errors in the performance of clinical laboratory examinations and procedures or erroneous reporting.

(4) Performing a test and rendering a report thereon to a person not authorized by law to receive such services.

(5) Knowingly having professional connection with or knowingly lending the use of the name of the licensed clinical laboratory or its director to an unlicensed clinical laboratory.

(6) Violating or aiding and abetting in the violation of any provision of this part or the rules *adopted under this part* ~~promulgated hereunder~~.

(7) Failing to file any report required by the provisions of this part or the rules *adopted under this part* ~~promulgated hereunder~~.

(8) Reporting a test result *for a clinical specimen if the* ~~when no laboratory~~ test was *not* performed on *the* ~~a~~ clinical specimen.

(9) Performing and reporting tests in a speciality or subspecialty in which the laboratory is not licensed.

(10) Knowingly advertising false services or credentials.

(11) *Failing* ~~Failure~~ to correct deficiencies within the time required by the *agency* ~~department~~.

Section 15. Section 483.221, Florida Statutes, is amended to read:

483.221 Administrative penalties.—

(1)(a) The *agency* ~~department~~ may deny, suspend, revoke, annul, limit, or deny renewal of a license or impose an administrative fine, not to exceed *$1,000* ~~$500~~ per violation, for the violation of any provision of this part or rules *adopted under this part* ~~promulgated hereunder~~. Each day of violation constitutes a separate violation and is subject to a separate fine.

(b) In determining the *penalty* ~~amount of fine~~ to be *imposed* ~~levied~~ for a violation, as provided in paragraph (a), the following factors *must* ~~shall~~ be considered:

1. The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted; the severity of the actual or potential harm; and the extent to which the provisions of this part were violated.

2. Actions taken by the licensee to correct the violation or to remedy complaints.

3. Any previous violation by the licensee.

4. The financial benefit to the licensee of committing or continuing the violation.

(c) All amounts collected *under* ~~pursuant to~~ this section *must* ~~shall~~ be deposited into the *Health Care* Trust Fund administered by the *agency* ~~department pursuant to this chapter~~.

(2) The *agency* ~~department~~ may issue an emergency order immediately suspending, revoking, annulling, or limiting a license *if* ~~when~~ it determines that any condition in the licensed facility presents a clear and present danger to public health *or* ~~and~~ safety.

Section 16. Section 483.23, Florida Statutes, 1992 Supplement, is amended to read:

483.23 Offenses; criminal penalties.—

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

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

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

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

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

(b) The performance of any act specified in paragraph (a) constitutes a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(2) Any use or attempted use of a forged license under this part or part IV of this chapter constitutes the crime of forgery.

Section 17. Section 483.245, Florida Statutes, is amended to read:

483.245 Rebates prohibited; penalties.—

(1) It is unlawful for any person to pay or receive any commission, bonus, kickback, or rebate or engage in any split-fee arrangement in any form whatsoever with any physician, surgeon, organization, agency, or person, either directly or indirectly, for patients referred to a clinical laboratory licensed under this *part* ~~chapter~~.

(2) The *agency* ~~Department of Health and Rehabilitative Services~~ shall adopt rules *that* ~~which~~ assess administrative penalties for acts prohibited by subsection (1). In the case of an entity licensed by the *agency* ~~department~~, such penalties may include any disciplinary action available to the *agency* ~~department~~ under the appropriate licensing laws. In the case of an entity not licensed by the *agency* ~~department~~, such penalties may include:

(a) A fine not to exceed $1,000;

(b) If applicable, a recommendation by the *agency* ~~department~~ to the appropriate licensing board that disciplinary action be taken.

Section 18. Section 483.25, Florida Statutes, is amended to read:

483.25 Injunction.—The operation or maintenance of an unlicensed clinical laboratory or the performance of any clinical laboratory procedure or operation in violation of this part is declared a nuisance, inimical to the public health, welfare, and safety. The *agency* ~~department~~, or any state attorney in the name of the people of the state, may, in addition to other remedies ~~herein~~ provided *in this part*, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of any such clinical laboratory or the performance of any laboratory procedure or operation in violation of this part, until compliance with ~~the provisions of~~ this part or the rules *adopted under this part* ~~promulgated hereunder~~ has been demonstrated to the satisfaction of the *agency* ~~department~~.

Section 19. The Agency for Health Care Administration may establish a technical advisory panel to assist the agency in rule revisions that

are necessary as a result of this act. This advisory input should be sought to expand public participation in agency decisions and to draw on the expertise of representatives from the various segments of health care which have an interest in laboratory procedures.

Section 20. Section 483.800, Florida Statutes, 1992 Supplement, is amended to read:

483.800 Declaration of policy and statement of purpose.—The purpose of this part is to protect the public health, safety, and welfare of the people of this state from the hazards of improper performance by clinical laboratory personnel. Clinical laboratories provide essential services to practitioners of the healing arts by furnishing vital information that is essential to a determination of the nature, cause, and extent of the condition involved. Unreliable and inaccurate reports may cause unnecessary anxiety, suffering, and financial burdens and may even contribute directly to death. The protection of public and individual health requires the licensure of clinical laboratory personnel who meet minimum requirements for safe practice. *The Legislature finds that laboratory testing technology continues to advance rapidly. The Legislature also finds that a hospital training program under the direction of the hospital clinical laboratory director offers an opportunity for individuals already trained in health care professions to expand the scope of their careers. The Legislature further finds that there is an immediate need for properly trained personnel to ensure patient access to testing. Therefore, the Legislature recognizes the patient-focused benefits of hospital-based training for laboratory and nonlaboratory personnel for testing within the laboratory and at alternate sites, and recognizes the benefits of a training program approved by the Board of Clinical Laboratory Personnel under the direction of the hospital clinical laboratory director.*

Section 21. Section 483.801, Florida Statutes, 1992 Supplement, is amended to read:

483.801 Exemptions.—This part applies to all clinical laboratories and clinical laboratory personnel within this state, except:

(1) Clinical laboratories operated by the United States Government.

~~(2) A clinical laboratory operated by five or fewer duly licensed practitioners of the healing arts exclusively in connection with the diagnosis and treatment of their own patients. However, if any referred work is received in the clinical laboratory or if any clinical laboratory work is done for patients referred by another practitioner, all provisions of this part shall apply. This exemption does not apply to a clinical laboratory operated by a practitioner of the healing arts who holds himself and the facilities of his laboratory out as available for the performance of diagnostic tests for other practitioners or their patients.~~

(2)~~(3)~~ Laboratories operated and maintained exclusively for research and teaching purposes, involving no patient or public health service whatsoever.

Section 22. Section 483.811, Florida Statutes, 1992 Supplement, is amended to read:

483.811 Approval of laboratory personnel training programs.—

(1) The board shall approve clinical laboratories for training programs upon presentation of satisfactory evidence that such laboratories are adequately staffed by qualified personnel and comply with rules adopted by the board to ensure that such laboratories provide training in clinical laboratory techniques adequate to prepare individuals to meet the requirements for licensure under this part.

(2) The board shall adopt rules for training programs, including, but not limited to, rules relating to curriculum, educational objectives, evaluation procedures, personnel licensure requirements, preentry educational requirements, and length of clinical training.

(3) The board shall adopt rules for the licensure, education, and training of personnel in laboratories operated pursuant to s. 483.035 based upon and not exceeding the standards contained in the federal Clinical Laboratory Improvement Amendments of 1988 and the federal regulations adopted thereunder. This subsection does not apply to a clinical laboratory operated by a practitioner who holds the facilities of the laboratory out as available for the performance of diagnostic tests for other practitioners or their patients. If a clinical laboratory receives any referred work, or performs any work for patients referred by another practitioner, all provisions of this part apply.

(4) The board shall approve training programs for laboratory technicians in a hospital or clinical laboratory which programs are under the supervision of a clinical laboratory director. The training must be accepted in lieu of educational requirements for licensure, but a trainee must have a high school diploma or its equivalent. Any person who completes a training program must pass, before licensure, an examination given by the department.

(5)~~(3)~~ The department may inspect laboratory personnel training programs.

(6)~~(4)~~ If the board finds that an approved program no longer meets the required standards, the department.

Section 23. Section 9 of chapter 92-178, Laws of Florida, appearing as section 455.238, Florida Statutes, 1992 Supplement, is repealed.

Section 24. There is hereby appropriated to the Agency for Health Care Administration, 21 full time positions and $927,918 from the Health Care Trust Fund to implement the additional responsibilities provided for in this act.

Section 25. Section 30 of chapter 83-276, Laws of Florida, is repealed.

Section 26. This act shall take effect October 1, 1993.

And the title is amended as follows:

In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to medical tests and procedures; amending s. 483.021, F.S.; providing legislative intent; amending s. 483.031, F.S.; providing for application of part I, ch. 483, F.S.; creating s. 483.035, F.S.; providing for exclusive use clinical laboratories; amending s. 483.041, F.S.; providing definitions; amending s. 483.051, F.S.; providing powers and duties of the Agency for Health Care Administration in regulating clinical laboratories; requiring the agency to prescribe certain standards; amending s. 483.061, F.S.; requiring the agency to inspect clinical laboratories; authorizing inspections by private accrediting organizations; amending s. 483.091, F.S.; prohibiting the operation of certain clinical laboratories without a license issued by the agency; requiring certain out-of-state laboratories to be licensed by the agency; amending s. 483.101, F.S.; providing application requirements for licensure of clinical laboratories; creating s. 483.106, F.S.; providing requirements for clinical laboratories that perform certain tests under a certificate of exemption; amending s. 483.111, F.S.; providing certain limitations on licensure; amending s. 483.172, F.S.; revising license fees; amending s. 483.181, F.S.; providing requirements for reporting and accepting the results of clinical laboratory tests; amending s. 483.191, F.S.; providing requirements for branch offices and collection stations operated by clinical laboratories; amending s. 483.201, F.S.; providing grounds under which the agency may take disciplinary action against clinical laboratories; amending ss. 483.221, 483.23, F.S.; providing penalties; amending s. 483.245, F.S.; prohibiting rebates for referring patients to a clinical laboratory; providing penalties; amending s. 483.25, F.S.; providing for injunctions; authorizing the agency to establish a technical advisory panel; amending s. 483.800, F.S.; expanding legislative purpose and policy provisions; amending s. 483.801, F.S.; deleting an exemption for specified laboratories; amending s. 483.811, F.S.; directing the Board of Clinical Laboratory Personnel to approve certain laboratory technician training programs; repealing s. 30, ch. 92-178, Laws of Florida, appearing as s. 455.238, F.S., relating to a prohibition against a health care provider charging a markup for services rendered outside the provider's practice; providing an appropriation; repealing s. 30, ch. 83-276, Laws of Florida; abrogating the repeal of part I, ch. 483, F.S., under the Regulatory Sunset Act; providing an effective date.

On motion by Senator Gutman, by two-thirds vote **HB 2071** as amended was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

The Senate resumed consideration of—

CS for HB 2069—A bill to be entitled An act relating to adult day care centers; amending s. 400.55, F.S.; modifying purpose of pt. IV of ch. 400, F.S.; amending ss. 400.551, 400.552, 400.556, 400.557, 400.5575, 400.558, 400.559, 400.56, and 400.562, F.S.; conforming definitions and language to transfer of responsibilities from the Department of Health

and Rehabilitative Services to the Agency for Health Care Administration; expanding definition of "basic services"; amending s. 400.553, F.S.; revising exemptions from regulation under pt. IV of ch. 400, F.S.; authorizing provision of certain services by an adult congregate living facility, nursing home facility, or hospital; requiring monitoring by the agency; amending s. 400.554, F.S.; providing for biennial rather than annual license fee; providing an additional fee; deleting license fee exemption for centers operated by local governments; amending s. 400.555, F.S.; providing additional license application requirements; amending s. 400.5565, F.S.; clarifying authority to impose fines; conditioning license renewal on payment of outstanding fines; saving pt. IV of ch. 400, F.S., from Sunset repeal; providing for future review and repeal; providing an effective date.

—with pending **Amendment 1.**

Senator McKay moved the following amendment to **Amendment 1** which was adopted:

Amendment 1A—On page 12, line 10, after "*Services*" insert: *in consultation with the agency and the Department of Elderly Affairs,*

Amendment 1 as amended was adopted.

On motion by Senator McKay, by two-thirds vote **CS for HB 2069** as amended was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—37 Nays—None

CS for SB 1080—A bill to be entitled An act relating to pari-mutuel wagering; amending s. 550.002, F.S., and repealing subsections (15), (28), (36), and (37) of that section; revising the definition of the term "harness racing" to delete unnecessary words and repealing several unnecessary definitions; amending s. 550.01215, F.S., to provide for other authorized uses for permitted facilities; creating s. 550.022, F.S.; restricting financial arrangements by pari-mutuel permitholders; amending s. 550.0235, F.S.; revising a limitation-of-liability provision; amending s. 550.0251, F.S.; revising powers and duties of the Division of Pari-mutuel Wagering of the Department of Business Regulation; amending s. 550.0351, F.S., to add a charity to the authorized list of charities on file with the division; repealing s. 550.0425(4), F.S.; deleting a provision allowing minors access to kennel compound areas; amending s. 550.054, F.S.; revising application requirements; providing permit procedures when a pari-mutuel facility is taken by eminent domain; revising reporting requirements when there is a change in ownership of a pari-mutuel permitholder; amending s. 550.0951, F.S.; providing tax exemptions; revising daily license fees for racetracks and jai alai games; deleting breaks tax on jai alai; revising tax rates; providing tax credits; providing a surtax; creating s. 550.09512, F.S.; providing for taxes on jai alai; providing for escheat of an abandoned interest in permit for nonpayment of taxes; providing for reissuance of an escheated permit; providing for expiration of section and for legislative review in advance thereof; amending s. 550.105, F.S.; revising application requirements for occupational licenses; amending s. 550.125, F.S., pertaining to bond requirements; improving clarity; amending s. 550.155, F.S.; providing limitations on takeout; providing for additional withholdings; amending s. 550.1625, F.S.; prescribing purse distributions for dog racing; creating s. 550.16355, F.S.; providing for Greyhound Race of Champions Meet; amending s. 550.1815, F.S.; revising provisions respecting persons who are prohibited from holding pari-mutuel permits; amending s. 550.2415, F.S.; revising procedures pertaining to euthanizing greyhounds; providing for the establishment of greyhound-adoption facilities under certain circumstances; amending s. 550.2614, F.S., pertaining to distribution of certain funds to a horsemen's association; revising a cross-reference; amending s. 550.2625, F.S.; providing an additional percentage of handle on exotic wagering which may be paid to the purse pool for use as additional overnight purses; revising certain purse and prize requirements pertaining to quarter horse racing; providing for certain funds to be withheld from purse pools; specifying the purposes for which such funds are to be used; creating s. 550.26352, F.S.; providing for the Breeders' Cup Meet; repealing s. 550.26353, F.S., pertaining to tax credits and tax exemptions; creating s. 550.26354, F.S.; providing for exemption from taxes on handle, breeders' award and purse requirements, and horsemen's payments on intertrack wagers; repealing s. 35, ch. 92-348, Laws of Florida, which limits the applicability of specified exemptions; creating s. 550.26365, F.S.; providing for the Breeders' Crown Meet; amending s. 550.334, F.S., pertaining to quarter horse racing; revising distance limitations; amending s. 550.3551, F.S., pertaining to transmission of racing and jai alai information; providing for takeout under certain circumstances; amending s. 550.3615, F.S., deleting a provision relating to certain pending bookmaking prosecutions; amending s. 550.375, F.S., pertaining to the operation of harness tracks; revising distance limitations; amending s. 550.495, F.S.; revising bond requirements for totalizator owners or operators; providing circumstances under which such bond may be waived by the division; revising fees for totalizator licenses; amending s. 550.5251, F.S.; allowing thoroughbred permitholders to operate any extra hour; providing circumstances under which a tax credit may be provided to a thoroughbred racing permitholder not running during the Breeders' Cup Meet; allowing thoroughbred permitholders to conduct up to three additional races composed of quarter horses; amending s. 550.615, F.S., providing tax rates and takeout distribution for certain thoroughbred permitholders conducting intertrack wagers; amending s. 550.70, F.S.; proving for additional player prize money from breaks; providing for reconversion of former jai alai permit; creating s. 550.71, F.S.; providing for the Jai Alai Tournament of Champions Meet; repealing s. 570.381(3), F.S., which provides for the Appaloosa Advisory Council; amending s. 772.102, F.S., pertaining to definitions for "criminal activity," to conform cross-references; amending s. 895.02, F.S., pertaining to definition of "racketeering activity," to conform cross-references; exempting certain permitholders from paying taxes on handle generated during the Breeders' Cup Meet and the Breeders' Crown Meet for the 1992-1993 racing season; providing a tax credit for certain permitholders located within 35 miles of the Breeders' Cup Meet conducted during that racing season; providing for an audit and for the repayment of certain overpayments; requiring review of occupational licensing scheme and submission of recommendations to the Legislature; providing for termination of existing administrative rules and for adoption of new rules governing the conduct of pari-mutuel wagering; directing the Department of Business Regulation to review and consider certain costs relating to its racing laboratory and report to the Legislature; repealing s. 68, ch. 92-348, Laws of Florida, pertaining to retroactivity of that law, which provides for regulation of pari-mutuel wagering; providing an effective date.

—was read the second time by title.

Senator Dudley moved the following amendment:

Amendment 1 (with Title Amendment)—On page 8, strike all of lines 28-30 and insert:

Section 7. Subsection (4) of section 550.0425, Florida Statutes, as created by section 10 of chapter 92-348, Laws of Florida, is amended to read:

550.0425 Minors attendance at pari-mutuel performances; restrictions.—

(4) Minor children of licensed greyhound trainers, kennel operators, or other licensed persons employed in the kennel compound areas *shall* ~~may~~ be granted access to kennel compound areas without being licensed, provided they are in no way employed unless properly licensed, and only when under the direct supervision of one of their parents or legal guardian.

And the title is amended as follows:

In title, on page 1, strike all of lines 19-21 and insert: the division; amending s. 550.0425, F.S.; requiring that certain minor children be granted access to greyhound kennel compound areas; amending s. 550.054, F.S.;

POINT OF ORDER

Senator Holzendorf raised a point of order that pursuant to Rules 7.1 and 4.8, **Amendment 1** was out of order.

The President referred the point of order to Senator Jennings, Chairman of the Committee on Rules and Calendar.

Further consideration of **CS for SB 1080** with pending **Amendment 1** was deferred.

CS for SB 152—A bill to be entitled An act relating to mobile home parks, lodging parks, recreational vehicle parks, and recreational camps; revising ss. 513.01-513.151, F.S., relating to the regulation and permitting of mobile home parks and recreational vehicle parks, and extending the applicability of certain of those provisions, as revised, to lodging parks, recreational camps; providing definitions; providing for enforcement of

public health laws with respect to mobile home, lodging, and recreational vehicle parks and recreational camps; providing for applicability of recreational vehicle park provisions to certain mobile home parks and lodging parks; providing for permitting of private parks and camps; providing for issuance of a permit upon transfer of a park or camp; providing for application for and issuance of permits; providing for permit fees and providing for collection and dispostion of such fees; providing rulemaking authority to the Department of Health and Rehabilitative Services for purposes of the chapter; providing for state preemption of sanitary standards; providing for inspection of such parks and camps; providing for prosecution of operators who commit specified violations; prescribing penalties for such violations; providing for revocation and suspension of permits; authorizing administrative fines and providing for disposition of such fines; providing for enforcement of chapter and rules adopted under the chapter by issuance of citations by department personnel; providing for disposition of fines imposed by citation; regulating the disposal of sewage from mobile homes and recreational vehicles and at recreational campsites; providing penalties for operating without a permit; regulating posting, advertising, and charging of site rates and providing penalties for violations related thereto; requiring operators to maintain guest registers and current copies of the laws; prescribing liability of operators for property of guests; providing for disposition of unclaimed property left by guests of recreational vehicle parks; providing for park rules and regulations; authorizing refusal of services for specified conduct on the premises of a park; prescribing penalties for obtaining accommodations in a park with intent to defraud; providing penalties for theft of property from such a park and providing for detention and arrest of violators; providing penalties for resisting such an arrest; providing for eviction from such a park and specifying grounds therefor; prescribing an operator's rights and remedies against transient guests in such a park; repealing s. 15, ch. 83-321, Laws of Florida, which provides for the expiration of specified sections of ch. 513, F.S., effective October 1, 1993, pursuant to Regulatory Sunset Review; amending s. 381.006, F.S., pertaining to environmental health, to conform to the expansion of the scope of ch. 513, F.S., to include lodging parks and recreational camps; amending s. 509.502, F.S., pertaining to definitions of terms used in ch. 509, F.S., to exclude recreational camps from regulation as campgrounds under that chapter; amending s. 633.022, F.S., pertaining to uniform firesafety standards, to authorize the Department of Insurance to establish uniform firesafety standards for lodging parks and recreational camps; providing an effective date.

—was read the second time by title.

The Committee on Health and Rehabilitative Services recommended the following amendment which was moved by Senator Bankhead and failed:

Amendment 1 (with Title Amendment)—On page 13, lines 15-31; on page 14, lines 1-31; and on page 15, lines 1 and 2, strike all of said lines and renumber subsequent sections.

And the title is amended as follows:

In title, on page 2, strike all of lines 1-5 and after the semicolon (;) on line 1 and insert: regulating the

Senator Kiser moved the following amendment which failed:

Amendment 2—On page 7, strike line 14 and insert: to mobile home parks *including, but not limited to chapter 723.*

Senator Kiser moved the following amendment:

Amendment 3 (with Title Amendment)—On page 36, between lines 30 and 31, insert:

Section 30. Subsection (3) of section 723.003, Florida Statutes, is amended and subsection (15) is added to said section to read:

723.003 Definitions.—As used in this chapter, the following words and terms have the following meaning unless clearly indicated otherwise:

(3) The term "mobile home" means a residential structure, transportable in one or more sections, which is 8 body feet or more in width, over 35 body feet in length with the hitch, built on an integral chasis, and designed to be used as a dwelling when connected to the required utilities, ~~and not originally sold as a recreational vehicle~~, and includes the plumbing, heating, air-conditioning, and electrical systems contained *in the structure* ~~therein~~.

Section 31. Paragraph (b) of subsection (5) of section 723.006 is amended to read:

723.006 Powers and duties of division.—

(5)

(b) The division may issue an order requiring the mobile home park owner, or its assignee or agent, to cease and desist from an unlawful practice and take such affirmative action as in the judgment of the division will carry out the purposes of this chapter. *The affirmative action may include the following:*

1. *Refunds of improper rent increases.*
2. *Refunds of improper assessments.*
3. *Refunds of improper pass-through charges.*
4. *Refunds of improper pass-on charges.*
5. *Notification of documents which are in violation of this chapter.*
6. *Any action which goes to correct a statutory or rule violation.*

Section 32. Section 723.007, F.S., is amended to read:

723.007 Annual fees.—Each mobile home park owner shall pay to the division, on or before October 1 of each year, an annual fee ~~in the amount of $3~~ for each mobile home lot within a mobile home park which he owns. *The fee for each mobile home lot shall be set by rule of the division and may be up to, but shall not exceed $4.* If the fee is not paid by December 31, the mobile home park owner shall be assessed a *late fee* ~~penalty~~ of 10 percent of the amount due, and he shall not have standing to maintain or defend any action in the courts of this state until the amount due, plus any penalty *and late fee*, is paid.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 3, line 15, after the semicolon (;) insert: amending s. 723.003, F.S., providing definitions; amending s. 723.006, F.S.; providing specified affirmative action which may be taken by the Division of Florida Land Sales, Condominiums and Mobile Homes; amending s. 723.007, F.S., providing for annual fees to be set by the division not to exceed a specified amount;

POINT OF ORDER

Senator Silver raised a point of order that pursuant to Rule 7.1, **Amendment 3** was out of order.

The President referred the point of order to Senator Jennings, Chairman of the Committee on Rules and Calendar.

Further consideration of **CS for SB 152** with pending **Amendment 3** was deferred.

On motions by Senator McKay, by two-thirds vote **CS for HB 2197** was withdrawn from the Committee on Health and Rehabilitative Services.

On motions by Senator McKay, by two-thirds vote—

CS for HB 2197—A bill to be entitled An act relating to adult congregate living facilities; amending s. 400.401, F.S.; providing legislative findings; amending s. 400.402, F.S.; revising definitions; amending s. 400.404, F.S.; revising exemptions; amending s. 400.407, F.S.; providing penalties for neglect; providing for care of residents designated as being mentally ill; revising requirements for existing facilities requesting to provide extended congregate care services; requiring annual monitoring of facilities with substantiated complaints; revising a restriction on facilities providing limited mental health services; providing for biennial license fees; providing a duplicate license fee; amending s. 400.408, F.S.; providing penalties for referral to an unlicensed facility, a facility whose license is under denial or has been suspended or revoked, or a facility that has a moratorium on admissions; amending s. 400.411, F.S.; providing an additional license application requirement; amending s. 400.412, F.S.; requiring a corrective action plan prior to transfer of ownership; amending s. 400.414, F.S.; providing additional grounds for license suspension, denial, or revocation, or administrative fine; providing for hearing;

requiring provision of specified information to the Division of Hotels and Restaurants of the Department of Business Regulation; amending s. 400.415, F.S.; providing for moratorium on admissions after license denial, suspension, or revocation; amending s. 400.4174, F.S.; requiring certain notice of confirmed reports of child abuse or neglect by a facility owner or employee; amending s. 400.4176, F.S.; increasing time period for notice of change of facility administrator; amending s. 400.418, F.S.; providing use of fees and fines; amending s. 400.419, F.S.; providing penalties for certain action by an administrator; providing an additional classification of violations; providing a penalty; providing for dissemination of information on facilities with violations; providing a fee; amending s. 400.42, F.S.; authorizing acceptance of third-party supplementation under specified circumstances; amending s. 400.422, F.S.; providing certain notice of receivership proceedings; revising provisions relating to expenditures to correct or eliminate deficiencies; amending s. 400.424, F.S.; requiring contract notice of a facility's policy on advance deposits; providing for disposition of personal belongings after termination date; specifying time period for refunds; providing a penalty; providing for disposition of fines; revising requirement for physical examination; amending s. 400.4255, F.S.; expanding authorized use of licensed personnel; providing for use of certified nursing assistants; amending s. 400.426, F.S.; revising provisions relating to assessment of appropriateness of placement and requirements for continued residency; requiring certain agreement or notice prior to moving a resident to another facility; amending s. 400.427, F.S.; modifying provisions relating to personal affairs of residents; prohibiting payment of benefits to an owner, administrator, or staff member without resident's consent; providing a penalty for certain misuse of a resident's personal needs allowance; amending s. 400.428, F.S.; revising the resident bill of rights; providing for extended visiting hours; requiring a grievance procedure; requiring telephone access to advocacy or special interest groups; requiring monitoring visits to facilities with certain violations; amending s. 400.431, F.S.; providing for relocation of residents receiving services from the Department of Health and Rehabilitative Services when a facility discontinues operation; extending period for return of payments by such a facility; amending s. 400.434, F.S.; authorizing inspection of facilities after license suspension or revocation; providing restrictions; amending s. 400.435, F.S.; providing copies of inspection reports to certain persons; amending s. 400.441, F.S.; revising rules relating to minimum standards for fire safety, food service inspection, and use of restraints; providing for distinct standards for facilities of different sizes; providing a restriction; amending s. 400.442, F.S.; requiring a corrective action plan for deficiencies in provision of medication; amending s. 400.444, F.S.; conforming terminology; amending s. 400.447, F.S.; deleting restrictions on advertising while under construction; providing a penalty for certain advertising violations; amending s. 400.452, F.S.; revising core educational requirements for staff; amending ss. 400.417, 400.4195, 400.421, 400.429, 400.4445, and 400.453, F.S.; conforming language to transfer of responsibilities to the Agency for Health Care Administration from the Department of Health and Rehabilitative Services; amending s. 509.032, F.S.; providing duties of the Division of Hotels and Restaurants of the Department of Business Regulation relating to inspection of public lodging establishments; amending s. 651.011, F.S.; correcting a cross reference; providing an appropriation; saving pt. II of ch. 400, F.S., from Sunset repeal; providing for future review and repeal; providing an effective date.

—a companion measure, was substituted for **CS for SB 298** and by two-thirds vote read the second time by title.

Senator McKay moved the following amendment which was adopted:

Amendment 1—On page 55, strike all of lines 3-7 and insert: problem. *A facility must not be required to retain a resident who requires more services or care than the facility is able to provide in accordance with its policies and criteria for admission and continued residency.*

Senator Sullivan moved the following amendment which was adopted:

Amendment 2 (with Title Amendment)—On page 55, strike all of lines 21-26 and insert: A terminally ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice *or home health agency;* ~~, and~~ the resident is under the care of a physician who agrees that the physical needs of the resident are being met; *arrangements have been made for emergency placement in a nursing home or inpatient hospice facility if the need arises; the hospice or home health agency has the capacity to provide 24-hour care when the resident requires more care than the facility can provide; and provisions have been made for the medical director of the hospice or home health agency to write emergency orders on behalf of a resident when the resident's primary physician is not available. The facility shall assure that the terminally ill resident, or the resident's legal representative pursuant to chapter 744 or 765, is provided with written information which clearly explains the types and costs of services offered by a hospice and home health agency. The terminally ill resident, or the resident's legal representative, shall choose which provider, hospice or home health care agency, will provide the service. Unless the resident, or resident's legal representative, expressly states another preference, hospice shall be the provider of choice for the terminally ill resident. Any hospice or home health agency that enters into an agreement pursuant to this subsection must guarantee that services will continue if the resident's Medicare, Medicaid, or other health care insurance coverage is exhausted. A facility that retains a terminally ill resident pursuant to this subsection shall ensure that the agency providing care assesses the resident's social, emotional, and family support needs, as well as physical and medical needs, and implements an interdisciplinary approach to meet such needs when appropriate.*

And the title is amended as follows:

In title, on page 3, line 5, after the semicolon (;) insert: allowing home health agencies to provide care for terminally ill residents;

Senator McKay moved the following amendment which was adopted:

Amendment 3—On page 65, line 16, after the comma (,) insert: *the agency,*

Senator Gutman moved the following amendments which were adopted:

Amendment 4—On page 6, strike all of lines 11-16 and insert:

(3) The principle that a license issued under this part is a public trust and a privilege and is not an entitlement should guide the finder of fact or trier of law at any administrative proceeding or in a court action initiated by the Agency for Health Care Administration to enforce this part.

Amendment 5—On page 39, line 20, after "*and*" insert: *, in the case of an owner-operated facility*

On motion by Senator McKay, by two-thirds vote **CS for HB 2197** as amended was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—33 Nays—None

LOCAL BILLS

SB 2378—A bill to be entitled An act relating to Lee County; prohibiting the taking of saltwater fish, except by hook and line, handheld cast net, or use of five or fewer blue crab traps, from specified manmade canals and waterways within the county; providing a penalty; providing an effective date.

—was read the second time by title. On motion by Senator Dudley, by two-thirds vote **SB 2378** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

SB 2386—A bill to be entitled An act relating to Lee County; amending ch. 76-411, Laws of Florida, as amended; expanding the boundaries of the San Carlos Park Fire Protection and Rescue Service District; providing for a referendum; providing an effective date.

—was read the second time by title. On motion by Senator Dudley, by two-thirds vote **SB 2386** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

SB 2390—A bill to be entitled An act relating to Manatee County; amending s. 10, ch. 90-420, Laws of Florida; postponing the expiration of ch. 90-420, Laws of Florida, relating to the licensing of gill nets in Manatee County saltwaters; providing an effective date.

—was read the second time by title. On motion by Senator McKay, by two-thirds vote **SB 2390** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

SB 2396—A bill to be entitled An act relating to the Nassau County Hospital Board; amending s. 9(3), ch. 21228, Laws of Florida, 1941, as amended; lowering the maximum millage that may be levied by the Nassau County Board of County Commissioners pursuant to the hospital board's budget request; providing an effective date.

—was read the second time by title. On motion by Senator Williams, by two-thirds vote **SB 2396** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

SB 2398—A bill to be entitled An act relating to Volusia County; creating the "City of DeBary Charter"; providing for the corporate name and purpose of the Charter; establishing territorial boundaries of the municipality and authorizing annexations; providing powers of the municipality and of certain officers; providing for election of a City Council, including the Mayor and Vice Mayor, and providing for qualifications, powers, and duties of its membership, and a procedure for establishing their compensation and expense reimbursement; establishing circumstances which create vacancies in office and providing for filling vacancies and for forfeiture and recall; requiring independent financial audit; providing for Council meetings, rules, recordkeeping, and voting at meetings; providing for nominations, elections, and terms of office of the Mayor and Council; providing for a City Manager, City Clerk, and City Attorney and powers and duties of each; authorizing establishment of administrative departments; providing definitions; providing procedures for adoption of ordinances and resolutions, and for handling finances; establishing a fiscal year and annual budgets; providing procedures for initiative and referendum; providing for Charter amendments and review; providing for severability; providing for transition, including initial election and terms, date of creation and establishment of the municipality, payment of certain revenues, and transitional comprehensive plan and land development regulations; entitling the City to state shared and local option gas tax revenues; providing for contractual services and facilities; eliminating transition elements; providing effective dates.

—was read the second time by title.

Senator Burt moved the following amendment which was adopted:

Amendment 1—On page 3, line 22, strike "said Section 36;" and insert: Section 36, Township 18S, Range 30E;

On motion by Senator Burt, by two-thirds vote **SB 2398** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—38 Nays—None

SB 2400—A bill to be entitled An act relating to the Braden River Fire Control and Rescue District, Manatee County; amending s. 11, ch. 85-454, Laws of Florida; deleting the residency requirement for the district fire marshal; prescribing the frequency of the fire marshal's inspections; amending s. 15, ch. 85-454, Laws of Florida, as amended; increasing the maximum assessment for certain classifications of property in the district; amending s. 16, ch. 85-454, Laws of Florida, as amended; increasing district impact fees for new development; providing an effective date.

—was read the second time by title. On motion by Senator McKay, by two-thirds vote **SB 2400** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

SB 2412—A bill to be entitled An act relating to Manatee County; requiring the election of district boards of fire commissioners for all fire-control districts in Manatee County; providing for the filling of vacancies; providing for compensation and reimbursement of per diem and travel expenses; providing an effective date.

—was read the second time by title. On motion by Senator McKay, by two-thirds vote **SB 2412** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

SB 2416—A bill to be entitled An act to validate all acts and proceedings taken in connection with the election held in Santa Rosa County, Florida, on January 26, 1993, including the publication of the notice of such election; declaring the election legal and valid; providing an effective date.

—was read the second time by title. On motion by Senator Harden, by two-thirds vote **SB 2416** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

RECESS

On motion by Senator Jennings, the Senate recessed at 12:02 p.m. to reconvene at 2:00 p.m.

AFTERNOON SESSION

The Senate was called to order by the President at 2:23 p.m. A quorum present—38:

Mr. President	Diaz-Balart	Jenne	Siegel
Bankhead	Dudley	Jennings	Silver
Beard	Dyer	Johnson	Sullivan
Boczar	Foley	Jones	Thomas
Brown-Waite	Forman	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Gutman	Kurth	Wexler
Childers	Harden	McKay	Williams
Crist	Hargrett	Meadows	
Dantzler	Holzendorf	Myers	

Consideration of **CS for SB's 1914, 2006, 1784 and 406** was deferred.

The Senate resumed consideration of—

CS for SB 1080—A bill to be entitled An act relating to pari-mutuel wagering; amending s. 550.002, F.S., and repealing subsections (15), (28), (36), and (37) of that section; revising the definition of the term "harness racing" to delete unnecessary words and repealing several unnecessary definitions; amending s. 550.01215, F.S., to provide for other authorized uses for permitted facilities; creating s. 550.022, F.S.; restricting financial arrangements by pari-mutuel permitholders; amending s. 550.0235, F.S.; revising a limitation-of-liability provision; amending s. 550.0251, F.S.; revising powers and duties of the Division of Pari-mutuel Wagering of the Department of Business Regulation; amending s. 550.0351, F.S., to add a charity to the authorized list of charities on file with the division; repealing s. 550.0425(4), F.S.; deleting a provision allowing minors access to kennel compound areas; amending s. 550.054, F.S.; revising application requirements; providing permit procedures when a pari-mutuel facility is taken by eminent domain; revising reporting requirements when there is a change in ownership of a pari-mutuel permitholder; amending s. 550.0951, F.S.; providing tax exemptions; revising daily license fees for racetracks and jai alai games; deleting breaks tax on jai alai; revising tax rates; providing tax credits; providing a surtax; creating s. 550.09512, F.S.; providing for taxes on jai alai; providing for escheat of an abandoned interest in permit for nonpayment of taxes; providing for reissuance of an escheated permit; providing for expiration of section and for legislative review in advance thereof; amending s. 550.105, F.S.; revising application

requirements for occupational licenses; amending s. 550.125, F.S., pertaining to bond requirements; improving clarity; amending s. 550.155, F.S.; providing limitations on takeout; providing for additional withholdings; amending s. 550.1625, F.S.; prescribing purse distributions for dog-racing; creating s. 550.16355, F.S.; providing for Greyhound Race of Champions Meet; amending s. 550.1815, F.S.; revising provisions respecting persons who are prohibited from holding pari-mutuel permits; amending s. 550.2415, F.S.; revising procedures pertaining to euthanizing greyhounds; providing for the establishment of greyhound-adoption facilities under certain circumstances; amending s. 550.2614, F.S., pertaining to distribution of certain funds to a horsemen's association; revising a cross-reference; amending s. 550.2625, F.S.; providing an additional percentage of handle on exotic wagering which may be paid to the purse pool for use as additional overnight purses; revising certain purse and prize requirements pertaining to quarter horse racing; providing for certain funds to be withheld from purse pools; specifying the purposes for which such funds are to be used; creating s. 550.26352, F.S.; providing for the Breeders' Cup Meet; repealing s. 550.26353, F.S., pertaining to tax credits and tax exemptions; creating s. 550.26354, F.S.; providing for exemption from taxes on handle, breeders' award and purse requirements, and horsemen's payments on intertrack wagers; repealing s. 35, ch. 92-348, Laws of Florida, which limits the applicability of specified exemptions, creating s. 550.26365, F.S.; providing for the Breeders' Crown Meet; amending s. 550.334, F.S., pertaining to quarter horse racing; revising distance limitations; amending s. 550.3551, F.S., pertaining to transmission of racing and jai alai information; providing for takeout under certain circumstances; amending s. 550.3615, F.S., deleting a provision relating to certain pending bookmaking prosecutions; amending s. 550.375, F.S., pertaining to the operation of harness tracks; revising distance limitations; amending s. 550.495, F.S.; revising bond requirements for totalizator owners or operators; providing circumstances under which such bond may be waived by the division; revising fees for totalizator licenses; amending s. 550.5251, F.S.; allowing thoroughbred permitholders to operate any extra hour; providing circumstances under which a tax credit may be provided to a thoroughbred racing permitholder not running during the Breeders' Cup Meet; allowing thoroughbred permitholders to conduct up to three additional races composed of quarter horses; amending s. 550.615, F.S., providing tax rates and takeout distribution for certain thoroughbred permitholders conducting intertrack wagers; amending s. 550.70, F.S.; proving for additional player prize money from breaks; providing for reconversion of former jai alai permit; creating s. 550.71, F.S.; providing for the Jai Alai Tournament of Champions Meet; repealing s. 570.381(3), F.S., which provides for the Appaloosa Advisory Council; amending s. 772.102, F.S., pertaining to definitions for "criminal activity," to conform cross-references; amending s. 895.02, F.S., pertaining to definition of "racketeering activity," to conform cross-references; exempting certain permitholders from paying taxes on handle generated during the Breeders' Cup Meet and the Breeders' Crown Meet for the 1992-1993 racing season; providing a tax credit for certain permitholders located within 35 miles of the Breeders' Cup Meet conducted during that racing season; providing for an audit and for the repayment of certain overpayments; requiring review of occupational licensing scheme and submission of recommendations to the Legislature; providing for termination of existing administrative rules and for adoption of new rules governing the conduct of pari-mutuel wagering; directing the Department of Business Regulation to review and consider certain costs relating to its racing laboratory and report to the Legislature; repealing s. 68, ch. 92-348, Laws of Florida, pertaining to retroactivity of that law, which provides for regulation of pari-mutuel wagering; providing an effective date.

—with pending **Amendment 1** by Senator Dudley, which was deferred on a point of order by Senator Holzendorf.

RULING ON POINT OF ORDER

On recommendation of Senator Jennings, Chairman of the Committee on Rules and Calendar, the President ruled the point well taken and the amendment out of order.

Senators Silver and Casas offered the following amendment which was moved by Senator Silver and adopted:

Amendment 2—On page 54, strike line 10 after "than" and insert: *7 p.m., provided that if a permitholder incurs delays in starting live races during a regularly scheduled performance of no more than 11 live races, this prohibition shall not prevent the completion of the regularly scheduled live races.*

Senator Jenne moved the following amendment which was adopted:

Amendment 3—On page 30, line 16, strike the period (.) and insert: , and, in the event any such permitholder withholds all sums authorized by this chapter, may at its discretion withhold an additional 2 percent of exotic wagers not to exceed a total of 25 percent.

Senator Dudley moved the following amendment which failed:

Amendment 4—On page 14, lines 19-31 through page 15, line 10, strike all of said lines

Senators Silver and Casas offered the following amendment which was moved by Senator Silver and failed:

Amendment 5 (with Title Amendment)—On page 55, line 15, after "subsection" insert: *(6) is amended and subsection*

and on page 55, line 18, after "wagering" insert: (6) In any area of the state where there are three or more horserace permitholders within 25 miles of each other, no intertrack wager may be taken by any permitholder without the consent of all operating permitholders within 25 miles of each other, *except that intertrack wagers may be taken on greyhound races by a greyhound permitholder, provided that all greyhound permitholders, within 25 miles of the guest track, consent.*

And the title is amended as follows:

In title, on page 4, line 6, after "providing" insert: for intertrack wagering; *providing restrictions on intertrack wagering in certain counties;*

On motion by Senator Grant, by two-thirds vote **CS for SB 1080** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—36 Nays—2

On motion by Senator Beard, by two-thirds vote **CS for HB 1485** was withdrawn from the Committee on Commerce.

On motion by Senator Beard—

CS for HB 1485—A bill to be entitled An act relating to health insurance; creating s. 624.021, F.S.; providing that contacts between providers and insurers or health maintenance organizations are not deemed to be insurance contracts under certain circumstances; amending ss. 627.6471 and 627.6472, F.S.; requiring a preferred provider network or an exclusive provider organization that offers psychotherapeutic services to include as members of the network or organization certain specified professionals licensed under ch. 490, F.S., or ch. 491, F.S.; requiring a preferred provider network and an exclusive provider organization to include osteopathic hospitals licensed under ch. 395, F.S.; providing that certain limitations or conditions apply equally to all licensed psychologists and psychotherapists without unfair discrimination; providing an effective date.

—a companion measure, was substituted for **CS for SB 522** and read the second time by title. On motion by Senator Beard, by two-thirds vote **CS for HB 1485** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—37 Nays—None

On motions by Senator Hargrett, by two-thirds vote **CS for HB 83** was withdrawn from the Committees on Transportation; Finance, Taxation and Claims; and Appropriations.

On motion by Senator Hargrett—

CS for HB 83—A bill to be entitled An act relating to motor vehicle licenses; providing for the creation of Florida Special Olympics license plates; providing purpose; creating s. 320.0896, F.S.; providing for the issuance of such license plates upon payment of the license tax and additional fees; providing for deposit of a portion of the fees; providing for the use of fees; providing for duties of Florida Special Olympics, Inc.; providing for deauthorization based on sales; providing an effective date.

—a companion measure, was substituted for **SB 724** and read the second time by title. On motion by Senator Hargrett, by two-thirds vote **CS for HB 83** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

CS for SB 1208—A bill to be entitled An act relating to financial matters; amending ss. 159.811, 215.65, and 215.655, F.S.; revising provisions which specify requirements relating to fees collected by the Division of Bond Finance and expenses of the division; amending s. 215.44, F.S.; providing for the confidentiality of records relating to investments by the State Board of Administration; providing for future review and repeal; amending s. 215.47, F.S., which specifies the securities eligible for investment by the State Board of Administration; providing additional eligible securities and revising limitations on investments; requiring the board to act in accordance with specified criteria; providing an effective date.

—was read the second time by title.

The Committee on Finance, Taxation and Claims recommended the following amendment which was moved by Senator Jones and adopted:

Amendment 1—On page 6, line 30, strike *"national"* and insert: *notional*

On motion by Senator Jones, by two-thirds vote **CS for SB 1208** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—37 Nays—None

SB 280—A bill to be entitled An act relating to jurors and grand jurors; amending s. 40.013, F.S.; providing that a person may not be excused from service on a civil trial jury solely because of deafness or hearing impairment; providing applicability; amending s. 90.6063, F.S.; requiring appointment of an interpreter to assist deaf jurors or grand jurors; amending s. 905.17, F.S.; authorizing interpreters to be present at grand jury deliberation or voting; amending s. 905.24, F.S.; prohibiting interpreters from disclosing grand jury proceedings; amending s. 913.03, F.S.; providing that deafness or hearing impairment shall not be the sole ground for challenging a juror in a civil action; providing an effective date.

—was read the second time by title. On motion by Senator Bankhead, by two-thirds vote **SB 280** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

SB 12—A bill to be entitled An act relating to the Health Care Cost Containment Board; repealing s. 407.60, F.S., relating to duties of the board with respect to establishing a fee schedule for radiation therapy procedures; providing an effective date.

—was read the second time by title.

One amendment was adopted to **SB 12** to conform the bill to **CS for HB 139**.

Pending further consideration of **SB 12** as amended, on motions by Senator Childers, by two-thirds vote **CS for HB 139** was withdrawn from the Committees on Health Care; Health and Rehabilitative Services; and Appropriations.

On motion by Senator Childers—

CS for HB 139—A bill to be entitled An act relating to health care cost containment; repealing s. 407.60, F.S., relating to charges for radiation therapy procedures; amending s. 15 of ch. 92-178, Laws of Florida; revising the divestiture date for designated health services; providing an effective date.

—a companion measure, was substituted for **SB 12** and read the second time by title. On motion by Senator Childers, by two-thirds vote **CS for HB 139** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

Consideration of **CS for SB 2260** was deferred.

SB 1086—A bill to be entitled An act relating to tax on sales, use, and other transactions; amending s. 212.05, F.S.; specifying that any law enforcement officer performing approved law enforcement duties is not performing detective, burglar protection, and other protection services for purposes of the tax on such services; providing an effective date.

—was read the second time by title.

The Committee on Finance, Taxation and Claims recommended the following amendment which was moved by Senator Hargrett:

Amendment 1 (with Title Amendment)—On page 2, strike all of lines 3-5 and insert: *command of his law enforcement agency, and in the uniform of his law enforcement agency, is performing law enforcement and public safety services and is not performing detective, burglar protection, or other protective services; provided, the law enforcement officer is performing his approved duties in a geographical area in which his law enforcement agency has jurisdiction.*

And the title is amended as follows:

In title, on page 1, line 8, before the semicolon (;) insert: under certain circumstances

Senator Forman moved the following amendment to **Amendment 1** which was adopted:

Amendment 1A (with Title Amendment)—On page 1, strike all of lines 12-18 and insert: *command of his law enforcement agency, and in his uniform as authorized by his law enforcement agency, is performing law enforcement and public safety services and is not performing defective, burglar protection, or other protective services,* if the *law enforcement officer is performing his approved duties in a geographical area in which the law enforcement officer has arrest jurisdiction.*

And the title is amended as follows:

In title, on page 1, line 8, before the semicolon (;) insert: under certain circumstances

Amendment 1 as amended was adopted.

Senator Hargrett moved the following amendment which was adopted:

Amendment 2 (with Title Amendment)—On page 2, between lines 22 and 23, insert:

Section 2. Effective upon this act becoming a law and applicable retroactively to January 1, 1986, subsection (10) of section 199.052, Florida Statutes, is amended to read:

199.052 Annual tax returns; payment of annual tax.—

(10) An affiliated group of corporations may elect to make a consolidated return for any year. The election shall be made by timely filing a consolidated return. Once made, an election may not be revoked, and it is binding for the tax year. The mere making of a consolidated return shall not in itself provide a business situs in this state for intangible personal property held by a corporation. The fact that members of an affiliated group own stock in corporations which do not qualify under the stock ownership requirements as members of an affiliated group shall not preclude the filing of a consolidated return on behalf of the qualified members. Where a consolidated return is made, intercompany accounts, including the capital stock of an includable corporation, other than the parent, owned by another includable corporation, shall not be subject to annual taxation. However, capital stock and other intercompany accounts of a nonqualified member of the affiliated group shall be subject to annual tax. Each consolidated return shall be accompanied by documentation identifying all intercompany accounts and containing such other information as the department shall require. *Failure to timely file a consolidated return shall not prejudice the taxpayer's right to file a consolidated return, provided that the failure to file a consolidated return is limited to 1 year and the taxpayer's intent to file a consolidated return is evidenced by the taxpayer having filed a consolidated return for the 3 years prior to the year the return was not timely filed.*

Section 3. Paragraph (d) is added to subsection (11) of section 212.06, Florida Statutes, 1992 Supplement, to read:

212.06 Sales, storage, use tax; collectible from dealers; "dealer" defined; dealers to collect from purchasers; legislative intent as to scope of tax.—

(11)

(d) This subsection applies retroactively to July 1, 1987.

And the title is amended as follows:

In title, on page 1, line 8, after the semicolon (;) insert: amending s. 199.052, F.S.; providing that failure to timely file a consolidated intangible personal property tax return does not prejudice a taxpayer's right to file such return under certain conditions; providing for retroactive effect; amending s. 212.06, F.S.; providing for retroactive application of the exemption from said tax for certain promotional materials which are exported outside the state;

Senator Myers moved the following amendment:

Amendment 3 (with Title Amendment)—On page 1, line 29, before the period (.) insert: *, except private security services provided at nuclear power plants when such services, are mandated by federal or state laws or authorities*

And the title is amended as follows:

In title, on page 1, line 3, following the second semicolon (;) insert: exempting specified private security services;

On motion by Senator Hargrett, further consideration of **SB 1086** with pending **Amendment 3** was deferred.

Consideration of **CS for HB 1085** and **CS for SB 368** was deferred.

CS for SB 536—A bill to be entitled An act relating to juveniles; amending s. 39.025, F.S., relating to juvenile delinquency and gang prevention; replacing juvenile delinquency and gang prevention councils with county and district juvenile justice plans, councils, and boards; providing legislative findings and intent; revising and providing definitions; providing for county juvenile justice councils, and providing for district juvenile justice boards, and providing for membership, organization, purpose, duties, and reporting; deleting provisions relating to grant application procedures and providing criteria for community juvenile justice partnership grants; amending s. 874.03, F.S.; redefining the term "pattern of youth and street gang activity" to eliminate "the purpose of furthering gang activity" for purposes of ch. 874, F.S., which increases the penalty for a felony or violent misdemeanor that is part of a pattern of youth and street gang activity, which provides a civil cause of action for a violation of the chapter, which provides for forfeiture of profits, proceeds, or instrumentalities of criminal activity of youth and street gangs, and which provides for reporting certain crime information; creating s. 39.0475, F.S.; authorizing a delinquency pretrial intervention program for limited purposes under certain circumstances; providing procedure; providing effective dates.

—was read the second time by title.

Senator Forman moved the following amendments which were adopted:

Amendment 1—On page 10, strike all of lines 21-25 and insert: *county within the district. To aid in the establishment of councils and the planning process, technical support shall be provided to each district council by an entity that is qualified to provide such assistance and that is broadly representative of the various components of the juvenile justice system. To aid the planning process the Department of Health and Rehabilitative Services shall provide routinely collected ethnicity data. The Department of Law Enforcement shall include ethnicity as a field in the Florida Intelligence Center database and collect the data routinely.*

Amendment 2—On page 24, lines 18-31 through page 25, lines 1-25, strike all of said lines

Amendment 3—On page 26, line 6, before the comma (,) insert: to the extent that funded programs are available

Amendment 4—On page 26, line 27, after "treatment" insert: , if resources and funding are available,

On motion by Senator Forman, by two-thirds vote **CS for SB 536** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—37 Nays—None

On motions by Senator Myers, by two-thirds vote **CS for HB 659** was withdrawn from the Committees on Health and Rehabilitative Services; and Appropriations.

On motions by Senator Myers, the rules were waived and—

CS for HB 659—A bill to be entitled An act relating to developmental disabilities; amending s. 393.068, F.S.; expanding services and support authorized under the family care program; requiring the Department of Health and Rehabilitative Services to prioritize increased appropriations and its 5-year plan for certain family-based services; amending s. 393.066, F.S.; requiring the Department of Health and Rehabilitative Services to prioritize increased appropriations and its 5-year plan for certain community-based services; creating family care councils within each service district of the Department of Health and Rehabilitative Services; providing for appointment of members; providing for meetings and continued existence; specifying purpose and functions; requiring the department to determine certain annual expenditures and provide information to the councils and others; providing for council review and recommendations; providing for a family-support planning process; requiring the Department of Health and Rehabilitative Services to use a family-support planning process; requiring the Department of Education to facilitate the use of the family-support planning process; specifying target populations to be served to the extent possible within existing resources; providing for the participation of local education agencies; providing for the development, implementation, and review of plans; requiring notice to families of certain exceptional circumstances; providing for technical assistance to communities; providing implementation timeframes; providing for rules; providing an effective date.

—a companion measure, was substituted for **CS for SB's 1774 and 1480** and read the second time by title. On motion by Senator Myers, by two-thirds vote **CS for HB 659** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

Consideration of **CS for SB 436** was deferred.

On motions by Senator Jones, by two-thirds vote **CS for HB 1017** was withdrawn from the Committees on Health Care; Rules and Calendar; and Appropriations.

On motion by Senator Jones—

CS for HB 1017—A bill to be entitled An act relating to health care; creating the "Minority Health Improvement Act"; providing definitions; providing legislative findings and intent; creating a study commission on minority health; providing membership; providing for administration, organization, and staff; providing duties; requiring an interim and final report to the Governor and Legislature; providing for the expiration of the commission; amending s. 394.875, F.S.; providing for the licensure of certain residential treatment facilities exclusively for the treatment of law enforcement personnel and their families who are suffering from nonacute stress-related mental health problems, including drug and alcohol abuse; specifying criteria for licensure; providing an effective date.

—a companion measure, was substituted for **CS for SB 652** and read the second time by title. On motion by Senator Jones, by two-thirds vote **CS for HB 1017** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

CS for SB 368—A bill to be entitled An act relating to public school funding; amending s. 236.081, F.S.; revising provisions relating to computation of the basic amount to be allocated to each school district for operation of schools; providing additional funding for school districts that implement total system change, as defined, in a single school as an initial step in an extended-school-year program; prescribing the elements of "total system change"; prescribing goals for the program; providing an effective date.

—was read the second time by title. On motion by Senator Sullivan, by two-thirds vote **CS for SB 368** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—33 Nays—None

Consideration of **CS for SB 884** was deferred.

SB 1644—A bill to be entitled An act relating to education; amending s. 233.0615, F.S.; providing for a values and law education program in the public schools; providing for content of the program; providing an effective date.

—was read the second time by title. On motion by Senator Dantzler, by two-thirds vote **SB 1644** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

Consideration of **CS for SB 2224** was deferred.

CS for SB 884—A bill to be entitled An act relating to sale and delivery of firearms; amending s. 790.065, F.S.; increasing the fee for firearms purchase records checks; providing for deposit into a segregated account and providing for reporting and disposition of funds; providing for the future repeal of s. 790.065, F.S.; reenacting s. 493.6121(6), F.S., relating to private investigators, to incorporate the amendment to s. 790.065, F.S., in a reference thereto; providing an effective date.

—was read the second time by title.

The Committee on Finance, Taxation and Claims recommended the following amendment which was moved by Senator Silver and adopted:

Amendment 1—On page 3, strike all of lines 13 and 14 and insert:

Section 3. This act shall take effect May 1, 1993.

On motion by Senator Silver, by two-thirds vote **CS for SB 884** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—36 Nays—1

CS for SB 436—A bill to be entitled An act relating to the Department of Highway Safety and Motor Vehicles; renaming the Accident Reports Trust Fund as the Highway Safety Operating Trust Fund, to be used to fund the general operations of the department; abolishing the Drivers' Education Trust Fund, the Florida Real Time Vehicle Information System Trust Fund, the Motor Vehicle Inspection Trust Fund, the Motor Vehicle License Plate Replacement Trust Fund, and the Odometer Fraud Prevention and Detection Trust Fund and providing for depositing revenues that are currently deposited into those funds into the Highway Safety Operating Trust Fund; repealing s. 215.20(4)(jj), F.S., relating to the Motor Vehicle Inspection Trust Fund; amending ss. 316.2124, 318.1451, 319.324, 320.06, 320.0607, 320.08, 320.0848, 320.089, 320.131, 320.27, 320.77, 321.23, 322.025, 322.095, 322.12, 322.17, 322.20, 325.214, 627.733, F.S.; providing for deposit or revenues into the Highway Safety Operating Trust Fund; providing for the free replacement of license plates under specified circumstances; amending ss. 319.32, 320.04, 320.0815, F.S., increasing the tax collector's service charge; amending s. 320.03, F.S.; providing for tax collectors to refund fees paid in relation to motor vehicle licenses and titles; amending s. 321.21, F.S.; increasing the funeral allowance for members of the Florida Highway Patrol and deleting authority to pay a funeral allowance for other employees of the department; providing effective dates.

—was read the second time by title.

Senator Diaz-Balart moved the following amendments which were adopted:

Amendment 1 (with Title Amendment)—On page 16, between lines 1 and 2, insert:

Section 22. Subsection (7) of section 316.2397, Florida Statutes, is amended to read:

316.2397 Certain lights prohibited; exceptions.—

(7) *Subsections* ~~Subsection~~ (1) *and (6) do* ~~does~~ not apply to police, fire, or authorized emergency vehicles while in the performance of their necessary duties.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 1, line 25, after the semicolon (;) insert: amending s. 316.2397, F.S.; authorizing law enforcement vehicles to flash their headlights;

Amendment 2 (with Title Amendment)—On page 21, before line 1, insert:

Section 4. Subsection (3) of section 316.2397, Florida Statutes, is amended to read:

316.2397 Certain lights prohibited; exceptions.—

(3) Vehicles of the fire department and fire patrol, including vehicles of volunteer firemen as permitted under s. 316.2398, vehicles of medical staff physicians or technicians of medical facilities licensed by the state as authorized under s. 316.2398, ambulances as authorized under this chapter, and buses and taxicabs as authorized under s. 316.2399 are permitted to show or display red lights. Wreckers, mosquito control fog and spray vehicles, and emergency vehicles of governmental departments or public service corporations may show or display amber lights when in actual operation or when a hazard exists provided they are not used going to and from the scene of operation or hazard without specific authorization of a law enforcement officer or law enforcement agency. Further, escort vehicles will be permitted to show or display amber lights when in the actual process of escorting over-dimensioned equipment, material, or buildings as authorized by law. School buses may show and display lights as provided in chapter 234 and may show and display flashing white strobe lights. Vehicles of private watchman, guard, or patrol agencies licensed pursuant to chapter 493 may show or display amber lights while patrolling condominium, cooperative, and private residential and business communities *and special taxing or assessment districts in downtown business districts* by which employed and which traverse public streets or highways.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 2, line 3, after the semicolon (;) insert: amending s. 316.2397, F.S.; providing an exemption;

Senators Silver and Hargrett offered the following amendment which was moved by Senator Hargrett and adopted:

Amendment 3 (with Title Amendment)—On page 17, between lines 20 and 21, insert:

(9) A nonrefundable fee of *$1* ~~50 cents~~ shall be charged on the initial and renewal registration of each automobile for private use, and on the initial and renewal registration of each truck having a net weight of 5,000 pounds or less. Such fees shall be deposited in the Transportation Disadvantaged Trust Fund created in part I of chapter 427 and shall be used as provided therein.

And the title is amended as follows:

In title, on page 1, line 28, after the semicolon (;) insert: increasing a fee;

On motion by Senator Diaz-Balart, by two-thirds vote **CS for SB 436** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—38 Nays—None

Consideration of **Senate Bills 612** and **676** was deferred.

CS for SB 752—A bill to be entitled An act relating to elections; amending s. 98.081, F.S.; providing notice requirements relating to status as a qualified elector; providing that certain persons may not vote or sign a petition; amending s. 98.211, F.S.; providing exceptions to public inspection of voter registration records; prohibiting the use of voter lists for commercial purposes; providing penalties; amending s. 99.021, F.S.; prescribing required oaths; amending s. 99.061, F.S.; providing for the decertification of candidates who violate certain qualification requirements; amending ss. 99.0955, 99.096, F.S.; providing deadlines for the filing and certification of certain petitions; amending s. 99.097, F.S.; providing for the verification of certain petitions by minor parties at no charge; amending ss. 101.041, 101.62, F.S.; providing for absentee balloting by facsimile transmission; amending s. 102.031, F.S.; regulating activities around polling places; amending s. 103.021, F.S.; providing for the replacement of independent vice-presidential candidates; amending s. 105.035, F.S.; deleting an oath requirement for judicial candidates seeking to qualify by petition; amending s. 106.07, F.S.; requiring certain disclosure related to the principals of entities that make campaign contributions; providing an effective date.

—was read the second time by title.

Senator Foley moved the following amendment which was adopted:

Amendment 1 (with Title Amendment)—On page 15, lines 10-31, on page 16, lines 1-31; and on page 17, lines 1-16, strike all of said lines and renumber subsequent sections.

And the title is amended as follows:

In title, on page 1, strike all of lines 21 and 22 and insert: transmission;

On motion by Senator Dudley, by two-thirds vote **CS for SB 752** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—34 Nays—None

On motion by Senator McKay, by two-thirds vote **HB 1001** was withdrawn from the Committee on Finance, Taxation and Claims.

On motion by Senator McKay—

HB 1001—A bill to be entitled An act relating to the Sarasota-Manatee Airport Authority; providing for the relief of Laurence Wallenstein, widow of Frank Colton Wallenstein, and Jennifer Wallenstein, Melanie Wallenstein, and Leif Wallenstein, children of Frank Colton Wallenstein, to permit the Sarasota-Manatee Airport Authority to compensate them for the death of Frank Colton Wallenstein by providing them with a death benefit equal to the benefit credited to Frank Colton Wallenstein under the Sarasota-Manatee Airport Authority retirement plan as of the time of his death; providing an appropriation; providing an effective date.

—a companion measure, was substituted for **SB 612** and read the second time by title. On motion by Senator McKay, by two-thirds vote **HB 1001** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—34 Nays—None

Consideration of **CS for SB 640** and **SB 1356** was deferred.

On motions by Senator Siegel, by two-thirds vote **CS for HB 1343** was withdrawn from the Committees on Natural Resources and Conservation; and Governmental Operations.

On motion by Senator Siegel—

CS for HB 1343—A bill to be entitled An act relating to aquifer protection; providing a definition; creating the Geneva Freshwater Lens Task Force; providing for membership; providing for meetings of the task force; requiring the task force to report to the Legislature; providing for agencies to cooperate with the task force; providing for travel expenses and per diem; requiring the St. Johns River Water Management District to provide administrative and fiscal support to the task force; providing an effective date.

—a companion measure, was substituted for **SB 2184** and read the second time by title. On motion by Senator Siegel, by two-thirds vote **CS for HB 1343** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

CS for CS for SB 1694—A bill to be entitled An act relating to DUI programs; amending s. 316.193, F.S.; providing for attendance at a substance abuse course licensed by the department; revising reporting requirements; amending s. 322.095, F.S., requiring instructor certification and monitoring by the department; authorizing driver improvement schools to offer the traffic law and substance abuse education courses; requiring an independent evaluation of course effectiveness to the Legislature by October 1, 2000; requiring financial audits of providers at their expense; amending s. 322.271, F.S., providing for additional duties of the department relating to regulation of DUI programs; creating s. 322.292, F.S., providing for the regulation of DUI programs by the department; providing powers and duties; authorizing existing DUI programs until relicensure by the department; creating s. 322.293, F.S., transferring the DUI Programs Coordination Office; providing for an assessment against persons enrolled in DUI programs; providing for disposition of fees; repealing s. 25.387, F.S., which creates the DUI Programs Coordination Trust Fund and provides for assessments and for disposition of proceeds; providing an effective date.

—was read the second time by title.

Senator Diaz-Balart moved the following amendments which were adopted:

Amendment 1—On page 3, strike all of lines 2-7 and insert: *A waiver may be granted where the department determines, in accordance with its rules, that the organization that conducts the substance abuse education and evaluation is the most appropriate Health and Rehabilitative Services-licensed treatment service provider. All DUI treatment programs must be*

Amendment 2—On page 8, line 23, after the period (.) insert: Such requirements must address the number of clients currently served in the circuit as well as improvements in service that may be derived from operation of an additional DUI program.

On motion by Senator Diaz-Balart, further consideration of **CS for CS for SB 1694** as amended was deferred.

Consideration of **CS for CS for CS for SB 1858** and **CS for SB 2130** was deferred.

SB 474—A bill to be entitled An act for the relief of R.M., a single woman; providing an appropriation to compensate her for injuries and damages sustained as the result of a violent rape; providing an effective date.

—was read the second time by title.

One amendment was adopted to **SB 474** to conform the bill to **CS for HB 277**.

Pending further consideration of **SB 474** as amended, on motion by Senator Kurth, by two-thirds vote **CS for HB 277** was withdrawn from the Committee on Finance, Taxation and Claims.

On motion by Senator Kurth—

CS for HB 277—A bill to be entitled An act for the relief of R.M., a single woman; providing that, notwithstanding the provisions of s. 960.01, F.S., the Department of Legal Affairs may review her claim for victim's compensation; providing an effective date.

—a companion measure, was substituted for **SB 474** and read the second time by title. On motion by Senator Kurth, by two-thirds vote **CS for HB 277** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—35 Nays—None

CS for SB 520—A bill to be entitled An act relating to lodging and food service establishments and member campgrounds; exempting persons or establishments licensed under ch. 509, F.S., from the licensure requirements of ch. 475, F.S., relating to real estate brokers, salesmen, schools, and appraisers; amending s. 509.242(1), F.S.; modifying the definition of the terms "resort condominium" and "resort dwelling"; providing an effective date.

—was read the second time by title.

Senator Hargrett moved the following amendment which was adopted:

Amendment 1 (with Title Amendment)—On page 1, line 15 through page 2, line 31, strike all of said lines and insert:

Section 1. Subsections (4) and (8) and paragraph (b) of subsection (5) of section 509.013, Florida Statutes, 1992 Supplement, are amended, present subsections (9) and (10) are renumbered as subsections (11) and (12), respectively, and new subsections (9) and (10) are added to that section, to read:

509.013 Definitions.—As used in this chapter, the term:

(4)(a) "Public lodging establishment" means any unit, group of units, dwelling, building, or group of buildings within a single complex of buildings, which is rented *to guests* more than three times in a calendar year for periods of less than 30 days or 1 calendar month, whichever is less, or which is advertised or held out to the public as a place regularly rented to *guests* ~~tenants or transients~~. License classifications of public lodging establishments, and the definitions therefor, are set out in s. 509.242. For the purpose of licensure, the term does not include condominium common elements as defined in s. 718.103.

(b) The following are excluded from the definition in paragraph (a):

1. Any dormitory or other living or sleeping facility maintained by a public or private school, college, or university for the use of students, faculty, or visitors;

2. Any hospital, nursing home, sanitarium, adult congregate living facility, or other similar place;

3. Any place renting four rental units or less, unless the rental units are advertised or held out to the public to be places that are regularly rented to *guests* ~~transients~~; ~~and~~

4. Any unit or group of units in a condominium, cooperative, or time-share plan and any individually or collectively owned one-family, two-family, three-family, or four-family dwelling house or dwelling unit that is rented for periods of at least 30 days or 1 calendar month, whichever is less, and that is not advertised or held out to the public as a place regularly rented for periods of less than 1 calendar month;

~~5.~~4. Any migrant labor camp inspected by the Department of Health and Rehabilitative Services; *and.*

6. Any establishment inspected by the Department of Health and Rehabilitative Services and regulated by chapter 513.

(5)(a) "Public food service establishment" means any building, vehicle, place, or structure, or any room or division in a building, vehicle, place, or structure where food is prepared, served, or sold for immediate consumption on or in the vicinity of the premises; called for or taken out by customers; or prepared prior to being delivered to another location for consumption.

(b) The following are excluded from the definition in paragraph (a):

1. Any place maintained and operated by a public or private school, college, or university:

a. For the use of students and faculty; or

b. Temporarily to serve such events as fairs, carnivals, and athletic contests.

2. Any eating place maintained and operated by a church or a religious, nonprofit fraternal, or nonprofit civic organization:

a. For the use of members and associates; or

b. Temporarily to serve such events as fairs, carnivals, or athletic contests.

3. Any eating place located on an airplane, train, bus, or watercraft which is a common carrier.

4. Any eating place maintained by a hospital, nursing home, sanitarium, adult congregate living facility, adult day care center, or other similar place *that is regulated under s. 381.0072.*

5. Any place of business issued a permit or inspected by the Department of Agriculture and Consumer Services which manufactures, processes, packages, holds, or sells food at retail pursuant to s. 500.12.

6. Any place of business where the food available for consumption is limited to ice, beverages with or without garnishment, popcorn, or prepackaged items sold without additions or preparation.

7. Any theater, if the primary use is as a theater and if patron service is limited to food items customarily served to the admittees of theaters.

8. Any vending machine that dispenses any food or beverages other than potentially hazardous foods, as defined by division rule.

9. Any vending machine that dispenses potentially hazardous food and which is located in a facility regulated under s. 381.0072.

(8) "Temporary food service event" means any event of *30* 3 days or less in duration where food is *prepared,* served, or sold to the general public.

(9) "Theme park or entertainment complex" means a complex comprised of at least 25 contiguous acres owned and controlled by the same business entity and which contains permanent exhibitions and a variety of recreational activities and has a minimum of one million visitors annually.

(10) "Transient establishment" means any public lodging establishment that is rented or leased to guests by an operator whose intention is that such guests' occupancy will be temporary.

Section 2. Section 509.032, Florida Statutes, 1992 Supplement, is amended to read:

509.032 Duties.—

(1) GENERAL.—

~~(a)~~ The division shall carry out all of the provisions of this chapter and all other applicable laws and rules relating to the inspection or regulation of public lodging establishments and public food service establishments for the purpose of safeguarding the public health, safety, and welfare. The division shall be responsible for ascertaining that an operator licensed under this chapter does not engage in any misleading advertising or unethical practices.

~~(b) The division shall keep accurate account of all expenses arising out of the performance of its duties and all fees collected under the provisions of this chapter. The division shall send the Governor a written report at the end of each fiscal year which shall contain the total number of inspections conducted, the number and type of violations reported, and recommendations for improved inspection procedures.~~

(2) INSPECTION OF PREMISES.—

(a) The division has responsibility and jurisdiction for all inspections required by this chapter. The division has responsibility for quality assurance. Each licensed establishment shall be inspected *at least biannually and at such other times as the division determines is necessary to ensure the public's health, safety, and welfare. The division shall establish a system to determine inspection frequency.* ~~in accordance with the following schedule:~~

~~1. Each~~ Public lodging ~~establishment renting transiently shall be inspected at least four times annually. However,~~ units classified as resort condominiums or resort dwellings *are* ~~shall~~ not ~~be~~ subject to this requirement, but shall be made available to the division upon request.

~~2. Each public lodging establishment classified as renting to nontransient tenants shall be inspected at least twice annually.~~

~~3. Statewide, the average number of public food service establishment inspections shall be four per year and shall be based on sanitary conditions of the establishment. Each establishment shall be inspected at least three times annually.~~

(b) For purposes of performing required inspections and the enforcement of this chapter, the division, or its agent, has the right of entry and access to public lodging establishments and public food service establishments at any reasonable time.

(c) Public food service establishment inspections shall be conducted to enforce provisions of this part and to educate, inform, and promote cooperation between the division and the establishment.

(d) The division shall adopt and enforce sanitation rules consistent with law to ensure the protection of the public from food-borne illness in those establishments licensed under this chapter. These rules shall provide the standards and requirements for *obtaining,* storing, preparing, processing, serving, or displaying food in public food service establishments, approving public food service establishment facility plans, conducting necessary public food service establishment inspections, cooperating and coordinating with the Department of Health and Rehabilitative Services in epidemiological investigations, and initiating enforcement actions, and for other such responsibilities deemed necessary by the division.

(e)1. Relating to facility plan approvals, the *division may establish, by rule, fees for conducting plan reviews and* ~~department~~ may grant variances from construction standards in hardship cases, which variances may be less restrictive than the provisions specified in this section or the rules adopted under this section. A variance may not be granted pursuant to this section until the *division* ~~department~~ is satisfied that:

a. The variance shall not adversely affect the health of the public.

b. No reasonable alternative to the required construction exists.

c. The hardship was not caused intentionally by the action of the applicant.

2. The *division's* ~~department's~~ advisory council shall review applications for variances and recommend agency action. The *division* ~~department~~ shall make arrangements to expedite emergency requests for variances, to ensure that such requests are acted upon within 30 days of receipt.

3. The *division* ~~department~~ shall establish, by rule, a fee for the cost of the variance process. Such fee shall not exceed $150 for routine variance requests and $300 for emergency variance requests.

(3) SANITARY STANDARDS; EMERGENCIES; TEMPORARY FOOD SERVICE EVENTS.—The division shall:

(a) Prescribe sanitary standards which shall be enforced in public food service establishments.

(b) Inspect public lodging establishments and public food service establishments whenever necessary to respond to an emergency or epidemiological condition.

(c) Administer a public notification process for temporary food service events ~~of 4 to 18 days' duration~~ and distribute educational materials that address safe food storage, preparation, and service procedures.

1. Sponsors ~~or vendors~~ of temporary food service events ~~of 4 to 18 days' duration~~ shall notify the division not less than 3 days prior to the scheduled event of the type of food service proposed, ~~and~~ the time and location of the event, *a complete list of food service vendor owners and operators participating in each event, and the current license numbers of all public food service establishments participating in each event.* Notification may be completed orally, by telephone, in person, or in writing. A *public food service establishment or food service* ~~sponsor or~~ vendor may not use this notification process to circumvent the license requirements of this chapter.

2. The division shall keep a record of all notifications received for proposed temporary food service events ~~of 4 to 18 days in duration~~ and shall provide appropriate educational materials to the event sponsors.

~~3. The following events are exempt from any fee charged for temporary food service events:~~

~~a. Any temporary event sponsored and operated by a public or private school, college, or university such as a fair, carnival, or athletic event.~~

~~b. Any temporary event sponsored and operated by a church or a religious, nonprofit fraternal, or nonprofit civic organization such as a fair, carnival, or athletic event.~~

4.a. A public food service establishment or other food vendor must obtain a license from the division for each temporary food service event in which it participates.

b. Public food service establishments holding current licenses from the division may operate under the regulations of such a license at temporary food service events of 3 days or less in duration.

(4) STOP-SALE ORDERS.—The division may stop the sale of food when the director or his designee determines that such food represents a threat to the public safety or welfare.

(5) REPORTS REQUIRED.—The division shall

~~(d)~~ send the Governor a written report at the end of each fiscal year, which report shall state, but not be limited to, the total number of inspections conducted by the division to ensure the enforcement of sanitary standards, the total number of inspections conducted in response to emergency or epidemiological conditions, the number of violations of each sanitary standard, and any recommendations for improved inspection procedures. *The division shall also keep accurate account of all expenses arising out of the performance of its duties and all fees collected under this chapter.*

(6)~~(4)~~ RULEMAKING AUTHORITY.—The division shall adopt such rules as are necessary to carry out the provisions of this chapter.

(7) PREEMPTION AUTHORITY.—The regulation and inspection of public lodging establishments and public food service establishments and the regulation of food safety protection standards for required training and testing of food service establishment personnel are preempted to the state.

Section 3. Section 509.035, Florida Statutes, is amended to read:

509.035 Immediate closure due to severe public health threat.—The *division shall, upon proper finding, immediately issue an order* ~~following procedure shall be used~~ to close an establishment licensed under this chapter in the instance of a severe and immediate public health *or safety or welfare* threat *as follows:*~~.~~

(1)*(a)* The *director* ~~division or the Department of Health and Rehabilitative Services~~ shall declare a public health threat upon a proper finding by the *state health officer* ~~director or administrator of the local health unit~~ that the continued operation of a licensed establishment presents a severe and immediate threat to the public health~~, safety, and welfare~~.

(b) The director shall declare a threat to the public safety or welfare upon a proper finding by the director that the continued operation of a licensed establishment presents a severe and immediate threat to the public safety or welfare.

(2) *Upon such determination,* ~~At the time of such declaration, the Department~~ of ~~Health and Rehabilitative Services shall immediately notify the division and shall forward to the division sufficient documentation in order for~~ the division *shall* ~~to~~ issue a notice to show cause and an emergency order of suspension. *Such order shall be served upon the establishment by the division or its agent, and the establishment shall be closed. An operator who resists such closure is subject to further administrative action by the division and is punishable as provided in s. 509 281 The division shall provide an inspection within 24 hours following such closure and shall review all relevant information to determine whether the facility has met the requirements to resume operations.*

(3) The division ~~or the Department of Health and Rehabilitative Services~~ may attach a sign which states "Closed to Protect Public Health and

Safety" to such an establishment and may require the licensee to immediately stop service *until notification to the contrary is provided by the director* ~~for a period of up to 12 hours after the time of notification to the division~~.

~~(4) The division shall immediately review the severe public health threat documentation and if such documentation is sufficient shall issue a notice to show cause and an emergency order of suspension. Such order shall be served upon the establishment by the division or its agent, and the establishment shall be closed. An operator who resists such closure is subject to further administrative action by the division.~~

(4)~~(5)~~ The division *may further* ~~shall~~ adopt rules for issuing emergency orders after business hours and on weekends and holidays in order to ensure the timely closure of an establishment under this section.

Section 4. Section 509.039, Florida Statutes, 1992 Supplement, is amended to read:

509.039 Food service manager certification.—It *is* ~~shall be~~ the duty of the division to adopt, by rule, food safety protection standards for the training and certification of all food service managers who are responsible for the storage, preparation, display, or serving of foods to the public in establishments regulated under this chapter. These standards are to be adopted by the division to ensure that, upon successfully passing a test, a manager of a food service establishment shall have demonstrated a knowledge of basic food protection practices. These standards shall also provide for a certification program which authorizes private or public agencies to conduct an approved test and certify the results of those tests to the division. The fee for the test shall not exceed $50. All managers employed by a food service establishment *must* ~~shall~~ have passed this test and received a certificate attesting thereto. Managers ~~shall~~ have a period of 90 days after employment to pass the required test. ~~The regulation of food safety protection standards for any required training and testing of food service establishment personnel is hereby preempted to the state.~~ The ranking of food service establishments is also preempted to the state; provided, however, that any local ordinances establishing a ranking system in existence prior to October 1, 1988, may remain in effect. ~~The regulation and inspection of food service establishments licensed by this chapter and regulation of food safety protection standards for required training and testing of food service establishment personnel are preempted to the state.~~

Section 5. Subsection (2) of section 509.101, Florida Statutes, is amended to read:

509.101 Establishment rules; posting of notice; maintenance of guest register; mobile food dispensing vehicle registry.—

(2) It is the duty of each operator of a *transient* ~~public lodging~~ establishment ~~renting to transient guests~~ to maintain at all times a register, signed by or for guests who occupy rental units within the establishment, showing the dates upon which the rental units were occupied by such guests and the rates charged for their occupancy. This register shall be maintained in chronological order and available for inspection by the division at any time. Operators need not make available registers which are more than 2 years old. Each operator shall maintain at all times a current copy of this chapter in the office of the licensed establishment which shall be made available to the public upon request.

Section 6. Subsection (1) of section 509.151, Florida Statutes, is amended to read:

509.151 Obtaining food or lodging with intent to defraud; penalty.—

(1) Any person who obtains food, lodging, or other accommodations having a value of less than $300 at any public food service establishment, or at any *transient* ~~public lodging~~ establishment ~~on a transient basis~~, with intent to defraud the operator thereof, is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083; if such food, lodging, or other accommodations have a value of $300 or more, such person is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 7. Subsection (4) of section 509.201, Florida Statutes, is amended to read:

509.201 Room rates; posting; advertising; penalties.—

(1) In each public lodging establishment renting by the day or week there shall be posted in a plainly legible fashion, in a conspicuous place in each rental unit, the rates at which each such unit is rented. Such posting shall show the maximum amount charged for occupancy per person; the amount charged for extra conveniences, more complete accommodations, or additional furnishings; and the dates during the year when such charges prevail. Copies of the posted rate schedules for all similar rental units in each establishment shall be filed with the division at least 5 days before such rates are to become effective and shall be kept current. The rates posted in the rental units may not exceed those on file with the division, and an establishment may not charge more than the rates posted in the rental units and filed with the division.

(2)(a) A person may not display or cause to be displayed any sign which may be seen from a public highway or street, which sign includes a statement or numbers relating to the rates charged at a public lodging establishment renting by the day or week, unless such sign includes, in letters and figures of similar size and prominence, the following information: the number of rental units in the establishment and the rates charged for each, whether the rates quoted are for single or multiple occupancy if such fact affects the rate charged, and the dates during which such rates are in effect. In each instance the rates charged may not exceed those filed with the division. A sign may not be displayed which includes a statement or numbers which appear to relate to the rate charged at a public lodging establishment when in fact the statement or numbers do not relate to such rates.

(b) A person may not publish or cause to be published any advertisement, other than those referred to in paragraph (a), which includes a statement or numbers relating to rates charged at a public lodging establishment renting by the day or week unless such advertisement includes, in letters or figures immediately adjacent to said rate, a statement as to whether the rates quoted are for single or multiple occupancy if such fact affects the rates charged. Any such advertisement shall also include the number of rental units in the establishment available at the published rates, the dates during which such rates are in effect, and an indication as to whether there are other rates in effect in the establishment. The advertised rate in each instance shall coincide with the rates posted in such rental units and may not exceed those filed for such units with the division. For any such advertisement, the type size of the required additional information may not be smaller than one-twelfth of the size of the rate figures advertised or equal to the type size used in the body of the advertisement, whichever is larger. The requirements of this paragraph apply to any type of display advertisement, regardless of whether it is printed in a magazine, newspaper, or other similar publication.

(c) The provisions of paragraph (b) do not apply to advertisements or listings in guides or directories which are published by nonprofit organizations or associations or to advertisements of a classified nature placed in the classified section of newspapers and other similar publications.

(d) An advertisement may not be published that contains false or misleading statements about any public lodging establishment.

(4) Subsection (1) and paragraphs (a), (b), and (c) of subsection (2) do not apply to any facility or unit classified as a resort condominium, *nontransient apartment*, or resort dwelling as described in s. 509.242(1)(c), *(d)*, and (g).

Section 8. Subsections (2), (5), (6), and (9) of section 509.221, Florida Statutes, are amended to read:

509.221 Sanitary regulations.—

(2) Each public lodging establishment and each public food service establishment shall maintain not less than one public bathroom for each sex, properly designated. *Each public lodging establishment and each public food service establishment undergoing plan review pursuant to s. 509.032(2)(d) after July 1, 1993, shall maintain not less than one public bathroom for each sex, properly designated, unless otherwise provided by rule. The division shall establish by rule categories of establishments not subject to the two bathroom requirement of this subsection. Such rules may not alter the exemption provided for theme parks in this subsection. Within a theme park or entertainment complex as defined in s. 509.031(9), the bathrooms are not required to be in the same building as the public food service establishment, so long as they are reasonably accessible.* Each *transient* ~~transiently rented public lodging~~ establishment that does not provide private or connecting bathrooms shall maintain one public bathroom on each floor for every 15 guests, or major fraction of that number, rooming on that floor.

(5) Each *transient* ~~public lodging~~ establishment ~~renting transiently~~ and each public food service establishment shall provide in the main public bathroom soap and clean towels or other approved hand-drying devices and each public lodging establishment shall furnish each guest with two clean individual towels so that two guests will not be required to use the same towel unless it has first been laundered.

(6) Each *transient* ~~public lodging~~ establishment ~~renting transiently~~ shall provide each bed, bunk, cot, or other sleeping place for the use of guests with clean pillowslips and under and top sheets. Sheets and pillowslips shall be laundered before they are used by another guest, a clean set being furnished each succeeding guest. All bedding, including mattresses, quilts, blankets, pillows, sheets, and comforters, shall be thoroughly aired, disinfected, and kept clean. Bedding, including mattresses, quilts, blankets, pillows, sheets, or comforters, may not be used if they are worn out or unfit for further use.

(9) Subsections (2), (5), and (6) do not apply to any facility or unit classified as a resort condominium, *nontransient apartment,* or resort dwelling as described in s. 509.242(1)(c), *(d),* and (g).

Section 9. Section 509.242, Florida Statutes, is amended to read:

509.242 Public lodging establishments; classifications.—

(1) A public lodging establishment shall be classified as a hotel, motel, resort condominium, nontransient apartment, transient apartment, rooming house, or resort dwelling if the establishment satisfies the following criteria:

(a) Hotel.—A hotel is any public lodging establishment containing sleeping room accommodations for 25 or more guests and providing the services generally provided by a hotel and recognized as a hotel in the community in which it is situated or by the industry.

(b) Motel.—A motel is any public lodging establishment which offers rental units with an exit to the outside of each rental unit, daily or weekly rates, offstreet parking for each unit, a central office on the property with specified hours of operation, a bathroom or connecting bathroom for each rental unit, and at least six rental units, and which is recognized as a motel in the community in which it is situated or by the industry.

(c) Resort condominium.—A resort condominium is any unit or group of units in a condominium, cooperative, or time-share plan which is rented more than three times in a calendar year for periods of less than 30 days or 1 calendar month, whichever is less, or which is advertised or held out to the public as a place regularly rented *for periods of less than 30 days or 1 calendar month, whichever is less* ~~to transients~~.

(d) Nontransient apartment.—A nontransient apartment is any apartment building in which 75 percent or more of the units are available for rent to nontransient tenants.

(e) Transient apartment.—A transient apartment is any apartment building in which units are advertised or held out to the public as available for transient occupancy.

(f) Rooming house.—A rooming house is any public lodging establishment that may not be classified as a hotel, motel, resort condominium, nontransient apartment, or transient apartment under this section. A rooming house includes, but is not limited to, a boarding house, hostel, and bed and breakfast inn.

(g) Resort dwelling.—A resort dwelling is any individually or collectively owned one-family, two-family, three-family, or four-family dwelling house or dwelling unit which is rented more than three times in a calendar year for periods of less than 30 days or 1 calendar month, whichever is less, or which is advertised or held out to the public as a place regularly rented *for periods of less than 30 days or 1 calendar month whichever is less* ~~to transients~~.

(2) If 25 percent or more of the units in any public lodging establishment fall within a classification different from the classification under which the establishment is licensed, such establishment shall obtain a separate license for the classification representing the 25 percent or more units which differ from the classification under which the establishment is licensed.

(3) A public lodging establishment may advertise or display signs which advertise a specific classification, if it has received a license which is applicable to the specific classification and it fulfills the requirements of that classification.

~~(4) The division shall study:~~

~~(a) The emerging issue of public lodging establishments which provide multiple lodging services. The appropriate sanitation and safety standards applicable to such establishments shall be determined, as well as any other action necessary to protect the public's health, safety, and welfare; and~~

~~(b) The certification of onsite managers or operators of public lodging establishments classified in s. 509.242(1)(d) and (e).~~

~~The cost for these studies shall be absorbed within the division's existing budget. Finally, the division shall report the findings of these studies and any recommendations as a result of these studies to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the minority leaders of both the Senate and the House of Representatives by November 1, 1991.~~

Section 10. Subsections (1) and (2) of section 509.251, Florida Statutes, are amended, and subsection (4) is added to that section, to read:

509.251 License fees.—

(1) The division shall adopt, by rule, a schedule of fees to be paid by each public lodging establishment as a prerequisite to issuance or renewal of a license. Such fees shall be based on the number of rental units in the establishment but shall not exceed $1,000. *The fee schedule shall also prescribe categories of fee adjustments based upon the number of inspections required as a result of the previous year's sanitation and safety record of the establishment.* Resort condominium units within separate buildings or at separate locations but managed by one licensed agent may be combined in a single license application, and the division shall charge a license fee as if all units in the application are in a single licensed establishment. Resort dwelling units may be licensed in the same manner as condominium units. The fee schedule shall require an establishment which applies for an initial license to pay the full license fee if application is made during the annual renewal period or more than 6 months prior to the next such renewal period and one-half of the fee if application is made 6 months or less prior to such period. The fee schedule shall include fees collected for the purpose of funding the Hospitality Education Program, pursuant to s. 509.302, which are payable in full for each application regardless of when the application is submitted..

(a) Upon making initial application or an application for change of ownership, the applicant shall pay to the division a fee as prescribed by rule, not to exceed $50, in addition to any other fees required by law, which shall cover all costs associated with initiating regulation of the establishment.

(b) A license renewal filed with the division within 30 days after the expiration date shall be accompanied by a delinquent fee as prescribed by rule, not to exceed $50, in addition to the renewal fee and any other fees required by law Thereafter, a new application is required, accompanied by a reinstatement fee as prescribed by rule, not to exceed $100, and any other fees required by law.

(2) The division shall adopt, by rule, a schedule of fees to be paid by each public food service establishment as a prerequisite to issuance or renewal of a license. The fee schedule shall prescribe a basic fee and additional fees based on seating capacity and services offered. *The fee schedule shall also prescribe categories of fee adjustments based upon the number of inspections required as a result of the previous year's sanitation record of the public food service establishment.*, ~~but~~ The aggregate fee per establishment charged any public food service establishment may not exceed $400. The fee schedule shall require an establishment which applies for an initial license to pay the full license fee if application is made during the annual renewal period or more than 6 months prior to the next such renewal period and one-half of the fee if application is made 6 months or less prior to such period. The fee schedule shall include fees collected for the purpose of funding the Hospitality Education Program, pursuant to s. 509.302, which are payable in full for each application regardless of when the application is submitted.

(a) Upon making initial application or an application for change of ownership, the applicant shall pay to the division a fee as prescribed by rule, not to exceed $50, in addition to any other fees required by law, which shall cover all costs associated with initiating regulation of the establishment.

(b) A license renewal filed with the division within 30 days after the expiration date shall be accompanied by a delinquent fee as prescribed

by rule, not to exceed $50, in addition to the renewal fee and any other fees required by law. Thereafter, a new application is required, accompanied by a reinstatement fee as prescribed by rule, not to exceed $100, and any other fees required by law.

(4) The actual costs associated with each epidemiological investigation conducted by the Department of Health and Rehabilitative Services in public food service establishments licensed pursuant to chapter 509 shall be accounted for and submitted to the division annually. The division shall journal transfer the total of all such amounts from the Hotel and Restaurant Trust Fund to the Department of Health and Rehabilitative Services annually; however, the total amount of such transfer may not exceed an amount equal to 5 percent of the annual public food service establishment licensure fees received by the division.

Section 11. Present subsections (2), (3), (4), (5), and (6) of section 509.261, Florida Statutes, are renumbered as subsections (3), (4), (5), (6), and (7), respectively, and a new subsection (2) is added to that section to read:

509.261 Revocation or suspension of licenses; fines; procedures.—

(2) For the purposes of this section, the division may regard as a separate offense each day or portion of a day on which an establishment is operated in violation of a "critical law or rule," as that term is defined by rule.

Section 12. Section 509.091, Florida Statutes, is amended to read:

509.091 Notices; form and service.—Each notice served by the division pursuant to this chapter must be in writing and must be delivered personally by an agent of the division or by registered letter to the operator of the public lodging establishment or public food service establishment. *If the operator refuses to accept service or evades service or the agent is otherwise unable to effect service after due diligence, the division may post such notice in a conspicuous place at the establishment.*

Section 13. Subsection (8) of section 381.0011, Florida Statutes, is amended to read:

381.0011 Duties and powers of the Department of Health and Rehabilitative Services.—It is the duty of the Department of Health and Rehabilitative Services to:

(8) Provide for the dissemination of information to the public relative to the prevention, control, and cure of diseases, illnesses, and hazards to human health. *The department shall conduct a workshop before issuing any health alert or advisory relating to food-borne illness or communicable disease in public lodging or food service establishments in order to inform persons, trade associations, and businesses of the risk to public health and to seek the input of affected persons, trade associations, and businesses on the best methods of informing and protecting the public, except in an emergency, in which case the workshop must be held within 14 days after the issuance of the emergency alert or advisory.*

Section 14. Paragraph (b) of subsection (1), subsection (2), and paragraph (a) of subsection (4) of section 381.0072, Florida Statutes, 1992 Supplement, are amended to read:

381.0072 Food service protection.—It shall be the duty of the Department of Health and Rehabilitative Services to adopt and enforce sanitation rules consistent with law to ensure the protection of the public from food-borne illness. These rules shall provide the standards and requirements for the storage, preparation, serving, or display of food in food service establishments as defined in this section and which are not permitted or licensed under chapter 500 or chapter 509.

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

(b) "Food service establishment" means any facility, as described in this paragraph, where food is prepared and intended for individual portion service, and includes the site at which individual portions are provided. The term includes any such facility regardless of whether consumption is on or off the premises and regardless of whether there is a charge for the food. The term includes detention facilities, child care facilities, schools, institutions, *civic or* ~~and~~ fraternal organizations, *and* ~~as well as~~ bars and lounges. The term does not include private homes where food is prepared or served for individual family consumption; nor does the term include churches, synagogues, or other not-for-profit religious organizations as long as these organizations serve only their members and guests and do not advertise food or drink for public consumption, or any facility or establishment permitted or licensed under chapter 500 or chapter 509; nor does the term include any theater, if the primary use is as a theater and if patron service is limited to food items customarily served to the admittees of theaters.

(2) DUTIES.—

(a) The department shall adopt rules consistent with law prescribing minimum sanitation standards and manager certification requirements as prescribed in s. 509.039, which shall be enforced in food service establishments as defined in this section. Public and private schools, hospitals licensed under chapter 395, nursing homes licensed under part I of chapter 400, child care facilities as defined in s. 402.301, and residential facilities colocated with a nursing home or hospital if all food is prepared in a central kitchen that complies with nursing or hospital regulations shall be exempt from the rules developed for manager certification. The department shall administer a comprehensive inspection, monitoring, and sampling program to ensure such standards are maintained. With respect to food service establishments permitted or licensed under chapter 500 or chapter 509, the department shall assist the Division of Hotels and Restaurants of the Department of Business Regulation and the Department of Agriculture and Consumer Services with rulemaking by providing technical information.

(b) The department shall carry out all provisions of this chapter and all other applicable laws and rules relating to the inspection or regulation of food service establishments as defined in this section, for the purpose of safeguarding the public's health, safety, and welfare.

(c) The department shall inspect each food service establishment as often as necessary to ensure compliance with applicable laws and rules. The department shall have the right of entry and access to these food service establishments at any reasonable time.

~~(d) Notwithstanding the provisions of chapter 509, 5 percent of the fees collected on all food service establishment permits and licenses issued by the Department of Business Regulation shall be journal transferred to the Department of Health and Rehabilitative Services to provide epidemiological services relating to outbreaks and investigations of food-borne illness.~~

(d)~~(e)~~ The department or other appropriate regulatory entity may inspect theaters exempted in subsection (1) to ensure compliance with applicable laws and rules pertaining to minimum sanitation standards. A fee for inspection shall be prescribed by rule, but the aggregate amount charged per year per theater establishment shall not exceed $300, regardless of the entity providing the inspection.

(4) LICENSE; INSPECTION; FEES.—

(a) The department is authorized to collect fees from establishments licensed under this section *and from those facilities exempted from licensure under paragraph (3)(a)*. It is the intent of the Legislature that the total fees assessed under this section be in an amount sufficient to meet the cost of carrying out the provisions of this section.

Section 15. Subsection (4) of section 509.036, Florida Statutes, as created by chapter 90-339, Laws of Florida, is repealed.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 1, line 10, after the semicolon (;) insert: amending s. 509.013, F.S.; clarifying the definitions of "public lodging establishment," "public food service establishment," and "temporary food service event"; defining "transient establishment" and "theme park or entertainment complex"; amending s. 509.032, F.S., relating to duties of the Division of Hotels and Restaurants of the Department of Business Regulation; clarifying reporting requirements; revising inspection requirements; providing for fees for plan review; requiring licenses for temporary food service events; deleting exemptions for temporary food service events; providing for stop-sale orders; providing preemption authority; amending s. 509.035, F.S.; revising provisions relative to immediate closure of licensed establishments due to severe public health threat; providing penalties; amending s. 509.039, F.S.; deleting a reference to preemption authority; amending ss. 509.101, 509.151, F.S.; clarifying requirements for transient establishments; amending s. 509.201, F.S.; providing an exemption from rate posting and advertising for nontransient apartments; amending s. 509.221, F.S.; specifying standards for transient establishments and exempting certain sanitary requirements for nontransient apartments

and certain theme parks and entertainment complexes; providing rulemaking authority; amending s. 509.242, F.S.; deleting obsolete language relating to submission of a report; clarifying classification of resort condominiums and resort dwellings; amending s. 509.251, F.S.; providing additional fees for initial application, delinquent renewal, and change-of-ownership applications; authorizing the division to set additional standards for assessing fees; providing for the accounting for and transfer of certain costs; amending s. 509.261, F.S.; clarifying penalties; amending s. 509.091, F.S.; providing for notice; amending s. 381.0011, F.S.; requiring the Department of Health and Rehabilitative Services to hold a workshop before issuing a nonemergency health alert or advisory relating to food-borne illness or disease in public food service establishments; amending s. 381.0072, F.S.; redefining the term "food service establishment" for purposes of department sanitation rules; providing for the department to collect fees from establishments exempted from licensure; repealing provisions relating to the transfer of certain fees to provide epidemiological services; repealing s. 509.036(4), F.S., deleting obsolete language;

Senator Dudley offered the following amendment which was moved by Senator Hargrett and adopted:

Amendment 2 (with Title Amendment)—On page 3, strike all of lines 1-6 and renumber subsequent sections.

And the title is amended as follows:

In title, on page 1, strike all of lines 4-8 and insert: amending s. 509.242(1), F.S.;

On motion by Senator Hargrett, by two-thirds vote **CS for SB 520** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—38 Nays—None

SB 1252—A bill to be entitled An act relating to securities; amending s. 517.021, F.S.; removing an exclusion from the definition of associated person; amending s. 517.07, F.S.; prohibiting selling unregistered securities, into, from, or within the state; providing for registration of securities of small corporate offerings; creating s. 517.0815, F.S.; authorizing the registration of certain small corporate initiative offerings; amending s. 517.101, F.S.; providing for consent to service of process; amending s. 517.111, F.S.; providing for revocation of registration of small corporate offerings; amending s. 517.12, F.S.; providing effective dates for registration of branch offices; amending s. 517.161, F.S.; providing dates for termination of a registration; clarifying the meaning of the term "ultimate equitable owner"; providing an appropriation; providing an effective date.

—was read the second time by title.

Senator Foley moved the following amendments which were adopted:

Amendment 1—On page 9, strike all of lines 18-20 and insert: The Department of Banking and Finance is authorized up to three postitions for the 1993-1994 fiscal year.

Amendment 2—On page 2, line 23, strike "from"

On motion by Senator Foley, by two-thirds vote **SB 1252** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—33 Nays—None

Reconsideration

On motion by Senator Foley, the Senate reconsidered the vote by which—

SB 1252—A bill to be entitled An act relating to securities; amending s. 517.021, F.S.; removing an exclusion from the definition of associated person; amending s. 517.07, F.S.; prohibiting selling unregistered securities, into, from, or within the state; providing for registration of securities of small corporate offerings; creating s. 517.0815, F.S.; authorizing the registration of certain small corporate initiative offerings; amending s. 517.101, F.S.; providing for consent to service of process; amending s. 517.111, F.S.; providing for revocation of registration of small corporate offerings; amending s. 517.12, F.S.; providing effective dates for registration of branch offices; amending s. 517.161, F.S.; providing dates for termination of a registration; clarifying the meaning of the term "ultimate equitable owner"; providing an appropriation; providing an effective date.

—passed as amended this day.

Senator Foley moved the following amendment which was adopted:

Amendment 3—In title, on page 1, line 6, strike "from," and line 20, strike "providing an appropriation"

On motion by Senator Foley, by two-thirds vote **SB 1252** as amended was read by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—36 Nays—None

Consideration of **SB 12** was deferred.

SENATOR CHILDERS PRESIDING

Consideration of **CS for CS for SB 288** was deferred.

SB 676—A bill to be entitled An act for the relief of Mr. and Mrs. Darriel Swindell; providing an appropriation to compensate them for injuries caused by the negligence of Prison Rehabilitative Industries and Diversified Enterprises, Inc. (PRIDE); providing an effective date.

—was read the second time by title.

The Committee on Finance, Taxation and Claims recommended the following amendment which was moved by Senator Silver:

Amendment 1—On page 2, strike all of lines 22-25 and insert:

Section 3. The Comptroller is directed to draw a warrant in favor of Mr. Darriel Swindell in the sum of $358,991, and a warrant in favor of Mrs. Darriel Swindell in the sum of $13,750, both warrants to be drawn out of funds in the State Treasury which are contained in the Grants and Donations Trust Fund of the Department of Corrections, which are contributed by the corporation authorized to carry out the provisions of Chapter 946, Part II, Florida Statutes, and the State Treasurer is directed to pay the same out of such funds in the State Treasury not otherwise appropriated.

Section 4. Nothing contained in this act shall be interpreted to require the corporation organized to carry out the provisions of Chapter 946, part II, Florida Statutes, to reimburse the Donations and Grants Trust Fund of the Department of Corrections for the appropriation required by this act.

(Renumber subsequent section.)

Senator Silver moved the following amendment to **Amendment 1** which was adopted:

Amendment 1A—On page 1, strike all of lines 12-27 and insert:

Section 3. The sum of $372,742 is appropriated for fiscal year 1993-1994 out of the funds in the State Treasury to the credit of the Department of Corrections and not otherwise appropriated, to be paid to Mr. and Mrs. Darriel Swindell as relief for injuries and damages sustained.

Section 4. The Comptroller is directed to draw a warrant in favor of Mr. Darriel Swindell in the sum of $358,991 on October 1, 1993, and a warrant in favor of Mrs. Darriel Swindell in the sum of $13,750 on October 1, 1993.

Section 5. This act may not be interpreted to require the corporation organized to carry out the provisions of chapter 946, part II, Florida Statutes, to reimburse the Department of Corrections for the appropriation required by this act.

Amendment 1 as amended was adopted.

On motion by Senator Silver, by two-thirds vote **SB 676** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—33 Nays—3

SB 1356—A bill to be entitled An act relating to education; providing legislative intent; authorizing the establishment of regional consortium service organizations; providing requirements for these organizations; providing eligibility and application procedures for incentive grants; providing an effective date.

—was read the second time by title. On motion by Senator Kirkpatrick, by two-thirds vote **SB 1356** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—35 Nays—None

The Senate resumed consideration of—

SB 1086—A bill to be entitled An act relating to tax on sales, use, and other transactions; amending s. 212.05, F.S.; specifying that any law enforcement officer performing approved law enforcement duties is not performing detective, burglar protection, and other protection services for purposes of the tax on such services; providing an effective date.

—which had been previously considered this day. Pending **Amendment 3** by Senator Myers was adopted.

Senators Sullivan and Jones offered the following amendment which was moved by Senator Sullivan and adopted:

Amendment 4 (with Title Amendment)—On page 2, between lines 22 and 23, insert:

Section 2. Paragraph (a) of subsection (1) of section 212.031, Florida Statutes, is amended to read:

212.031 Lease or rental of or license in real property.—

(1)(a) It is declared to be the legislative intent that every person is exercising a taxable privilege who engages in the business of renting, leasing, letting, or granting a license for the use of any real property unless such property is:

1. Assessed as agricultural property under s. 193.461.

2. Used exclusively as dwelling units.

3. Property subject to tax on parking, docking, or storage spaces under s. 212.03(6).

4. Recreational property or the common elements of a condominium when subject to a lease between the developer or owner thereof and the condominium association in its own right or as agent for the owners of individual condominium units or the owners of individual condominium units. However, only the lease payments on such property shall be exempt from the tax imposed by this chapter, and any other use made by the owner or the condominium association shall be fully taxable under this chapter.

5. A public or private street or right-of-way occupied or used by a utility for utility purposes.

6. A public street or road which is used for transportation purposes.

7. Property used at an airport exclusively for the purpose of aircraft landing or aircraft taxiing or property used by an airline for the purpose of loading or unloading passengers or property onto or from aircraft or for fueling aircraft or, for the period July 1, 1990, through June 30, 1991, property used at an airport to operate advertising displays in any county as defined in s. 125.011(1).

8. Property used at a port authority, as defined in s. 315.02(2), exclusively for the purpose of oceangoing vessels or tugs docking, or such vessels mooring on property used by a port authority for the purpose of loading or unloading passengers or cargo onto or from such a vessel, or property used at a port authority for fueling such vessels.

9. Property used as an integral part of the performance of qualified production services. As used in this subparagraph, the term "qualified production services" means any activity or service performed directly in connection with the production of a qualified motion picture, as defined in s. 212.06(1)(b), and includes:

a. Photography, sound and recording, casting, location managing and scouting, shooting, creation of special and optical effects, animation, adaptation (language, media, electronic, or otherwise), technological modifications, computer graphics, set and stage support (such as electricians, lighting designers and operators, greensmen, prop managers and assistants, and grips), wardrobe (design, preparation, and management), hair and makeup (design, production, and application), performing (such as acting, dancing, and playing), designing and executing stunts, coaching, consulting, writing, scoring, composing, choreographing, script supervising, directing, producing, transmitting dailies, dubbing, mixing, editing, cutting, looping, printing, processing, duplicating, storing, and distributing;

b. The design, planning, engineering, construction, alteration, repair, and maintenance of real or personal property including stages, sets, props, models, paintings, and facilities principally required for the performance of those services listed in sub-subparagraph a.; and

c. Property management services directly related to property used in connection with the services described in sub-subparagraphs a. and b.

10. Leased, subleased, or rented to a person providing food and drink concessionaire services within the premises of a movie theater, a business operated under a permit issued pursuant to chapter 550 or chapter 551, or any publicly owned arena, sports stadium, convention hall, exhibition hall, auditorium, or recreational facility. A person providing retail concessionaire services involving the sale of food and drink or other tangible personal property within the premises of an airport shall be subject to tax on the rental of real property used for that purpose, but shall not be subject to the tax on any license to use the property. For purposes of this subparagraph, the term "sale" shall not include the leasing of tangible personal property.

11. Property occupied pursuant to an instrument calling for payments which the department has declared, in a Technical Assistance Advisement issued on or before March 15, 1993, to be nontaxable pursuant to FAC Rule 12A-1.070(19)(c); provided that this subparagraph shall only apply to property occupied by the same person before and after the execution of the subject instrument and only to those payments made pursuant to such instrument, exclusive of renewals and extensions thereof occurring after March 15, 1993.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 1, line 8, following the semicolon (;) insert: amending s. 212.05, F.S.; exempting certain properties from taxation, on the rental, lease, letting, or granting a license for use, pursuant to a previously issued Technical Assistance Advisory;

On motion by Senator Hargrett, by two-thirds vote **SB 1086** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—35 Nays—None

Reconsideration

On motion by Senator Hargrett, the Senate reconsidered the vote by which—

SB 1086—A bill to be entitled An act relating to tax on sales, use, and other transactions; amending s. 212.05, F.S.; specifying that any law enforcement officer performing approved law enforcement duties is not performing detective, burglar protection, and other protection services for purposes of the tax on such services; providing an effective date.

—passed as amended this day.

On motion by Senator Hargrett, by two-thirds vote the Senate reconsidered the vote by which **SB 1086** was read the third time.

On motion by Senator Hargrett, the Senate reconsidered the vote by which **Amendment 3** was adopted. **Amendment 3** was withdrawn.

On motion by Senator Hargrett, by two-thirds vote **SB 1086** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—34 Nays—None

On motions by Senator Weinstein, by two-thirds vote **HB 127** was withdrawn from the Committees on Criminal Justice and Appropriations.

HB 127—A bill to be entitled An act relating to vehicular accidents that result in death or personal injury; amending s. 316.027, F.S.; increasing the penalty imposed on a driver who fails to stop and remain at the scene of such accident if the accident results in a death; providing an effective date.

—was read the second time by title. On motion by Senator Weinstein, by two-thirds vote **HB 127** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

CS for CS for SB 288—A bill to be entitled An act relating to professional sports facilities; amending s. 212.20, F.S.; providing for distribution of a portion of revenues from the tax on sales, use, and other transactions to a professional golf hall of fame facility; creating s. 288.1168, F.S.; providing for certification of such facility by the Department of Commerce; providing requirements for certification and distribution of funds; providing for use of the funds distributed to the facility; providing for audits by the Department of Revenue; providing for confidentiality and for review and repeal; providing for recertification; providing an effective date.

—was read the second time by title.

Senators Forman and Gutman offered the following amendment which was moved by Senator Forman and adopted:

Amendment 1 (with Title Amendment)—On page 7, between lines 26 and 27, insert:

Section 3. Section 212.097, Florida Statutes, is created to read:

212.097 Rebuilding of certain hotels; exemption; deferral.—

(1) As used in this section, "eligible hotel" means a facility as defined by s. 509.242(1)(a), (c), or (g), which held a license as such within the 12-month period prior to the occurrence of a catastrophic disaster, which is located in a region of the state which has been affected by a catastrophic disaster, which sustained damage in excess of $1 million during the catastrophic disaster, and which has been substantially closed for business during the entire time subsequent to the occurrence of the disaster until the proposal is made under subsection (2). "Substantially closed for business" means that the hotel offers not more than 10 percent of the previously licensed rooms for rental. A "catastrophic disaster" is any natural, technological, or manmade emergency that causes damage of sufficient severity and magnitude so that massive state and federal assistance, including immediate military involvement, will be required in the affected area, if the disaster affecting a specified region is so designated by the Governor, except that for purposes of this section, Hurricane Andrew, which occurred on August 24, 1992, shall be considered a catastrophic disaster affecting Monroe, Dade, Broward, and Collier Counties.

(2) An eligible hotel that wishes to qualify for the exemption authorized by subsection (3) shall submit to the department a proposal to rebuild, in the form specified by the department. The proposal must be submitted within 3 years after the date of the occurrence of the disaster or within 3 years after the effective date of this section, whichever is later, and shall include documentary evidence as required by the department which clearly indicates:

(a) That the hotel is an eligible hotel as defined by subsection (1).

(b) That, when rebuilding is completed, the hotel will contain 400 or more separate units for guests.

(c) That a portion of the expenses for rebuilding the hotel is for enhancements to the facility beyond the rebuilding necessary to restore the facility to its condition immediately prior to the disaster, and that the cost of that enhancement portion when substantially completed equals an amount which exceeds 100 percent of the assessed value for ad valorem tax purposes of the entire facility, including tangible personal property, immediately prior to the disaster. "Substantially completed" has the same meaning as provided in s. 192.042(1).

(d) That, when rebuilding is completed, the hotel will offer a wide variety of tourist services, including convention, meeting, restaurant, and conference facilities sufficient to serve at any single event the needs of 70 percent of the guests in residence at the hotel, and will attract predominantly events and guests from national and international markets.

(3)(a) If the department determines that the proposal to rebuild meets the requirements of subsection (2), the hotel shall be eligible for an exemption from the tax imposed by this part as provided in this subsection. Depreciable properties such as building materials and equipment, and furnishings which have a useful life of 3 years or more, purchased in connection with the rebuilding of the hotel, and which are permanent on-site improvements of the hotel, which contribute to increasing the assessed value of the hotel above its assessed value immediately prior to the date of the disaster described in subsection (1) shall be exempt from said tax as follows: the exemption granted for such items is equal to the ratio of the difference between the assessed value after the rebuilding and the assessed value before the catastrophic disaster divided by the assessed value after the rebuilding, times the sales and use taxes paid on such items.

(b) This exemption inures to the hotel only through a refund of previously paid taxes. A refund shall be authorized upon an affirmative showing by the hotel to the satisfaction of the department that the requirements of this subsection have been met, upon completion of the rebuilding of the hotel. The provisions of s. 215.26 do not apply to any refund application made pursuant to this paragraph if the initial refund application was timely filed pursuant to s. 215.26. The right to refund shall continue in effect for 3 years from the date the application was filed, however, no more than one exemption through a refund of previously paid taxes shall be permitted for an eligible hotel. To receive a refund, the hotel must file under oath an application which includes:

1. The name and address of the eligible hotel.

2. A copy of the department's determination that the proposal to rebuild meets the requirements of subsection (2).

3. All evidence required by the department to enable it to determine the assessed value of the eligible hotel immediately prior to the date of the disaster described in subsection (1) and the assessed value after the rebuilding.

4. A specific description of the building materials, equipment, and furnishings for which a refund is sought.

5. A sworn statement, under penalty of perjury, from the general contractor or subcontractor licensed in this state with whom the applicant contracted to make the improvements necessary to accomplish the rebuilding, which statement lists the building materials, equipment, and furnishings used in the improvements, the actual cost of the building materials, equipment, and furnishings, the amount of sales tax paid in this state on the building materials, equipment, and furnishings, the date of purchase, and the name and address of the person from whom the building materials, equipment, and furnishings were purchased. In the event that a contractor has not been used, the applicant shall provide this information in a sworn statement, under the penalty of perjury. Copies of the invoices or other proof of purchase which evidences the purchase of the building materials, equipment, and furnishings used in such improvements and proof of payment of sales tax on said items shall be attached to the sworn statement provided by the contractor or the applicant to support the refund claim.

(c) Upon approval of the application submitted pursuant to paragraph (b), the department shall determine the amount of such purchases which are qualified for exemption under this subsection. A refund approved pursuant to this paragraph shall be made within 30 days of formal approval by the department of the application for the refund. The department is authorized to adopt rules governing the manner and form of refund applications and may establish guidelines as to the requisites for an affirmative showing of qualification for exemption under this subsection. The provisions of s. 212.095 do not apply to any refund application made pursuant to this subsection.

(d) If the department determines that building materials, equipment, or furnishings for which exemption has been granted under this subsection were not used in the rebuilding of the eligible hotel, the amount of taxes refunded to the hotel purchasing such building materials, equipment, or furnishings shall immediately be due and payable to the department, together with the appropriate interest and penalty, computed from the date of refund, in the manner provided by this chapter.

(e) The total amount of tax refunds approved pursuant to this subsection relative to a specific catastrophic disaster shall not exceed $2.5 million in any single year. Prior to March 1 of each year, a hotel may apply to the department for a refund. The application shall state the total dollar amount of refund. Each year a hotel shall receive the exemption only to the extent of $2,500,000 multiplied by the ratio that its receipts bear to the total of the receipts of all hotels applying for the exemption in such year.

(4) An eligible hotel that has qualified for and received the tax exemption authorized by subsection (3) shall also be eligible, subsequent to the completion of the rebuilding of the hotel, to defer payment of all taxes imposed each year by this part, except for any local option taxes authorized by this part, and collected on sales and rentals by the hotel in excess of the base tax collection amount. The "base tax collection amount" is the annual average amount of such taxes collected by the hotel for the most recent 3 calendar years the hotel was in operation prior to the date of the disaster described in subsection (1). Payment of these taxes may be deferred for each year for up to 5 years commencing with completion of the rebuilding of the hotel, if the requirements of this subsection are met. During that period and the repayment period, no penalties or interest shall apply to the amounts deferred if payments are made according to the schedule required by this subsection. An eligible hotel that defers payment of these taxes waives the right to contest payment of the taxes and any penalties and interest related to any failure to timely pay the installment payments provided for in this subsection, must execute documents prepared by the department so as to encumber the property relative to amounts due for the deferred taxes and penalties and interest related thereto, and must agree to pay the deferred amounts when due as required by this subsection. The hotel must submit a statement with each return required by this part for taxes not deferred stating the amount of taxes for which payment is deferred. At the end of the 5-year period, the total amount of taxes deferred each year shall become due, and shall be paid in monthly installments pursuant to s. 212.11 on a prorated basis over the next 10 years. In addition, in lieu of any interest or penalties that might otherwise have been due during the 5-year period, the hotel must agree to repay on a prorated basis over the 10-year period any amounts refunded pursuant to subsection (3). In order to remain eligible for deferral of taxes after the first deferral year, the value of the hotel that is encumbered by mortgage or other lien shall not exceed 80 percent of the total market value of the hotel, and the hotel must certify to the department that this requirement has been met at the close of each year during the deferral period. If at any time this requirement is not met or the taxes are not timely paid, the hotel will no longer be eligible for deferral of taxes under this subsection for any additional time period, and all amounts previously deferred or otherwise owed shall become due and payable immediately together with penalties and interest as provided in s. 212.12 from the date of deferral until paid.

(5) The department is authorized to promulgate rules and prescribe forms necessary to implement this section.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 1, strike all of lines 2-16 and insert: An act relating to professional sports facilities; amending s. 212.20, F.S.; providing for distribution of a portion of revenues from the tax on sales, use, and other transactions to a professional golf hall of fame facility; creating s. 288.1168, F.S.; providing for certification of such facility by the Department of Commerce; providing requirements for certification and distribution of funds; providing for use of the funds distributed to the facility; providing for audits by the Department of Revenue; providing for confidentiality and for review and repeal; providing for recertification; creating s. 212.097, F.S.; defining "eligible hotel"; providing an exemption for certain purchases associated with rebuilding such hotels; providing for refunds; providing conditions and requirements; providing a limitation; providing for deferral of payment of a portion of taxes collected on sales at such hotels that have received such exemption; providing conditions and requirements; providing for repayment of deferred amounts; providing duties of the Department of Revenue; providing an effective date.

Senator Siegel moved the following amendments which were adopted:

Amendment 2—On page 7, between lines 26 and 27, insert:

Section 2. Paragraph (ee) is added to subsection (7) of section 212.08, Florida Statutes, 1992 Supplement, to read:

212.08 Sales, rental, use, consumption, distribution, and storage tax; specified exemptions.—The sale at retail, the rental, the use, the consumption, the distribution, and the storage to be used or consumed in this state of the following are hereby specifically exempt from the tax imposed by this part.

(7) MISCELLANEOUS EXEMPTIONS.—

(ee) Aircraft repair and maintenance services.—There shall be exempt from the tax imposed by this part all labor charges for the repair and maintenance of aircraft of more than 20,000 pounds maximum certificated take-off weight. Charges for parts and equipment furnished in connection with such labor charges are taxable.

Section 3. Section 2 shall take effect October 1, 1993.

Amendment 3—In title, on page 1, line 15, after the semicolon (;) insert: amending s. 212.08, F.S.; exempting from the tax on sales, use, and other transactions labor charges for repair and maintenance of certain aircraft;

On motion by Senator Holzendorf, by two-thirds vote **CS for CS for SB 288** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—24 Nays—9

SB 212—A bill to be entitled An act relating to saltwater fishing licenses; amending s. 370.0605, F.S.; deleting requirements for increased fees for residents of states contiguous to Florida; providing an effective date.

—was read the second time by title.

The Committee on Natural Resources and Conservation recommended the following amendment which was moved by Senator Thomas and adopted:

Amendment 1 (with Title Amendment)—On page 1, lines 14 and 15, strike "$10 for a 10-day license and" and insert: ~~$10 for a 10-day license and~~

And the title is amended as follows:

In title, on page 1, line 5, after the semicolon (;) insert: deleting a 10-day license for residents;

Senator Thomas moved the following amendment:

Amendment 2 (with Title Amendment)—On page 1, line 9, strike everything after the enacting clause and insert:

Section 1. Subsections (22) and (23) are added to section 370.01, Florida Statutes, to read:

370.01 Definitions.—In construing these statutes, where the context does not clearly indicate otherwise, the word, phrase, or term:

(22) "Resident alien" shall mean those persons who have continuously resided in this state for at least one year and six months in the county and can provide documentation from the Immigration and Naturalization Service evidencing permanent residency status in the United States. For the purposes of this chapter, a "resident alien" shall be considered a "resident."

(23) "Nonresident alien" shall mean those individuals from other states who can provide documentation from the Immigration and Naturalization Service evidencing permanent residency status in the United States. For the purposes of this chapter, a "nonresident alien" shall be considered a "nonresident."

Section 2. Paragraph (a) of subsection (2) of section 370.0605, Florida Statutes, is amended to read:

370.0605 Saltwater fishing license required; fees.—

(2) Saltwater fishing license fees are as follows:

(a)1. For a resident of the state, $10 for a 10-day license and $12 for a 1-year license.

2. For a resident of the state, $60 for 5 consecutive years from the date of purchase.

3. For a nonresident of the state, $5 for a 3-day license, $15 for a 7-day license, and $30 for a 1-year license. ~~However, effective July 1, 1993, with respect to individuals who are residents of states contiguous to Florida, the fee for a 3-day license shall be $25, for a 7-day license shall be $75, and for a 1-year license shall be $150 unless such state has a reciprocal agreement with Florida and the fees are reduced pursuant to paragraph (e).~~

4. For purposes of this section, "resident" has the same meaning as that found in s. 372.001.

Section 3. Paragraphs (j) and (k) are added to subsection (3) of section 370.0605, Florida Statutes, to read:

370.0605 Saltwater fishing license required; fees.—

(3) A saltwater fishing license is not required for:

(j) Any Florida resident who is fishing for mullet in freshwater and has a valid Florida freshwater fishing license.

(k) Any Florida resident fishing for a saltwater species in freshwater from land or from a structure fixed to the land.

Section 4. This act shall take effect upon becoming a law.

And the title is amended as follows:

In title, on page 1, strike all of lines 2-6 and insert: An act relating to saltwater fisheries; amending s. 370.01, F.S.; providing definitions; amending s. 370.0605, F.S.; deleting requirements for increased fees for residents of states contiguous to Florida; providing an exemption from requirements to obtain a saltwater fishing license; providing an effective date.

Senator Turner moved the following amendment to **Amendment 2** which was adopted:

Amendment 2A—On page 2, between lines 24 and 25, insert:

Section 4. Moratorium program for purse seine fishery in North Florida; development by Marine Fisheries Commission; expiration.—

(1) The Marine Fisheries Commission is hereby directed to provide by rule adopted within 120 days after the effective date of this act for a moratorium program for the purse seine fishery in North Florida, Levy County through Escambia County, which shall include the following features:

(a) Traditional purse seine vessels that have a valid purse seine permit as of July 1, 1993, and have a record of trip ticket reports to the Department of Natural Resources or National Fisheries Service detailing their harvesting of purse seine species in North Florida, Levy County through Escambia County, would be authorized to fish for those traditional species with purse seines under the moratorium program.

(b) The total annual harvest level for each species shall not exceed the highest level attained in any one of the last 3 years according to the trip ticket records of the Department of Natural Resources.

Reconsideration of Amendment

On motion by Senator Thomas, the Senate reconsidered the vote by which **Amendment 2A** was adopted. **Amendment 2A** was withdrawn.

Senator Kiser moved the following amendment to **Amendment 2** which was adopted:

Amendment 2B (with Title Amendment)—On page 2, between lines 24 and 25, insert:

Section 4. There is created a special recreational crawfish license, to be issued to qualified persons as provided by this section for the recreational harvest of crawfish (spiny lobster) beginning August 5, 1994.

(1) The special recreational crawfish license shall be available to any individual crawfish trap number holder who also possesses a saltwater products license during the 1993-1994 license year. For the 1994-1995 license year and for each license year thereafter, a person issued a special recreational crawfish license may not also possess a trap number.

(2) Beginning August 5, 1994, the special recreational crawfish license is required in order to harvest crawfish from state territorial waters in quantities in excess of the regular recreational bag limit but not in excess of a special bag limit to be established by the Marine Fisheries Commission for these harvesters before the 1994-1995 license year. Such special bag limit does not apply during the 2-day sport season established by the commission.

(3) The holder of a special recreational crawfish license must also possess the recreational crawfish stamp required by section 370.14(11), Florida Statutes, and the license required by section 370.0605, Florida Statutes.

(4) As a condition precedent to the issuance of a special recreational crawfish license, the applicant must agree to file quarterly reports with the Division of Marine Resources of the Department of Natural Resources, in such form as the division requires, detailing the amount of the licenseholder's crawfish (spiny lobster) harvest in the previous quarter, including the harvest of other recreational harvesters aboard the licenseholder's vessel.

(5) The Department of Natural Resources shall issue special recreational crawfish licenses beginning in 1994 for the 1994-1995 license year. The fee for each such license is $100 per year. Each license issued in 1994 for the 1994-1995 license year must be renewed by June 30 of each subsequent year by the initial individual holder thereof. Noncompliance with the reporting requirement in subsection (4) or with the special recreational bag limit established under subsection (6) constitutes grounds for which the department may refuse to renew the license for a subsequent license year. The number of such licenses outstanding in any one license year may not exceed the number issued for the 1994-1995 license year. A license is not transferable by any method. Licenses that are not renewed expire and may be reissued by the department beginning in the 1995-1996 license year to new applicants otherwise qualified under this section.

(6) To promote conservation of the spiny lobster (crawfish) resource, consistent with equitable distribution and availability of the resource, the Marine Fisheries Commission shall establish a spiny lobster management plan incorporating the special recreational crawfish license, including, but not limited to, the establishment of a special recreational bag limit for the holders of such license as required by subsection (2). Such special recreational bag limit must not be less than twice the higher of the daily recreational bag limits.

(7) The proceeds of the fees collected under this section must be deposited as follows:

(a) Thirty-five percent must be deposited into the Marine Biological Research Trust Fund for research and the development of reliable recreational catch statistics for the crawfish (spiny lobster) fishery.

(b) Forty-five percent must be deposited into the Motorboat Revolving Trust Fund to be used by the Department of Natural Resources for administration and enforcement of this section.

(c) Twenty percent must be deposited in the Marine Fisheries Commission Trust Fund to be used for the purposes of this section.

Section 5. The Department of Natural Resources may adopt rules to carry out the purpose and intent of the special recreational lobster license program.

Section 6. Notwithstanding the provisions of Rule 46-24.001(4), Rule 46-24.002(2), and 46-24.004(4), Florida Administrative Code, designation of spiny lobster (crawfish) as a restricted species may not occur until August 1, 1994. To the extent that such provisions implement the restricted species designation for spiny lobster (crawfish) before that date, such implementation is hereby delayed until August 1, 1994.

Section 7. Paragraph (d) of subsection (2) of section 370.142, Florida Statutes, 1992 Supplement, is amended, paragraph (g) of subsection (4) of that section is amended, and present paragraph (h) of subsection (4) is redesignated as paragraph (i) and a new paragraph (h) is added to that subsection, to read:

370.142 Spiny lobster trap certificate program.—

(2) TRANSFERABLE TRAP CERTIFICATES; TRAP TAGS; FEES; PENALTIES.—The Department of Natural Resources shall establish a trap certificate program for the spiny lobster fishery of this state and shall be responsible for its administration and enforcement as follows:

(d) Prohibitions; penalties.—

1. Effective July 1, 1991, it shall be unlawful for a person to possess or use a spiny lobster trap in or on state waters or adjacent federal waters without having affixed thereto the trap tag required by this section. *It is unlawful for a person to possess or use any other gear or device designed to attract and enclose or otherwise aid in the taking of spiny lobster by trapping that is not a trap as defined in chapter 46-24.006(2), Florida Administrative Code.*

2. Effective April 1, 1993, it shall be unlawful for a person to possess or use spiny lobster trap tags without having the necessary number of certificates on record as required by this section.

3. Unless otherwise provided in this section, a commercial harvester, as defined by chapter 46-24.002(1), Florida Administrative Code, who violates the provisions of this section, or the provisions of chapter 46-24, Florida Administrative Code, shall be punished as follows:

a. If the first violation is for violation of subparagraph 1. or subparagraph 2., the department shall assess a civil penalty of up to $1,000 and the crawfish trap number issued pursuant to s. 370.14(2) or (7) may be suspended for the remainder of the current license year. For all other first violations, the department shall assess a civil penalty of up to $500.

b. For a second violation of subparagraph 1. or subparagraph 2. which occurs within 24 months of any previous such violation, the department shall assess a civil penalty of up to $2,000 and the crawfish trap number issued pursuant to s. 370.14(2) or (7) may be suspended for the remainder of the current license year.

c. For a third or subsequent violation of subparagraph 1. or subparagraph 2. which occurs within 36 months of any previous two such violations, the department shall assess a civil penalty of up to $5,000 and may suspend the crawfish trap number issued pursuant to s. 370.14(2) or (7) for a period of up to 24 months or may revoke the crawfish trap number and, if revoking the crawfish trap number, may also proceed against the licenseholder's saltwater products license in accordance with the provisions of s. 370.021(2)(e).

d. Any person assessed a civil penalty pursuant to this section shall within 30 calendar days after notification:

(I) Pay the civil penalty to the department; or

(II) Request an administrative hearing pursuant to the provisions of s. 120.60.

e. The department shall suspend the crawfish trap number issued pursuant to s. 370.14(2) or (7) for any person failing to comply with the provisions of sub-subparagraph d.

4.a. It is unlawful for any person to make, alter, forge, counterfeit, or reproduce a spiny lobster trap tag or certificate.

b. It is unlawful for any person to knowingly have in his possession a forged, counterfeit, or imitation spiny lobster trap tag or certificate.

c. It is unlawful for any person to barter, trade, sell, supply, agree to supply, aid in supplying, or give away a spiny lobster trap tag or certificate or to conspire to barter, trade, sell, supply, aid in supplying, or give away a spiny lobster trap tag or certificate unless such action is duly authorized by the department as provided in this chapter or in the rules of the department.

5.a. Any person who violates the provisions of subparagraph 4., or any person who engages in the commercial harvest, trapping, or possession of spiny lobster without a crawfish trap number as required by s. 370.14(2) or (7) or during any period while such crawfish trap number is under suspension or revocation, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

b. In addition to any penalty imposed pursuant to sub-subparagraph a., the department shall levy a fine of up to twice the amount of the appropriate surcharge to be paid on the fair market value of the transferred certificates, as provided in subparagraph (a)1., on any person who violates the provisions of sub-subparagraph 4.c.

6. Any certificates for which the annual certificate fee is not paid for a period of 3 years shall be considered abandoned and shall revert to the department. During any period of trap reduction, any certificates reverting to the department shall become permanently unavailable and be considered in that amount to be reduced during the next license-year period. Otherwise, any certificates that revert to the department are to be reallotted in such manner as provided by the department.

7. The proceeds of all civil penalties collected pursuant to subparagraph 3. and all fines collected pursuant to sub-subparagraph 5.b. shall be deposited into the Marine Biological Research Trust Fund.

8. All traps shall be removed from the water during any period of suspension or revocation.

(4) TRAP CERTIFICATE TECHNICAL ADVISORY AND APPEALS BOARD.—There is hereby established the Trap Certificate Technical Advisory and Appeals Board. Such board shall consider and advise the department on disputes and other problems arising from the implementation of the spiny lobster trap certificate program. The board may also provide information to the department on the operation of the trap certificate program.

(g) In addition to those certificates allotted pursuant to the provisions of subparagraph (2)(a)1., up to *125,000* ~~50,000~~ certificates may be allotted by the board to settle disputes or other problems arising from implementation of the trap certificate program during the 1992-1993 and 1993-1994 license years. Any certificates not allotted by March 31, 1994, shall become permanently unavailable and shall be considered as part of the 1994-1995 reduction schedule. *All appeals for additional certificates or other disputes must be filed with the board before October 1, 1993.*

(h) Any trap certificates issued by the department as a result of the appeals process must be added to the existing number of trap certificates for the purposes of determining the total number of certificates from which the subsequent season's trap reduction is calculated.

(i)~~(h)~~ On and after July 1, 1994, the board shall no longer consider and advise the department on disputes and other problems arising from implementation of the trap certificate program nor allot any certificates with respect thereto.

Section 8. Paragraph (a) of subsection (2) of section 370.06, Florida Statutes, 1992 Supplement, is amended to read:

370.06 Licenses.—

(2) SALTWATER PRODUCTS LICENSE.—

(a) Every person, firm, or corporation which sells, offers for sale, barters, or exchanges for merchandise any saltwater products, or which harvests saltwater products with certain gear or equipment as specified by law, must have a valid saltwater products license. Each saltwater products license allows the holder to engage in any of the activities for which the license is required. The license must be in the possession of the licenseholder or aboard the vessel and shall be subject to inspection at any time that harvesting activities for which a license is required are being conducted. A restricted species endorsement on the saltwater products license is required to sell to a licensed wholesale dealer those species which the state, by law or rule, has designated as "restricted species." This endorsement may be issued only to a person *who is at least 16 years of age, or to a firm* ~~or firm~~ certifying that over 25 percent of its income or $5,000 of its income, whichever is less, is attributable to the sale of saltwater products pursuant to a license issued under this paragraph or a similar license from another state. This endorsement may also be issued to a for-profit corporation if it certifies that at least $5,000 of its income is attributable to the sale of saltwater products pursuant to a license issued under this paragraph or a similar license from another state. However, if at least 50 percent of the annual income of a person, firm, or for-profit corporation is derived from charter fishing, the person, firm, or for-profit corporation must certify that at least $2,500 of the income of the person, firm, or corporation is attributable to the sale of saltwater products pursuant to a license issued under this paragraph or a similar license from another state, in order to be issued the endorsement. Such income attribution must apply to at least 1 year out of the last 3 years. For the purpose of this section "income" means that income which is attributable to work, employment, entrepreneurship, pensions, retirement benefits, and social security benefits.

1. The department is authorized to require verification of such income. Acceptable proof of income earned from the sale of saltwater products shall be:

a. Copies of trip ticket records generated pursuant to this subsection (marine fisheries information system), documenting qualifying sale of saltwater products;

b. Copies of sales records from locales other than Florida documenting qualifying sale of saltwater products;

c. A copy of the applicable federal income tax return, including Form 1099 attachments, verifying income earned from the sale of saltwater products;

d. Crew share statements verifying income earned from the sale of saltwater products; or

e. A certified public accountant's notarized statement attesting to qualifying source and amount of income.

Any provision of this section or any other section of the Florida Statutes to the contrary notwithstanding, any person who owns a retail seafood market and/or restaurant at a fixed location for at least 3 years who has had an occupational license for 3 years prior to January 1, 1990, who harvests saltwater products to supply his retail store and has had a saltwater products license for 1 of the past 3 years prior to January 1, 1990, may provide proof of his verification of income and sales value at his retail seafood market and/or restaurant and in his saltwater products enterprise by affidavit and shall thereupon be issued a restricted species endorsement.

2. Exceptions from income requirements shall be as follows:

a. A permanent restricted species endorsement shall be available to those persons age 62 and older who have qualified for such endorsement for at least 3 out of the last 5 years.

b. Active military duty time shall be excluded from consideration of time necessary to qualify and shall not be counted against the applicant for purposes of qualifying.

c. Upon the sale of a used commercial fishing vessel owned by a person, firm, or corporation possessing or eligible for a restricted species endorsement, the purchaser of such vessel shall be exempted from the qualifying income requirement for the purpose of obtaining a restricted species endorsement for a period of 1 year after purchase of the vessel.

d. Upon the death or permanent disablement of a person possessing a restricted species endorsement, an immediate family member wishing to carry on the fishing operation shall be exempted from the qualifying income requirement for the purpose of obtaining a restricted species endorsement for a period of 1 year after the death or disablement.

e. A restricted species endorsement may be issued on an individual saltwater products license to a person age 62 or older who documents that at least $2,500 is attributable to the sale of saltwater products pursuant to the provisions of this paragraph.

f. A permanent restricted species endorsement may also be issued on an individual saltwater products license to a person age 70 or older who has held a saltwater products license for at least 3 of the last 5 license years.

At least one saltwater products license bearing a restricted species endorsement shall be aboard any vessel harvesting restricted species in excess of any bag limit or when fishing under a commercial quota or in commercial quantities, and such vessel shall have a commercial vessel registration. This subsection does not apply to any person, firm, or corporation licensed under s. 370.07(1)(a)1. or s. 370.07(1)(b) for activities pursuant to such licenses. A saltwater products license may be issued in the name of an individual or a valid boat registration number. Such license is not transferable. A decal shall be issued with each saltwater products license issued to a valid boat registration number. The saltwater products license decal shall be the same color as the vessel registration decal issued each year pursuant to s. 327.11(7) and shall indicate the period of time such license is valid. The saltwater products license decal shall be placed beside the vessel registration decal and, in the case of an undocumented vessel, shall be placed so that the vessel registration decal lies between the vessel registration number and the saltwater products license decal. Any saltwater products license decal for a previous year shall be removed from a vessel operating on the waters of the state. A resident shall pay an annual license fee of $50 for a saltwater products license issued in the name of an individual or $100 for a saltwater products license issued to a valid boat registration number. A nonresident shall pay an annual license fee of $200 for a saltwater products license issued in the name of an individual or $400 for a saltwater products license issued to a valid boat registration number. An alien shall pay an annual license fee of $300 for a saltwater products license issued in the name of an individual or $600 for a saltwater products license issued to a valid boat registration number. Any person who sells saltwater products pursuant to this license may sell only to a licensed wholesale dealer. A saltwater products license must be presented to the licensed wholesale dealer each time saltwater products are sold, and an imprint made thereof. The wholesale dealer shall keep records of each transaction in such detail as may be required by rule of the Department of Natural Resources not in conflict with s. 370.07(6), and shall provide the holder of the saltwater products license with a copy of the record. It is unlawful for any licensed wholesale dealer to buy saltwater products from any unlicensed person under the provisions of this section, except that a licensed wholesale dealer may buy from another licensed wholesale dealer. It is unlawful for any licensed wholesale dealer to buy saltwater products designated as "restricted species" from any person, firm, or corporation not possessing a restricted species endorsement on his saltwater products license under the provisions of this section, except that a licensed wholesale dealer may buy from another licensed wholesale dealer. The Department of Natural Resources shall be the licensing agency, may contract with private persons or entities to implement aspects of the licensing program, and shall establish by rule a marine fisheries information system in conjunction with the licensing program to gather fisheries data.

Section 9. Paragraph (c) of subsection (2) of section 370.142, Florida Statutes, as amended by section 2 of chapter 92-60, Laws of Florida, is repealed.

And the title is amended as follows:

In title, on page 3, line 18, after the semicolon (;) insert: creating a special recreational crawfish license; providing eligibility requirements; prohibiting the use of traps by special recreational crawfish licenseholders during the 1994-1995 license year and therafter; providing requirements for said license; requiring holders of the special recreational crawfish license to possess certain other license and stamp; providing reporting requirements; providing for a fee and license renewal; limiting the number of special recreational licenses which may be issued; providing for a crawfish management plan to be developed; providing for disposition of license fees; authorizing the development of rules; delaying the date when crawfish will become a restricted species; amending s. 370.142, F.S.; limiting gear that may be used; increasing the number of trap certificates that may be issued by the Trap Certificate Technical Advisory and Appeals Board; requiring appeals for additional certificates or other disputes to be filed with the board before a specified date; amending s. 370.06, F.S.; establishing a minimum age for holders of trap certificates; repealing s. 370.142(2)(c), F.S., relating to recreational trap tags;

Amendment 2 as amended was adopted.

On motion by Senator Thomas, by two-thirds vote **SB 212** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—36 Nays—None

Consideration of **CS for HB 1295** was deferred.

On motions by Senator Dyer, by two-thirds vote **CS for HB 1221** was withdrawn from the Committees on Transportation and Appropriations.

CS for HB 1221—A bill to be entitled An act relating to drivers' licenses; amending s. 230.23, F.S.; providing a duty of school districts; reenacting and amending s. 322.0601, F.S., relating to the issuance of drivers' licenses to certain persons under the age of 18 and compulsory school attendance; providing for certain reporting; repealing section 7 of chapter 89-112, Laws of Florida, to conform; providing for future repeal; providing an effective date.

—was read the second time by title. On motion by Senator Dyer, by two-thirds vote **CS for HB 1221** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—1

CS for HB 21—A bill to be entitled An act relating to civil immunity; creating the Florida Volunteer Protection Act; limiting civil liability for certain volunteers; providing for application; providing an effective date.

—was read the second time by title. On motion by Senator Foley, by two-thirds vote **CS for HB 21** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—37 Nays—None

Consideration of **CS for HB 55** and **CS for HB 113** was deferred.

CS for HB 163—A bill to be entitled An act relating to Broward County; providing for the relief of Daniel Baker, to compensate him for serious and permanent personal injuries sustained as a result of the negligence of an employee of Broward County; providing for payment by the Board of County Commissioners of Broward County; providing an effective date.

—was read the second time by title. On motion by Senator Forman, by two-thirds vote **CS for HB 163** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

HB 275—A bill to be entitled An act relating to Broward County; providing for the relief of Angela Lee Nelson and Carl Nelson, as natural parents of Brittany Lee Nelson, the latter who sustained injuries as a result of the negligence of the South Broward Hospital District, d.b.a. Memorial Hospital; providing an appropriation; providing an effective date.

—was read the second time by title. On motion by Senator Forman, by two-thirds vote **HB 275** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—34 Nays—None

CS for HB 113—A bill to be entitled An act providing for the relief of Robert Connors and Rose Bean, on behalf of Jason Crisante, surviving son of Cathy Connors Crisante, who died as a result of an accident involving a Charlotte County Sheriff's Department vehicle; providing an appropriation; providing an effective date.

—was read the second time by title. On motion by Senator Boczar, by two-thirds vote **CS for HB 113** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—33 Nays—1

CS for HB 55—A bill to be entitled An act relating to Dade County; providing for the relief of Raul Gutierrez and Julia Gutierrez, parents of the decedent, Rabsary Gutierrez; authorizing and directing the Dade County School Board to compensate them for the loss of their daughter, Rabsary Gutierrez, as a result of the negligence of the Dade County School Board; providing an effective date.

—was read the second time by title. On motion by Senator Bankhead, by two-thirds vote **CS for HB 55** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

On motions by Senator Dudley, by two-thirds vote **CS for HB 1295** was withdrawn from the Committees on Judiciary and Appropriations.

CS for HB 1295—A bill to be entitled An act relating to probate and trust; amending s. 731.301, F.S.; providing an additional method for service of a petition under the probate code; amending s. 518.11, F.S.; providing for investments by fiduciaries and for the prudent investor rule; creating s. 518.112, F.S.; providing for the delegation of investment functions; creating s. 733.6171, F.S.; providing for the compensation of the attorney for the personal representative; amending s. 660.43, F.S.; revising language with respect to common trust fund investments; creating s. 660.431, F.S.; providing for the prudent investor rule; amending s. 731.201, F.S.; revising definitions; amending s. 733.212, F.S.; providing for notice of administration to trustees; amending s. 733.607, F.S.; providing for the payment of certain expenses; amending s. 733.617, F.S.; providing for the compensation of the personal representative; amending s. 733.707, F.S.; revising language with respect to the order of payment of expenses and obligations; creating s. 737.207, F.S.; providing that a penalty clause for contesting a trust instrument is unenforceable; amending s. 737.302, F.S.; revising language with respect to the trustee's standard of care and performance; creating s. 737.3056, F.S.; providing for the trustee's duty to pay expenses and obligations of the settlor's estate; creating s. 737.3057, F.S.; providing for the trustee's duty to provide notice to creditors; creating part VI of chapter 737, F.S.; consisting of ss. 737.621-737.627, F.S.; providing for rules of construction and general provisions; providing for change in securities, accessions, and nonademption; providing for the construction of generic terms; providing that certain gifts are to be per stirpes; providing that a killer is not entitled to receive property or other benefits by reason of the victim's death; providing for costs and attorney's fees; amending s. 738.12, F.S.; revising language with respect to underproductive property; providing effective dates.

—was read the second time by title. On motion by Senator Dudley, by two-thirds vote **CS for HB 1295** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—35 Nays—None

Consideration of **CS for SB 1954** was deferred.

On motions by Senator Siegel, by two-thirds vote **HB 541** was withdrawn from the Committees on Criminal Justice and Appropriations.

On motion by Senator Siegel—

HB 541—A bill to be entitled An act relating to driving or operating a vessel under the influence; amending s. 316.193, F.S.; lowering the blood alcohol level that constitutes an element of the offense of driving under the influence; requiring installation of certain devices to render motor vehicles undrivable under certain circumstances; amending s. 316.1934, F.S.; revising provisions relating to presumption of impairment to conform to the amendment of s. 316.193, F.S.; amending s. 316.1937, F.S.; authorizing the court to order installation of breath alcohol ignition interlock devices on certain motor vehicles under certain circumstances; requiring certification of such devices by the Department of Highway Safety and Motor Vehicles; authorizing the department to adopt rules setting the alcohol percentage threshhold for operation of such devices; providing for waiver from required use under certain circumstances; requiring compliance with the manufacturer's operating and maintenance instructions; prohibiting interference with installation, monitoring, or repair of such devices by certain persons; providing penalties; amending s. 193.1938, F.S., to conform; amending s. 316.1933, F.S.; providing for substantial compliance; amending s. 316.1934, F.S.; revising provisions relating to presumption of impairment to conform to the amendment of s. 316.193, F.S.; providing for substantial compliance; amending s. 322.291, F.S.; requiring persons whose driver's license was suspended for driving with an unlawful blood alcohol level to present evidence of enrollment in an advance driver improvement course or substance abuse education course before his driving privilege may be reinstated; amending s. 322.64, F.S.; amending provisions relating to operating a commercial motor vehicle to conform to the amendment of s. 316.193, F.S.; amending s. 327.35, F.S.; lowering the blood alcohol level that constitutes an element of the offense of operating a vessel under the influence; amending s. 327.351, F.S.; providing that the offense of operating a vessel while intoxicated is a third-degree felony if such operation causes serious bodily injury; amending s. 327.354, F.S.; revising provisions relating to presumption of impairment to conform to the amendment of s. 327.35, F.S.; providing penalties; providing an effective date.

—a companion measure, was substituted for **CS for SB 50** and read the second time by title.

Senator Siegel moved the following amendments which were adopted:

Amendment 1 (with Title Amendment)—On page 7, lines 8-20; on page 10, lines 29 and 30; on pages 11-16, lines 1-31; and on page 17, lines 1-10, strike all of said lines and renumber subsequent sections.

And the title is amended as follows:

In title, on page 1, strike all of lines 6-28 and insert: driving under the influence; amending s. 316.1934, F.S.; revising provisions relating to presumption of impairment to conform to the amendment of s. 316.193, F.S.; amending s. 316.1933, F.S.;

Amendment 2—On page 21, lines 30 and 31 and on page 22, line 1, strike all underlined language and insert: *before January 1, 1994, was suspended for driving with an unlawful blood alcohol level of 0.08 percent or higher after December 31, 1993*

Senator Bankhead moved the following amendment:

Amendment 3 (with Title Amendment)—On page 27, between lines 26 and 27, insert:

Section 13. Subsection (1) of section 316.193, Florida Statutes, 1992 Supplement, is reenacted, and subsection (6) of that section is amended, to read:

316.193 Driving under the influence; penalties.—

(1) A person is guilty of the offense of driving under the influence and is subject to punishment as provided in subsection (2) if such person is driving or in actual physical control of a vehicle within this state and:

(a) The person is under the influence of alcoholic beverages, any chemical substance set forth in s. 877.111, or any substance controlled under chapter 893, when affected to the extent that his normal faculties are impaired; or

(b) The person has a blood or breath alcohol level of 0.10 percent or higher.

(6) With respect to any person convicted of a violation of subsection (1), regardless of any penalty imposed pursuant to subsection (2), subsection (3), or subsection (4):

(a) For the first conviction thereof, the court shall place the defendant on probation for a period not to exceed 1 year and, as a condition of such probation, shall order the defendant to participate in public service or a community work project for a minimum of 50 hours. In lieu of such participation, the court may order that any defendant pay an additional fine of $10 for each hour of public service or community work otherwise required, if, after consideration of the residence or location of the defendant at the time such public service or community work is required, payment of the fine is in the best interests of the state. However, in no event may the total period of probation and incarceration exceed 1 year.

(b) For the second conviction within a period of 3 years from the date of a prior conviction for violation of this section, the court shall order imprisonment for not less than 10 days.

(c) For the third conviction within a period of 5 years from the date of a prior conviction for violation of this section, the court shall order imprisonment for not less than 30 days.

(d) In addition to the penalty imposed under paragraph (a), paragraph (b), or paragraph (c), the court shall also order the impoundment or immobilization of the vehicle that was driven by, or in the actual physical control of, the person who is convicted, unless the court finds that the family of the owner of the vehicle has no other public or private means of transportation. The period of impoundment or immobilization is 10 days, or, for the second conviction within 3 years, 30 days, or, for the third conviction within 5 years, 90 days and may not be concurrent with probation or imprisonment. If the vehicle is leased or rented, the period of impoundment or immobilization may not extend beyond the expiration of the lease or rental agreement. Within 7 business days after the date that the court issues the order of impoundment or immobilization, the clerk of the court shall send notice by certified mail, return receipt requested, to the registered owner of the vehicle if the registered owner is a person other than the person convicted under subsection (1) and to each person of record claiming a lien against the vehicle. All costs and fees for the impoundment or immobilization must be paid by the owner of the vehicle or, if the vehicle is leased or rented, by the person leasing or renting the vehicle. The person who owns a vehicle that is impounded or immobilized under this paragraph, or a person having a lien of record against such a vehicle, may, within 10 days after the date that person has knowledge of the location of the vehicle, file a complaint in the county in which the owner resides to determine whether the vehicle was wrongfully taken or withheld from the owner or lienholder. Upon the filing of a complaint, the owner or lienholder may have the vehicle released by posting with the court a bond or other adequate security equal to the amount of the costs and fees for impoundment or immobilization, including towing or storage, to ensure the payment of such costs and fees if the owner or lienholder does not prevail. When the bond is posted and the fee is paid as set forth in s. 28.24, the clerk of the court shall issue a certificate releasing the vehicle. At the time of release, after reasonable inspection, the owner or lienholder must give a receipt to the towing or storage company indicating any loss or damage to the vehicle or to the contents of the vehicle.

(e)~~(d)~~ A defendant, in the court's discretion, may be required to serve all or any portion of a term of imprisonment to which he has been sentenced pursuant to this section in a residential alcoholism treatment program or a residential drug abuse treatment program. Any time spent in such a program *must* ~~shall~~ be credited by the court toward the term of imprisonment.

For the purposes of this section, a previous conviction for the violation of former s. 316.1931, former s. 860.01, or former s. 316.028, or a previous conviction outside this state for driving under the influence, driving while intoxicated, driving with an unlawful blood alcohol level, or any other similar alcohol-related or drug-related traffic offense, *is* ~~shall~~ also ~~be~~ considered a previous conviction for violation of this section. Notwithstanding any other provision of this section, $100 shall be added to any fine imposed pursuant to this section, of which one-quarter shall be deposited in the Emergency Medical Services Trust Fund, one-half shall be deposited in the Administrative Trust Fund of the Department of Law Enforcement to be used for operational expenses of the Division of Local Law Enforcement Assistance in conducting the statewide criminal analysis laboratory system established in s. 943.32, and one-quarter shall be deposited in the Impaired Drivers and Speeders Trust Fund created in s. 413.613. However, in satisfaction of the fine imposed pursuant to this section, the court may, upon a finding that the defendant is financially unable to pay either all or part of the fine, order that the defendant participate for a specified additional period of time in public service or a community work project in lieu of payment of that portion of the fine which the court determines the defendant is unable to pay. In determining such additional sentence, the court shall consider the amount of the unpaid portion of the fine and the reasonable value of the services to be ordered; however, the court shall not compute the reasonable value of services at a rate less than the federal minimum wage at the time of sentencing.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 2, line 23, after the semicolon (;) insert: amending s. 316.193, F.S.; providing for a court to order the impoundment or immobilization of the vehicle driven by or in the actual physical control of an individual while committing the offense of driving under the influence; providing an exception; providing for various periods of impoundment or immobilization, for notice, for costs and fees; providing remedies of the owner or lienholder;

Senator Bankhead moved the following amendment to **Amendment 3** which was adopted:

Amendment 3A—On page 2, line 29 through page 3, line 10, strike all of said lines and insert: *imprisonment. If the vehicle is leased the period of impoundment or immobilization may not extend beyond the expiration of the lease agreement. Within 7 business days after the date that the court issues the order of impoundment or immobilization, the clerk of the court shall send notice by certified mail, return receipt requested, to the registered owner of the vehicle if the registered owner is a person other than the person convicted under subsection (1) and to each person of record claiming a lien against the vehicle. All costs and fees for the impoundment or immobilization, including the cost of notification, must be paid by the owner of the vehicle or, if the vehicle is leased, by the person leasing the vehicle. The person who owns a vehicle that is*

Amendment 3 as amended was adopted.

On motion by Senator Siegel, by two-thirds vote **HB 541** as amended was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

RECONSIDERATION

On motion by Senator Hargrett, the Senate reconsidered the vote by which—

SB 1086—A bill to be entitled An act relating to tax on sales, use, and other transactions; amending s. 212.05, F.S.; specifying that any law enforcement officer performing approved law enforcement duties is not performing detective, burglar protection, and other protection services for purposes of the tax on such services; providing an effective date.

—passed as amended this day.

Senator Hargrett moved the following amendment which was adopted:

Amendment 5—In title, on page 1, strike all of lines 2 and 3 and insert: An act relating to taxation; amending s. 212.05, F.S.;

On motion by Senator Hargrett, **SB 1086** as amended was read by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—36 Nays—None

MOTION

On motion by Senator Jennings, the rules were waived and time of recess was extended until 6:30 p.m.

CS for SB 1954—A bill to be entitled An act relating to education; creating s. 233.0561, F.S.; creating the "Blind Persons' Literacy Rights and Education Act"; providing legislative intent; providing definitions; providing for assessment of blind students and development of individualized education programs; providing for instructional materials; providing teacher certification requirements; providing an effective date.

—was read the second time by title. On motion by Senator Johnson, by two-thirds vote **CS for SB 1954** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—34 Nays—None

SB 74—A bill to be entitled An act relating to theft, robbery, and related crimes; creating s. 812.131, F.S.; providing definitions; prohibiting home-invasion robbery; providing a penalty; providing for the application of the section with respect to certain other provisions of law; providing an effective date.

—was read the second time by title.

The Committee on Appropriations recommended the following amendment which was moved by Senator Jenne and adopted:

Amendment 1—On page 1, strike all of lines 28-30 and insert: Subject to the provisions of s. 921.001. A defendant sentenced under this section

Senator Jenne moved the following amendment which was adopted:

Amendment 2 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Section 812.133, Florida Statutes, is created to read:

812.133 Carjacking.—

(1) "Carjacking" means the taking of a motor vehicle which may be the subject of larceny from the person or custody of another, with intent to either permanently or temporarily deprive the person or the owner of the motor vehicle, when in the course of the taking there is the use of force, violence, assault, or putting in fear.

(2)(a) If in the course of committing the carjacking the offender carried a firearm or other deadly weapon, then the carjacking is a felony of the first degree, punishable by imprisonment for a term of years not exceeding life imprisonment or as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If in the course of committing the carjacking the offender carried no firearm, deadly weapon, or other weapon, then the carjacking is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3)(a) An act shall be deemed "in the course of committing the carjacking" if it occurs in an attempt to commit carjacking or in flight after the attempt or commission.

(b) An act shall be deemed "in the course of the taking" if it occurs either prior to, contemporaneous with, or subsequent to the taking of the property and if it and the act of taking constitute a continuous series of acts or events.

Section 2. Section 812.131, Florida Statutes, is created to read:

812.131 Home-invasion robbery.—

(1) As used in this section:

(a) "Dwelling" means any building or conveyance of any kind, either temporary or permanent, mobile or immobile, which has a roof over it and is designed to be occupied by people lodging therein at night, together with the curtilage thereof.

(b) "Home-invasion robbery" means any robbery that occurs when the offender enters a dwelling with the intent to commit a robbery, and does commit a robbery of the occupants therein.

(2) A person who commits a home-invasion robbery is guilty of a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) A sentence imposed under this section is not subject to the provisions of s. 921.001. A defendant sentenced under this section is not eligible for gain-time granted by the Department of Corrections, except that the department may grant up to 20 days of incentive gain-time each month as provided for in s. 944.275(4)(b).

Section 3. Section 782.04, Florida Statutes, is amended to read:

782.04 Murder.—

(1)(a) The unlawful killing of a human being:

1. When perpetrated from a premeditated design to effect the death of the person killed or any human being; or

2. When committed by a person engaged in the perpetration of, or in the attempt to perpetrate, any:

a. Trafficking offense prohibited by s. 893.135(1),

b. Arson,

c. Sexual battery,

d. Robbery,

e. Burglary,

f. Kidnapping,

g. Escape,

h. Aggravated child abuse,

i. Aircraft piracy, or

j. Unlawful throwing, placing, or discharging of a destructive device or bomb; ~~or~~

k. Carjacking;

l. Home-invasion robbery; or

3. Which resulted from the unlawful distribution of any substance controlled under s. 893.03(1), cocaine as described in s. 893.03(2)(a)4., or opium or any synthetic or natural salt, compound, derivative, or preparation of opium by a person 18 years of age or older, when such drug is proven to be the proximate cause of the death of the user,

is murder in the first degree and constitutes a capital felony, punishable as provided in s. 775.082.

(b) In all cases under this section, the procedure set forth in s. 921.141 shall be followed in order to determine sentence of death or life imprisonment.

(2) The unlawful killing of a human being, when perpetrated by any act imminently dangerous to another and evincing a depraved mind regardless of human life, although without any premeditated design to effect the death of any particular individual, is murder in the second degree and constitutes a felony of the first degree, punishable by imprisonment for a term of years not exceeding life or as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) When a person is killed in the perpetration of, or in the attempt to perpetrate, any:

(a) Trafficking offense prohibited by s. 893.135(1),

(b) Arson,

(c) Sexual battery,

(d) Robbery,

(e) Burglary,

(f) Kidnapping,

(g) Escape,

(h) Aggravated child abuse,

(i) Aircraft piracy, ~~or~~

(j) Unlawful throwing, placing, or discharging of a destructive device or bomb,

(k) Carjacking, or

(l) Home-invasion robbery

by a person other than the person engaged in the perpetration of or in the attempt to perpetrate such felony, the person perpetrating or attempting to perpetrate such felony is guilty of murder in the second degree, which constitutes a felony of the first degree, punishable by imprisonment for a term of years not exceeding life or as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) The unlawful killing of a human being, when perpetrated without any design to effect death, by a person engaged in the perpetration of, or in the attempt to perpetrate, any felony other than any:

(a) Trafficking offense prohibited by s. 893.135(1),

(b) Arson,

(c) Sexual battery,

(d) Robbery,

(e) Burglary,

(f) Kidnapping,

(g) Escape,

(h) Aggravated child abuse,

(i) Aircraft piracy,

(j) Unlawful throwing, placing, or discharging of a destructive device or bomb, ~~or~~

(k) Unlawful distribution of any substance controlled under s. 893.03(1), cocaine as described in s. 893.03(2)(a)4., or opium or any synthetic or natural salt, compound, derivative, or preparation of opium by a person 18 years of age or older, when such drug is proven to be the proximate cause of the death of the user,

(l) Carjacking, or

(m) Home-invasion robbery

is murder in the third degree and constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 4. Subsection (1) of section 16.56, Florida Statutes, is amended to read:

16.56 Office of Statewide Prosecution.—

(1) There is created in the Department of Legal Affairs an Office of Statewide Prosecution. The office shall be a separate "budget entity" as that term is defined in chapter 216. The office may:

(a) Investigate and prosecute the offenses of bribery, burglary, criminal usury, extortion, gambling, kidnapping, larceny, murder, prostitution, perjury, ~~and~~ robbery, *and carjacking, and home-invasion robbery;* of crimes involving narcotic or other dangerous drugs; of any violation of the provisions of the Florida RICO (Racketeer Influenced and Corrupt Organization) Act, including any offense comprising part of a pattern of racketeering activity in any RICO offense as charged; of any violation of the provisions of the Florida Anti-Fencing Act; of any violation of the provisions of the Florida Antitrust Act of 1980, as amended; of any crime involving, or resulting in, fraud or deceit upon any person; or of any attempt, solicitation, or conspiracy to commit any of the crimes specifically enumerated above. The office shall have such power only when any such offense is occurring, or has occurred, in two or more judicial circuits as part of a related transaction, or when any such offense is connected with an organized criminal conspiracy affecting two or more judicial circuits.

(b) Upon request, cooperate with and assist state attorneys and state and local law enforcement officials in their efforts against organized crimes.

(c) Request and receive from any department, division, board, bureau, commission, or other agency of the state, or of any political subdivision thereof, cooperation and assistance in the performance of its duties.

Section 5. Section 776.08, Florida Statutes, is amended to read:

776.08 Forcible felony.—"Forcible felony" means treason; murder; manslaughter; sexual battery; *carjacking; home-invasion robbery;* robbery; burglary; arson; kidnapping; aggravated assault; aggravated battery; aircraft piracy; unlawful throwing, placing, or discharging of a destructive device or bomb; and any other felony which involves the use or threat of physical force or violence against any individual.

Section 6. Section 905.34, Florida Statutes, is amended to read:

905.34 Powers and duties; law applicable.—The jurisdiction of a statewide grand jury impaneled under this chapter shall extend throughout the state. The subject matter jurisdiction of the statewide grand jury shall be limited to the offenses of bribery, burglary, *carjacking, home-invasion robbery* criminal usury, extortion, gambling, kidnapping, larceny, murder, prostitution, perjury, and robbery; crimes involving narcotic or other dangerous drugs; any violation of the provisions of the Florida RICO (Racketeer Influenced and Corrupt Organization) Act, including any offense comprising part of a pattern of racketeering activity in any RICO offense as charged; any violation of the provisions of the Florida Anti-Fencing Act; any violation of the provisions of the Florida Antitrust Act of 1980, as amended; any crime involving, or resulting in, fraud or deceit upon any person; or any attempt, solicitation, or conspiracy to commit any violation of the crimes specifically enumerated above, when any such offense is occurring, or has occurred, in two or more judicial circuits as part of a related transaction or when any such offense is connected with an organized criminal conspiracy affecting two or more judicial circuits. The statewide grand jury may return indictments and presentments irrespective of the county or judicial circuit where the offense is committed or triable. If an indictment is returned, it shall be certified and transferred for trial to the county where the offense was committed. The powers and duties of, and law applicable to, county grand juries shall apply to a statewide grand jury except when such powers, duties, and law are inconsistent with the provisions of ss. 905.31-905.40.

Section 7. Subsection (4) of section 907.041, Florida Statutes, is amended to read:

907.041 Pretrial detention and release.—

(4) PRETRIAL DETENTION.—

(a) As used in this subsection, "dangerous crime" means any of the following felonies:

1. Arson;

2. Aggravated assault;

3. Aggravated battery;

4. Illegal use of explosives;

5. Child abuse;

6. Hijacking;

7. Kidnapping;

8. Homicide;

9. Manslaughter;

10. Sexual battery;

11. Robbery;

12. Carjacking;

13.~~12.~~ Lewd, lascivious, or indecent assault or act upon or in presence of a child under the age of 16 years;

14.~~13.~~ Sexual activity with a child, who is 12 years of age or older but less than 18 years of age, by or at solicitation of person in familial or custodial authority;

15.~~14.~~ Burglary of a dwelling; ~~and~~

16.~~15.~~ Attempting or conspiring to commit any such crime; *and home-invasion robbery.*

(b) The court may order pretrial detention if it finds a substantial probability, based on a defendant's past and present patterns of behavior, the criteria in s. 903.046, and any other relevant facts, that:

1. The defendant has previously violated conditions of release and that no further conditions of release are reasonably likely to assure his appearance at subsequent proceedings;

2. The defendant, with the intent to obstruct the judicial process, has threatened, intimidated, or injured any victim, potential witness, juror, or judicial officer, or has attempted or conspired to do so, and that no condition of release will reasonably prevent the obstruction of the judicial process;

3. The defendant is charged with trafficking in controlled substances as defined by s. 893.135, that there is a substantial probability that the defendant has committed the offense, and that no conditions of release will reasonably assure the defendant's appearance at subsequent criminal proceedings; or

4. The defendant poses the threat of harm to the community. The court may so conclude if it finds that the defendant is presently charged with a dangerous crime, that there is a substantial probability that the defendant committed such crime, that the factual circumstances of the crime indicate a disregard for the safety of the community, and that there are no conditions of release reasonably sufficient to protect the community from the risk of physical harm to persons. In addition, the court must find that at least one of the following conditions is present:

a. The defendant has previously been convicted of a crime punishable by death or life imprisonment.

b. The defendant has been convicted of a dangerous crime within the 10 years immediately preceding the date of his arrest for the crime presently charged.

c. The defendant is on probation, parole, or other release pending completion of sentence or on pretrial release for a dangerous crime at the time of the current arrest.

Section 8. Subsection (2) of section 39.052, Florida Statutes, is amended to read:

39.052 Hearings.—

(2) WAIVER HEARING.—

(a) Within 7 days, excluding Saturdays, Sundays, and legal holidays, after the date a petition alleging that a child has committed a delinquent act or violation of law has been filed, which shall also be before an adjudicatory hearing and after considering the recommendation of the intake counselor or case manager, the state attorney may file a motion requesting the court to transfer the child for criminal prosecution if the child was 14 or more years of age at the time of commission of the alleged delinquent act or violation of law for which he is charged. If the child has been previously adjudicated delinquent for murder, sexual battery, armed or strong-armed robbery, *carjacking, home-invasion robbery,* aggravated battery, or aggravated assault, and is currently charged with a second or subsequent violent crime against a person, the state attorney shall file a motion requesting the court to transfer the child for criminal prosecution or, if the child was 16 or 17 years of age at the time of commission of the alleged offense, shall file an information pursuant to s. 39.047(4)(e)5., if applicable.

(b) Following the filing of the motion of the state attorney, summonses shall be issued and served in conformity with the provisions of s. 39.049. A copy of the motion and a copy of the delinquency petition, if not already served, shall be attached to each summons.

(c) The court shall conduct a hearing on all such motions for the purpose of determining whether a child should be transferred. In making its determination, the court shall consider:

1. The seriousness of the alleged offense to the community and whether the protection of the community is best served by transferring the child for adult sanctions.

2. Whether the alleged offense was committed in an aggressive, violent, premeditated, or willful manner.

3. Whether the alleged offense was against persons or against property, greater weight being given to offenses against persons, especially if personal injury resulted.

4. The prosecutive merits of the report, affidavit, or complaint.

5. The desirability of trial and disposition of the entire offense in one court when the child's associates in the alleged crime are adults or children who are to be tried as adults.

6. The sophistication and maturity of the child.

7. The record and previous history of the child, including:

a. Previous contacts with the department, other law enforcement agencies, and courts;

b. Prior periods of probation or community control;

c. Prior adjudications that the child committed a delinquent act or violation of law, greater weight being given if the child has previously been found by a court to have committed a delinquent act or violation of law involving an offense classified as a felony or has twice previously been found to have committed a delinquent act or violation of law involving an offense classified as a misdemeanor; and

d. Prior commitments to institutions.

8. The prospects for adequate protection of the public and the likelihood of reasonable rehabilitation of the child, if he is found to have committed the alleged offense, by the use of procedures, services, and facilities currently available to the court.

(d) Prior to a hearing on the motion by the state attorney, a study and report to the court, relevant to the factors in paragraph (c), shall be made in writing by an authorized agent of the department. The child and his parents or guardians and counsel and the state attorney shall have the right to examine these reports and to question the parties responsible for them at the hearing.

(e) Any decision to transfer a child for criminal prosecution shall be in writing and shall include consideration of, and findings of fact with respect to, all criteria in paragraph (c). The court shall render an order including a specific finding of fact and the reasons for a decision to impose adult sanctions. The order shall be reviewable on appeal pursuant to s. 39.069 and the Florida Rules of Appellate Procedure.

Section 9. This act shall take effect July 1, 1993.

And the title is amended as follows:

In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to robbery; creating s. 812.133, F.S.; describing the criminal offense and providing escalating criminal penalties; creating s. 812.131, F.S.; providing definitions; prohibiting home-invasion robbery; providing a penalty; providing for the application of the section with respect to certain other provisions of law; amending s. 782.04, F.S.; providing that commission of carjacking and home-invasion robbery are felony murder when death results; amending s. 16.56, F.S.; providing that the Office of Statewide Prosecution may investigate and prosecute the offenses of carjacking and home-invasion robbery; amending s. 776.08, F.S.; providing that the offenses of carjacking and home-invasion robbery are included in the term "forcible felony"; amending s. 905.34, F.S.; providing that the statewide grand jury has subject matter jurisdiction over the offenses of carjacking and home-invasion robbery; amending s. 907.041, F.S.; defining the term "dangerous crime" to include the offenses of carjacking and home-invasion robbery; amending s. 39.052, F.S.; requiring the state attorney to request criminal prosecution in certain circumstances; providing an effective date.

WHEREAS, the Florida Legislature is determined to protect Florida's residents and visitors from harm, and punish those who would injure or abuse any resident or visitor, and

WHEREAS, the incidence of armed motor vehicle theft is a threat to human life and to the well-being of all of the citizens of the State of Florida and to the visitors we welcome, and

WHEREAS, Floridians recognize armed motor vehicle theft as the crime of "carjacking", a forcible felony, and

WHEREAS, carjacking is also a threat to the physical, emotional and economic well-being of the citizens and visitors of this state, and

WHEREAS, any person convicted of such felony, or a similar crime, should not have adjudication of guilt suspended, deferred, or withheld unless the offender successfully completes probation or community control; NOW, THEREFORE,

On motion by Senator Jenne, by two-thirds vote **SB 74** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—30 Nays—None

SB 614—A bill to be entitled An act relating to state agencies; creating s. 16.58, F.S.; creating the Florida Legal Resource Center in the Department of Legal Affairs; providing for a director of the center; providing definitions; providing intent; providing duties; creating the Advisory Council to the Florida Legal Resource Center; providing for council members; providing for per diem for members; assigning duties to the council; providing for public meetings of the council; providing for rules; providing for staggered terms; amending s. 120.54, F.S.; requiring state agencies to notify the Department of State before formally adopting a rule; requiring a statement of change or notice of no changes; amending s. 120.55, F.S.; providing for publication of the Florida Administrative Code; creating s. 282.20, F.S.; providing definitions; assigning duties to the Administrative Management Information Center of the Department of Management Services; providing an effective date.

—was read the second time by title.

The Committee on Governmental Operations recommended the following amendment which was moved by Senator Harden and adopted:

Amendment 1 (with Title Amendment)—On page 7, line 19 through page 8, line 31, strike all of said lines and insert:

Section 4. Section 120.55, Florida Statutes, is amended to read:

120.55 Publication.—

(1) The Department of State shall:

(a)1. Publish in a permanent compilation entitled "Florida Administrative Code" all rules adopted by each agency, citing the specific rulemaking authority *under* ~~pursuant to~~ which each rule was adopted, all history notes as authorized in s. 120.545(8), and complete indexes to all rules contained in the code. Supplementation *must* ~~shall~~ be made as often as practicable, but at least monthly. The department *may* ~~shall~~ contract with a publishing firm for the publication, in a timely and useful form, of the Florida Administrative Code; however, the department *remains responsible* ~~shall retain responsibility~~ for the code as provided in this section. This publication *constitutes* ~~shall be~~ the official compilation of the administrative rules of this state.

2. Rules general in form but applicable to only one school district, community college district, or county, or a part thereof, or university rules relating to internal personnel or business and finance *may* ~~shall~~ not be published in the Florida Administrative Code. Exclusion from publication in the Florida Administrative Code *does* ~~shall~~ not affect the validity or effectiveness of such rules.

3. At the beginning of the section of the code dealing with an agency that files copies of its rules with the department, the department shall publish a summary or listing of all rules of that agency excluded from publication in the code and a statement as to where those rules may be inspected or examined and shall also publish any exemptions granted that agency *under* ~~pursuant to~~ s. 120.63, including the termination date of the exemption and a statement whether the exemption *may* ~~can~~ be renewed *under* ~~pursuant to~~ s. 120.63(2)(b).

4. Forms *may* ~~shall~~ not be published in the Florida Administrative Code; but any form *that* ~~which~~ an agency uses in its dealings with the public, along with any accompanying instructions, *must* ~~shall~~ be filed with the committee before it is used. Any form or instruction *that* ~~which~~ meets the definition of "rule" provided in s. 120.52(16) *must* ~~shall~~ be incorporated by reference into the appropriate rule. The reference *must* ~~shall~~ specifically state that the form is being incorporated by reference and *must* ~~shall~~ include the number, title, and effective date of the form and an explanation of how the form *can* ~~may~~ be obtained.

(b) Publish a weekly publication entitled the "Florida Administrative Weekly," which shall contain:

1. Notice of adoption of, and an index to, all rules filed during the preceding week.

2. All hearing notices required by s. 120.54(1), showing the time, place, and date of the hearings and the text of all rules proposed for consideration or a reference to the location in the Florida Administrative Weekly where the text of the proposed rules is published.

3. All notices of meetings, hearings, and workshops conducted in accordance with the provisions of s. 120.53(1)(d), including a statement of the manner in which a copy of the agenda may be obtained.

4. A notice of each request for authorization to amend or repeal an existing model rule or for the adoption of new model rules.

5. A notice of each request for exemption from any provision of this chapter.

6. Notice of petitions for declaratory statements or administrative determinations.

7. A summary of each objection to any rule filed by the Administrative Procedures Committee during the preceding week.

8. Any other material required or authorized by law or deemed useful by the department.

The department may contract with a publishing firm for publication of the Florida Administrative Weekly.

(c) Prescribe by rule the style and form required for rules submitted for filing and establish the form for their certification.

(d) Correct grammatical, typographical, and like errors not affecting the construction or meaning of the rules, after having obtained the advice and consent of the appropriate agency, and insert history notes.

(e) Make copies of the Florida Administrative Weekly available on an annual subscription basis computed to cover a pro rata share of 50 percent of the costs related to the publication of the Florida Administrative Weekly.

(f) Charge each agency using the Florida Administrative Weekly a space rate computed to cover a pro rata share of 50 percent of the costs related to the Florida Administrative Weekly.

(2) Each agency shall print or distribute copies of its rules, citing the specific rulemaking authority pursuant to which each rule was adopted.

(3) Any publication of a proposed rule promulgated by an agency, whether published in the Florida Administrative Code or elsewhere, shall include, along with the rule, the name of the person or persons originating such rule, the name of the supervisor or person who approved the rule, and the date upon which the rule was approved.

(4)(a) Each year the Department of State shall furnish the Florida Administrative Weekly, without charge and upon request, as follows:

1. One subscription to each federal and state court having jurisdiction over the residents of the state; the Legislative Library; each state university library; the State Library; each depository library designated pursuant to s. 257.05; and each standing committee of the Senate and House of Representatives and each state legislator upon request of the Senate President's or House Speaker's Office.

2. Two subscriptions to each state department.

3. Three subscriptions to the library of the Supreme Court of Florida, the library of each state district court of appeal, the division, the library of the Attorney General, each law school library in Florida, the Secretary of the Senate, and the Clerk of the House.

4. Ten subscriptions to the committee.

(b) The Department of State shall furnish one copy of the Florida Administrative Weekly, at no cost, to each clerk of the circuit court and each state department, for posting for public inspection.

(5)(a) There is hereby created in the State Treasury a revolving fund to be known as the "Publication Revolving Trust Fund" of the Department of State.

(b) All fees and moneys collected by the Department of State under this chapter shall be deposited in the revolving trust fund for the purpose of paying for the publication and distribution of the Florida Administrative Code and the Florida Administrative Weekly and for associated costs incurred by the department in carrying out this chapter.

(c) The unencumbered balance in the revolving trust fund at the beginning of each fiscal year shall not exceed *$300,000* ~~$100,000~~, and any excess shall be transferred to the General Revenue Fund.

(d) It is the intent of the Legislature that the Florida Administrative Weekly be supported entirely from funds collected for subscriptions to and advertisements in the Florida Administrative Weekly. To that end, the Department of State is authorized to add a surcharge of 10 percent to any charge relating to the Florida Administrative Weekly until such time as the Publication Revolving Trust Fund has transferred to the General Revenue Fund an amount equal to all funds appropriated to the trust fund.

And the title is amended as follows:

In title, on page 1, strike line 19 and insert: Administrative Code; increasing the beginning balance in the Publication Revolving Trust Fund; creating s. 282.20, F.S.;

The Committee on Appropriations recommended the following amendment which was moved by Senator Harden and adopted:

Amendment 2—On page 3, between lines 27 and 28, insert:

(i) Monitor and report on the status of public and private legal representation on behalf of state agencies and multi-county special districts each fiscal year. The center shall provide a report to the Governor, the Speaker of the House of Representatives, and the President of the Senate annually by January 1. The report shall contain at least the following information:

1. The use of private legal representation by state agencies and multi-county special districts.

2. A review of all contracts and invoices for private legal services in excess of $10,000 by state agencies and multi-county special districts. All state agencies, governmental entities, multi-county special districts, community colleges, and state universities must cooperate with the center in the preparation and compilation of data necessary for the annual report.

(Renumber subsequent paragraphs.)

On motion by Senator Harden, by two-thirds vote **SB 614** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—28 Nays—None

SENATOR THOMAS PRESIDING

On motions by Senator Silver, by two-thirds vote—

CS for HB 321—A bill to be entitled An act relating to testimony by child victims or witnesses; amending ss. 92.53, 92.54, and 92.55, F.S., relating to videotaping, closed circuit television, and other special protections for child victims and witnesses; requiring a finding that the harm caused if the child were required to testify would be due to the presence of the defendant; deleting the sexual abuse or child abuse limitation on the videotaping of a child's testimony and the sexual offense limitation on the use of closed circuit television; preserving the defendant's right to immediate consultation with counsel when closed circuit television is used for the child's testimony; requiring the Supreme Court to adopt rules; providing an effective date.

—a companion measure, was substituted for **SB 670** and by two-thirds vote read the second time by title. On motion by Senator Silver, by two-thirds vote **CS for HB 321** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—32 Nays—None

Consideration of **CS for SB 790** was deferred.

SB 794—A bill to be entitled An act relating to disabled veterans; amending s. 320.0848, F.S.; providing a reduced fee for exemption parking permits for certain veterans; providing for the fee to be paid to the county tax collector; providing an effective date.

—was read the second time by title.

The Committee on Community Affairs recommended the following amendment which was moved by Senator Brown-Waite and adopted:

Amendment 1—On page 2, line 11, strike *"renewel"* and insert: *renewal*

The Committee on Transportation recommended the following amendment which was moved by Senator Brown-Waite and adopted:

Amendment 2—On page 2, strike all of lines 8 and 9 and insert: *greater and is in receipt of both disability retirement pay from the United States Armed Forces and has a signed physician's statement of qualification for the handicapped parking permits, the fees are $1.50 for the*

The Committee on Finance, Taxation and Claims recommended the following amendments which were moved by Senator Brown-Waite and adopted:

Amendment 3—On page 2, strike all of lines 1-3 and insert:

2. If an applicant who is a disabled veteran who is a resident of this state, has been honorably discharged, and either has been

Amendment 4—On page 2, line 9, strike "United States Armed Forces" and insert: *Veteran's Administration*

On motion by Senator Brown-Waite, by two-thirds vote **SB 794** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—35 Nays—None

SENATOR CHILDERS PRESIDING

SB 816—A bill to be entitled An act relating to African-American affairs; creating s. 14.27, F.S.; establishing the Florida Commission on African-American Affairs; providing for membership, terms, and organization; providing duties, including an ongoing study and an annual report; authorizing the commission to receive funds and other assistance; providing for review and repeal; providing an appropriation; providing an effective date.

—was read the second time by title.

One amendment failed, and five were adopted to **SB 816** to conform the bill to **HB 683**.

Pending further consideration of **SB 816** as amended, on motions by Senator Meadows, by two-thirds vote **HB 683** was withdrawn from the Committees on Governmental Operations and Appropriations.

On motion by Senator Meadows—

HB 683—A bill to be entitled An act relating to African-American affairs; creating s. 14.27, F.S.; establishing the Florida Commission on African-American Affairs; providing for membership, terms, and organization; providing duties, including an ongoing study and an annual report; authorizing the commission to receive funds and other assistance; providing for review and repeal; providing an appropriation; providing an effective date.

—a companion measure, was substituted for **SB 816** and read the second time by title. On motion by Senator Meadows, by two-thirds vote **HB 683** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

CS for SB 2260—A bill to be entitled An act relating to the duties of the Comptroller and the Department of Banking and Finance; amending s. 17.19, F.S.; revising requirements for examination of public official surety bonds; amending s. 17.20, F.S.; authorizing a collection agent of the department to add a fee for services to the amount collected; amending s. 17.26, F.S.; revising the procedure for reporting and remitting funds represented by canceled state warrants as unclaimed property; amending s. 175.111, F.S.; eliminating a requirement for filing with the department copies of certain municipal ordinances; amending s. 185.09, F.S.; eliminating a requirement for insurance companies to file with the department reports of certain premiums received; amending s. 215 422, F.S.; eliminating applicability of the section to payments made to state agencies, the judiciary, and the legislature; amending s. 216.102, F.S.; imposing requirements on certain governmental entities regarding the form of financial information submitted to the Comptroller; amending s. 218.34, F.S.; revising requirements regarding special district financial matters; providing an effective date.

—was read the second time by title. On motion by Senator Harden, by two-thirds vote **CS for SB 2260** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—32 Nays—None

SB 820—A bill to be entitled An act relating to false imprisonment; amending s. 787.02, F.S.; deleting a provision that precludes the offense from being a lesser included offense for purposes of s. 787.01, F.S., which establishes the offense of kidnapping, and reenacting s. 910.14, F.S., relating to kidnapping, to incorporate said amendment in a reference thereto; providing an effective date.

—was read the second time by title.

The Committee on Criminal Justice recommended the following amendment which was moved by Senator Wexler and adopted:

Amendment 1—In title, on page 1, strike all of lines 4 and 5 and insert: requires the purpose for committing false imprisonment to be other than the purposes required for committing a violation of s. 787.01,

Senator Brown-Waite moved the following amendment which was adopted:

Amendment 2 (with Title Amendment)—On page 2, between lines 29 and 30, insert:

Section 3. Section 794.011, Florida Statutes, 1992 Supplement, is amended to read:

794.011 Sexual battery.—

(1) *As used in this chapter* ~~Definitions~~:

(a) ~~The term~~ "Consent" means intelligent, knowing, and voluntary consent and *does* ~~shall~~ not ~~be construed to~~ include coerced submission.

(b) ~~The term~~ "Mentally defective" means ~~that a person suffers from~~ a mental disease or defect which renders *a* ~~that~~ person temporarily or permanently incapable of appraising the nature of his or her conduct.

(c) ~~The term~~ "Mentally incapacitated" means ~~that a person is rendered~~ temporarily incapable of appraising or controlling *a person's own* ~~his or her~~ conduct due to the influence of a narcotic, anesthetic, or intoxicating substance administered ~~to that person~~ without his or her consent or due to any other act committed upon that person without his or her consent.

(d) ~~The term~~ "Offender" means a person accused of a sexual offense *in violation of a provision of this chapter.*

(e) ~~The term~~ "Physically helpless" means ~~that a person is~~ unconscious, asleep, or for any other reason physically unable to communicate unwillingness to an act.

(f) ~~The term~~ "Retaliation" includes, but is not limited to, threats of future physical punishment, kidnapping, false imprisonment or forcible confinement, or extortion.

(g) ~~The term~~ "Serious personal injury" means great bodily harm or pain, permanent disability, or permanent disfigurement.

(h) ~~The term~~ "Sexual battery" means oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object; however, sexual battery does not include an act done for a bona fide medical purpose.

(i) ~~The term~~ "Victim" means *a* ~~the~~ person *who has* ~~alleging to have~~ been the object of a sexual offense.

(j) ~~The term~~ "Physically incapacitated" means ~~that a person is~~ bodily impaired or handicapped and substantially limited in ~~his or her~~ ability to resist or flee ~~an act~~.

(2)*(a)* A person 18 years of age or older who commits sexual battery upon, or *in an attempt to commit sexual battery* injures the sexual organs of, a person less than 12 years of age ~~in an attempt to commit sexual battery upon such person~~ commits a capital felony, punishable as provided in ss. 775.082 and 921.141.

(b) A person less than 18 years of age who commits sexual battery upon, or in an attempt to commit sexual battery injures the sexual organs of, a person less than 12 years of age commits ~~If the offender is under the age of 18, that person is guilty of~~ a life felony, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) A person who commits sexual battery upon a person 12 years of age or older, without that person's consent, and in the process thereof uses or threatens to use a deadly weapon or uses actual physical force likely to cause serious personal injury *commits* ~~is guilty of~~ a life felony, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) A person who commits sexual battery upon a person 12 years of age or older, without that person's consent, under any of the following circumstances, *commits* ~~is guilty of~~ a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084:

(a) When the victim is physically helpless to resist.

(b) When the offender coerces the victim to submit by threatening to use force or violence likely to cause serious personal injury on the victim, and the victim reasonably believes that the offender has the present ability to execute the threat.

(c) When the offender coerces the victim to submit by threatening to retaliate against the victim, or any other person, and the victim reasonably believes that the offender has the ability to execute the threat in the future.

(d) When the offender, without the prior knowledge or consent of the victim, administers or has knowledge of someone else administering to the victim any narcotic, anesthetic, or other intoxicating substance which mentally or physically incapacitates the victim.

(e) When the victim is mentally defective and the offender has reason to believe this or has actual knowledge of this fact.

(f) When the victim is physically incapacitated.

(5) A person who commits sexual battery upon a person 12 years of age or older, without that person's consent, and in the process thereof uses physical force and violence not likely to cause serious personal injury *commits* ~~is guilty of~~ a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

~~(6) Evidence of the victim's mental incapacity or defect is admissible to prove that the consent was not intelligent, knowing, or voluntary; and the court shall instruct the jury accordingly.~~

(6)~~(7)~~ The offense described in subsection (5) is included in any sexual battery offense charged under subsection (3) or subsection (4).

(7)~~(8)~~ A person who is convicted of committing a sexual battery on or after October 1, 1992, is not eligible for basic gain-time under s. 944.275. This subsection may be cited as the "Junny Rios-Martinez, Jr. Act of 1992."

(8) Without regard to the willingness or consent of the victim, which is not a defense to prosecution under this subsection, a person who is in a position of familial or custodial authority to a person less than 18 years of age and who:

(a) Solicits that person to engage in any act which would constitute sexual battery under paragraph (1)(h) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Engages in any act with that person while the person is 12 years of age or older but less than 18 years of age which constitutes sexual battery under paragraph (1)(h) commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Engages in any act with that person while the person is less than 12 years of age which constitutes sexual battery under paragraph (1)(h), or in an attempt to commit sexual battery injures the sexual organs of such person commits a capital or life felony, punishable pursuant to subsection (2).

Section 4. Section 794.041, Florida Statutes, is hereby repealed.

Section 5. Paragraph (b) of subsection (3) of section 39.001, Florida Statutes, is amended to read:

39.001 Short title, purposes, and intent.—

(3) The Department of Health and Rehabilitative Services may contract with the Federal Government, other state departments and agencies, county and municipal governments and agencies, public and private agencies, and private individuals and corporations in carrying out the purposes of, and the responsibilities established in, this chapter.

(b) The department shall establish minimum standards for good moral character, based on screening, for personnel in programs for children or youths. Such minimum standards shall ensure that no personnel have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following sections of the Florida Statutes or under a similar statute of another jurisdiction:

1. Section 782.04, relating to murder.

2. Section 782.07, relating to manslaughter.

3. Section 782.071, relating to vehicular homicide.

4. Section 782.09, relating to killing an unborn child by injury to the mother.

5. Section 784.011, relating to assault, if the victim of the offense was a minor.

6. Section 784.021, relating to aggravated assault.

7. Section 784.03, relating to battery, if the victim of the offense was a minor.

8. Section 784.045, relating to aggravated battery.

9. Section 787.01, relating to kidnapping.

10. Section 787.02, relating to false imprisonment.

11. Section 787.04, relating to removing minors from the state or concealing minors contrary to state agency or court order.

12. Section 794.011, relating to sexual battery.

~~13. Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

13.~~14.~~ Chapter 796, relating to prostitution.

14.~~15.~~ Section 798.02, relating to lewd and lascivious behavior.

15.~~16.~~ Chapter 800, relating to lewdness and indecent exposure.

16.~~17.~~ Section 806.01, relating to arson.

17.~~18.~~ Section 812.13, relating to robbery.

18.~~19.~~ Section 826.04, relating to incest.

19.~~20.~~ Section 827.03, relating to aggravated child abuse.

20.~~21.~~ Section 827.04, relating to child abuse.

21.~~22.~~ Section 827.05, relating to negligent treatment of children.

22.~~23.~~ Section 827.071, relating to sexual performance by a child.

23.~~24.~~ Section 415.111, relating to abuse, neglect, or exploitation of aged or disabled persons.

24.~~25.~~ Chapter 847, relating to obscene literature.

25.~~26.~~ Chapter 893, relating to drug abuse prevention and control, if the offense was a felony or if any other person involved in the offense was a minor.

26.~~27.~~ Section 817.563, relating to fraudulent sale of controlled substances, if the offense was a felony.

For the purposes of this section, a finding of delinquency or a plea of nolo contendere or other plea amounting to an admission of guilt to a petition alleging delinquency pursuant to part II, or a similar statute of another jurisdiction for any of the foregoing acts has the same effect as a finding of guilt, regardless of adjudication or disposition.

Section 6. Subsections (3) and (5) of section 39.076, Florida Statutes, are amended to read:

39.076 Departmental contracting powers.—

(3) The department shall establish minimum standards for good moral character, based on screening, for personnel in delinquency facilities, services, and programs. Such minimum standards shall ensure that no personnel have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under similar laws of other jurisdictions:

(a) Section 782.04, relating to murder.

(b) Section 782.07, relating to manslaughter.

(c) Section 782.071, relating to vehicular homicide.

(d) Section 782.09, relating to killing of an unborn child by injury to the mother.

(e) Section 784.011, relating to assault, if the victim of the offense was a minor.

(f) Section 784.021, relating to aggravated assault.

(g) Section 784.03, relating to battery, if the victim of the offense was a minor.

(h) Section 784.045, relating to aggravated battery.

(i) Section 787.01, relating to kidnapping.

(j) Section 787.02, relating to false imprisonment.

(k) Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.

(l) Section 794.011, relating to sexual battery.

~~(m) Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

(m)~~(n)~~ Chapter 796, relating to prostitution.

(n)~~(o)~~ Section 798.02, relating to lewd and lascivious behavior.

(o)~~(p)~~ Chapter 800, relating to lewdness and indecent exposure.

(p)~~(q)~~ Section 806.01, relating to arson.

(q)~~(r)~~ Section 812.13, relating to robbery.

(r)~~(s)~~ Section 826.04, relating to incest.

(s)~~(t)~~ Section 827.03, relating to aggravated child abuse.

(t)~~(u)~~ Section 827.04, relating to child abuse.

(u)~~(v)~~ Section 827.05, relating to negligent treatment of children.

(v)~~(w)~~ Section 827.071, relating to sexual performance by a child.

(w)~~(x)~~ Section 415.111, relating to abuse, neglect, or exploitation of aged or disabled persons.

(x)~~(y)~~ Chapter 847, relating to obscene literature.

(y)~~(z)~~ Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a child.

(z)~~(aa)~~ Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

For the purposes of this section, a finding of delinquency or a plea of nolo contendere or other plea amounting to an admission of guilt to a petition alleging delinquency pursuant to this chapter, or any similar law of another jurisdiction, for any of the foregoing acts has the same effect as a finding of guilt, regardless of adjudication or disposition.

(5) For the following, the department may grant to any person an exemption from disqualification from working with children:

(a) Felonies, other than specified felonies, prohibited under any of the foregoing Florida Statutes cited in this section, or any similar law of another jurisdiction, committed more than 3 years previously. For the purposes of this section, "specified felony" means those felonies enumerated in paragraphs (3)(a), (b), (d), (l), (m), *(o)* ~~(n), (p)~~, *(r)*, (s), (t), *(v)* ~~(u)~~, *(x)* ~~(w)~~, (y), *and* (z), ~~and (aa),~~ and under similar laws of other jurisdictions;

(b) Misdemeanors prohibited under any of the foregoing Florida Statutes cited in this section or under similar laws of other jurisdictions;

(c) Offenses which were a felony when committed but are now a misdemeanor;

(d) Findings of delinquency as specified in this section;

(e) Judicial determinations of abuse or neglect under this chapter;

(f) Confirmed reports of abuse, neglect, or exploitation under chapter 415; or

(g) Commission of domestic violence.

Section 7. Subsection (5) of section 39.4105, Florida Statutes, is amended to read:

39.4105 Grandparents rights.—Notwithstanding any other provision of law, a maternal or paternal grandparent as well as a step-grandparent is entitled to reasonable visitation with his or her grandchild who has been adjudicated a dependent child and taken from the physical custody of his or her parent, custodian, legal guardian, or caregiver unless the court finds that such visitation is not in the best interest of the child or that such visitation would interfere with the goals of the performance agreement pursuant to s. 39.451. Reasonable visitation may be unsupervised and, where appropriate and feasible, may be frequent and continuing.

(5) In determining whether grandparental visitation is not in the child's best interest, consideration may be given to the finding of guilt, regardless of adjudication, or entry or plea of guilty or nolo contendere to charges under the following statutes, or similar statutes of other jurisdictions: s. 787.04, relating to removing minors from the state or concealing minors contrary to court order; s. 794.011, relating to sexual battery; ~~s. 794.041, relating to prohibited acts of persons in familial or custodial authority;~~ s. 798.02, relating to lewd and lascivious behavior; chapter 800, relating to lewdness and indecent exposure; or chapter 827, relating to the abuse of children. Consideration may also be given to a finding of confirmed abuse under ss. 415.101-415.113 and ss. 415.502-415.514.

Section 8. Paragraphs (a) and (b) of subsection (3) of section 110.1127, Florida Statutes, 1992 Supplement, are amended to read:

110.1127 Employee security checks.—

(3)(a) Within the Department of Health and Rehabilitative Services, all positions in programs providing care to children or the developmentally disabled for 15 hours or more per week are deemed to be positions of special trust or responsibility, and a person shall be disqualified for employment in any such position by reason of:

1. Having been found guilty of, regardless of adjudication, or having entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

a. Section 782.04, relating to murder.

b. Section 782.07, relating to manslaughter.

c. Section 782.071, relating to vehicular homicide.

d. Section 782.09, relating to killing of an unborn child by injury to the mother.

e. Section 784.011, relating to assault, if the victim of the offense was a minor.

f. Section 784.021, relating to aggravated assault.

g. Section 784.03, relating to battery, if the victim of the offense was a minor.

h. Section 784.045, relating to aggravated battery.

i. Section 787.01, relating to kidnapping.

j. Section 787.02, relating to false imprisonment.

k. Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.

l. Section 794.011, relating to sexual battery.

~~m. Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

m.~~n.~~ Chapter 796, relating to prostitution.

n.~~o.~~ Section 798.02, relating to lewd and lascivious behavior.

o.~~p.~~ Chapter 800, relating to lewdness and indecent exposure.

p.~~q.~~ Section 806.01, relating to arson.

q.~~r.~~ Section 812.13, relating to robbery.

r.~~s.~~ Section 826.04, relating to incest.

s.~~t.~~ Section 827.03, relating to aggravated child abuse.

t.~~u.~~ Section 827.04, relating to child abuse.

u.~~v.~~ Section 827.05, relating to negligent treatment of children.

v.~~w.~~ Section 827.071, relating to sexual performance by a child.

w.~~x.~~ Section 415.111, relating to abuse, neglect, or exploitation of aged or disabled persons.

x.~~y.~~ Chapter 847, relating to obscene literature.

y.~~z.~~ Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

z.~~aa.~~ Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony; or

(b)1. For the following, the department may grant to any person an exemption from disqualification from working with children or the developmentally disabled:

a. Felonies, other than specified felonies, prohibited under any of the foregoing Florida Statutes cited in paragraph (a) or under similar statutes of other jurisdictions, committed more than 3 years previously. For the purposes of this sub-subparagraph, "specified felony" means those felonies in the Florida Statutes enumerated in sub-subparagraphs (a)1.a., b., d., l., m., *o.* ~~n.~~, *r.* ~~p.~~, s., t., *v.* ~~u.~~, *x.* ~~w.~~, y., *and* z., ~~and aa.,~~ or under any similar statute of another jurisdiction;

b. Misdemeanors prohibited under any of the foregoing Florida Statutes cited in this subsection or under similar statutes of another jurisdiction;

c. Offenses which were a felony when committed but are now a misdemeanor;

d. Findings of delinquency as specified in this subsection;

e. Judicial determinations of abuse or neglect under chapter 39;

f. Confirmed reports of abuse, neglect, or exploitation under chapter 415 which have been uncontested or have been upheld pursuant to the procedures provided in s. 415.103 or s. 415.504; or

g. Commissions of domestic violence.

2. In order to grant an exemption to a person, the department must have clear and convincing evidence to support a reasonable belief that the person is of good character as to justify an exemption. The person shall bear the burden of setting forth sufficient evidence of rehabilitation,

including, but not limited to, the circumstances surrounding the incident, the time period that has elapsed since the incident, the nature of the harm occasioned to the victim, and the history of the person since the incident, or such other circumstances as indicate that the person will not present a danger to the safety or well-being of children. The decision of the department regarding an exemption may be contested through the hearing procedures set forth in chapter 120.

Section 9. Paragraph (a) of subsection (3) of section 242.335, Florida Statutes, is amended to read:

242.335 Personnel screening; Florida School for the Deaf and the Blind.—

(3)(a) An employee or applicant for a position in a program providing care to enrolled students may be terminated from or disqualified for employment in any such position by reason of:

1. Having been found guilty of, regardless of adjudication, or having entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

a. Section 782.04, relating to murder.

b. Section 782.07, relating to manslaughter.

c. Section 782.071, relating to vehicular homicide.

d. Section 782.09, relating to killing of an unborn child by injury to the mother.

e. Section 784.011, relating to assault, if the victim of the offense was a minor.

f. Section 784.021, relating to aggravated assault.

g. Section 784.03, relating to battery, if the victim of the offense was a minor.

h. Section 784.045, relating to aggravated battery.

i. Section 787.01, relating to kidnapping.

j. Section 787.02, relating to false imprisonment.

k. Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.

l. Section 794.011, relating to sexual battery.

~~m. Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

m.~~n.~~ Chapter 796, relating to prostitution.

n.~~o.~~ Section 798.02, relating to lewd and lascivious behavior.

o.~~p.~~ Chapter 800, relating to lewdness and indecent exposure.

p.~~q.~~ Section 806.01, relating to arson.

q.~~r.~~ Section 812.13, relating to robbery.

r.~~s.~~ Section 826.04, relating to incest.

s.~~t.~~ Section 827.03, relating to aggravated child abuse.

t.~~u.~~ Section 827.04, relating to child abuse.

u.~~v.~~ Section 827.05, relating to negligent treatment of children.

v.~~w.~~ Section 827.071, relating to sexual performance by a child.

w.~~x.~~ Section 415.111, relating to abuse, neglect, or exploitation of aged or disabled persons.

x.~~y.~~ Chapter 847, relating to obscene literature.

y.~~z.~~ Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

z.~~aa.~~ Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony;

2. Having had a finding of delinquency or having entered a plea of nolo contendere or a plea amounting to an admission of guilt to a petition alleging delinquency pursuant to part II of chapter 39, or similar statutes of other jurisdictions, for any of the acts set forth in subparagraph 1., regardless of adjudication or disposition. For the purposes of this subparagraph, such a finding or plea has the same effect as a finding of guilt;

3. Having been judicially determined to have committed abuse or neglect against a child as defined in s. 39.01(2) and (37);

4. Having a confirmed report of abuse, neglect, or exploitation as defined in s. 415.102(5) or abuse or neglect as defined in s. 415.503(6) which has been uncontested or upheld pursuant to the procedures provided in s. 415.103 or s. 415.504; or

5. Having committed an act which constitutes domestic violence as defined in s. 741.30.

Section 10. Subsection (1) and paragraph (a) of subsection (3) of section 393.0655, Florida Statutes, are amended to read:

393.0655 Screening of caretakers.—

(1) MINIMUM STANDARDS.—The department shall establish minimum standards as to good moral character, based on screening, for caretakers who are unrelated to their clients. Such minimum standards for screening shall ensure that no caretaker unrelated to his client has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

(a) Section 782.04, relating to murder.

(b) Section 782.07, relating to manslaughter.

(c) Section 782.071, relating to vehicular homicide.

(d) Section 782.09, relating to killing of an unborn child by injury to the mother.

(e) Section 784.021, relating to aggravated assault.

(f) Section 784.045, relating to aggravated battery.

(g) Section 787.01, relating to kidnapping.

(h) Section 787.02, relating to false imprisonment.

(i) Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.

(j) Section 794.011, relating to sexual battery.

~~(k) Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

(k)~~(l)~~ Chapter 796, relating to prostitution.

(l)~~(m)~~ Section 798.02, relating to lewd and lascivious behavior.

(m)~~(n)~~ Chapter 800, relating to lewdness and indecent exposure.

(n)~~(o)~~ Section 806.01, relating to arson.

(o)~~(p)~~ Section 812.13, relating to robbery.

(p)~~(q)~~ Section 826.04, relating to incest.

(q)~~(r)~~ Section 827.03, relating to aggravated child abuse.

(r)~~(s)~~ Section 827.04, relating to child abuse.

(s)~~(t)~~ Section 827.05, relating to negligent treatment of children.

(t)~~(u)~~ Section 827.071, relating to sexual performance by a child.

(u)~~(v)~~ Section 415.111, relating to abuse, neglect, or exploitation of aged or disabled persons.

(v)~~(w)~~ Chapter 847, relating to obscene literature.

(w)~~(x)~~ Section 784.011, relating to assault, if the victim of the offense was a minor.

(x)~~(y)~~ Section 784.03, relating to battery, if the victim of the offense was a minor.

(y)~~(z)~~ Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(z)~~(aa)~~ Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

For the purposes of this section, a finding of delinquency or a plea of nolo contendere or other plea amounting to an admission of guilt to a petition alleging delinquency pursuant to part II, chapter 39, or a similar statute of another jurisdiction, for any of the foregoing acts has the same effect as a finding of guilt, regardless of adjudication or disposition.

(3) EXEMPTIONS FROM DISQUALIFICATION.—

(a) For the following, the department may grant to any person an exemption from disqualification from working with children or the developmentally disabled:

1. Felonies, other than specified felonies, prohibited under any of the foregoing Florida Statutes cited in subsection (1) or under similar statutes of other jurisdictions, committed more than 3 years previously. For the purposes of this subparagraph, "specified felony" means those felonies in the Florida Statutes, enumerated in paragraphs (1)(a), (b), (d), (j), (k), *(m)* ~~(l)~~, *(p)* ~~(n)~~, (q), (r), *(t)* ~~(s)~~, *(v)* ~~(u)~~, *(y)* ~~(w)~~, *and* (z), ~~and (aa),~~ or under any similar statute of another jurisdiction;

2. Misdemeanors prohibited under any of the foregoing Florida Statutes cited in this section or under similar statutes of other jurisdictions;

3. Offenses which were a felony when committed but are now a misdemeanor;

4. Findings of delinquency as specified in this section;

5. Judicial determinations of abuse or neglect under chapter 39;

6. Confirmed reports of abuse, neglect, or exploitation under chapter 415 which have been uncontested or have been upheld pursuant to the procedures provided in s. 415.103 or s. 415.504; or

7. Commissions of domestic violence.

Section 11. Paragraphs (a) and (c) of subsection (6) of section 394.457, Florida Statutes, are amended to read:

394.457 Operation and administration.—

(6) SCREENING OF MENTAL HEALTH PERSONNEL.—

(a) The department shall establish minimum standards as to good moral character, based on screening, for mental health personnel. Such minimum standards for screening shall ensure that no mental health personnel have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

1. Section 782.04, relating to murder.

2. Section 782.07, relating to manslaughter.

3. Section 782.071, relating to vehicular homicide.

4. Section 782.09, relating to killing of an unborn child by injury to the mother.

5. Section 784.021, relating to aggravated assault.

6. Section 784.045, relating to aggravated battery.

7. Section 787.01, relating to kidnapping.

8. Section 787.02, relating to false imprisonment.

9. Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.

10. Section 794.011, relating to sexual battery.

~~11. Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

11.~~12.~~ Chapter 796, relating to prostitution.

12.~~13.~~ Section 798.02, relating to lewd and lascivious behavior.

13.~~14.~~ Chapter 800, relating to lewdness and indecent exposure.

14.~~15.~~ Section 806.01, relating to arson.

15.~~16.~~ Section 812.13, relating to robbery.

16.~~17.~~ Section 826.04, relating to incest.

17.~~18.~~ Section 827.03, relating to aggravated child abuse.

18.~~19.~~ Section 827.04, relating to child abuse.

19.~~20.~~ Section 827.05, relating to negligent treatment of children.

20.~~21.~~ Section 827.071, relating to sexual performance by a child.

21.~~22.~~ Section 415.11, relating to abuse, neglect, or exploitation of aged or disabled persons.

22.~~23.~~ Chapter 847, relating to obscene literature.

23.~~24.~~ Section 784.011, relating to assault, if the victim of the offense was a minor.

24.~~25.~~ Section 784.03, relating to battery, if the victim of the offense was a minor.

25.~~26.~~ Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

26.~~27.~~ Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

For the purposes of this subsection, a finding of delinquency or a plea of nolo contendere or other plea amounting to an admission of guilt to a petition alleging delinquency pursuant to part II, chapter 39, or similar statutes of another jurisdiction, for any of the foregoing acts has the same effect as a finding of guilt, regardless of adjudication or disposition.

(c)1. For the following, the department may grant to any person an exemption from disqualification from working with children or the developmentally disabled:

a. Felonies, other than specified felonies, prohibited under any of the foregoing Florida Statutes cited in paragraph (a) or under similar statutes of other jurisdictions, committed more than 3 years previously. For the purposes of this sub-subparagraph, "specified felony" means those felonies in the Florida Statutes enumerated in subparagraphs (a)1., 2., 4., 10., 11., *13.* ~~12.~~, *16.* ~~14.~~, 17., 18., *20.* ~~19.~~, *22.* ~~21.~~, *25.* ~~23.~~, *and* 26., ~~and 27.,~~ or under any similar statute of another jurisdiction;

b. Misdemeanors prohibited under any of the foregoing Florida Statutes cited in this subsection or under similar statutes of other jurisdictions;

c. Offenses which were a felony when committed but are now a misdemeanor;

d. Findings of delinquency as specified in this subsection;

e. Judicial determinations of abuse or neglect under chapter 39;

f. Confirmed reports of abuse, neglect, or exploitation under chapter 415 which have been uncontested or have been upheld pursuant to the procedures provided in s. 415.103 or s. 415.504; or

g. Commissions of domestic violence.

2. In order to grant an exemption to a person, the department must have clear and convincing evidence to support a reasonable belief that the person is of good character so as to justify an exemption. The person shall bear the burden of setting forth sufficient evidence of rehabilitation, including, but not limited to, the circumstances surrounding the incident, the time period that has elapsed since the incident, the nature of the harm occasioned to the victim, and the history of the person since the incident or such other circumstances that shall by the aforementioned standards indicate that the person will not present a danger to the safety or well-being of children. The decision of the department regarding an exemption may be contested through a hearing under chapter 120.

Section 12. Subsection (1) and paragraph (a) of subsection (3) of section 396.0425, Florida Statutes, are amended to read:

396.0425 Screening of treatment resource personnel.—

(1) MINIMUM STANDARDS.—The department shall establish minimum standards as to good moral character, based on screening, for treatment resource personnel. Such minimum standards for screening shall ensure that no treatment resource personnel have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under similar statutes of other jurisdictions:

(a) Section 782.04, relating to murder.

(b) Section 782.07, relating to manslaughter.

(c) Section 782.071, relating to vehicular homicide.

(d) Section 782.09, relating to killing of an unborn child by injury to the mother.

(e) Section 784.021, relating to aggravated assault.

(f) Section 784.045, relating to aggravated battery.

(g) Section 787.01, relating to kidnapping.

(h) Section 787.02, relating to false imprisonment.

(i) Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.

(j) Section 794.011, relating to sexual battery.

~~(k) Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

(k)~~(l)~~ Chapter 796, relating to prostitution.

(l)~~(m)~~ Section 798.02, relating to lewd and lascivious behavior.

(m)~~(n)~~ Chapter 800, relating to lewdness and indecent exposure.

(n)~~(o)~~ Section 806.01, relating to arson.

(o)~~(p)~~ Section 812.13, relating to robbery.

(p)~~(q)~~ Section 826.04, relating to incest.

(q)~~(r)~~ Section 827.03, relating to aggravated child abuse.

(r)~~(s)~~ Section 827.04, relating to child abuse.

(s)~~(t)~~ Section 827.05, relating to negligent treatment of children.

(t)~~(u)~~ Section 827.071, relating to sexual performance by a child.

(u)~~(v)~~ Section 415.111, relating to abuse, neglect, or exploitation of aged or disabled persons.

(v)~~(w)~~ Chapter 847, relating to obscene literature.

(w)~~(x)~~ Section 784.011, relating to assault, if the victim of the offense was a minor.

(x)~~(y)~~ Section 784.03, relating to battery, if the victim of the offense was a minor.

(y)~~(z)~~ Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(z)~~(aa)~~ Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

For purposes of this subsection, a finding of delinquency or a plea of nolo contendere or other plea amounting to an admission of guilt to a petition alleging delinquency pursuant to part II, chapter 39, or similar statutes of other jurisdictions for any of the foregoing acts has the same effect as a finding of guilt, regardless of adjudication or disposition.

(3) EXEMPTIONS FROM DISQUALIFICATION.—

(a) For the following, the department may grant to any treatment resource personnel an exemption from disqualification from working with children or the developmentally disabled:

1. Felonies, other than specified felonies, prohibited under any of the foregoing Florida Statutes cited in subsection (1) or under similar statutes of other jurisdictions, committed more than 3 years previously. For the purposes of this subparagraph, "specified felony" means those felonies in the Florida Statutes enumerated in paragraphs (1)(a), (b), (d), (j), (k), *(m)* ~~(l), (n)~~, *(p)*, (q), (r), *(t)* ~~(s)~~, *(v)* ~~(u)~~, *(y)* ~~(w)~~, *and* (z), ~~and (aa),~~ or under any similar statute of another jurisdiction;

2. Misdemeanors prohibited under any of the foregoing Florida Statutes cited in this section or under similar statutes of other jurisdictions;

3. Offenses which were a felony when committed but are now a misdemeanor;

4. Findings of delinquency as specified in this subsection;

5. Judicial determinations of abuse or neglect under chapter 39;

6. Confirmed reports of abuse, neglect, or exploitation under chapter 415 which have been uncontested or have been upheld pursuant to the procedures provided in s. 415.103 or s. 415.504; or

7. Commissions of domestic violence.

Section 13. Subsection (1) and paragraph (a) of subsection (3) of section 397.0715, Florida Statutes, are amended to read:

397.0715 Screening of treatment resource personnel.—

(1) MINIMUM STANDARDS.—The department shall establish minimum standards as to good moral character, based on screening, for treatment resource personnel. Such minimum standards for screening shall ensure that no treatment resource personnel have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under similar statutes of other jurisdictions:

(a) Section 782.04, relating to murder.

(b) Section 782.07, relating to manslaughter.

(c) Section 782.071, relating to vehicular homicide.

(d) Section 782.09, relating to killing of an unborn child by injury to the mother.

(e) Section 784.021, relating to aggravated assault.

(f) Section 784.045, relating to aggravated battery.

(g) Section 787.01, relating to kidnapping.

(h) Section 787.02, relating to false imprisonment.

(i) Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.

(j) Section 794.011, relating to sexual battery.

~~(k) Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

(k)~~(l)~~ Chapter 796, relating to prostitution.

(l)~~(m)~~ Section 798.02, relating to lewd and lascivious behavior.

(m)~~(n)~~ Chapter 800, relating to lewdness and indecent exposure.

(n)~~(o)~~ Section 806.01, relating to arson.

(o)~~(p)~~ Section 812.13, relating to robbery.

(p)~~(q)~~ Section 826.04, relating to incest.

(q)~~(r)~~ Section 827.03, relating to aggravated child abuse.

(r)~~(s)~~ Section 827.04, relating to child abuse.

(s)~~(t)~~ Section 827.05, relating to negligent treatment of children.

(t)~~(u)~~ Section 827.071, relating to sexual performance by a child.

(u)~~(v)~~ Section 415.111, relating to abuse, neglect, or exploitation of aged or disabled persons.

(v)~~(w)~~ Chapter 847, relating to obscene literature.

(w)~~(x)~~ Section 784.011, relating to assault, if the victim of the offense was a minor.

(x)~~(y)~~ Section 784.03, relating to battery, if the victim of the offense was a minor.

(y)~~(z)~~ Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(z)~~(aa)~~ Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

For purposes of this subsection, a finding of delinquency or a plea of nolo contendere or other plea amounting to an admission of guilt to a petition

alleging delinquency pursuant to part II, chapter 39, or similar statutes of other jurisdictions, for any of the foregoing acts, has the same effect as a finding of guilt, regardless of adjudication or disposition.

(3) EXEMPTIONS FROM DISQUALIFICATION.—

(a) For the following, the department may grant to any treatment resource personnel an exemption from disqualification from working with children or the developmentally disabled:

1. Felonies, other than specified felonies, prohibited under any of the foregoing Florida Statutes cited in subsection (1) or under similar statutes of other jurisdictions, committed more than 3 years previously. For the purposes of this subparagraph, "specified felony" means those felonies in the Florida Statutes enumerated in paragraphs (1)(a), (b), (d), (j), (k), *(m)* ~~(l), (n)~~, *(p)*, (q), (r), *(t)* ~~(s)~~, *(v)* ~~(u)~~, *(y)* ~~(w)~~, *and* (z), ~~and (aa),~~ or under any similar statute of another jurisdiction;

2. Misdemeanors prohibited under any of the foregoing Florida Statutes cited in this section or under similar statutes of other jurisdictions;

3. Offenses which were a felony when committed but are now a misdemeanor;

4. Findings of delinquency as specified in this subsection;

5. Judicial determinations of abuse or neglect under chapter 39;

6. Confirmed reports of abuse, neglect, or exploitation under chapter 415 which have been uncontested or have been upheld pursuant to the procedures provided in s. 415.103 or s. 415.504; or

7. Commissions of domestic violence.

Section 14. Paragraphs (a) and (c) of subsection (2) of section 402.305, Florida Statutes, 1992 Supplement, are amended to read:

402.305 Licensing standards; child care facilities.—

(2) PERSONNEL.—Minimum standards for child care personnel shall include minimum requirements as to:

(a) Good moral character based upon screening. Such minimum standards for screening shall ensure that no child care personnel at a child care facility or other child care program have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under a similar statute of another jurisdiction:

1. Section 782.04, relating to murder.

2. Section 782.07, relating to manslaughter.

3. Section 782.071, relating to vehicular homicide.

4. Section 782.09, relating to killing of an unborn child by injury to the mother.

5. Section 784.021, relating to aggravated assault.

6. Section 784.045, relating to aggravated battery.

7. Section 787.01, relating to kidnapping.

8. Section 787.02, relating to false imprisonment.

9. Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.

10. Section 794.011, relating to sexual battery.

~~11. Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

11.~~12.~~ Chapter 796, relating to prostitution.

12.~~13.~~ Section 798.02, relating to lewd and lascivious behavior.

13.~~14.~~ Chapter 800, relating to lewdness and indecent exposure.

14.~~15.~~ Section 806.01, relating to arson.

15.~~16.~~ Section 812.13, relating to robbery.

16.~~17.~~ Section 826.04, relating to incest.

17.~~18.~~ Section 827.03, relating to aggravated child abuse.

18.~~19.~~ Section 827.04, relating to child abuse.

19.~~20.~~ Section 827.05, relating to negligent treatment of children.

20.~~21.~~ Section 827.071, relating to sexual performance by a child.

21.~~22.~~ Section 415.111, relating to abuse, neglect, or exploitation of aged or disabled persons.

22.~~23.~~ Chapter 847, relating to obscene literature.

23.~~24.~~ Section 784.011, relating to assault, if the victim of the offense was a minor.

24.~~25.~~ Section 784.03, relating to battery, if the victim of the offense was a minor.

25.~~26.~~ Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

26.~~27.~~ Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

For purposes of this subsection, a finding of delinquency or a plea of nolo contendere or other plea amounting to an admission of guilt to a petition alleging delinquency pursuant to part II of chapter 39 or similar statutes of other jurisdictions, for any of the foregoing acts, has the same effect as a finding of guilt, regardless of adjudication or disposition.

(c)1. For the following, the department may grant to any person an exemption from disqualification from working with children or the developmentally disabled:

a. Felonies, other than specified felonies, prohibited under any of the foregoing Florida Statutes cited in paragraph (a) or under similar statutes of other jurisdictions, committed more than 3 years previously. For the purposes of this sub-subparagraph, "specified felony" means those felonies in the Florida Statutes enumerated in subparagraphs (a)1., 2., 4., 10., 11., *13.* ~~12.~~, *16.* ~~14.~~, 17., 18., *20.* ~~19.~~, *22.* ~~21.~~, *25.* ~~23.~~, *and* 26., ~~and 27.,~~ or under any similar statute of another jurisdiction;

b. Misdemeanors prohibited under any of the Florida Statutes cited in this subsection or under similar statutes of other jurisdictions;

c. Offenses which were a felony when committed but are now a misdemeanor;

d. Findings of delinquency as specified in this subsection;

e. Judicial determinations of abuse or neglect under chapter 39;

f. Confirmed reports of abuse, neglect, or exploitation under chapter 415 which have been uncontested or have been upheld pursuant to the procedures provided in s. 415.103 or s. 415.504; or

g. Commissions of domestic violence.

2. In order to grant an exemption to a person, the department must have clear and convincing evidence to support a reasonable belief that the person is of good character so as to justify an exemption. The person shall bear the burden of setting forth sufficient evidence of rehabilitation, including, but not limited to, the circumstances surrounding the incident, the time period that has elapsed since the incident, the nature of the harm occasioned to the victim, and the history of the person since the incident, or such other circumstances that shall by the aforementioned standards indicate that the person will not present a danger to the safety or well-being of children. The decision of the department regarding an exemption may be contested through the hearing procedures set forth in chapter 120. The decision of the local licensing board may be contested through the hearing procedures in s. 402.3055.

Section 15. Paragraph (a) of subsection (4) of section 409.175, Florida Statutes, is amended to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies.—

(4)(a) The department shall adopt and amend licensing rules for family foster homes, residential child-caring agencies, and child-placing agencies. The department may also adopt rules relating to the screening requirements for summer day camps and summer 24-hour camps. The requirements for licensure and operation of family foster homes, residential child-caring agencies, and child-placing agencies shall include:

1. The operation, conduct, and maintenance of these homes and agencies and the responsibility which they assume for children served and the evidence of need for that service.

2. The provision of food, clothing, educational opportunities, services, equipment, and individual supplies to assure the healthy physical, emotional, and mental development of the children served.

3. The appropriateness, safety, cleanliness, and general adequacy of the premises, including fire prevention and health standards, to provide for the physical comfort, care, and well-being of the children served.

4. The ratio of staff to children required to provide adequate care and supervision of the children served and, in the case of foster homes, the maximum number of children in the home.

5. The education, training, and experience requirements of persons responsible for the care and well-being of the children served.

6. The good moral character based upon screening, education, training, and experience requirements for personnel. At a minimum, screening shall ensure that no personnel at a child-placing agency, family foster home, residential child-caring agency, summer day camp, or summer 24-hour camp providing care for children have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

a. Section 782.04, relating to murder.

b. Section 782.07, relating to manslaughter.

c. Section 782.071, relating to vehicular homicide.

d. Section 782.09, relating to killing of an unborn child by injury to the mother.

e. Section 784.011, relating to assault, if the victim of the offense was a minor.

f. Section 784.021, relating to aggravated assault.

g. Section 784.03, relating to battery, if the victim of the offense was a minor.

h. Section 784.045, relating to aggravated battery.

i. Section 787.01, relating to kidnapping.

j. Section 787.02, relating to false imprisonment.

k. Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.

l. Section 794.011, relating to sexual battery.

~~m. Section 794.041, relating to prohibited acts of persons in familial or custodial authority.~~

m.~~n.~~ Chapter 796, relating to prostitution.

n.~~o.~~ Section 798.02, relating to lewd and lascivious behavior.

o.~~p.~~ Chapter 800, relating to lewdness and indecent exposure.

p.~~q.~~ Section 806.01, relating to arson.

q.~~r.~~ Section 812.13, relating to robbery.

r.~~s.~~ Section 826.04, relating to incest.

s.~~t.~~ Section 827.03, relating to aggravated child abuse.

t.~~u.~~ Section 827.04, relating to child abuse.

u.~~v.~~ Section 827.05, relating to negligent treatment of children.

v.~~w.~~ Section 827.071, relating to sexual performance by a child.

w.~~x.~~ Section 415.111, relating to abuse, neglect, or exploitation of aged or disabled persons.

x.~~y.~~ Chapter 847, relating to obscene literature.

y.~~z.~~ Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

z.~~aa.~~ Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

For the purposes of this subparagraph, a finding of delinquency or a plea of nolo contendere or other plea amounting to an admission of guilt to a petition alleging delinquency pursuant to part II, chapter 39, or a similar statute of another jurisdiction, for any of the foregoing acts has the same effect as a finding of guilt, regardless of adjudication or disposition.

7. Standards for screening shall also ensure that the person:

a. Has not been judicially determined to have committed abuse or neglect against a child as defined in s. 39.01(2) and (37); or

b. Does not have a confirmed report of abuse, neglect, or exploitation as defined in s. 415.102(5) or abuse or neglect as defined in s. 415.503(6) which has been uncontested or upheld pursuant to the procedures of s. 415.103 or s. 415.504; or

c. Has not committed an act which constitutes domestic violence as defined in s. 741.30.

8.a. For the following, the department may grant to any person an exemption from disqualification from working with children or the developmentally disabled:

(I) Felonies, other than specified felonies, prohibited under any of the foregoing Florida Statutes cited in subparagraph 6. or under similar statutes of other jurisdictions, committed more than 3 years previously. For the purposes of this sub-sub-subparagraph, "specified felony" means those felonies in the Florida Statutes enumerated in sub-subparagraphs 6.a., b., d., l., m., *o.* ~~n.~~, *r.* ~~p.~~, s., t., *v.* ~~u.~~, *x.* ~~w.~~, y., *and* z., ~~and aa.~~ or under similar statutes of another jurisdiction;

(II) Misdemeanors prohibited under any of the foregoing Florida Statutes cited in this paragraph or under similar statutes of other jurisdictions;

(III) Offenses which were a felony when committed but are now a misdemeanor;

(IV) Findings of delinquency as specified in this subsection;

(V) Judicial determinations of abuse or neglect under chapter 39;

(VI) Confirmed reports of abuse, neglect, or exploitation under chapter 415 which have been uncontested or have been upheld pursuant to the procedures provided in s. 415.103 or s. 415.504; or

(VII) Commissions of domestic violence.

b. In order to grant an exemption to a person, the department shall have clear and convincing evidence to support a reasonable belief that the person is of good character so as to justify an exemption. The person shall bear the burden of setting forth sufficient evidence of rehabilitation, including, but not limited to, the circumstances surrounding the incident, the time period that has elapsed since the incident, the nature of the harm occasioned to the victim, and the history of the person since the incident or such other circumstances that shall by the aforementioned standards indicate that the person will not present a danger to the safety or well-being of children. The decision of the department regarding an exemption may be contested through the hearing procedures set forth in chapter 120.

c. The disqualification from employment provided in subparagraph 6. shall not be removed from any person found guilty of, regardless of adjudication, or having entered a plea of nolo contendere or guilty to, any felony covered by subparagraph 6. solely by reason of any pardon, executive clemency, or restoration of civil rights.

9. The provision of preservice and inservice training for all foster parents and agency staff.

10. Satisfactory evidence of financial ability to provide care for the children in compliance with licensing requirements.

11. The maintenance by the agency of records pertaining to admission, progress, health, and discharge of children served, including written case plans and reports to the department.

12. The provision for parental involvement to encourage preservation and strengthening of a child's relationship with his family.

13. The transportation safety of children served.

14. The provisions for safeguarding the cultural, religious, and ethnic values of a child.

15. Provisions to safeguard the legal rights of children served.

Section 16. For the purpose of incorporating the amendment to section 794.011, Florida Statutes, in references thereto, the subsection (7) of section 775.15, Florida Statutes, is reenacted to read:

775.15 Time limitations.—

(7) If the victim of a violation of s. 794.011, s. 794.05, s. 800.04, or s. 826.04 is under the age of 16, the applicable period of limitation, if any, does not begin to run until the victim has reached the age of 16 or the violation is reported to a law enforcement agency or other governmental agency, whichever occurs earlier. Such law enforcement agency or other governmental agency shall promptly report such allegation to the state attorney for the judicial circuit in which the alleged violation occurred. This subsection applies to any such offense except an offense the prosecution of which would have been barred by subsection (2) on or before December 31, 1984.

Section 17. For the purpose of incorporating the amendment to section 794.011, Florida Statutes, in references thereto, subsection (2) of section 794.023, Florida Statutes, is reenacted to read:

794.023 Sexual battery by multiple perpetrators; enhanced penalties.—

(2) The penalty for a violation of s. 794.011 shall be increased as provided in this subsection if it is charged and proven by the prosecution that, during the same criminal transaction or episode, more than one person committed an act of sexual battery on the same victim.

(a) A felony of the second degree shall be punishable as if it were a felony of the first degree.

(b) A felony of the first degree shall be punishable as if it were a life felony.

This subsection does not apply to life felonies or capital felonies.

Section 18. For the purpose of incorporating the amendment to section 794.011, Florida Statutes, in references thereto, section 903.133, Florida Statutes, is reenacted to read:

903.133 Bail on appeal; prohibited for certain felony convictions.—Notwithstanding the provisions of s. 903.132, no person adjudged guilty of a felony of the first degree for a violation of s. 782.04(2) or (3), s. 787.01, s. 794.011(4), s. 806.01, s. 893.13, or s. 893.135, or adjudged guilty of a violation of s. 794.011(2) or (3), shall be admitted to bail pending review either by posttrial motion or appeal.

Section 19. For the purpose of incorporating the amendment to section 794.011, Florida Statutes, in references thereto, section 914.16, Florida Statutes, is reenacted to read:

914.16 Child abuse and sexual abuse victims under age 16; limits on interviews.—The chief judge of each judicial circuit, after consultation with the state attorney and the public defender for the judicial circuit, the appropriate chief law enforcement officer, and any other person deemed appropriate by the chief judge, shall provide by order reasonable limits on the number of interviews that a victim of a violation of s. 794.011, s. 800.04, s. 827.03, or s. 827.04 who is under 16 years of age must submit to for law enforcement or discovery purposes. The order shall, to the extent possible, protect the victim from the psychological damage of repeated interrogations while preserving the rights of the public, the victim, and the person charged with the violation.

Section 20. Subsection (3) of section 944.033, Florida Statutes, is amended to read:

944.033 Community correctional centers; existence; location; purpose; restriction.—

(3) No person convicted of sexual battery pursuant to s. 794.011 ~~or any other sex offense specified in s. 917.012(1)~~ is eligible for placement in any community correctional center ~~unless he has successfully completed a program of treatment pursuant to s. 917.012~~.

Section 21. Subsection (3) of section 945.091, Florida Statutes, 1992 Supplement, is amended to read:

945.091 Extension of the limits of confinement; restitution by employed inmates.—

(3) The department may adopt regulations as to the eligibility of inmates for the extension of confinement, the disbursement of any earnings of these inmates, or the entering into of agreements between itself and any city or county or federal agency for the housing of these inmates in a local place of confinement. However, no person convicted of sexual battery pursuant to s. 794.011 ~~or any other sex offense specified in s. 917.012(1)~~ is eligible for any extension of the limits of confinement under this section ~~unless he has successfully completed a program of treatment pursuant to s. 917.012~~.

Section 22. Subsection (4) of section 946.40, Florida Statutes, 1992 Supplement, is amended to read:

946.40 Use of prisoners in public works.—

(4) No person convicted of sexual battery pursuant to s. 794.011 *is* ~~or any other sex offense specified in s. 917.012(1) shall be~~ eligible for any program under the provisions of this section.

Section 23. Paragraph (c) of subsection (2) of section 951.24, Florida Statutes, is amended to read:

951.24 Extend the limits of confinement for county prisoners.—

(2)

(c) No person convicted of sexual battery pursuant to s. 794.011 ~~or any other sex offense specified in s. 917.012(1)~~ is eligible for any work-release program or any other extension of the limits of confinement under this section.

Section 24. Subsection (2) of section 958.09, Florida Statutes, is amended to read:

958.09 Extension of limits of confinement.—

(2) The department shall adopt rules as to the eligibility of youthful offenders for such extension of confinement, the disbursement of any earnings of youthful offenders, or the entering into of agreements between the department and any municipal, county, or federal agency for the housing of youthful offenders in a local place of confinement. However, no youthful offender convicted of sexual battery pursuant to s. 794.011 *is* ~~or any other sex offense specified in s. 917.012(1) shall be~~ eligible for any extension of the limits of confinement under this section ~~unless he has successfully completed a program of treatment pursuant to s. 917.012~~.

Section 25. Section 794.022, Florida Statutes, is amended to read:

794.022 Rules of evidence.—

(1) The testimony of the victim need not be corroborated in a prosecution under s. 794.011 ~~or s. 794.041~~.

(2) Specific instances of prior consensual sexual activity between the victim and any person other than the offender shall not be admitted into evidence in a prosecution under s. 794.011 ~~or s. 794.041~~. However, such evidence may be admitted if it is first established to the court in a proceeding in camera that such evidence may prove that the defendant was not the source of the semen, pregnancy, injury, or disease; or, when consent by the victim is at issue, such evidence may be admitted if it is first established to the court in a proceeding in camera that such evidence tends to establish a pattern of conduct or behavior on the part of the victim which is so similar to the conduct or behavior in the case that it is relevant to the issue of consent.

(3) Notwithstanding any other provision of law, reputation evidence relating to a victim's prior sexual conduct or evidence presented for the purpose of showing that manner of dress of the victim at the time of the offense incited the sexual battery shall not be admitted into evidence in a prosecution under s. 794.011 ~~or s. 794.041~~.

(4) When consent of the victim is a defense to prosecution under s. 794.011, evidence of the victim's mental incapacity or defect is admissible to prove that the consent was not intelligent, knowing, or voluntary; and the court shall instruct the jury accordingly.

Section 26. For the purpose of incorporating the amendment to section 794.022, Florida Statutes, in a reference thereto, paragraph (b) of subsection (1) of section 90.404, Florida Statutes, is reenacted to read:

90.404 Character evidence; when admissible.—

(1) CHARACTER EVIDENCE GENERALLY.—Evidence of a person's character or a trait of his character is inadmissible to prove that he acted in conformity with it on a particular occasion, except:

(b) Character of victim.—

1. Except as provided in s. 794.022, evidence of a pertinent trait of character of the victim of the crime offered by an accused, or by the prosecution to rebut the trait; or

2. Evidence of a character trait of peacefulness of the victim offered by the prosecution in a homicide case to rebut evidence that the victim was the aggressor.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 1, strike all of lines 2-10 and insert: amending s. 787.02, F.S.; deleting a provision that precludes the offense from being a lesser included offense for purposes of s. 787.01, F.S., which establishes the offense of kidnapping, and reenacting s. 910.14, F.S., relating to kidnapping, to incorporate said amendment in a reference thereto; amending s. 794.011, F.S.; providing a definition and providing technical changes; deleting an evidentiary provision and incorporating into the sexual battery section the substance of s. 794.041, F.S., relating to the offense of sexual activity with a person who is under a specified age by or at solicitation of a person in familial or custodial authority and deleting an age minimum for the solicitation offense; repealing s. 794.041, F.S., relating to unlawful sexual activity with a child by or at the solicitation of a person in familial or custodial authority to the child; amending ss. 39.001, 39.076, 39.4105, 110.1127, 242.335, 393.0655, 394.457, 396.0425, 397.0715, 402.305, 409.175, F.S., relating to juvenile program personnel screening, grandparental visitation, employee security checks, and personnel screening for the Florida School for the Deaf and the Blind, developmental disabilities caretakers, mental health and substance abuse treatment personnel, and child care and family foster home personnel, conforming provisions to the amendments to ss. 794.011, 794.041, F.S.; reenacting ss. 775.15(7), 794.023(2), 903.133, 914.16, 944.033(3), 945.091(3), 946.40(4), 951.24(2)(c), 958.09(2), F.S., relating to time limitations, sexual battery by multiple perpetrators, bail on appeal, sexual abuse victims under age 16, community correctional centers, use of prisoners in public works, and extensions of limits of confinement for inmates, to incorporate the amendment to s. 794.011, F.S., in references thereto; amending s. 794.022, F.S., to conform to the amendments to ss. 794.011, 794.041, F.S.; adding an evidentiary provision; reenacting s. 90.404(1)(b), F.S., relating to character evidence, to incorporate the amendment to s. 794.022, F.S., in a reference thereto;

Senator Silver moved the following amendment which was adopted:

Amendment 3 (with Title Amendment)—On page 1, line 13, insert:

Section 1. Subsection (1) of section 27.3455, Florida Statutes, is amended to read:

27.3455 Additional court costs; collection, use, and distribution of funds.—

(1) When any person pleads nolo contendere to a misdemeanor or criminal traffic offense under s. 318.14(10)(a) or pleads guilty or nolo contendere to, or is found guilty of, any felony, misdemeanor, or criminal traffic offense under the laws of this state or the violation of any municipal or county ordinance which adopts by reference any misdemeanor under state law, there shall be imposed as a cost in the case, in addition to any other cost required to be imposed by law, a sum in accordance with the following schedule:

(a) Felonies $200

(b) Misdemeanors $50

(c) Criminal traffic offenses $50

A judge may remove the fee only for just cause, as stated in writing. If the fee is not removed, the cost must be paid before probation can be satisfied.

Section 2. For the purpose of incorporating the amendment to section 27.3455, Florida Statutes, in a reference thereto, paragraph (a) of subsection (1) of section 27.56, Florida Statutes, is reenacted to read:

27.56 Assistance; lien for payment of attorney's fees or costs.—

(1)(a) The court having jurisdiction over any defendant who has been determined to be guilty of a criminal act by a court or jury or through a plea of guilty or nolo contendere and who has received the assistance of the public defender's office or a special assistant public defender, or the services of a private attorney appointed pursuant to the Florida Statutes or the Florida Rules of Criminal Procedure, may assess attorney's fees and costs against the defendant. At the sentencing hearing or at such stage in the proceedings as the court may deem appropriate, the public defender, the special assistant public defender, or the private attorney representing such defendant shall move the court to assess attorney's fees and costs against the defendant. Such costs may include the cost of depositions; cost of transcripts of depositions, including the cost of defendant's copy, which transcripts are certified by the defendant's attorney as having served a useful purpose in the disposition of the case; investigative costs; witness fees; the cost of psychiatric examinations; or other reasonable costs specially incurred by the county for the defense of the defendant in criminal prosecutions within the county. Costs shall not include expenses inherent in providing a constitutionally guaranteed jury trial or expenditures in connection with the maintenance and operation of government agencies that must be made by the public irrespective of specific violations of law. Any cost assessed pursuant to this paragraph shall be reduced by any amount assessed against a defendant pursuant to s. 27.3455.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 1, strike line 2 and insert: An act relating to criminal law; amending s. 27.3455, F.S.; providing that certain costs may be removed for just cause, but if not removed must be paid to satisfy probation, and reenacting s. 27.56(1)(a), F.S., relating to attorney's fees and costs, to incorporate said amendment in a reference thereto; amending

On motion by Senator Wexler, by two-thirds vote **SB 820** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—34 Nays—None

SB 1204—A bill to be entitled An act relating to court-ordered mediation and arbitration; amending s. 35.22, F.S., relating to fees collected by the district courts of appeal; authorizing teleconferencing fees; amending s. 44.102, F.S.; revising the confidentiality privilege in court-ordered mediation cases; amending s. 44.103, F.S.; providing specific authorization for the practice of having parties pay for court-ordered, nonbinding arbitration services; providing for compensation of arbitrators by the county or the parties; providing for volunteer arbitrators; repealing s. 44.105, F.S., for the purpose of deleting the limitation on referral to both mediation and arbitration; providing an effective date.

—was read the second time by title.

The Committee on Judiciary recommended the following amendment which was moved by Senator Weinstein and adopted:

Amendment 1 (with Title Amendment)—On page 4, between lines 17 and 18, insert:

Section 4. Section 683.19, Florida Statutes, is amended to read:

683.19 Rosh Hashanah, ~~and~~ Yom Kippur, *and Good Friday*; designation as legal holiday by chief circuit judges.—The chief judge of any judicial circuit is authorized to designate Rosh Hashanah, ~~and~~ Yom Kippur, *and Good Friday* as legal holidays for the courts within the judicial circuit. If the holidays are so designated, the courts in the judicial circuit may remain closed on Rosh Hashanah, ~~and~~ Yom Kippur, *and Good Friday* and those days will be holidays for persons employed by the courts.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 1, line 14, after the semicolon (;) insert: amending s. 683.19, F.S.; authorizing each chief circuit judge to designate Good Friday as a legal holiday for the courts within the judicial circuit;

The Committee on Appropriations recommended the following amendment which was moved by Senator Weinstein and adopted:

Amendment 2—On page 2, line 2, after *"teleconference"* insert: *and shall be deposited in the Mediation/Arbitration Trust Fund*

Senators Weinstein and Dyer offered the following amendment which was moved by Senator Dyer and adopted:

Amendment 3 (with Title Amendment)—On page 4, between lines 20 and 21, insert:

Section 5. Section 16.58, Florida Statutes, is created to read:

16.58 Florida Legal Resource Center.—

(1)(a) There is created within the Department of Legal Affairs the Florida Legal Resource Center, hereinafter referred to as the "center."

(b) The resources of the center, with the exception of state-staffed court reporters, shall be equally available to state agencies, multicounty special districts, universities, community and junior colleges, and city and county governments.

(2) The center shall:

(a) Facilitate interagency legal information sharing and communications through the Florida Information Resource Network or the Administrative Management Information Center, whichever is most appropriate. Executive and judicial entities shall cooperate in the identification of legal bodies of information to be made available to government attorneys through state resources. All entities identified as owning a necessary body of information shall take all action necessary to continually provide electronic access to such information to all government entities requiring the information. The Attorney General shall coordinate these activities.

(b) Establish and maintain a statewide research bank. All state agencies, multicounty special districts exclusive of those created by interlocal agreement, universities, and community and junior colleges are encouraged to participate in the submission of memoranda, briefs, and opinions to be deposited in the research bank. The Attorney General shall adopt a procedure for agency submission to the research bank.

(c) Coordinate and assist in the development of statewide in-service continuing legal education training designed specifically for attorneys employed by the state.

(d) Serve as a centralized acquisition entity for discounted or negotiated purchasing of computerized and printed legal information resources.

(e) Serve as a clearinghouse to facilitate the exchange of attorney expertise between agencies.

(f) Develop interagency communications instruments with the goal of tying the state's legal units into a single information network.

(g) Develop, in consultation with the Florida Court Reporters Association, a pilot project of staff or contract court reporters to provide court reporting services to state agencies. Recommendations for the pilot project shall be transmitted to the Governor and the Speaker of the House of Representatives and the President of the Senate prior to January 1, 1994.

(3) On or before January 1 of each year, and beginning January 1, 1994, the center shall prepare and transmit to the Governor and the Legislature a report of center program activities for the preceding fiscal year. This report shall include a report of legal activities within the state, including the usage of the center by state agencies, universities, community and junior colleges, multicounty special districts exclusive of those created by interlocal agreement, and city and county governments; costs and activities of staff attorney services; and costs and activities of private attorneys by agency, as well as cost-saving opportunities. All state agencies, multicounty special districts exclusive of those created by interlocal agreement, universities, and community and junior colleges shall cooperate with the office of the Attorney General in the preparation and compilation of this report.

Section 6. Paragraph (f) of subsection (3) of section 287.057, Florida Statutes, 1992 Supplement, is amended to read:

287.057 Procurement of commodities or contractual services.—

(3) When the purchase price of commodities or contractual services exceeds the threshold amount provided in s. 287.017 for CATEGORY TWO, no purchase of commodities or contractual services may be made without receiving competitive sealed bids or competitive sealed proposals unless:

(f) The following contractual services are not subject to the competitive sealed bid requirements of this section:

1. Artistic services.

2. Academic program reviews.

3. Lectures by individuals.

4. Auditing services.

5. Legal services, including *attorney, paralegal,* ~~paralegals;~~ expert *witness* ~~witnesses~~, ~~including~~ appraisal, *or* ~~services; and~~ *mediator services* ~~court reporters~~.

6. Health services involving examination, diagnosis, treatment, prevention, medical consultation, or administration.

7. Services provided to persons with mental or physical disabilities by not-for-profit corporations which have obtained exemptions under the provisions of s. 501(c)(3) of the United States Internal Revenue Code or when such services are governed by the provisions of Office of Management and Budget Circular A-122. However, in acquiring such services, the agency shall consider the ability of the contractor, past performance, willingness to meet time requirements, and price.

8. Medicaid services delivered to an eligible Medicaid recipient by a health care provider who has not previously applied for and received a Medicaid provider number from the Department of Health and Rehabilitative Services. However, this exception shall be valid for a period not to exceed 90 days after the date of delivery to the Medicaid recipient and shall not be renewed by the department.

9. Family placement services.

10. Prevention services related to mental health, including drug abuse prevention programs, child abuse prevention programs, and shelters for runaways, operated by not-for-profit corporations. However, in acquiring such services, the agency shall consider the ability of the contractor, past performance, willingness to meet time requirements, and price.

11. Training and education services provided to injured employees pursuant to s. 440.49(1).

12. Contracts entered into pursuant to s. 337.11.

13. Services provided by governmental agencies.

Section 7. For the purpose of incorporating the amendment to section 287.057(3)(f), Florida Statutes, 1992 Supplement, in a reference thereto, the subdivision of Florida Statutes set forth below is reenacted to read:

287.058 Contract document.—

(5) Unless otherwise provided in the General Appropriations Act or the substantive bill implementing the General Appropriations Act, the Comptroller may waive the requirements of this section for services which are included in s. 287.057(3)(f).

Section 8. Section 287.059, Florida Statutes, 1992 Supplement, is amended to read:

287.059 Private *attorney* ~~legal~~ services.—

(1) For purposes of this section, the term "agency" or "state agency" includes state officers, departments, boards, commissions, divisions, bureaus, councils, and units of organization, however designated, of the executive branch of state government, community and junior colleges, and multicounty special districts exclusive of those created by interlocal agreement or which have elected governing boards.

(2)~~(1)~~ *No agency shall contract* ~~No funds shall be expended by an agency~~ for private *attorney* ~~legal~~ services without the prior *written* ~~initial~~ approval of the Attorney General, *except that such written approval is not required for private attorney services:*

(a) Procured by the Executive Office of the Governor or any department under the exclusive jurisdiction of a single Cabinet officer.

(b) Procured by the Department of Health and Rehabilitative Services for child support enforcement pursuant to s. 409.2557.

(c) Provided by legal services organizations to indigent clients.

(d) Necessary to represent the state in litigation involving the Florida Casualty Insurance Risk Management Trust Fund pursuant to part II of chapter 284.

(e) Procured by the Board of Regents for defense of comprehensive general liability claims, including professional liability claims, which are covered by the self-insurance programs created pursuant to s. 240.213.

(f) Procured by community and junior colleges and multicounty special districts.

(3) An agency ~~State agencies~~ requesting approval for the use of private *attorney* ~~legal~~ services shall first offer to contract with the Department of Legal Affairs for such *attorney* ~~legal~~ services at a cost pursuant to mutual agreement. The Attorney General *shall* ~~may~~ decide on a case-by-case basis to accept or decline to provide such *attorney* ~~legal~~ services ~~using Department of Legal Services personnel~~ as staffing, ~~and~~ expertise, *or other legal or economic considerations warrant* ~~permit~~. If the Attorney General declines to provide the requested *attorney* ~~legal~~ services, the *Attorney General's written* ~~initial~~ approval shall include a *statement* ~~certification~~ that the private *attorney* ~~legal~~ services requested cannot be provided by the office of the Attorney General or that such private *attorney* ~~legal~~ services are cost effective in the opinion of the Attorney General. *The Attorney General shall not consider political affiliation in making such decision.* The office of the Attorney General shall respond to the request of an agency for prior *written* ~~initial~~ approval within 10 working days after receiving such request. *The Attorney General may request additional information necessary for evaluation of a request. The Attorney General shall respond to the request within 10 working days after receipt of the requested information.* The Attorney General may adopt, by rule, a form on which agencies requesting *written* ~~initial~~ approval for private *attorney* ~~legal~~ services shall provide information concerning:

(a) The nature of the *attorney* ~~legal~~ services to be provided and the *issues* ~~controversy~~ involved.

(b) The need for use of private *attorneys* ~~counsel~~, rather than agency staff *attorneys, utilizing the criteria provided in subsection (8)* ~~counsel~~.

(c) The criteria by which the agency selected the private *attorney* ~~legal counsel~~ or law firm it proposes to employ, *utilizing the criteria provided in subsection (9).*

(d) ~~Information concerning~~ Competitive fees for similar *attorney* ~~legal~~ services.

(e) *The agency's analysis estimating* the number of hours *for attorney* ~~the agency estimates that the legal~~ services ~~will require~~, *the costs,* ~~and~~ the ~~estimated~~ total contract amount, *and, when appropriate, a risk or cost benefit analysis.*

(f) Which partners, associates, paralegals, research associates, or other personnel will be used, and how their time will be billed to the agency.

(g) Any other information which the Attorney General deems appropriate for the proper evaluation of the need for such private *attorney* ~~legal~~ services.

(4) ~~(2)~~ *When written* ~~initial~~ approval has been received from the Attorney General, *written* final approval must be obtained *from the agency head, or designee of the agency head,* prior to the *contracting* ~~expenditure of funds~~ for private *attorney* ~~legal~~ services.~~:~~

~~(a) From the Governor for expenditures by the Executive Office of the Governor;~~

~~(b) From the appropriate Cabinet officer for expenditures by an agency under the jurisdiction of a Cabinet officer; or~~

~~(c) From the Governor and Cabinet for an agency under the jurisdiction of the Governor and Cabinet.~~

~~(3) This section does not apply to contracts for:~~

~~(a) Legal services entered into by the Department of Health and Rehabilitative Services for child support enforcement pursuant to s. 409.2557;~~

~~(b) Services to be provided by legal services organizations to indigent clients;~~

~~(c) Legal services necessary to represent the state in litigation involving the Florida Casualty Insurance Risk Management Trust Fund pursuant to part II of chapter 284; or~~

~~(d) Contracts for legal services entered into by the Board of Regents for defense of comprehensive general liability claims, including professional liability claims, which are covered by the self-insurance programs created pursuant to s. 240.213.~~

~~(4) Initial approval by the Attorney General is not required for legal services procured by the Executive Office of the Governor or any department under the jurisdiction of a Cabinet officer. Final approval as provided in subsection (2) is required before the expenditure of funds for private legal services by these agencies.~~

(5) The agency head or a designee shall give written approval prior to contracting for private attorney services for all agencies exempt from written approval of the Attorney General as described in paragraphs (2)(a)-(f).

(6) ~~(5)~~ The Attorney General shall, by rule, adopt a standard fee schedule for *private attorney* ~~legal~~ services *using hourly rates or an alternative billing methodology. The Attorney General* ~~which~~ shall take into consideration the following factors:

(a) Type of controversy involved and complexity of the legal services needed.

(b) Geographic area where the *attorney* ~~legal~~ services are to be provided.

(c) Novelty of the legal questions involved.

(d) Amount of experience desired for the particular kind of *attorney* ~~legal~~ services to be provided.

(e) Other factors deemed appropriate by the Attorney General.

(f) The most cost-effective or appropriate billing methodology.

(7) ~~(6)~~ All agencies, when contracting for *private attorney* ~~legal~~ services, must use the standard fee schedule for *private attorney* ~~legal~~ services as established pursuant to this section unless the head of the agency ~~or department~~ waives use of the schedule and sets forth the reasons for deviating from the schedule in writing to the Attorney General. Such waiver must demonstrate necessity based upon criteria for deviation from the schedule which the Attorney General shall establish by rule.

~~(7) This section does not apply to services provided by paralegals; expert witnesses, including appraisal services; or court reporters.~~

(8) The Attorney General shall develop guidelines that may be used by agencies to determine when it is necessary and appropriate to seek private attorney services in lieu of staff attorney services.

(9) Agencies are encouraged to use the following criteria when selecting outside firms for attorney services:

(a) The magnitude or complexity of the case.

(b) The firm's ratings and certifications.

(c) The firm's minority status.

(d) The firm's physical proximity to the case and the agency.

(e) The firm's prior experience with the agency.

(f) The firm's prior experience with similar cases or issues.

(g) The firm's billing methodology and proposed rate.

(h) The firm's current or past adversarial position, or conflict of interest, with the agency.

(i) The firm's willingness to use resources of the agency to minimize costs.

(10) The Attorney General shall develop a standard addendum to every contract for attorney services that must be used by all agencies, unless waived by the Attorney General, describing in detail what is expected of both the contracted private attorney and the contracting agency.

(11) Contracts for attorney services shall be originally executed for 1 year only, except that multiyear contracts may be entered into provided they are subject to annual appropriations and annual written approval from the Attorney General as described in subsection (3). Any amendments to extend the contract period or increase the billing rate or overall contract amount shall be considered new contracts for purposes of the written approval process described in subsection (3).

(12) The office of the Attorney General shall periodically prepare and distribute to agencies a roster by geographic location of private attorneys under contract with agencies, their fees, and primary area of legal specialization.

(13) The Office of the Attorney General is authorized to competitively bid and contract with one or more court reporting services, on a circuit-wide basis, on behalf of all state agencies in accordance with s. 287.057(2). The Office of the Attorney General shall develop requests for proposal for court reporter services in consultation with the Florida Court Reporters Association. All agencies shall utilize the contracts for court reporting services entered into by the Office of the Attorney General where in force, unless otherwise ordered by a court or unless an agency has a contract for court reporting services executed prior to the effective date of this act.

(14) The Attorney General's Office may, by rule, adopt standard fee schedules for court reporting services for each judicial circuit in consultation with the Florida Court Reporters Association. Agencies, when contracting for court reporting services, must use the standard fee schedule for court reporting services established pursuant to this section, provided no state contract is applicable or unless the head of the agency or his designee waives use of the schedule and sets forth the reasons for deviating from the schedule in writing to the Attorney General. Such waiver must demonstrate necessity based upon criteria for deviation from the schedule which the Attorney General shall establish by rule. Any proposed fee schedule under this section shall be submitted to the Governor, the Speaker of the House of Representatives, the President of the Senate and the Chief Justice of the Florida Supreme Court at least 60 days prior to publication of the notice to adopt the rule.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 1, line 17, after the semicolon (;) insert: creating s. 16.58, F.S.; creating the Florida Legal Resource Center within the Department of Legal Affairs; providing for the duties of the center; providing for reports; amending s. 287.057, F.S.; revising language with respect to the procurement of specified legal services; reenacting s. 287.058(5), F.S., relating to contract documents, to incorporate the amendment to s. 287.057, F.S., in a reference thereto; amending s. 287.059, F.S.; revising language with respect to private attorney services; providing a definition; providing criteria for contracting for private attorney services; providing requirements to be used by the Attorney General with respect to the use of private attorney services; providing for rules; authorizing the Attorney General to competitively bid contract court reporting services;

Senator Weinstein moved the following amendment which was adopted:

Amendment 4—In title, on page 1, strike all of lines 2 and 3 and insert: An act relating to the courts; amending s. 35.22, F.S.; relating

On motion by Senator Weinstein, by two-thirds vote **SB 1204** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—37 Nays—None

SB 1214—A bill to be entitled An act relating to education; authorizing the Department of Education to assist school districts to implement certain programs through the Federal Chapter 1 program; providing an effective date.

—was read the second time by title. On motion by Senator Turner, by two-thirds vote **SB 1214** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—37 Nays—None

SB 1238—A bill to be entitled An act relating to motor vehicle license plates; amending ss. 320.0805, 320.08065, 320.08066, 320.0808, 320.0809, 320.083, 320.089, 320.0895, 320.1325, F.S.; authorizing the Department of Highway Safety and Motor Vehicles to issue certain motor vehicle license plates to lessees of those vehicles in the same manner and for the same fees as those license plates are issued to owners of those motor vehicles; providing an effective date.

—was read the second time by title.

The Committee on Finance, Taxation and Claims recommended the following amendments which were moved by Senator Kurth and adopted:

Amendment 1—On page 3, strike all of lines 11-15 and insert:

(1) A person who is the owner *or lessee* of *any motor vehicle except a vehicle registered under the International Registration Plan or a commercial truck required to display two license plates pursuant to s. 320.0706* ~~an automobile for private use, a truck weighing not more than 5,000 pounds, or a recreational vehicle as specified in s. 320.08(9)(c) or (d), which is not used for hire or commercial use~~; who is a resident of the state; and who holds a valid

Amendment 2—On page 4, strike all of lines 1-31 and insert:

(1) Each owner *or lessee* of *any motor vehicle, except a vehicle registered under the International Registration Plan or a commercial truck required to display two license plates pursuant to s 320 0706* ~~an automobile for private use, truck weighing not more than 5,000 pounds, or recreational vehicle as specified in s. 320.08(9)(c) or (d), which is not used for hire or commercial use~~, who is a resident of the state and an active member of the Florida National Guard, a survivor of the attack on Pearl Harbor, a recipient of the Purple Heart medal, or an active member of any branch of the United States Armed Forces Reserve shall, upon application to the department, accompanied by proof of active membership in the Florida National Guard, proof of membership in the Pearl Harbor Survivors Association or proof of active military duty in Pearl Harbor on December 7, 1941, proof of being a Purple Heart medal recipient, or proof of active membership in any branch of the Armed Forces Reserve, and upon payment of the license tax for the vehicle as provided in s. 320.08, be issued a license plate as provided by s. 320.06, upon which, in lieu of the serial numbers prescribed by s. 320.06, shall be stamped the words "National Guard," "Pearl Harbor Survivor," "Combat-wounded veteran," or "U.S. Reserve," as appropriate, followed by the serial number of the license plate. Additionally, the Purple Heart plate may have the words "Purple Heart" stamped on the plate and the likeness of the Purple Heart medal appearing on the plate. A fee of $2.50 shall be assessed upon the purchase or renewal of the Purple Heart license plate until $16,000 has been collected and deposited in the Motor Vehicle License Plate Replacement Trust Fund.

(2) Each owner *or lessee* of *any motor vehicle, except a vehicle registered under the International Registration Plan or a commercial truck required to display two license plates pursuant to s. 320.0706* ~~an automobile for private use, truck weighing not more than 5,000 pounds, or recreational vehicle as specified in s. 320.08(9)(c) or (d), which is not used for hire or commercial use~~, who is a

Amendment 3—On page 6, between lines 18 and 19, insert:

(c) If a vehicle owner to whom the department has issued a Florida Salutes Veterans license plate acquires a replacement vehicle within the owner's registration period, the department shall authorize a transfer of the license plate to the replacement vehicle in accordance with the provisions of s. 320.0609.

(d) An applicant for a Florida Salutes Veterans license plate may combine the request with one for a personalized prestige license plate. The department shall supply a form for combined requests, and such requests shall be subject to the additional fees in s. 320.0805(2)(b) and (c), and to the other requirements of s. 320.0805.

On motion by Senator Kurth, by two-thirds vote **SB 1238** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—37 Nays—None

CS for SB 1442—A bill to be entitled An act relating to municipalities; authorizing municipalities to enforce ordinances and prescribe penalties for violations of municipal ordinances; prescribing limitations; providing an effective date.

—was read the second time by title. On motion by Senator Dyer, by two-thirds vote **CS for SB 1442** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

Consideration of **SB 1424** was deferred.

On motions by Senator Bankhead, by two-thirds vote **CS for HB 1029** was withdrawn from the Committees on Commerce and Appropriations.

On motion by Senator Bankhead—

CS for HB 1029—A bill to be entitled An act relating to the sale of liquefied petroleum gas; amending s. 527.01, F.S.; revising definitions relating to installer license categories; amending s. 527.02, F.S.; revising certain license fees and requirements for issuance of a license; revising examination requirements; providing for issuance of a qualifier identification card; providing for confidentiality of examinations and exemption from public records requirements; providing a fee for a duplicate license or qualifier card; deleting reference to requalification of portable cylinders; amending s. 527.065, F.S.; providing definition and requirements relating to accidents; amending s. 527.10, F.S.; revising provisions relating to restrictions on use of unsafe containers; amending s. 527.13, F.S.; allowing administrative action to continue; repealing s. 20.13(2)(d), F.S., relating to the Division of Liquefied Petroleum Gas in the Department of Insurance; amending s. 527.01, F.S.; redefining department to be the Department of Agriculture and Consumer Services; transferring the powers, duties, records, personnel, property, and certain funds of the Division of Liquefied Petroleum Gas to the Department of Agriculture and Consumer Services; providing effective dates.

—a companion measure, was substituted for **CS for SB 1554** and read the second time by title. On motion by Senator Bankhead, by two-thirds vote **CS for HB 1029** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—37 Nays—None

CS for SB 1658—A bill to be entitled An act relating to agricultural industry; amending s. 570.02, F.S.; defining agricultural business products; amending s. 570.07, F.S.; revising powers, duties, and functions of the department; revising procedures relating to operation of advisory committees; amending s. 570.071, F.S., relating to the Florida Agricultural Exposition; amending s. 570.072, F.S., relating to commodity distribution; amending s. 570.073, F.S., relating to department law enforcement officers; amending s. 570.091, F.S., relating to deputy commissioners; amending s. 570.10, F.S., relating to department counsel; restricting prosecution to criminal violations; amending s. 570.11, F.S., relating to department directors' oath of office; amending s. 570.13, F.S., relating to department salaries; amending s. 570.14, F.S., relating to department seal; amending s. 570.15, F.S.; revising provisions relating to access to places of business and vehicles; amending s. 570.16, F.S., relating to interference of employees in performance of duties; amending s. 570.20, F.S., relating to the General Inspection Trust Fund; amending s. 570.21, F.S., relating to department publications; amending s. 570.23, F.S.; revising provisions relating to the State Agricultural Advisory Council; amending s. 570.30, F.S., relating to duties of the Division of Administration; amending ss. 570.32 and 570.33, F.S., relating to duties of the Division of Plant Industry and division director; amending s. 570.34, F.S.; revising provisions relating to the Plant Industry Technical Council; amending s. 570.37, F.S., relating to duties of the director of the Division of Animal Industry; amending s. 570.38, F.S.; revising provisions relating to the Animal Industry Technical Council; amending s. 570.41, F.S., relating to the director of the Division of Dairy Industry; amending s. 570.42, F.S.; revising provisions relating to the Dairy Industry Technical Council; amending s. 570.44, F.S., relating to duties of the Division of Agricultural Environmental Services; amending ss. 570.48 and 570.49, F.S., relating to duties of the Division of Fruit and Vegetables and division director; amending s. 570.481, F.S.; correcting a cross reference; amending s. 570.50, F.S., relating to duties of the Division of Food Safety; amending ss. 570.53 and 570.54, F.S., relating to duties of the department, the Division of Marketing and Development, and the division director; amending s. 570.541, F.S.; revising provisions relating to the Racing Quarter Horse Advisory Council; amending s. 570.543, F.S.; revising provisions relating to the Florida Consumers' Council; amending s. 570.544, F.S., relating to duties of the director of the Division of Consumer Services; amending s. 570.55, F.S., relating to sellers and handlers of avocados, mangoes, limes, or tomatoes; repealing s. 570.60, F.S., relating to the Community Gardening Program; amending ss. 570.902 and 570.903, F.S.; revising provisions relating to direct-support organizations; repealing ss. 570.904, 570.905, 570.906, 570.911, 570.913, 570.914, and 570.915, F.S., relating to contracts, insurance, prohibitions, definitions, property, and audit of direct-support organizations; amending s. 570.912, F.S.; authorizing creation of a direct-support organization for the Florida agriculture-in-the-classroom program; amending s. 571.23, F.S.; redefining "agricultural product" under the Florida Agricultural Promotional Campaign Act; amending s. 571.28, F.S.; revising provisions relating to the Florida Agricultural Promotional Campaign Council; amending s. 576.091, F.S.; revising provisions relating to the Fertilizer Technical Council; amending s. 580.151, F.S.; revising provisions relating to the Commercial Feed Technical Council; amending s. 581.011, F.S.; revising definitions relating to plant industry; amending s. 581.031, F.S.; revising department duties with respect to plant industry; amending s. 581.083, F.S., relating to introduction or release of plant pests or noxious weeds; amending s. 581.101, F.S., relating to quarantines; amending s. 581.111, F.S., relating to emergencies; amending s. 581.131, F.S., relating to certificates of registration; requiring renewal application and fees by anniversary date; amending s. 581.141, F.S., relating to revocation or suspension of certificates and imposition of fines; providing for probation; amending s. 581.142, F.S., relating to viable nursery stock; amending s. 581.145, F.S., relating to aquatic plant nursery registration and special permit requirements; repealing s. 581.171, F.S., relating to printed copies as evidence; amending s. 581.181, F.S., relating to notice of infection of plants; amending s. 581.185, F.S., relating to preservation of native flora; amending s. 581.186, F.S.; revising provisions relating to the Endangered Plant Advisory Council; reenacting s. 581.193(2), F.S., relating to payment of the excise tax on citrus nursery stock, to incorporate the amendment to s. 581.141, F.S., in a reference thereto; creating s. 581.195, F.S.; providing for a direct-support organization; amending s. 581.199, F.S., relating to confidential business information; amending s. 581.201, F.S., relating to injunction; amending s. 581.211, F.S.; specifying additional acts which violate plant industry laws; providing penalties; providing for administrative fine and probation; amending s. 582.06, F.S.; revising provisions relating to the Soil and Water Conservation Council; amending s. 585.01, F.S.; expanding definition of "domestic animal" to include emus and rheas; amending s. 585.155, F.S., relating to whole-herd and calf vaccination; modifying requirements for vaccination tags; revising procedures for elimination of brucellosis infection; amending s. 585.61, F.S.; deleting reference to an animal disease diagnostic laboratory in Pasco County; amending s. 586.025, F.S.; providing unlawful acts with respect to honeybees; amending s. 586.03, F.S.; providing for special certification and fees; deleting prohibition against the use of specified terms; repealing s. 586.035, F.S., relating to unlawful sale, receipt, or concealment of honeybees, honeybee pests, or equipment; amending s. 586.045, F.S.; providing for certificates of registration and inspection; revising provisions relating to renewal and a late filing fee; repealing s. 586.09, F.S., relating to certificates of inspection and permits; amending s. 586.10, F.S.; expanding powers and duties of the department; amending s. 586.11, F.S.; providing for enforcement of provisions relating to movement of bees and equipment; repealing s. 586.115, F.S., relating to fumigation, destruction, and treatment of honeybees, products, and equipment; amending s. 586.13, F.S., relating to removal, destruction, or treatment of infected bees or equipment; amending s. 586.14, F.S.; revising compensation for bees or equipment destroyed due to infection; amending s. 586.15, F.S., relating to penalties; amending s. 586.16, F.S., relating to handling of fees and penalties collected; amending s. 586.161, F.S.; revising provisions relating to the Honeybee Technical Council; providing staggered terms for council members; amending s. 589.011, F.S.; expanding authority of the Division of Forestry to charge fees or rent for the use of facilities; expanding division enforcement authority; providing a penalty; amending s. 589.04, F.S.; revising division duties; amending s. 590.091, F.S., relating to railroad rights-of-way; amending s. 590.14, F.S., and repealing s. 590.26, F.S., relating to liability for costs of suppressing an unauthorized fire; amending s. 590.612, F.S.; revising provisions relat-

ing to a direct-support organization for the forestry alert program; amending s. 599.002, F.S.; revising provisions relating to the Viticulture Advisory Council; repealing ss. 590.611, 590.613, 590.614, and 590.615, F.S., relating to definitions, authority, and prohibitions of the direct-support organization; repealing s. 817.27, F.S., relating to prohibition against cutting off the ears or head of an animal before dressed; providing effective dates.

—was read the second time by title.

The Committee on Governmental Operations recommended the following amendments which were moved by Senator Foley and adopted:

Amendment 1 (with Title Amendment)—On page 109, between lines 8 and 9, insert:

Section 87. Definitions.—As used in this act:

(1) "Engages in an equine activity" means riding, training, assisting in veterinary treatment of, driving, or being a passenger upon an equine, whether mounted or unmounted, visiting or touring or utilizing an equine facility as part of an organized event or activity, or any person assisting a participant or show management. The term "engages in an equine activity" does not include being a spectator at an equine activity, except in cases where a spectator places himself in an unauthorized area.

(2) "Equine" means a horse, pony, mule, or donkey.

(3) "Equine activity" means:

(a) Equine shows, fairs, competitions, performances, or parades that involve any or all breeds of equines and any of the equine disciplines including, but not limited to, dressage, hunter and jumper horse shows, grand prix jumping, three-day events, combined training, rodeos, riding, driving, pulling, cutting, polo, steeplechasing, English and western performance riding, endurance trail riding, gymkhana games, and hunting.

(b) Equine training or teaching activities or both.

(c) Boarding, including normal daily care of equine.

(d) Riding, inspecting, or evaluating an equine belonging to another by a purchaser or an agent, whether or not the owner has received monetary consideration or other thing of value for the use of the equine or is permitting a prospective purchaser to ride, inspect, or evaluate it.

(e) Rides, trips, hunts, or other equine activities of any type, no matter how informal or impromptu, that are sponsored by an equine activity sponsor.

(f) Placing or replacing horseshoes or hoof trimming on an equine.

(g) Providing or assisting in veterinary treatment.

(4) "Equine activity sponsor" means an individual, group, club, partnership, or corporation, whether or not the sponsor is operating for profit or nonprofit, which sponsors, organizes, or provides the facilities for an equine activity, including, but not limited to: pony clubs, 4-H clubs, hunt clubs, riding clubs, school and college-sponsored classes, programs, and activities, therapeutic riding programs, stable and farm owners and operators, instructors, and promoters of equine facilities, including, but not limited to, farms, stables, clubhouses, pony ride strings, fairs, and arenas at which the activity is held.

(5) "Equine professional" means a person engaged for compensation:

(a) In instructing a participant or renting to a participant an equine for the purpose of riding, driving, or being a passenger upon the equine;

(b) In renting equipment or tack to a participant;

(c) To provide daily care of horses boarded at an equine facility; or

(d) To train an equine.

(6) "Inherent risks of equine activities" means those dangers or conditions which are an integral part of equine activities, including, but not limited to:

(a) The propensity of equines to behave in ways that may result in injury, harm, or death to persons on or around them.

(b) The unpredictability of an equine's reaction to such things as sounds, sudden movement, and unfamiliar objects, persons, or other animals.

(c) Certain hazards such as surface and subsurface conditions.

(d) Collisions with other equines or objects.

(e) The potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within his or her ability.

(7) "Participant" means any person, whether amateur or professional, who engages in an equine activity, whether or not a fee is paid to participate in the equine activity.

Section 88. General provisions.—Except as provided in section 3, an equine activity sponsor, an equine professional, or any other person, which shall include a corporation or partnership, shall not be liable for an injury to or the death of a participant resulting from the inherent risks of equine activities and, except as provided in section 3, no participant nor any participant's representative shall have any claim against or recover from any equine activity sponsor, equine professional, or any other person for injury, loss, damage, or death of the participant resulting from any of the inherent risks of equine activities.

Section 89. Limitation on liability for equine activity; exceptions.—

(1) This section shall not apply to the horseracing industry as defined in chapter 550, Florida Statutes.

(2) Nothing in section 2 shall prevent or limit the liability of an equine activity sponsor, an equine professional, or any other person if the equine activity sponsor, equine professional, or person:

(a) Provided the equipment or tack, and knew or should have known that the equipment or tack was faulty, and it was so faulty as to be totally or partially responsible for the injury;

(b) Provided the equine and failed to make reasonable and prudent efforts to determine the ability of the participant to engage safely in the equine activity, or to determine the ability of the participant to safely manage the particular equine based on the participant's representation of his ability;

(c) Owns, leases, rents, has authorized use of, or is otherwise in lawful possession and control of the land or facilities upon which the participant was injured, and the injury was due totally or in part, to a dangerous latent condition which was known to the equine activity sponsor, equine professional, or person and failed to post warning signs;

(d) Commits an act or omission that a reasonably prudent person would not have done or omitted under the same or similar circumstances or that constitutes willful or wanton disregard for the safety of the participant, which act or omission was a proximate cause of the injury; or

(e) Intentionally injures the participant.

Section 90. Posting and notification.—

(1) Every equine activity sponsor and equine professional shall:

(a) Post and maintain one or more signs which contain the warning notice specified in subsection (2). These signs shall be placed in a clearly visible location near to where the equine activity begins. The warning notice specified in subsection (2) shall appear on the sign in black letters, with each letter to be a minimum of 1 inch in height, with sufficient color contrast to be clearly distinguishable.

(b) Give the participant a written document which the participant shall sign with the warning notice specified in subsection (2) clearly printed on it. Said written document may be used in lieu of posting the warning on the site of the equine activity sponsor's or equine professional's facility, and shall be given to any participant in an equine event not on the location of the equine activity sponsor's or equine professional's facility.

(2) The signs and document described in subsection (1) shall contain the following warning notice:

WARNING

Under Florida law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

Section 91. Nothing in this act shall be construed to limit in any way the limitation of liability granted to private citizens who allow the public to use their land for recreational purposes, as provided in s. 375.251, Florida Statutes.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 6, line 30, after the semi-colon (;) insert: relating to equine recreational activities; providing definitions; limiting liability for equine activities; providing exceptions; providing for posting and notification; clarifying effect on other laws;

Amendment 2—On page 109, line 10, strike "October 1, 1993." and insert: upon becoming law.

Senator Foley moved the following amendment which was adopted:

Amendment 3—On page 28, line 26, strike "Six percent of all income of a revenue nature" and insert: *A percentage of all* ~~Six percent of all income of a~~ revenue ~~nature~~

Senators Kirkpatrick and Williams offered the following amendment which was moved by Senator Kirkpatrick and adopted:

Amendment 4 (with Title Amendment)—On page 109, between lines 6 and 7 insert:

Section 86. Section 589.081, Florida Statutes, is amended to read:

589.081 Withlacoochee State Forest *and Goethe State Forest*; payment to counties of portion of gross receipts.—The Division of Forestry shall pay 15 percent of the gross receipts from Withlacoochee State Forest *and the Goethe State Forest* to Hernando, Citrus, Sumter, *Levy,* and Pasco Counties in proportion to the *forest* acreage located in each county. The funds *must* ~~shall~~ be equally divided between the board of county commissioners and the school board of each county~~, all the acreage of the Withlacoochee State Forest being within the said four counties. The provisions of this act shall apply to the fiscal year beginning July 1, 1960.~~

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 6, line 24, after the semicolon (;) insert: amending s. 589.081, F.S.; providing for the distribution of a portion of gross receipts from the Withlacoochee State Forest and the Goethe State Forest to the counties in which forest acreage is located; providing for a portion to be distributed to school boards in those counties;

On motion by Senator Foley, by two-thirds vote **CS for SB 1658** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—37 Nays—None

On motions by Senator Forman, by two-thirds vote **CS for HB 835** was withdrawn from the Committees on Education; Finance, Taxation and Claims; and Appropriations.

On motion by Senator Forman, the rules were waived and—

CS for HB 835—A bill to be entitled An act relating to educational facilities; amending s. 200.065, F.S.; revising information that school boards must include in advertisements of proposed tax increases; amending s. 235.056, F.S.; revising provisions relating to lease and lease-purchase of educational facilities and sites; providing inspection and review requirements; requiring correction of deficiencies; providing for funding; amending s. 236.25, F.S.; revising provisions relating to use of district school tax for capital outlay purposes; providing an effective date.

—a companion measure, was substituted for **SB 1424** and read the second time by title. On motion by Senator Forman, by two-thirds vote **CS for HB 835** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

CS for SB 1764—A bill to be entitled An act relating to the compensation of district school board members and elected school superintendents; creating s. 230.203, F.S.; providing a procedure for annual salary adjustments; amending s. 230.303, F.S.; providing for special qualification salary for superintendents; ratifying salary adjustments granted before July 1, 1992; providing an effective date.

—was read the second time by title.

One amendment was adopted to **CS for SB 1764** to conform the bill to **HB 1545**.

Pending further consideration of **CS for SB 1764** as amended, on motions by Senator Dudley, by two-thirds vote **HB 1545** was withdrawn from the Committees on Education; Personnel, Retirement and Collective Bargaining; and Appropriations.

On motion by Senator Dudley—

HB 1545—A bill to be entitled An act relating to compensation of district school board members and elected school superintendents; amending s. 145.131, F.S.; deleting authorization to fix salaries of district school board members by special or local law; amending s. 145.16, F.S.; prohibiting special laws or general laws of local application pertaining to such compensation; amending s. 145.19, F.S.; providing for salary adjustments; amending ss. 230.202 and 230.303, F.S.; providing for payment of specified salaries and ratification of previously paid salaries; repealing certain local or special laws or general laws of local application; providing an effective date.

—a companion measure, was substituted for **CS for SB 1764** and read the second time by title. On motion by Senator Dudley, by two-thirds vote **HB 1545** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—35 Nays—None

SB 1760—A bill to be entitled An act relating to motor vehicle licenses; amending s. 320.08065, F.S.; redistributing the proceeds of the Florida panther license plate annual use fee; providing an effective date.

—was read the second time by title.

Senator Kirkpatrick moved the following amendment which was adopted:

Amendment 1 (with Title Amendment)—On page 1, strike lines 9-12 and insert:

Section 1. Present subsection (7) of section 320.08065, Florida Statutes, is renumbered as subsection (8) and amended, and a new subsection (7) is added to that section, to read:

320.08065 Florida panther license plates.—

(7) A person or corporation that purchases 10,000 or more panther license plates shall pay an annual use fee of $5 and an annual processing fee of $2 per plate, in addition to the applicable license tax required under s. 320.08.

(8)~~(7)~~ The department shall distribute the Florida

And the title is amended as follows:

In title, on page 1, line 3, after the semicolon (;) insert: prescribing the amount of the annual use and processing fees for purchasers of 10,000 or more Florida panther license plates;

On motion by Senator Kirkpatrick, by two-thirds vote **SB 1760** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—38 Nays—None

Consideration of **CS for SB 1710, SB 1872** and **CS for SB 1982** was deferred.

SB 2084—A bill to be entitled An act relating to cancer control and research; amending s. 240.5121, F.S.; providing an additional member of the Florida Cancer Control and Research Advisory Council; providing an effective date.

—was read the second time by title.

The Committee on Health Care recommended the following amendments which were moved by Senator Siegel and adopted:

Amendment 1 (with Title Amendment)—On page 1, line 19, strike "*31*" and insert: *32*

And the title is amended as follows:

In title, on page 1, lines 3 and 4, strike "an additional member" and insert: two additional members

Amendment 2—On page 1, line 30, after the semicolon (;) insert: *one member must be a representative of the University of Florida Shands Cancer Center;*

The Committee on Health Care recommended the following amendment which was moved by Senator Siegel:

Amendment 3 (with Title Amendment)—On page 1, strike line 8 and insert:

WHEREAS, the Legislature finds that the incidence of breast cancer has increased at an estimated rate of 3 percent per year since 1980, that one out of nine women will develop breast cancer over their lifetimes, and that this rate has climbed steadily since 1960 when one out of 14 women developed breast cancer, and

WHEREAS, the Legislature also finds that an estimated 10,500 women in this state will develop breast cancer in 1991 and that there is a greater incidence of breast cancer than any other form of cancer in women, and that breast cancer was projected to account for 14.4 percent of all cancers diagnosed in this state in 1991 and has been estimated to represent 7.9 percent of all cancer-related deaths in 1991, and

WHEREAS, the Legislature finds that 58 percent of all deaths caused by breast cancer could be prevented through early detection and prompt treatment, and

WHEREAS, through the establishment of a state task force on breast cancer, the Legislature intends to decrease the number of deaths due to breast cancer by increasing public awareness of breast cancer and by increasing, through public education, the percentage of women who conduct self examinations of the breast, seek breast examinations by physicians, and obtain mammograms, NOW, THEREFORE,

Section 1. Breast Cancer Task Force.—

(1) There is created within H. Lee Moffitt Cancer Center and Research Institute, the Breast Cancer Task Force to identify where public awareness and public education about breast cancer are lacking and to prepare recommendations to increase the public's awareness of the importance of the early detection and treatment of breast cancer.

(2) The task force is composed of 15 members to be appointed by July 1, 1993. The Governor shall appoint one representative of the University of Miami School of Medicine, one representative of the public who is a consumer advocate and who has been diagnosed with breast cancer, one representative of the Florida Cancer Control and Research Advisory Council, one representative of the H. Lee Moffitt Cancer Center and Research Institute, and the Secretary of Health and Rehabilitative Services or his designee. The President of the Senate shall appoint one representative of a business that has fewer than 100 employees, one representative of the University of Florida College of Medicine, one representative of the American Cancer Society, one representative of the public who is a consumer advocate and who has been diagnosed with breast cancer, and one member of the Senate. At least one member appointed by the President of the Senate shall be a member of an ethnic or racial minority group. The Speaker of the House of Representative shall appoint one representative of a business that has more than 300 employees, one representative of the University of South Florida College of Medicine, one representative of the Association of Community Cancer Centers, one representative of the public who is a consumer advocate, and one member of the House of Representatives. At least one member appointed by the Speaker of the House of Representatives shall be a member of an ethnic or racial minority group.

(3) The task force shall exist for 1 1/2 years and shall meet as often as necessary to carry out its duties and responsibilities. Within existing resources, the H. Lee Moffitt Cancer Center and Research Institute shall provide support services to the task force.

(4) The members of the task force shall serve without compensation.

(5) The task force may obtain information and assistance from any state agency. All state agencies must give the task force all relevant information and reasonable assistance on matters related to breast cancer.

(6) The task force shall collect research and information on breast cancer and shall prepare recommendations for reducing the number of deaths related to breast cancer in this state in an interim report to the Governor and the Legislature by January 15, 1994, to be followed by a final report to the Governor and the Legislature by January 15, 1995. The reports must include specific recommendations on:

(a) Approaches to be used by state and local governments to increase public awareness of breast cancer;

(b) A plan for reducing the number of deaths related to breast cancer in this state, including:

1. The best methods to ensure that the percentage of women in this state who receive mammograms increases;

2. The best methods to ensure that the percentage of women in this state who conduct breast self examinations and who seek breast examinations from physicians increases;

(c) A system to evaluate compliance with sections 232.246, 627.6418, and 627.6613, Florida Statutes; and

(d) A program to monitor the implementation and effectiveness of task force recommendations.

(7) The task force shall provide the Florida Cancer Control and Research Advisory Council a copy of its report and all relevant materials upon the completion of its work.

(8) The task force shall cease to exist on January 15, 1995.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 1, line 2, after the semicolon (;) insert: establishing the Breast Cancer Task Force; providing for representation on the task force; providing responsibilities; requiring a report to the Governor and the Legislature;

Senator Dyer moved the following amendment to **Amendment 3** which was adopted:

Amendment 3A—On page 2, strike lines 14-21 and insert:

(2) The task force is composed of 16 members to be appointed by July 1, 1993. The Governor shall appoint one representative of the University of Miami School of Medicine, one representative of the public who is a consumer advocate and who has been diagnosed with breast cancer, one representative of the Florida Cancer Control and Research Advisory Council, one representative of the H. Lee Moffitt Cancer Center and Research Institute, one representative from a statutory teaching hospital affiliated with a community-based cancer center, and the Secretary of

Amendment 3 as amended was adopted.

The Committee on Health Care recommended the following amendment which was moved by Senator Siegel and adopted:

Amendment 4—On page 3, strike line 6 and insert:

Section 3. This act shall take effect upon becoming a law.

Senators Holzendorf and Hargrett offered the following amendment which was moved by Senator Forman:

Amendment 5—On page 3, line 5, after the period (.) insert: *Of the members of the council appointed by the Governor, at least 10 must be individuals who are minority persons as defined by s. 288.703(3).*

Senators Holzendorf and Hargrett offered the following amendment to **Amendment 5** which was adopted:

Amendment 5A—On page 2, line 22, after the period (.) insert: At least two members appointed by the Governor shall be members of an ethnic or racial minority group.

Amendment 5 as amended was adopted.

On motion by Senator Siegel, by two-thirds vote **SB 2084** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—35 Nays—None

CS for SB 1982—A bill to be entitled An act relating to solicitation of funds; amending s. 496.404, F.S.; revising the definition of the term "contribution"; amending s. 496.405, F.S.; providing procedures for processing applications for registration which charitable organizations that intend to solicit contributions in this state must file with the Division of Consumer Services of the Department of Agriculture and Consumer Services; providing an effective date.

—was read the second time by title. On motion by Senator Kurth, by two-thirds vote **CS for SB 1982** was read the third time by title, passed, and certified to the House. The vote on passage was:

Yeas—36 Nays—None

Consideration of **CS for SB 2082** was deferred.

CS for SB 1988—A bill to be entitled An act relating to energy efficiency in buildings; amending s. 553.71, F.S.; defining "load management control device"; amending s. 553.79, F.S.; exempting load management control devices from permit and fee requirements under the State Minimum Building Codes; amending s. 553.901, F.S.; providing for triennial determinations and updates of the Florida Thermal Efficiency Code; amending ss. 553.903, 553.904, and 553.905, F.S.; providing applicability of thermal efficiency standards to products covered by the Florida Energy Efficiency Code for Building Construction; amending s. 553.9085, F.S.; requiring energy performance levels for new residential buildings to be disclosed upon request by prospective purchasers; requiring the energy performance level display card to be signed, completed, and certified by the builder as accurate and correct and included as an addendum to each sales contract; amending ss. 553.909 and 553.963, F.S.; modifying certain energy conservation standards; authorizing inclusion of standards for certain additional appliances in the energy efficiency construction code; amending s. 553.955, F.S.; redefining the term "energy conservation standard"; creating part XI of chapter 553, F.S., the Florida Building Energy-Efficiency Rating Act, consisting of ss. 553.990-553.998, F.S.; requiring the Department of Community Affairs to develop and maintain a statewide uniform energy-efficiency rating system for new and existing buildings to encourage the consideration of the energy-efficiency rating in the market and provide market rewards for energy-efficient buildings; providing definitions and applicability; providing rating system schedules for the different classes of buildings; providing minimum requirements of the system; providing for an interest group of volunteers to advise and assist the department; providing for training and certification of raters, including a fee therefor; providing for rating disclosure and supplemental information; providing for compliance; providing an effective date.

—was read the second time by title.

Senator Wexler moved the following amendments which were adopted:

Amendment 1—On page 10, lines 1-24, strike all of those lines and insert:

(3) The department shall establish a voluntary working group of persons interested in the energy-efficiency rating system or energy efficiency, including, but not limited to, such persons as electrical engineers, mechanical engineers, architects, public utilities, and builders. The interest group shall advise the department in the development of the energy-efficiency rating system and shall assist the department in the implementation of the rating system by coordinating educational programs for designers, builders, businesses, and other interested persons to assist compliance and to facilitate incorporation of the rating system into existing practices.

(4) The department shall develop a training and certification program to certify raters. In addition to the department, ratings may be conducted by any local government or private entity, provided that the appropriate persons have completed the necessary training and have been certified by the department. The Department of Management Services shall rate state-owned or state-leased buildings, provided that the appropriate persons have completed the necessary training and have been certified by the Department of Community Affairs. A state agency which has building construction regulation authority may rate its own buildings and those it is responsible for, if the appropriate persons have completed the necessary training and have been certified by the Department of Community Affairs.

Amendment 2—On page 11, strike all of lines 5-18 and insert:

(1)(a) In accordance with the schedules in s. 553.994, the prospective purchaser of real property with a building for occupancy located thereon shall be provided written notification that the purchaser may have the building's energy efficiency rating determined. Such notice shall be provided at the time of, or prior to, the purchaser's execution of the contract for sale and purchase.

(b) The energy efficiency rating of a new residential or commercial building shall be provided to the prospective purchaser, in writing, at the time of, or prior to, the purchaser's execution of the contract for sale and purchase.

(2) Concurrent with the provisions of subsection (1), the prospective purchaser shall be provided with a copy of an informational brochure prepared and provided at no cost by the department. Such brochure shall contain information relevant to that class of building, including, but not limited to:

Amendment 3 (with Title Amendment)—On page 13, between lines 12 and 13, insert:

Section 12. Subsection (2) of section 163.04, Florida Statutes, 1992 Supplement, is amended to read:

163.04 Energy devices based on renewable resources.—

(2) No deed restrictions, covenants, or similar binding agreements running with the land shall prohibit or have the effect of prohibiting solar collectors, clotheslines, or other energy devices based on renewable resources from being installed on buildings erected on the lots or parcels covered by the deed restrictions, covenants, or binding agreements. A property owner may not be denied permission to install solar collectors or other energy devices based on renewable resources by any entity granted the power or right in any deed restriction, covenant, or similar binding agreement to approve, forbid, control, or direct alteration of property with respect to residential dwellings not exceeding three stories in height. *For purposes of this subsection, such entity may determine the specific location where solar collectors may be installed on the roof within an orientation to the south or within 45 degrees east or west of due south provided that such determination does not impair the effective operation of the solar collectors.* ~~For purposes of this subsection, a property owner may not be prohibited from installing solar collectors on the roof with an orientation to the south or within 45° east or west of due south.~~

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 2, line 16, after the semicolon (;) insert: amending s. 163.04, F.S.; providing clarification regarding the installation of solar collectors in a certain manner;

Senator Forman moved the following amendment which was adopted:

Amendment 4 (with Title Amendment)—On page 2, between lines 20 and 21, insert:

Section 1. Paragraphs (h), (i), (j), and (k) of subsection (3) of section 377.703, Florida Statutes, 1992 Supplement, are redesignated as paragraphs (i), (j), (k), and (l), respectively, a new paragraph (h) is added to said subsection, and paragraph (k) is amended, to read:

377.703 Additional functions of the Department of Community Affairs; energy emergency contingency plan; federal and state conservation programs.—

(3) DEPARTMENT OF COMMUNITY AFFAIRS; DUTIES.—The Department of Community Affairs shall, in addition to assuming the duties and responsibilities provided by ss. 20.18 and 377.701, perform the following functions consistent with the development of a state energy policy:

(h) Promote the development and use of renewable energy resources, in conformance with the provisions of chapter 187 and s. 377.601, by:

1. Establishing goals and strategies for increasing the use of solar energy in this state.

2. Aiding and promoting the commercialization of solar energy technology, in cooperation with the Florida Solar Energy Center, the Department of Commerce, and any other federal, state, or local governmental agency which may seek to promote research, development, and demonstration of solar energy equipment and technology.

3. Identifying barriers to greater use of solar energy systems in this state, and developing specific recommendations for overcoming identified barriers, with findings and recommendations to be submitted annually in the report to the Legislature required under paragraph (f).

4. In cooperation with the Department of Transportation, the Department of Commerce, the Florida Solar Energy Center, and the Florida Solar Energy Industries Association, investigating opportunities, pursuant to the National Energy Policy Act of 1992 and the Housing and Community Development Act of 1992, for solar electric vehicles and other solar energy manufacturing, distribution, installation, and financing efforts which will enhance this state's position as the leader in solar energy research, development, and use.

5. Undertaking other initiatives to advance the development and use of renewable energy resources in this state.

In the exercise of its responsibilities under this paragraph, the department shall seek the assistance of the solar energy industry in this state and other interested parties, and is authorized to enter into contracts, retain professional consulting services, and expend funds appropriated by the Legislature for such purposes.

(k)~~(j)~~ The department shall coordinate energy-related programs of state government, including, but not limited to, the programs provided in this section. To this end, the department shall:

1. Provide assistance to other state agencies, counties, municipalities, and regional planning agencies to further and promote their energy planning activities.

2. Require, in cooperation with the Department of Management Services, all state agencies to operate state-owned and state-leased buildings in accordance with energy conservation standards as adopted by the Department of Management Services. ~~Beginning 120 days following July 1, 1978, and~~ Every 3 months ~~thereafter~~, the Department of Management Services shall furnish the department data on agencies' energy consumption in a format mutually agreed upon by the two departments.

3. Promote the development and use of renewable energy resources, ~~and~~ energy *efficiency* ~~conservation~~ technologies, *and conservation measures.* ~~To this end, the department shall:~~

~~a. Aid and promote the commercialization of solar energy technology, in cooperation with the Florida Solar Energy Center of the State University System, the Department of Commerce, and any other federal, state, or local governmental agency which may seek to promote research, development, and demonstration of solar energy equipment and technology.~~

4.~~b.~~ Promote the recovery of energy from wastes, including, but not limited to, the use of waste heat, the use of agricultural products as a source of energy, and recycling of manufactured products. Such promotion shall be conducted in conjunction with, and after consultation with, the Department of Environmental Regulation, the Florida Public Service Commission where electrical generation or natural gas is involved, and any other relevant federal, state, or local governmental agency having responsibility for resource recovery programs.

Section 2. Section 288.041, Florida Statutes, is created to read:

288.041 Solar energy industry; legislative findings and policy; promotional activities.—

(1) It is hereby found and declared that:

(a) The solar energy industry in this state has been a leader in the nation in the manufacture, supply, and delivery of solar energy systems.

(b) The use of solar energy in this state has been demonstrated to save conventional energy sources and reduce the need for expensive power plants which contribute to pollution of the air and water of this state.

(c) The solar energy industry offers the prospect for improved economic welfare of this state through creation of jobs, increased energy security, and enhancing the quality of the environment of this state.

(d) Through helping to provide for a clean environment and healthy economy, the solar energy industry contributes to the continued growth and development of the tourist industry of this state.

(2) It is the policy of this state to promote, stimulate, develop, and advance the growth of the solar energy industry in this state.

(3) The Division of Economic Development of the Department of Commerce shall assist in the expansion of the solar energy industry in this state in cooperation with the Department of Community Affairs, the Florida Solar Energy Center, and the Florida Solar Energy Industries Association. Such assistance may include, but shall not be limited to, promotional and educational programs on the benefits of solar energy, including programs that facilitate the use of solar technologies by the state's business sector, programs which aid the export market potential of solar applications, and programs which further develop the employment creation potential of solar technologies.

In the exercise of its responsibilities under this section, the department shall seek the assistance of the solar energy industry in this state and other interested parties, and is authorized to enter into contracts, retain professional consulting services, and expend funds appropriated by the Legislature for such purposes.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 1, lines 2 and 3, strike "in buildings" and insert: amending s. 377.703, F.S.; providing duties and responsibilities of the Department of Community Affairs with respect to solar energy resource promotion and development; requiring a report; creating s. 288.041, F.S.; providing legislative intent; providing duties and responsibilities of the Department of Commerce with respect to solar energy resource promotion and development;

On motion by Senator Wexler, by two-thirds vote **CS for SB 1988** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—37 Nays—None

Consideration of **SB 698, CS for SB 952** and **SB 978** was deferred.

RECONSIDERATION

On motion by Senator Forman, the Senate reconsidered the vote by which—

CS for SB 536—A bill to be entitled An act relating to juveniles; amending s. 39.025, F.S., relating to juvenile delinquency and gang prevention; replacing juvenile delinquency and gang prevention councils with county and district juvenile justice plans, councils, and boards; providing legislative findings and intent; revising and providing definitions; providing for county juvenile justice councils, and providing for district juvenile justice boards, and providing for membership, organization, purpose, duties, and reporting; deleting provisions relating to grant application procedures and providing criteria for community juvenile justice partnership grants; amending s. 874.03, F.S.; redefining the term "pattern of youth and street gang activity" to eliminate "the purpose of furthering gang activity" for purposes of ch. 874, F.S., which increases the penalty for a felony or violent misdemeanor that is part of a pattern of youth and street gang activity, which provides a civil cause of action for a violation of the chapter, which provides for forfeiture of profits, proceeds, or instrumentalities of criminal activity of youth and street gangs, and which provides for reporting certain crime information; creating s.

39.0475, F.S.; authorizing a delinquency pretrial intervention program for limited purposes under certain circumstances; providing procedure; providing effective dates.

—passed as amended this day.

On motion by Senator Forman, by two-thirds vote the Senate reconsidered the vote by which **CS for SB 536** was read the third time.

On motion by Senator Forman, the Senate reconsidered the vote by which **Amendments 1, 2, 3** and **4** were adopted. **Amendments 1, 2, 3** and **4** were withdrawn.

Senator Forman moved the following amendment which was adopted:

Amendment 5 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Paragraphs (c), (d), (e), and (f) of subsection (4) and paragraphs (a) and (c) of subsection (5) of section 39.025, Florida Statutes, 1992 Supplement, are amended to read:

39.025 Juvenile delinquency and gang prevention.—

(4) JUVENILE DELINQUENCY AND GANG PREVENTION COUNCILS.—

(c) Each *juvenile delinquency and* gang prevention council has the following powers and duties:

1. Develop and implement a delinquency prevention plan and an advisory plan for the provision and coordination of delinquency programs and services to meet the needs of the communities represented in the judicial circuit.

2. Advise and assist the district administrator in the provision of optional, innovative delinquency services in the judicial circuit to meet the unique needs of delinquent children.

3. Develop, in consultation with the district administrator, funding sources external to the department for the provision and maintenance of additional programs and services in the circuit for delinquent children and their families. The ~~gang prevention~~ council may apply for and receive funds, under contract or other funding arrangement, from federal, state, county, city, and other public agencies, and from public and private foundations, agencies, and charities for the purpose of funding optional, innovative prevention, diversion, or treatment services in the circuit to meet the unique needs of delinquent children. *To aid this process, the department shall provide fiscal-agency services for the councils.*

4. Contract with city, county, or other public agencies or private entities for the provision and maintenance of optional, innovative additional prevention and diversion programs and services in the circuit for delinquent children and their families, in consultation with the district administrator. In contracting with public and private entities, the ~~gang prevention~~ council may use any funds available to it, including, but not limited to, funds raised external to the department. Departmental funds available to the ~~gang prevention~~ council shall be coordinated with and subject to the health and human services board. The ~~gang prevention~~ council shall actively solicit proposals for new contract and purchase of service programs and services from community organizations, associations, and groups representing the racial and ethnic mix of the community which is being served. *Administrative charges may not exceed 2 percent of all funds raised by the councils.*

5. Make, through the office of the district administrator, annual financial audits of the records and accounts, and annual performance audits of the operations, of each grant, contract, and purchase of service agreement entered into between the ~~gang prevention~~ council and any public or private entity to carry out any purpose or responsibility of the department, and of each juvenile delinquency and gang prevention program grant awarded by the department.

6. Collect information and statistical data helpful in assessing the need for delinquent children services in the circuit.

7. Collect data on ethnicity by use of social security numbers or other numbers.

8.~~7.~~ Consult and coordinate with other circuits and agencies dedicated to the provision of delinquent children services in order to ensure *availability of sufficient services* and prevent overlapping of services.

9.~~8.~~ Review the annual budget for the circuit and make recommendations to the district administrator and the health and human services board concerning the budget for prevention, diversion, and treatment services in the circuit.

10.~~9.~~ Meet at least quarterly and convene special meetings at the call of the chair or the district administrator.

11.~~10.~~ Advise, assist, and approve juvenile delinquency and gang prevention program grants submitted by the local public or private entities for department funds. The council shall send a letter from the chair to the department confirming that the grant application meets the circuit council delinquency prevention plan.

(d) Each *juvenile delinquency and* gang prevention council is an agency of the state and serves the department. Each ~~gang prevention~~ council is subject to chapter 120.

(e) Each *juvenile delinquency and* gang prevention council shall:

1. Immediately after the members are appointed, elect a chair and a vice chair from among its members, and elect other officers as deemed necessary by the council. The district administrator or his designee may not serve as the chair, vice chair, or other officer.

2. Immediately after the members are appointed and officers are elected, identify and assess the needs of delinquent children and their families in the circuit served by the council and submit to the district administrator a written description of:

a. The services to be provided; the anticipated schedule for providing those services; the manner in which the services are to be provided, including a description of arrangements and agreements to be made with community organizations, state and local educational agencies, federal agencies, public assistance agencies, the juvenile courts, foster care agencies, and other applicable public and private agencies and organizations.

b. The strategy to be used for interagency coordination to maximize existing human and fiscal resources.

3. Make and adopt bylaws and rules for the operation of the council, provided such bylaws and rules are not inconsistent with federal or state laws or county ordinances. The bylaws and rules must be submitted to the district administrator for approval.

4. Provide an annual written report to the district administrator and the health and human services board no later than October 1. The annual report must contain, but is not limited to, the following information: information on the effectiveness of delinquent children services in the circuit, including cost-effectiveness; detailed information on the various programs, services, and activities available in the circuit and the degree to which the programs, services, and activities have been successfully used; information on programs, services, and activities that should be eliminated, continued, or added with respect to services in the circuit for delinquent children and their families.

(f) Members of each *juvenile delinquency and* gang prevention council shall serve without compensation, but are entitled to receive reimbursement for per diem and travel expenses as provided in s. 112.061.

(5) DELINQUENCY PREVENTION PLAN; PROGRAMS; GRANTS.—

(a) A delinquency prevention plan is authorized in each circuit for the purpose of reducing delinquent acts, juvenile arrests, and gang activity. Juvenile delinquency and gang prevention programs under such plan shall be administered *in conjunction with* ~~by~~ the Department of Health and Rehabilitative Services in cooperation with other appropriate governmental organizations and public and private agencies. A juvenile delinquency and gang prevention program under this section may be planned, implemented, and conducted in any circuit pursuant to a proposal developed and approved as specified in subsection (6).

(c) The *juvenile delinquency and* gang prevention council *shall* ~~may~~ use public hearings and other appropriate processes to solicit input regarding the development and updating of the delinquency prevention plan. Input may be provided by parties which include, but are not limited to:

1. Local level public and private service providers, advocacy organizations, and other organizations working with delinquent children.

2. County and municipal governments.

3. State agencies that provide services to delinquent children.

4. University youth centers.

5. Judges, state attorneys, public defenders, and The Florida Bar.

6. Victims of crimes committed by children.

7. Law enforcement.

8. Delinquent children and their families and caregivers.

9. Schools.

10. Agencies that provide treatment services to youth who have committed delinquent acts.

The gang prevention council must develop its delinquency prevention plan in close cooperation with the health and human services board, local school districts, and with local law enforcement in order to maximize services for delinquent children. The gang prevention council must update the delinquency prevention plan for delinquent children policies and programs every year. *To aid the planning process the Department of Health and Rehabilitative Services shall provide routinely collected ethnicity data. The Department of Law Enforcement shall include ethnicity as a field in the Florida Intelligence Center database and collect the data routinely.*

Section 2. Subsection (5) of section 39.045, Florida Statutes, is amended to read:

39.045 Oaths; records; confidential information.—

(5) Except as provided in subsections (3) and (8), all information obtained *under* ~~pursuant to~~ this chapter in the discharge of official duty by any judge, any employee of the court, any authorized agent of the department, the Parole Commission, the Commission on Juvenile Justice, the Department of Corrections, *the juvenile delinquency and gang prevention councils,* or any law enforcement agent *is* ~~shall be~~ confidential and *may* ~~shall not~~ be disclosed *only* to ~~anyone other than~~ the authorized personnel of the court, the department and its designees, the Department of Corrections, the Parole Commission, the Commission on Juvenile Justice, law enforcement agents, school superintendents and their designees, and others entitled under this chapter to receive that information, *or* ~~except~~ upon order of the court.

Section 3. Section 39.0475, Florida Statutes, is created to read:

39.0475 Delinquency pretrial intervention program.—

(1)(a) Notwithstanding any provision of law to the contrary, a child who is charged under chapter 893 with a felony of the second or third degree for purchase or possession of a controlled substance, and who has not previously been adjudicated for a felony nor been admitted to a delinquency pretrial intervention program under this section, is eligible for admission into a delinquency pretrial substance abuse education and treatment intervention program approved by the chief judge of the circuit to the extent that funded programs are available, for a period of not less than 1 year in duration, upon motion of either party or the court's own motion. If the state attorney believes that the facts and circumstances of the case suggest the child's involvement in the dealing and selling of controlled substances, the court shall hold a preadmission hearing. If the state attorney establishes by a preponderance of the evidence at such hearing that the child was involved in the dealing and selling of controlled substances, the court shall deny the child's admission into a delinquency pretrial intervention program.

(b) At the end of the delinquency pretrial intervention period, the court shall consider the recommendation of the state attorney and the program administrator as to disposition of the pending charges. The court shall determine, by written finding, whether the child has successfully completed the delinquency pretrial intervention program.

(c)1. If the court finds that the child has not successfully completed the delinquency pretrial intervention program, the court may order the child to continue in education and treatment if resources and funding are available or order that the charges revert to normal channels for prosecution.

2. The court may dismiss the charges upon a finding that the child has successfully completed the delinquency pretrial intervention program.

(d) Any entity, whether public or private, providing a pretrial substance abuse education and treatment intervention program under this section must contract with the county or appropriate governmental entity, and the terms of the contract must include, but need not be limited to, the requirements established for private entities under s. 948.15(2). It is the intent of the Legislature that public or private entities providing substance abuse education and treatment intervention programs involve the active participation of parents, schools, churches, businesses, law enforcement, and the department or its contract providers.

(2) The chief judge in each circuit may appoint an advisory committee for the delinquency pretrial intervention program composed of the chief judge or designee, who shall serve as chair; the state attorney, the public defender, and the program administrator, or their designees; and such other persons as the chair deems appropriate. The committee may also include persons representing any other agencies to which children released to the delinquency pretrial intervention program may be referred.

Section 4. Paragraph (c) of subsection (1) of section 39.0585, Florida Statutes, 1992 Supplement, is amended to read:

39.0585 Information systems.—

(1)

(c) As used in this section, the term "certain juvenile offender" means a juvenile who has been adjudicated delinquent and who meets one or more of the following criteria:

1. Is arrested for a capital, life, or first degree felony offense or sexual battery.

2. Has five or more arrests, at least three of which are for felony offenses. Three of such arrests must have occurred within the preceding 12-month period.

3. Has ten or more arrests, at least two of which are for felony offenses. Three of such arrests must have occurred within the preceding 12-month period.

4. Has four or more arrests, at least one of which is for a felony offense and occurred within the preceding 12-month period.

5. Has ten or more arrests, at least eight of which are for any of the following offenses:

a. Petit theft;

b. Misdemeanor assault;

c. Possession of a controlled substance;

d. Weapon or firearm violation; or

e. Substance abuse.

Four of such arrests must have occurred within the preceding 12-month period.

6. Meets at least one of the criteria for youth and street gang membership.

Section 5. This act shall take effect July 1, 1993.

And the title is amended as follows:

In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to juvenile delinquency and gang prevention; amending s. 39.025, F.S.; requiring the Department of Health and Rehabilitative Services to make fiscal agency provisions for juvenile delinquency and gang prevention councils; providing limitation on councils' administrative charges; authorizing councils to collect data on ethnicity; requiring public hearings for input on development of delinquency prevention plans; providing additional topics for input at these hearings; requiring the Department of Health and Rehabilitative Services and the Department of Law Enforcement to include ethnicity as a field in their information system; amending s. 39.045, F.S.; providing for confidentiality of information obtained by juvenile delinquency and gang prevention councils; creating s. 39.0475, F.S.; authorizing a delinquency pretrial intervention program for limited purposes under certain circumstances; providing procedure; amending s. 39.0585, F.S.; providing additional criteria for determining a certain juvenile offender for purposes of maintaining central identification files; providing an effective date.

On motion by Senator Forman, by two-thirds vote **CS for SB 536** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—38 Nays—None

RECONSIDERATION

On motion by Senator Wexler, the Senate reconsidered the vote by which—

CS for SB 1988—A bill to be entitled An act relating to energy efficiency in buildings; amending s. 553.71, F.S.; defining "load management control device"; amending s. 553.79, F.S.; exempting load management control devices from permit and fee requirements under the State Minimum Building Codes; amending s. 553.901, F.S.; providing for triennial determinations and updates of the Florida Thermal Efficiency Code; amending ss. 553.903, 553.904, and 553.905, F.S.; providing applicability of thermal efficiency standards to products covered by the Florida Energy Efficiency Code for Building Construction; amending s. 553.9085, F.S.; requiring energy performance levels for new residential buildings to be disclosed upon request by prospective purchasers; requiring the energy performance level display card to be signed, completed, and certified by the builder as accurate and correct and included as an addendum to each sales contract; amending ss. 553.909 and 553.963, F.S.; modifying certain energy conservation standards; authorizing inclusion of standards for certain additional appliances in the energy efficiency construction code; amending s. 553.955, F.S.; redefining the term "energy conservation standard"; creating part XI of chapter 553, F.S., the Florida Building Energy-Efficiency Rating Act, consisting of ss. 553.990-553.998, F.S.; requiring the Department of Community Affairs to develop and maintain a statewide uniform energy-efficiency rating system for new and existing buildings to encourage the consideration of the energy-efficiency rating in the market and provide market rewards for energy-efficient buildings; providing definitions and applicability; providing rating system schedules for the different classes of buildings; providing minimum requirements of the system; providing for an interest group of volunteers to advise and assist the department; providing for training and certification of raters, including a fee therefor; providing for rating disclosure and supplemental information; providing for compliance; providing an effective date.

—passed as amended this day.

On motion by Senator Wexler, by two-thirds vote **CS for HB 1045** was withdrawn from the Committee on Rules and Calendar.

On motions by Senator Wexler, by two-thirds vote—

CS for HB 1045—A bill to be entitled An act relating to energy efficiency; amending s. 377.703, F.S.; providing duties and responsibilities of the Department of Community Affairs with respect to solar energy resource promotion and development; requiring a report; creating s. 288.041, F.S.; providing legislative intent; providing duties and responsibilities of the Department of Commerce with respect to solar energy resource promotion and development; amending s. 553.71, F.S.; defining "load management control device"; amending s. 553.79, F.S.; exempting load management control devices from permit and fee requirements under the State Minimum Building Codes; amending s. 553.901, F.S.; providing for triennial determinations and updates of the Florida Thermal Efficiency Code; amending ss. 553.903, 553.904, and 553.905, F.S.; providing applicability of thermal efficiency standards to products covered by the Florida Energy Efficiency Code for Building Construction; amending s. 553.9085, F.S.; requiring energy performance levels for new residential buildings to be disclosed upon request by prospective purchasers; requiring the energy performance level display card to be signed, completed, and certified by the builder as accurate and correct and included as an addendum to each sales contract; amending ss. 553.909 and 553.963, F.S.; modifying certain energy conservation standards; authorizing inclusion of standards for certain additional appliances in the energy efficiency construction code; amending s. 553.955, F.S.; redefining the term "energy conservation standard"; creating part XI of chapter 553, F.S., the Florida Building Energy-Efficiency Rating Act; requiring the Department of Community Affairs to develop and maintain a statewide uniform energy-efficiency rating system for new and existing buildings to encourage the consideration of the energy-efficiency rating in the market and provide market rewards for energy-efficient buildings; providing definitions and applicability; providing rating system schedules for the different classes of buildings; providing minimum requirements of the system; providing for an interest group of volunteers to advise and assist the department; providing for training and certification of raters, including a fee therefor; providing for rating disclosure and supplemental information; providing for compliance; amending s. 163.04, F.S. (1992 Supp.), providing clarification regarding the installation of solar collectors in a certain manner; providing an effective date.

—a companion measure, was substituted for **CS for SB 1988** and by two-thirds vote read the second time by title. On motion by Senator Wexler, by two-thirds vote **CS for HB 1045** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—37 Nays—None

Consideration of **CS for SB 952, SB 954, SB 1856** and **SB 716** was deferred.

HB 1307—A reviser's bill to be entitled An act relating to the Florida Statutes; amending s. 330.40, Florida Statutes, and repealing s. 796.01, Florida Statutes, to conform to judicial decisions holding said provisions or parts thereof unconstitutional.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1307** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

HB 1309—A reviser's bill to be entitled An act relating to the Florida Statutes; repealing ss. 403.7083, 403.7227, 571.30, 629.50, 629.501, 629.502, 629.504, 629.506, 629.507, 629.508, 629.509, 629.511, 629.512, 629.513, 629.514, 629.516, 629.517, 629.518, and 629.519, Florida Statutes, and s. 468.1695(2), Florida Statutes (1992 Supplement), all of which provisions have become inoperative by noncurrent repeal or expiration and, pursuant to s. 11.242(5)(b) and (i), may be omitted from publication in the Florida Statutes 1993 only through a reviser's bill duly enacted by the Legislature.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1309** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

HB 1311—A reviser's bill to be entitled An act relating to the Florida Statutes; repealing ss. 154.067(2), 210.52, 212.0599(1), 212.67(1)(f), (g), 233.0576(3), 236.022, 316.614(7)(b), 336.044(3), 370.0605(2)(d), 373.457(2), 491.005(5), 641.48(2), and 946.508(2)(b), Florida Statutes, and ss. 24.105(11), 24.120(6), 212.63, 229.602(5), 232.246(2), 408.001(4), 420.6075(3), (4), 627.351(4)(j), 627.410(7)(f), and 877.04(4), Florida Statutes (1992 Supplement), pursuant to s. 11.242, Florida Statutes; deleting provisions which have become obsolete, have had their effect, have served their purpose, or have been impliedly repealed or superseded.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1311** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—35 Nays—None

HB 1313—A reviser's bill to be entitled An act relating to the Florida Statutes; amending ss. 475.001, 475.01(1)(e), (2), 475.011(6), 475.02(1), 475.045(2), (3), 475.17(1), (2), (3), (4), (5), 475.181(1), 475.182(1), 475.215, 475.23, 475.31(1), 475.37, 475.41, 475.42(1)(a), (b), (c), (d), (j), (m), (n), 475.43, 475 451(6), 475.453, 475.455(1), 475.482(1), (2), (3), 475.483(2), and 475.484(1), (4), (7), Florida Statutes, pursuant to the directive in s. 10, ch 91-89, Laws of Florida, to change the term "salesman" to "salesperson" wherever that term appears in chapter 475, Florida Statutes.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1313** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

HB 1315—A reviser's bill to be entitled An act relating to the Florida Statutes; amending ss. 106.24(7), 154.01(5), 240.241(8), 311.09(10), 393.001(7)(a), and 648.26(4)(b), Florida Statutes, and ss. 20.315(13), 122.35(3), 402.165(5)(d), and 455.203(3), Florida Statutes (1992 Supplement), pursuant to s. 41, ch. 91-109, Laws of Florida, to conform the statutes to the changes made to the annual budget process by that act.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1315** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—34 Nays—None

HB 1317—A reviser's bill to be entitled An act relating to the Florida Statutes; amending s. 230.71(6)(a), Florida Statutes, pursuant to s. 11.242, Florida Statutes; and to the directive in s. 9, ch. 91-115, Laws of Florida, to conform to s. 1, ch. 91-115, which transferred all powers, duties, and functions from the Pepper Commission on Aging to the Department of Elderly Affairs.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1317** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—33 Nays—None

HB 1319—A reviser's bill to be entitled An act relating to the Florida Statutes; amending ss. 384.25(4), 392.53(4), and 403.860(6), Florida Statutes, and s. 381.004(3)(i), Florida Statutes (1992 Supplement), pursuant to s. 11.242, Florida Statutes; replacing incorrect cross-references pursuant to the directive in s. 63, ch. 91-297, Laws of Florida.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1319** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—34 Nays—None

HB 1321—A reviser's bill to be entitled An act relating to the Florida Statutes; repealing ss. 374.011, 374.021, 374.031, 374.041, 374.051, 374.061, 374.071, 374.081, 374.091, 374.101, 374.111, 374.122, 374.132, 374.141, 374.151, 374.161, 374.171, 374.181, 374.301, 374.311, 374.321, 374.331, 374.341, 374.351, 374.361, 374.371, 374.391, 374.401, 374.411, 374.421, 374.431, 374.441, 374.451, 374.461, 374.471, 374.481, 374.491, 374.501, 374.511, and 374.521, Florida Statutes, all of which provisions have become inoperative by noncurrent repeal and, pursuant to s. 11.242(5)(b) and (i), may be omitted from publication in the Florida Statutes 1993 only through a reviser's bill duly enacted by the Legislature.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1321** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—34 Nays—None

HB 1323—A reviser's bill to be entitled An act relating to the Florida Statutes; repealing ss. 10.101, 10.102, 10.103, 10.104, and 10.105, Florida Statutes, pursuant to s. 11.242, Florida Statutes; deleting provisions providing for apportionment of the Florida Legislature which have been superseded.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1323** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

HB 1325—A reviser's bill to be entitled An act relating to the Florida Statutes: amending ss. 458.324(1), (2)(a), and 459.0125(1) and (2)(a), Florida Statutes, and ss. 381.0072(3)(a), 385.103(2)(d), 393.066(3), 393.068(4), 394.75(11)(b), and 408.033(2), Florida Statutes (1992 Supplement), pursuant to the directive in s. 59, ch. 92-58, Laws of Florida; conforming the Florida Statutes to the changes made by ch. 92-58, in order to properly implement the legislative intent expressed therein.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1325** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—33 Nays—None

HB 1327—A reviser's bill to be entitled An act relating to the Florida Statutes; amending ss. 28.2401(1)(i), 110.119, 113.01, 196.091(1), (2), 196.24, 295.01(1)(b), 295.0195(1), 295.08, 295.16, 295.17(1)(a), 320.084(1), (2), 320.0848(1)(a), 322.21(7), 338.155(3), 370.0605(4), 372.561(5)(b), 372.57(6)(b), 394.4672, 400.404(2)(e), 402.33(1)(a), 461.002(3), 466.002(3), 501.1375(12), 518.01, 518.06, 518.07(1), 518.09, 518.10, 520.08(5), 626.785(1)(c), 626.788, 626.831(1)(c), 626.833, 687.03(2)(a), 687.14(4), 716.02(5), 744.421, 744.602(2), 744.604, 744.607, 744.609, 744.613, 744.616, 744.617(1), 744.622, 744.624, 744.625(1), (4), 744.626, 744.634(1), (2), (5), 744.637, 744.638, 744.641, 744.643, 744.646, 744.652, and 916.107(8)(a), Florida Statutes, and ss. 39.058(4)(i), 39.0582(4)(i), 61.046(4), 110.2135(1), 196.012(11), 196.081(1), (2), 196.101(3), (4), (5), 215.47(2)(b), 394.455(2), (9), and 766.314(4)(b), Florida Statutes (1992 Supplement), conforming to the redesignation of the United States Veterans' Administration and the Administrator of Veterans' Affairs as the United States Department of Veterans Affairs and the Secretary of Veterans Affairs, respectively, by ss. 2, 10, Pub. L. No. 100-527.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1327** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—34 Nays—None

HB 1329—A reviser's bill to be entitled An act relating to the Florida Statutes; amending s. 790.25(3)(a), Florida Statutes, and s. 251.17, Florida Statutes (1992 Supplement); conforming to s. 8, ch. 92-86, Laws of Florida, which changed the name of the Florida State Guard to the Florida State Defense Force.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1329** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—37 Nays—None

HB 1331—A reviser's bill to be entitled An act relating to the Florida Statutes; amending ss. 570.15(1), (3), and 570.21(1), Florida Statutes, and ss. 534.081(1) and 573.118(1), Florida Statutes (1992 Supplement), pursuant to s. 11.242, Florida Statutes, and to the directive in s. 101, ch. 92-291, Laws of Florida, to make the necessary name changes of the divisions of the Department of Agriculture and Consumer Services, and to conform to the redesignation of roadguard inspection special officers as agricultural law enforcement officers.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1331** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

HB 1333—A reviser's bill to be entitled An act relating to the Florida Statutes; repealing ss. 8.001, 8.01, 8.011, 8.03, and 8.061, Florida Statutes, pursuant to s. 11.242, Florida Statutes; deleting provisions providing for apportionment of congressional districts within the State of Florida which have been superseded.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1333** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—35 Nays—None

HB 1335—A bill to be entitled An act relating to the official Florida Statutes; amending ss. 11.2421, 11.2422, 11.2424, and 11.2425, Florida Statutes; adopting the Florida Statutes 1993 and designating the portions thereof that are to constitute the official law of the state; providing that

the Florida Statutes 1993 shall be effective immediately upon publication; providing that general laws enacted during the 1991 regular and special legislative sessions up to and including the special session of June 6, 1991, and prior thereto and not included in the Florida Statutes 1993 are repealed; providing that general laws enacted during the December 1991 special session, the 1992 regular and special sessions, and the 1993 regular session are not repealed by this adoption act.

—was read the second time by title. On motion by Senator Jennings, by two-thirds vote **HB 1335** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—37 Nays—None

CS for SB 952—A bill to be entitled An act relating to mercury-containing devices and lamps; providing for the environmentally sound management of those devices and lamps; providing definitions; prohibiting the incineration or disposal of mercury-containing devices; prohibiting the incineration of spent lamps; providing a waste management requirement for spent lamps, providing for depositing mercury-recycling program funds into the Solid Waste Management Trust Fund; providing for uses of those funds; providing for rulemaking by the Department of Environmental Regulation; providing for obtaining a reclamation facility permit; providing for permit fees; providing standards for these facilities; requiring public service information and warning signs to be provided; providing for a demonstration project; providing an appropriation for the demonstration project; providing an effective date.

—was read the second time by title. On motion by Senator Bankhead, by two-thirds vote **CS for SB 952** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—38 Nays—None

SB 716—A bill to be entitled An act relating to energy-conservation contracts; authorizing the state to enter into contracts with a qualified provider to reduce energy or operating costs of state-owned buildings or state-owned hospitals through energy-conservation measures, providing definitions; providing procedures; prescribing contract provisions; providing for public hearings; providing an effective date.

—was read the second time by title.

Senator Silver moved the following amendments which were adopted:

Amendment 1—On page 2, line 28, strike "and" and insert: or

Amendment 2 (with Title Amendment)—On page 3, lines 2, 7, 16, and 21 and on page 4, lines 3 and 13, strike "provider" and insert: provider or providers

And the title is amended as follows:

In title, on page 1, line 4, strike "provider" and insert: provider or providers

On motion by Senator Silver, by two-thirds vote **SB 716** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—32 Nays—None

CS for SB 1666—A bill to be entitled An act relating to elections; amending s. 99.095, F.S.; providing limitations to use of alternative method of qualifying; amending s. 99.0955, F.S.; providing primary ballot access to independent candidates; providing dates for obtaining forms; providing for voting by all qualified electors in first primary to nominate an independent candidate when more than one independent candidate qualifies for an office; providing that the name of the independent candidate who gets the most votes in the primary election will be placed on the general election ballot; providing for grouping the names of independent candidates on the first primary ballot; amending s. 101.5606; to conform; amending s. 106.011, F.S.; redefining the term "independent expenditure"; exempting land trusts from definitions of "political committee" and "person"; amending s. 106.03, F.S.; requiring additional information required in political committee statements of organization; amending s. 106.04, F.S.; deleting an assessment on contributions which has been declared unconstitutional; increasing the fine for late filing of reports by committees of continuous existence; amending s. 106.07, F.S.; expanding campaign reporting requirements; deleting an assessment on contributions which has been declared unconstitutional; revising filing deadline requirements; increasing fines for late filing; providing penalties; amending s. 106.071, F.S.; expanding disclosure requirements on independent expenditures; providing penalties; amending s. 106.08, F.S.; prohibiting contributions by landtrusts; creating s. 106.083, F.S.; prohibiting legislators from soliciting or accepting campaign contributions during any regular session; providing certain additional campaign contribution reporting requirements covering special sessions and the period from qualifying to the general election; providing penalties; amending s. 106.141, F.S.; eliminating the disposition of campaign funds to the candidate's political party; amending s. 106.19, F.S.; providing penalties applicable to receipt of unlawful campaign contributions; reenacting s. 106.18(1), F.S., relating to omitting a candidate's name from the ballot, to incorporate the amendment to s. 106.19, F.S., in a reference thereto; amending s. 106.21, F.S.; revising cross-references to conform; amending s. 106.265, F.S.; increasing the civil penalty for violations of campaign financing law; amending s. 106.29, F.S.; deleting an assessment on contributions which has been declared unconstitutional; prohibiting national executive committees of political parties from using or expending for an election contributions received within a specified period prior to that election; repealing s. 106.32(3), F.S., relating to deposit into the Election Campaign Financing Trust Fund of the proceeds of certain assessments on contributions which have been declared unconstitutional; providing severability; providing an effective date.

—was read the second time by title.

Senator Dudley moved the following amendment which was adopted:

Amendment 1 (with Title Amendment)—On page 36, strike line 29 and insert: filed *by 12:01 p.m.* on the Friday immediately preceding the first primary

And the title is amended as follows:

In title, on page 2, line 25, after the semicolon (;) insert: requiring political parties to file reports by a certain time;

Senator Dudley moved the following amendment:

Amendment 2—On page 38, strike line 12 and insert: the reports of the contributor and recipient. *Any political party which exceeds the contribution limits to candidates or nominees of that party is subject to a civil penalty equal to three times the amount involved in the illegal act. Such penalty may be in addition to the penalty provided by s. 106.265, and shall be paid into the Election Campaign Financing Trust Fund.*

And the title is amended as follows:

In title, on page 2, line 31, after the semicolon (;) insert: providing a penalty;

POINT OF ORDER

Senator Holzendorf raised a point of order that pursuant to Rule 7.1, **Amendment 2** contained language of a bill not reported favorably by a Senate committee and was therefore out of order.

The point of order was referred to Senator Jennings, Chairman of the Committee on Rules and Calendar.

On motion by Senator Johnson, further consideration of **CS for SB 1666** with pending **Amendment 2** was deferred.

CS for SB 1668—A bill to be entitled An act relating to ethics; amending s. 11.045, F.S.; expanding and modifying registration and disclosure requirements for legislative lobbyists; providing definitions; providing penalties; creating s. 11.063, F.S.; prohibiting legislative lobbyists from contracting for or accepting any contingency fee; providing penalties; creating s. 11.064, F.S.; requiring legislative lobbyists and principals to retain records for a specified period; providing penalties; amending s. 112.3215, F.S., and creating ss. 112.3216 and 112.3217, F.S., to apply the registration and reporting requirements, contingency fee restrictions, record retention requirements, and penalties applicable to legislative lobbyists and principals pursuant to this act to executive branch lobbyists and principals; amending s. 112.324, F.S; requiring that persons filing

complaints with the Commission on Ethics have personal knowledge of the matters set forth in the complaint; providing severability; providing an effective date.

—was read the second time by title.

Senators Johnson and Harden offered the following amendment which was moved by Senator Johnson:

Amendment 1—On page 1, lines 20-23, strike "requiring that persons filing complaints with the Commission on Ethics have personal knowledge of the matters set forth in the complaint;"

On motion by Senator Johnson, further consideration of **CS for SB 1668** with pending **Amendment 1** was deferred.

THE PRESIDENT PRESIDING

RECESS

On motion by Senator Jennings, the Senate recessed at 6:33 p.m. to reconvene at 7:00 p.m.

EVENING SESSION

The Senate was called to order by the President at 7:19 p.m. A quorum present—40:

Mr. President	Diaz-Balart	Holzendorf	Myers
Bankhead	Dudley	Jenne	Scott
Beard	Dyer	Jennings	Siegel
Boczar	Foley	Johnson	Silver
Brown-Waite	Forman	Jones	Sullivan
Burt	Grant	Kirkpatrick	Thomas
Casas	Grogan	Kiser	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

SPECIAL ORDER, continued

CS for SB's 1914, 2006, 1784 and 406—A bill to be entitled An act relating to health care; amending s. 20.42, F.S., relating to organization of the Agency for Health Care Administration; modifying the organization and responsibilities of the agency; delaying transfer to the agency of certain responsibilities relating to the regulation of health care professionals; creating the Health Care Advisory Commission within the agency; providing for membership of the commission; providing duties of the commission; renaming the Division of Health Policy and Planning as the Division of Health Policy and Cost Control; providing additional responsibilities relating to state and local health planning, certificate-of-need review, hospital budget review, and the administration of specified contracts; providing duties of the Division Director for State Health Purchasing; redesignating the Agency for Health Care Administration as the Department of Health Care Administration on a specified date; amending s. 20.30, F.S.; reinstating the Division of Medical Quality Assurance within the Department of Professional Regulation; reestablishing the Board of Nursing Home Administrators and the Board of Opticianry within the Division of Professions of the Department of Professional Regulation; reestablishing the Board of Medicine, the Board of Osteopathic Medicine, the Board of Acupuncture, the Board of Chiropractic, the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, the Board of Dentistry, the Board of Nursing, the Board of Optometry, the Board of Pharmacy, the Board of Physical Therapy Practice, the Board of Podiatric Medicine, the Board of Psychological Examiners, the Board of Speech-Language Pathology and Audiology, and the Board of Clinical Laboratory Personnel within the Division of Medical Quality Assurance; providing for future transfer of the Division of Medical Quality Assurance within the Department of Professional Regulation to the Division of Health Quality Assurance within the Department of Health Care Administration; amending s. 33, ch. 92-33, Laws of Florida; delaying the transfer of powers, duties, and funds of the Division of Medical Quality Assurance of the Department of Professional Regulation to the Department of Health Care Administration; amending s. 110.123, F.S., relating to the state group insurance program; providing legislative intent; providing agency responsibilities; transferring powers, duties, records, property, and unexpended allocations of funds associated with positions in the State Employees Health Insurance Program to the Division of State Health Purchasing of the Agency for Health Care Administration; transferring powers, duties, records, property, and unexpended allocations of funds of the Medicaid program within the Department of Health and Rehabilitative Services to the Division of State Health Purchasing of the Agency for Health Care Administration; amending s. 20.19, F.S.; conforming provisions to such transfer; amending s. 112.0455, F.S.; providing duties of the agency under the Drug-Free Workplace Act; providing for regulation of drug testing laboratories by the agency; amending ss. 154.011, 154.205, 154.245, 154.304, 154.306, 154.308, 154.309, 154.31, 154.3105, 154.312, F.S., relating to certificates of need and the Health Care Responsibility Act of 1988; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the agency; amending ss. 159.27, 186.003, F.S.; conforming cross-references; amending ss. 189.415, 196.1975, 205.1965, F.S., relating to certificate-of-need review and agency licensure of homes for the aged and adult congregate living facilities; amending s. 215.20, F.S.; conforming terminology relating to the name of a trust fund; amending s. 240.4067, F.S., relating to the Medical Education Reimbursement and Loan Repayment Program; providing for penalties for noncompliance; deleting a limitation on the payment period; providing additional categories of eligibility; amending s. 240.4075, F.S.; adding birth centers, community mental health centers, and alcohol and drug abuse programs to the list of eligible employing institutions for the Nursing Student Loan Forgiveness Program; amending s. 381.026, F.S., relating to the Florida Patient's Bill of Rights and Responsibilities; providing a penalty; amending s. 381.0261, F.S., relating to the distribution of summaries of health care information; conforming provisions to changes made by the act; amending s. 381.0302, F.S.; providing additional membership in the Florida Health Services Corps; authorizing the Department of Health and Rehabilitative Services to provide certain financial assistance to students in additional medical programs; providing additional requirements for corps members; authorizing use of certain appropriated funds as federal matching funds; creating s. 381.0406, F.S., relating to rural health networks; providing legislative findings and intent; providing definitions; providing for organization, administration, and nonprofit corporate status; specifying services to be provided; requiring participation of certain trauma agencies; providing for public and private financing; providing for phased-in implementation; specifying responsibilities of the agency and the State Health Office relating to establishment and certification of rural health networks; providing for rules; creating s. 381.0407, F.S.; authorizing special consideration under the certificate-of-need program for certain rural regional hospital systems; authorizing rural regional hospital systems to establish tax districts that cross county boundaries; creating s. 381.0408, F.S.; providing for designation of rural health care innovation zones by the Agency for Health Care Administration; providing special consideration of certificate-of-need applicants located in rural health care innovation zones; authorizing the Department of Health and Rehabilitative Services to seek funding to support health care facilities and providers in rural health care innovation zones; amending s. 381.045, F.S., relating to procedures and services for certain health care professionals infected with hepatitis B or human immunodeficiency virus; amending s. 381.0602, F.S., relating to the Organ Transplant Advisory Council; amending and renumbering s. 381.0605, F.S., relating to a survey of state hospital facilities; amending ss. 381.6021, 381.6022, 381.6023, 381.6024, 381.6025, F.S., relating to organ and tissue procurement; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the agency; amending and renumbering s. 381.695, F.S., relating to certificate-of-need exemption for health care facilities within the Department of Corrections; amending and renumbering s. 381.698, F.S., relating to the Florida Blood Transfusion Act; amending ss. 383.302, 383.305, 383.307, 383.308, 383.309, 383.31, 383.312, 383.313, 383.318, 383.32, 383.324, 383.325, 383.327, 383.33, 383.331, 383.335, F.S., relating to regulation and licensure of birth centers; amending ss. 390.001, 390.002, 390.011, 390.012, 390.014, 390.015, 390.016, 390.017, 390.018, 390.019, 390.021, F.S., relating to termination of pregnancies; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; amending s. 395.1055, F.S.; providing for separate standards for statutory rural hospitals; amending s. 395.403, F.S.; conforming provisions to changes made by the act; creating s. 395.606, F.S., relating to rural health network cooperative agreements; providing legislative intent with respect to antitrust laws; specifying conditions under which health care providers who are members of rural health networks may consolidate services or enter into cooperative agreements; requiring approval and oversight by the agency; providing for administrative and judicial review; amending s. 408.001, F.S.; revising requirements for the bylaws of the board of directors of the Florida

Health Care Purchasing Cooperative; providing additional membership requirements for the board of directors; revising the membership of the board; conforming provisions to changes made by the act; amending s. 408.002, F.S., relating to the Florida Health Plan; amending s. 408.003, F.S., relating to appointment of the Health Care Board; providing for ethnic, geographic, and gender composition; providing for removal of members; providing for meetings, notice, and a quorum; providing for per diem and travel expenses; amending s. 408.01, F.S.; providing for a council advising the agency on health insurance and cost containment to include group health care purchasing organizations; amending s. 408.02, F.S.; revising requirements for the agency in establishing practice parameters; amending ss. 408.032, 408.033, 408.034, 408.035, 408.036, 408.037, 408.038, 408.039, 408.040, 408.041, 408.043, 408.044, 408.045, F.S., relating to certificate of need and authority to license health care facilities and health service providers; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services and the Health Care Board to the agency; providing an additional exemption from certificate-of-need review; providing for preference in certificate-of-need awards to rural health networks under certain conditions; amending s. 408.05, F.S., relating to the State Center for Health Statistics; amending s. 408.061, F.S., relating to health care data collection; providing additional data to be collected from health care facilities by the Agency for Health Care Administration; requiring nursing homes to submit to the agency audited actual experience and statistical profiles of nursing home residents; requiring the agency and the Department of Health and Rehabilitative Services to review the statistical profiles and include findings in the Florida Health Plan; requiring the agency to collect information on certain drugs and medical equipment and supplies; deleting a requirement with respect to the establishment of a health care data base; amending s. 408.062, F.S.; revising requirements of the Health Care Board in evaluating data from nursing home financial reports; amending s. 408.063, F.S.; requiring the agency to collect data on retail prices of certain drugs and medical equipment and supplies; requiring the agency to distribute brochures to pharmacies and retail sellers of medical equipment and supplies; amending s. 408.07, F.S.; redefining the term "banked points" for purposes of agency review of hospital budgets; amending ss. 408.072, 408.08, F.S.; modifying provisions relating to review of hospital budgets; amending s. 408.09, F.S., relating to assistance on cost containment strategies; clarifying provisions; amending s. 408.20, F.S.; conforming terminology relating to the name of a trust fund; creating s. 408.70, F.S.; providing legislative intent regarding the need to reform the state's health care delivery system; proposing the creation of managed competition throughout the state; proposing the creation of community health purchasing alliances; creating s. 408.701, F.S.; providing definitions; creating s. 408.702, F.S.; establishing community health purchasing alliance regions; providing for the merger of certain alliances; providing for alliance standards; providing for voluntary membership; providing duties, powers, and responsibilities; providing for membership fees; creating s. 408.703, F.S.; providing community health purchasing alliance membership requirements for small employers; creating s. 408.704, F.S.; providing agency responsibilities with respect to community health purchasing alliances; authorizing the agency to contract with alliances and provide startup funds; requiring an annual review; requiring alliances to submit certain data to the agency; establishing an advisory data committee and specifying membership; requiring a report to the Legislature; requiring the submission of data by health care providers; requiring the agency to adopt and implement recommendations of the advisory data committee; establishing an appeals process for grievances; exempting certain records from public disclosure requirements; providing for future legislative review of this exemption under the Open Government Sunset Review Act; creating s. 408.7045, F.S.; establishing community health purchasing alliance marketing requirements; creating s. 408.705, F.S.; providing for boards of directors for community health purchasing alliances; providing for membership, appointment, and terms; providing for staff; creating s. 408.706, F.S.; establishing standards for accountable health partnerships; providing for designation of accountable health partnerships by the agency; specifying standards and requirements; creating s. 408.90, F.S.; providing legislative findings and intent; creating s. 408.901, F.S.; providing definitions; creating s. 408.902, F.S.; creating the MedAccess program within the Agency for Health Care Administration; providing for a report; creating s. 408.903, F.S.; providing eligibility requirements; creating s. 408.904, F.S.; providing health care benefits; creating s. 408.905, F.S.; providing limitations and exclusions; creating s. 408.906, F.S.; providing for the payment of claims; creating s. 408.907, F.S.; providing for the collection of premiums; creating s. 408.908, F.S.; providing agency responsibilities for the administration of the MedAccess program; amending s. 409.335, F.S.; conforming provisions to changes made by the act; amending s. 409.701, F.S.; authorizing the Florida Health Access Corporation to provide subsidized or nonsubsidized coverage to small employers; expanding the program statewide; authorizing the corporation to serve businesses with fewer than a specified number of employees; changing the composition of the board of directors of the Florida Health Access Corporation; deleting a requirement that the Department of Insurance provide certain assistance to the corporation; amending s. 409.7015, F.S.; delaying the repeal of the corporation's access to certain data from the Department of Labor and Employment Security; amending ss. 409.901, 409.902, 409.903, 409.904, F.S.; conforming provisions and references to the transfer of responsibilities for the Medicaid program to the agency; amending s. 409.905, F.S.; providing for Medicaid nursing facility services for recipients in rural hospitals; amending ss. 409.906, 409.907, 409.910, F.S.; conforming provisions; amending s. 409.908, F.S.; revising the methodology for reimbursing providers for physician services under Medicaid; amending s. 409.911, F.S.; providing additional requirements for hospitals that receive distributions under the disproportionate share program; amending s. 409.9113, F.S.; providing an additional requirement for teaching hospitals that receive distributions under the disproportionate share program; amending ss. 409.9112, 409.9115, F.S., and s. 2, ch. 92-33, Laws of Florida; conforming provisions; creating s. 409.9116, F.S.; establishing a disproportionate share program for rural hospitals; providing requirements for rural hospitals that receive distributions under the program; amending s. 409.912, F.S.; providing for inclusion of health maintenance organizations and prepaid health plans in the agency's definition of a managed care provider; creating s. 409.9121, F.S.; providing legislative findings and intent; creating s. 409.9122, F.S.; providing for the expansion of the Medi-Pass program; directing the agency to encourage the enrollment of Medicaid recipients in managed care plans; providing for a study of the feasibility of managed care programs for Medicaid recipients with special needs; providing for funds for technical assistance in developing Medicaid prepaid health plans; requiring state agencies to provide access to managed health care providers to market their benefit plans in buildings owned, rented, or leased by the agencies; amending s. 409.913, F.S.; authorizing the agency to conduct certain investigations of Medicaid providers; providing circumstances under which the agency may withhold payments to a provider under the Medicaid program; providing for notice to the provider; providing that certain payments are due to the agency upon demand; amending ss. 409.914, 409.915, 409.916, 409.919, 409.920, 411.222, F.S.; conforming provisions; amending ss. 415.107, 415.51, F.S.; providing duties of the Agency for Health Care Administration with respect to the confidentiality of reports and records in cases of abuse, neglect, or exploitation of aged persons, disabled adults, and children; amending ss. 419.001, 419.002, F.S.; providing duties of the agency with respect to the regulation of community residential homes; amending s. 440.102, F.S., relating to requirements for the drug-free workplace program; conforming provisions to the transfer of certain duties and functions to the agency; amending ss. 455.201, 455.203, 455.205, 455.207, 455.208, 455.209, 455.211, F.S.; conforming provisions to changes made by the act; amending s. 43, ch. 92-33, Laws of Florida, relating to license renewal for certain medical professions; delaying the repeal of s. 455.213(6) and (7), F.S.; amending ss. 44 and 46, ch. 92-33, Laws of Florida, delaying the creation of ss. 455.2141, 455.2173, F.S., relating to duties of the Agency for Health Care Administration with respect to licensing; amending ss. 455.2175, 455.218, F.S.; conforming provisions to changes made by the act; revising licensure requirements for certain foreign-trained professionals; amending ss. 49 and 50, ch. 92-33, Laws of Florida, delaying the creation of ss. 455.220, 455.2205, F.S., relating to the Health Care Trust Fund; amending ss. 455.221, 455.223, 455.224, 455.225, 455.227, 455.2273, 455.2275, 455.228, 455.2285, 455.229, 455.232, 455.241, 455.243, 455.245, 455.26, F.S.; conforming provisions to changes made by the act; amending s. 455.25, F.S.; providing exceptions to the prohibition against an entity's providing items or services to a patient without making a specified written disclosure of certain financial relationships and fees and other matters; amending s. 464.009, F.S.; revising the requirements for applicants for licensure as a professional or practical nurse with respect to licensure by endorsement; amending ss. 483.610, 483.613, 483.614, 483.615, 483.616, 483.619, 483.620, 483.621, 483.622, 483.624, F.S., relating to the Cholesterol Screening Center Licensure Act; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the agency; amending s. 624.91, F.S.; increasing the membership of the board of directors of the Florida Healthy Kids Corporation; transferring the Florida Healthy Kids Trust Fund to the Agency for Health Care Administration; amending s. 626.9545, F.S.; requiring insurers to establish a financial incentive program for policy holders to report errors or over-

charges; amending s. 627.613, F.S.; increasing the amount an insurer must pay to an insured for reporting improper billings that result in a reduction in the amount paid to a provider; amending ss. 641.21, 641.225, F.S.; conforming cross-references to changes made by the act; amending ss. 641.47, 641.48, 641.49, 641.495, 641.511, 641.512, 641.515, 641.52, 641.54, 641.55, 641.56, 641.57, 641.58, F.S., relating to health maintenance organizations and prepaid health clinics; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the agency; providing an exemption from the health maintenance organization and prepaid health clinic regulatory assessment; amending s. 651.118, F.S.; transferring responsibilities of the Department of Health and Rehabilitative Services with respect to certificates of need for sheltered beds and community beds to the Agency for Health Care Administration; amending s. 743.0645, F.S.; providing for consent for medical care of a minor in a facility licensed by the agency; amending s. 766.1115, F.S.; expanding the definition of the term "health care provider" under the Access to Health Care Act; amending s. 768.28, F.S.; conforming a cross-reference to changes made by the act; amending s. 15, ch. 91-178, Laws of Florida; revising the date that the prohibition against referrals by certain investors in designated health services applies; amending s. 627.410, F.S.; providing for filing certificates for certain groups for information purposes; amending s. 627.4106, F.S.; revising a definition; amending s. 627.6699, F.S.; providing definitions; requiring guarantee issue of all health plans to small employers; requiring modified community rating of health plans issued to small employers; revising definition of small employer; revising preexisting conditions requirements for certain groups; requiring Department of Insurance specification of geographic regions for rating purposes; providing for guaranteed renewability of small group health plans; requiring carriers to maintain records; providing confidentiality; providing for review and repeal; providing for revisions in the standard and basic health benefit plans; requiring the reinsurance board to report complaints of abuse and misrepresentation to the Department of Insurance; providing for alliance membership on the health benefit plan committee; amending s. 641.30, F.S.; specifying applicability for certain health maintenance organization contracts; requiring the Agency for Health Care Administration to develop a standardized claims form and an electronic claims format; requiring health care payers, insurers, and providers to use such claims form or claims format by a specified date; requiring the agency to develop an electronic medical information and billing system; providing for a pilot project; providing circumstances under which a participant in a health care program may use an alternate provider for the purpose of providing prescribed medicine services; requiring the agency to form a work group to examine licensing and training issues with respect to rural hospitals and health care professional shortages; providing membership of the work group; requiring the agency to establish an Interagency Work Group on Health Care Fraud and Abuse; providing for membership and duties; requiring a report; requiring the agency to conduct an assessment and a participation study of community health purchasing alliances; requiring the agency, in consultation with the Department of Legal Affairs, to assess the effects of antitrust laws on community health purchasing alliances and accountable health partnerships; requiring the agency to develop and implement a UB-92 based system; requiring the Governor to establish an interagency task force to study the most appropriate structure of governmental agencies for the delivery of health care and children's services; requiring a report; providing appropriations; repealing s. 409.9114, F.S., relating to the extraordinary disproportionate share program; repealing s. 407.60, F.S., relating to the Health Care Cost Containment Board; repealing s. 3, ch. 92-304, F.S., relating to directions for preparing a reviser's bill; repealing s. 455.238, F.S., relating to markup provisions; repealing s. 627.4106, F.S., relating to small group health insurance; providing effective dates.

—was read the second time by title.

Senators Gutman and Holzendorf offered the following amendment which was moved by Senator Gutman and failed:

Amendment 1 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Section 33 of chapter 92-33, Laws of Florida, is repealed.

Section 2. Section 20.30, Florida Statutes, 1992 Supplement, as amended by section 32 of chapter 92-33, Laws of Florida, section 35 of chapter 92-58, Laws of Florida, sections 1, 72, and 159 of chapter 92-149, Laws of Florida, and sections 1 and 2 of chapter 92-292, Laws of Florida is amended to read:

20.30 Department of Professional Regulation.—There is created a Department of Professional Regulation.

(1) The head of the Department of Professional Regulation is the Secretary of Professional Regulation. The secretary shall be appointed by the Governor subject to confirmation by the Senate. The secretary shall serve at the pleasure of the Governor.

(2) The following divisions of the Department of Professional Regulation are established:

(a) Division of Technology, Testing and Training.

(b) Division of Professions.

(c) Division of Medical Quality Assurance.

1. The director of the division shall be appointed by the Secretary of Professional Regulation.

2. The division shall concentrate sufficient resources and efforts on the investigation and discipline of health care practitioners regulated by the department who are in violation of the unprofessional conduct provisions of the applicable practice acts and other provisions of law, as are necessary to meet the challenge of identifying those health care practitioners who are not providing adequate medical care in order to take forceful corrective measures to assure quality medical care throughout the state.

3. The division shall coordinate closely with the Agency for Health Care Administration to ensure that the state's regulation of health care facilities and the health care practitioners who practice therein is consistent and offers adequate protection to the public.

4. The division shall establish and maintain a disciplinary training program for division staff and board members designed to ensure the proper and appropriate administration of medical quality assurance. The program shall provide for initial and periodic training in the grounds for disciplinary action, the actions which may be taken, changes in any relevant law, sanctions which are most appropriate for specified types of unprofessional conduct, guidelines for the conduct of hearings, and any other matters which the division shall determine may be necessary or useful.

(d)~~(c)~~ Division of Real Estate.

1. The director of the division shall be appointed by the Secretary of Professional Regulation, subject to approval by a majority of the Florida Real Estate Commission.

2. The offices of the Division of Real Estate shall be located in Orlando.

(e)~~(d)~~ Division of Regulation.

(f)~~(e)~~ Division of Administration.

(g)~~(f)~~ Division of Certified Public Accounting.

1. The director of the division shall be appointed by the Secretary of Professional Regulation, subject to approval by a majority of the Board of Accountancy.

2. The offices of the division shall be located in Gainesville.

(3) There shall be a director for each division established within this section. Each division director shall directly administer the division and shall be responsible to the secretary of the department. The secretary of the department may appoint assistant secretaries as necessary to fulfill the secretary's statutory obligations.

(4) The following boards are established within the Department of Professional Regulation, Division of Professions:

(a) Board of Architecture and Interior Design, created under part I of chapter 481.

(b) Board of Auctioneers, created under part VI of chapter 468.

(c) Barbers' Board, created under chapter 476.

(d) Construction Industry Licensing Board, created under part I of chapter 489

(e) Board of Cosmetology, created under chapter 477.

(f) Electrical Contractors' Licensing Board, created under part II of chapter 489.

(g) Board of Professional Engineers, created under chapter 471.

(h) Board of Funeral Directors and Embalmers, created under chapter 470.

(i) Board of Professional Geologists, created under chapter 492.

(j) Board of Hearing Aid Specialists, created under part II of chapter 484.

(k) Board of Professional Land Surveyors, created under chapter 472.

(l) Board of Landscape Architecture, created under part II of chapter 481.

(m) Board of Massage, created under chapter 480.

(n) Board of Nursing Home Administrators, created under part II of chapter 468.

(o) Board of Opticianry, created under part I of chapter 484.

(p)~~(n)~~ Board of Pilot Commissioners, created under chapter 310.

(q)~~(o)~~ Board of Employee Leasing Companies, created under part XI of chapter 468.

~~(p) Board of Veterinary Medicine, created under chapter 474.~~

(5) The following boards are established within the Department of Professional Regulation, Division of Medical Quality Assurance:

(a) Board of Medicine, created under chapter 458.

(b) Board of Osteopathic Medicine, created under chapter 459.

(c) Board of Acupuncture, created under chapter 457

(d) Board of Chiropractic, created under chapter 460

(e) Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

(f) Board of Dentistry, created under chapter 466.

(g) Board of Nursing, created under chapter 464.

(h) Board of Optometry, created under chapter 463.

(i) Board of Pharmacy, created under chapter 465.

(j) Board of Physical Therapy Practice, created under chapter 486.

(k) Board of Podiatric Medicine, created under chapter 461.

(l) Board of Psychological Examiners, created under chapter 490.

(m) Board of Veterinary Medicine, created under chapter 474.

(n) Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

(o) Board of Clinical Laboratory Personnel, created by s. 483.805.

(6)~~(5)~~ The following board and commission are established within the Department of Professional Regulation, Division of Real Estate:

(a) Florida Real Estate Commission, created under part I of chapter 475.

(b) Florida Real Estate Appraisal Board, created under part II of chapter 475.

(7)~~(6)~~ The following board is established within the Department of Professional Regulation, Division of Certified Public Accounting.

(a) Board of Accountancy, created under chapter 473.

(8)~~(7)~~ The members of each board established pursuant to subsections (4), (5), ~~and~~ (6), *and (7)* shall be appointed by the Governor, subject to confirmation by the Senate. Consumer members on the board shall be appointed pursuant to subsection *(9)* ~~(8)~~. Members shall be appointed for 4-year terms, and such terms shall expire on October 31. However, a term of less than 4 years may be utilized to ensure the following:

(a) No more than two members' terms shall expire during the same calendar year for boards consisting of seven or eight members.

(b) No more than three members' terms shall expire during the same calendar year for boards consisting of nine to twelve members.

(c) No more than five members' terms shall expire during the same calendar year for boards consisting of thirteen or more members.

(d) A member whose term has expired shall continue to serve on the board until such time as a replacement is appointed.

A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment. No member shall serve for more than the remaining portion of a previous member's unexpired term, plus two consecutive 4-year terms of the member's own appointment thereafter.

(9)~~(8)~~ Each board with five or more members shall have at least two consumer members who are not, and have never been, members or practitioners of the profession regulated by *the* ~~such~~ board or of any closely related profession. Each board with fewer than five members shall have at least one consumer member who is not, and has never been, a member or practitioner of the profession regulated by *the* ~~such~~ board or of any closely related profession.

(10)~~(9)~~ No board, with the exception of joint coordinatorships, shall be transferred from its present location unless authorized by the Legislature in the General Appropriations Act.

(11)~~(10)~~ It is legislative intent that all newly regulated professions, and all professions newly regulated under the department, shall be regulated directly under the department unless a compelling need for the existence of a board is documented. In an instance where a board is statutorily established, the department shall not create the board for a minimum of 1 full year after statutory authority regulating a profession becomes effective, and the profession shall initially be directly regulated by the department. Prior to implementing a new board or council, the department shall seek and receive specific legislative authorization. Such recommendation to establish a new board or council shall be included in the department's annual report to the Legislature required by s. 455.2285.

Section 3. Section 20.42, Florida Statutes, 1992 Supplement, is amended to read:

20.42 Agency for Health Care Administration.—There is created the Agency for Health Care Administration within the Department of Professional Regulation. The agency shall be a separate budget entity, and the director of the agency shall be the agency head for all purposes. The agency shall not be subject to control, supervision, or direction by the Department of Professional Regulation in any manner, including, but not limited to, personnel, purchasing, transactions involving real or personal property, and budgetary matters.

(1) DIRECTOR OF HEALTH CARE ADMINISTRATION.—The head of the agency is the Director of Health Care Administration, who shall be appointed by the Governor. The director shall serve at the pleasure of and report to the Governor.

(2) ORGANIZATION OF THE AGENCY.—The agency shall be organized as follows:

(a) ~~Effective July 1, 1993,~~ The Division of Health Quality Assurance, which shall be responsible for *health care:* facility licensure and inspection.~~;~~

(b) The Health Care Advisory Commission, composed of the chairpersons of: ~~certificate of need;~~ the Board of Medicine, created under chapter 458; the Board of Osteopathic Medicine, created under chapter 459; the Board of Acupuncture, created under chapter 457; the Board of Chiropractic, created under chapter 460; the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491; the Board of Dentistry, created under chapter 466; the Board of Optometry, created under chapter 463; the Board of Pharmacy, created under chapter 465; the Board of Podiatric Medicine, created under chapter 461; the Board of Nursing, created under chapter 464; the Board of Psychological Examiners, created under chapter 490; the Board of Speech-Language Pathology and Audiology, created under chapter 468; the Board of Nursing Home Administrators, created under part II of chapter 468; *the Board of* ~~occupational therapy, as regulated~~

~~*under part III of chapter 468; respiratory therapy, as regulated under part V of chapter 468;*~~ *Physical Therapy, created* ~~as regulated~~ under chapter 486; *the Board of Clinical Laboratory Personnel, created under part IV of chapter 483;* and the Board of Opticianry, created under part I of chapter 484. *The director is chairman of the commission.*

1. The commission shall review and evaluate any legislation or rules proposed by any board represented on the commission which may directly affect more than one board, and make recommendations to the Secretary of Professional Regulation, the Governor, and the Legislature regarding such proposed legislation or rules. The commission shall also make recommendations to the Health Care Board, as requested by the director or the Health Care Board, regarding hospital budget review, nursing home financial review, and special studies conducted by the Health Care Board or the agency. !mt2. *The commission shall annually prepare and submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report stating its findings and making specific programmatic recommendations it deems appropriate. The reports shall be submitted no later than December 31 of each year, beginning December 31, 1994.*

3. The commission shall meet at least once each quarter. The members of the commission are entitled to reimbursement for all necessary expenses in the performance of their duties, including travel expenses, in accordance with s. 112.061.

4. The agency, the Department of Professional Regulation, and all boards represented on the commission shall supply information, assistance, and facilities as the commission deems necessary for it to carry out its duties under this section, and shall provide staff assistance necessary for the performance of required clerical and administrative functions of the commission.

(c)~~(b)~~ The Division of Health Policy and *Cost Control* ~~Planning~~, which shall be responsible for *health policy,* the State Center for Health Statistics, the development of The Florida Health Plan, *state and local health planning under s. 408.033, certificate-of-need review, hospital budget review,* and research and analysis.

(d)~~(c) Effective July 1, 1993,~~ The Division of State Health Purchasing, which shall be responsible for *the Medicaid program* ~~supervising the purchase of health care by: Medicaid; the Florida Health Access Program; the Pooled Purchasing Cooperative;~~ and *the* state employee health insurance *program, including functions related to: the selection of the entity that administers the state employee health insurance plan; the development of the plan's benefit design; the establishment of the plan's cost sharing and cost containment requirements; the creation and maintenance of administrative cost controls; the collection and analysis of data; and the monitoring and evaluation of the administrator and provider network performance. The division shall also administer the contracts with the Florida Health Access Corporation, the Florida Health Care Purchasing Cooperative, and the Florida Healthy Kids Corporation.*

(e)~~(d)~~ The Health Care Board, which shall be responsible for hospital budget review, nursing home financial analysis, and special studies as assigned by the *director* ~~secretary~~ or the Legislature.

(f)~~(e)~~ The Division of Administrative Services, which shall be responsible for revenue management, budget, personnel, *management information services,* and general services.

(3) *DIVISION* ~~DEPUTY~~ DIRECTOR FOR HEALTH QUALITY ASSURANCE.—The director shall appoint a *Division* ~~Deputy~~ Director for Health Quality Assurance who shall serve at the pleasure of, and be directly responsible to, the director. The *Division* ~~Deputy~~ Director for Health Quality Assurance shall be responsible for the Division of Health Quality Assurance.

(4) *DIVISION* ~~DEPUTY~~ DIRECTOR FOR HEALTH POLICY AND *COST CONTROL* ~~PLANNING~~.—The director shall appoint a *Division* ~~Deputy~~ Director for Health Policy and *Cost Control* ~~Planning~~ who shall serve at the pleasure of, and be directly responsible to, the director. The *Division* ~~Deputy~~ Director for Health Policy and *Cost Control* ~~Planning~~ shall be responsible for the Division of Health Policy and *Cost Control* ~~Planning and the Division of State Health Purchasing~~.

(5) DIVISION DIRECTOR FOR STATE HEALTH PURCHASING.—The director shall appoint a Division Director for State Health Purchasing who shall serve at the pleasure of, and be directly responsible to, the director. The Division Director for State Health Purchasing shall be responsible for the Division of State Health Purchasing.

(6)~~(5)~~ HEALTH CARE BOARD.—The Health Care Board shall be composed of 11 members appointed by the Governor, subject to confirmation by the Senate. The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall be responsible for hospital budget review, nursing home financial review and analysis, and special studies requested by ~~the Governor,~~ the Legislature~~,~~ or the director.

(7)~~(6)~~ *DIVISION* ~~DEPUTY~~ DIRECTOR *FOR* ~~OF~~ ADMINISTRATIVE SERVICES.—The director shall appoint a *Division* ~~Deputy~~ Director of Administrative Services who shall serve at the pleasure of, and be directly responsible to, the director. The *Division* ~~deputy~~ Director *for Administrative Services is* ~~shall be~~ responsible for the Division of Administrative Services.

Section 4. Effective July 1, 1993, subsections (3) and (5) of section 110.123, Florida Statutes, 1992 Supplement, are amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(a) It is the intent of the Legislature to offer a comprehensive package of health insurance benefits for state employees which are provided in a cost-efficient and prudent manner, and to allow state employees the option to choose benefit plans which best suit their individual needs. Therefore, the state group insurance program is established which may include the state group health insurance plan, health maintenance organization plans, group life insurance plans, group accidental death and dismemberment plans, and group disability insurance plans. Furthermore, the department is additionally authorized to establish and provide as part of the state group insurance program any other group insurance plans which are consistent with the provisions of this section.

(b) Notwithstanding any provision in this section to the contrary, it is the intent of the Legislature that the Agency for Health Care Administration shall be responsible for all aspects of the purchase of health care for state employees under the state group health insurance plan and the health maintenance organizations plans. Responsibilities shall include, but not be limited to, the development of requests for proposals for state employee health services, the determination of health care benefits to be provided, and the negotiation of contracts for health care and health care administrative services. Prior to the negotiation of contracts for health care services, the Legislature intends that the Agency for Health Care Administration shall develop, in consultation with the Department of Management Services with respect to state collective bargaining issues, the health benefits and terms to be included in the state group health insurance program. The Agency for Health Care Administration shall adopt rules necessary to perform its responsibilities pursuant to this section. It is the intent of the Legislature that the Department of Management Services shall be responsible for the contract management and day-to-day management of the state employee health insurance program, including, but not limited to, employee enrollment, premium collection, payment to health care providers and other administrative functions related to the program.

(c)~~(b)~~ Except as provided for in subparagraph (d)2., the percentage of state contribution toward the cost of any plan in the state group insurance program shall be uniform with respect to all state employees in state collective bargaining units participating in the same plan or any similar plan. Nothing contained within this section prohibits the development of separate benefit plans for officers and employees exempt from collective bargaining or the development of separate benefit plans for each collective bargaining unit.

(d)~~(c)~~1. Participation by individuals in the program shall be available to all state officers, full-time state employees, and part-time state employees; and such participation in the program or any plan thereof shall be voluntary. Participation in the program shall also be available to retired state officers and employees who elect at the time of retirement to continue coverage under the program, but they may elect to continue all or only part of the coverage they had at the time of retirement. A surviving spouse may elect to continue coverage only under the state group health insurance plan or a health maintenance organization plan.

2. Notwithstanding any previous rejection or cancellation of participation in any group insurance plan or self-insurance plan provided under this section, participation in the insurance plan shall be offered beginning September 1, 1991, to all former employees who retired before September 1, 1991, and to the eligible dependents of these former employees. An

employer who provides insurance under this section shall, before September 1, 1991, notify his previously retired former employees and their eligible dependents, in writing, of their eligibility to participate in the group insurance plan or self-insurance plan as provided in this section. The employees and their eligible dependents shall have until October 31, 1991, to accept or reject, in writing, participation in their former employer's group insurance plan or self-insurance plan.

(e)~~(d)~~1. A person eligible to participate in the state group health insurance plan may be authorized by rules *approved by the Agency for Health Care Administration and* adopted by the department, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. *Subject to the approval of and supervision by the Agency for Health Care Administration,* the department shall contract with health maintenance organizations to participate in the state group insurance program through a request for proposal based upon a premium and a minimum benefit package as follows:

a. ~~The department shall establish~~ A minimum benefit package to be provided by a participating HMO ~~which~~ shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO.

b. ~~The department may establish~~ A uniform schedule for deductibles and copayments *may be established* for all participating HMOs.

c. Based upon the minimum benefit package and copayments and deductibles contained in sub-subparagraphs a. and b., the *Agency for Health Care Administration* ~~department~~ shall issue a request for proposal for all HMOs which are interested in participating in the state group insurance program. Upon receipt of all proposals, the *Agency for Health Care Administration* ~~department~~ may, as it deems appropriate, enter into contract negotiations with HMOs submitting bids. As part of the request for proposal process, the *Agency for Health Care Administration* ~~department~~ may require detailed financial data from each HMO which participates in the bidding process for the purpose of determining the financial stability of the HMO.

d. In determining which HMOs to contract with, the *Agency for Health Care Administration may* ~~department shall~~, at a minimum, consider: each proposed contractor's previous experience and expertise in providing prepaid health benefits; each proposed contractor's historical experience in enrolling and providing health care services to participants in the state group insurance program; the cost of the premiums; the plan's ability to adequately provide service coverage and administrative support services as determined by the *Agency for Health Care Administration* ~~department~~; plan benefits in addition to the minimum benefit package; accessibility to providers; and the financial solvency of the plan. Nothing shall preclude the *Agency for Health Care Administration* ~~department~~ from negotiating regional or statewide contracts with health maintenance organization plans when this is cost-effective and when the *Agency for Health Care Administration* ~~department~~ determines the plan has the best overall benefit package for the service areas involved. However, no HMO shall be eligible for a contract if the HMO's retiree Medicare premium exceeds the retiree rate as set by the department for the state group health insurance plan.

e. The department, *subject to the review and approval of the Agency for Health Care Administration,* may limit the number of HMOs that it contracts with in each service area based on the nature of the *proposals the Agency for Health Care Administration* ~~bids it~~ receives, the number of state employees in the service area, and any unique geographical characteristics of the service area. The department, *subject to the review and approval of the Agency for Health Care Administration,* shall establish by rule service areas throughout the state.

f. All persons participating in the state group insurance program who are required to contribute towards a total state group health premium shall be subject to the same dollar contribution regardless of whether the enrollee enrolls in the state group health insurance plan or in an HMO plan.

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

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

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

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

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

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

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

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

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

6. Any HMO participating in the state group insurance program shall, upon the request of the *Agency for Health Care Administration* ~~department~~, submit to the *Agency for Health Care Administration* ~~department~~ standardized data for the purpose of comparison of the appropriateness, quality, and efficiency of care provided by the HMO. Such standardized data shall include: membership profiles; inpatient and outpatient utilization by age and sex, type of service, provider type, and facility; and emergency care experience. Requirements and timetables for submission of such standardized data and such other data as the *Agency for Health Care Administration* ~~department~~ deems necessary to evaluate the performance of participating HMOs shall be promulgated by rule.

7. The department shall, after consultation with *the Agency for Health Care Administration and* representatives from each of the unions representing state and university employees, establish a comprehensive package of insurance benefits including, but not limited to, supplemental health and life coverage, dental care, and vision care to allow state employees the option to choose the benefit plans which best suit their individual needs.

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

5,500 or more state employees currently enrolled may be included by the department in the supplemental insurance benefit plan established by the department *or the Agency for Health Care Administration* without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans.

b. Pursuant to the applicable provisions of s. 110.161, and s. 125 of the Internal Revenue Code of 1986, the department shall enroll in the pretax benefit program those state employees who voluntarily elect coverage in any of the supplemental insurance benefit plans as provided by sub-subparagraph a., *and such plans shall not be available on a post-tax, payroll-deduction basis.*

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans, *except those supplemental insurance benefit plans included in sub-subparagraphs a. and b.*

(f)~~(e)~~ The benefits of the insurance authorized by this section shall not be in lieu of any benefits payable under chapter 440, the Workers' Compensation Law. The insurance authorized by this law shall not be deemed to constitute insurance to secure workers' compensation benefits as required by chapter 440.

(5) DEPARTMENT OF MANAGEMENT SERVICES; POWERS AND DUTIES.—The Department of Management Services is responsible for the administration of the state group insurance program. The department shall initiate and supervise the program as established by this section and shall adopt such rules as are necessary to perform its responsibilities. To implement this program, the department shall, with prior ~~legislative~~ approval *by the Legislature and, for state employee health insurance, by the Agency for Health Care Administration*:

(a) Determine the benefits to be provided and the contributions to be required for the state group insurance program. Such determinations, whether for a contracted plan or a self-insurance plan pursuant to paragraph (c), do not constitute rules within the meaning of s. 120.52(16) or orders within the meaning of s. 120.52(11). Any physician's fee schedule used in the health and accident plan shall not be available for inspection or copying by medical providers or other persons not involved in the administration of the program. However, in the determination of the design of the program, the department *or the Agency for Health Care Administration* shall consider existing and complementary benefits provided by the Florida Retirement System and the Social Security System.

(b) Prepare, in cooperation with the Department of Insurance *and the Agency for Health Care Administration*, the specifications necessary to implement the program.

(c) Contract on a competitive proposal basis with an insurance carrier or carriers, or professional administrator, determined by the Department of Insurance to be fully qualified, financially sound, and capable of meeting all servicing requirements. Alternatively, the Department of Management Services may self-insure any plan or plans contained in the state group insurance program subject to approval based on actuarial soundness by the Department of Insurance. The department may contract with an insurance company or professional administrator qualified and approved by the Department of Insurance to administer such plan. Before entering into any contract, the Department of Management Services *or, for state employee health insurance, the Agency for Health Care Administration* shall advertise for competitive proposals, and such contract shall be let upon the consideration of the benefits provided in relationship to the cost of such benefits. The department, *subject to the review and approval of the Agency for Health Care Administration,* may contract for medical services which will improve the health or reduce medical costs for employees who participate in the state group insurance plan.

(d) With respect to the state group health insurance plan, be authorized, *subject to the review and approval of the Agency for Health Care Administration,* to require copayments with respect to all providers under the plan.

(e) Have authority to establish, *subject to the review and approval of the Agency for Health Care Administration,* a voluntary program for comprehensive health maintenance, which may include health educational components and health appraisals.

Final decisions concerning the existence of coverage or benefits under the state group health insurance plan shall not be delegated or deemed to have been delegated by the department, *except that such decisions shall be subject to the review and approval of the Agency for Health Care Administration.*

Section 5. Effective July 1, 1993, the powers, duties and functions, records, property, and unexpended allocations of funds associated with seven career service positions, including $434,379 from the State Employee Health Trust Fund in the State Employees Health Insurance Program shall be transferred from the Division of State Health Purchasing of the Agency for Management Services by a type four transfer, as defined in section 20.06(4), Florida Statutes, to the Division of State Health Purchasing of the Agency for Health Care Administration. The seven positions include two benefit analysts and one secretary specialist from the benefits programs section and one administrator, one secretary specialist, and two auditors from the state benefits audit section. Any employee who is transferred pursuant to this section may be suspended or dismissed only after a clear and convincing finding of cause pursuant to section 110.227, Florida Statutes.

Section 6. All powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Medicaid program within the Department of Health and Rehabilitative Services, as well as the infrastructure and support services that support the program, including, but not limited to, investigative, licensing, legal, and administrative activities, are transferred by a type four transfer, as defined in section 20.06(4), Florida Statutes, to the Division of State Health Purchasing of the Agency for Health Care Administration. Administrative infrastructure associated with finance and accounting, personnel, budget and general services shall also be transferred to the department and shall include at a minimum: 41 full time career service positions, one select exempt position and, $870,261 from general revenue funds to be used as a fifty/fifty match for the federal Medicaid financial participation. Such transfer shall take effect July 1, 1993 Any rules promulgated by or for the Medicaid program are included in such transfer.

Section 7. Effective July 1, 1993, paragraph (b) of subsection (4), and paragraph (f) of subsection (11) of section 20.19, Florida Statutes, 1992 Supplement, are amended to read:

20.19 Department of Health and Rehabilitative Services.—There is created a Department of Health and Rehabilitative Services.

(4) DEPUTY SECRETARY FOR HUMAN SERVICES.—The secretary shall appoint a Deputy Secretary for Human Services who serves at the pleasure of, and is directly responsible to, the secretary. The secretary shall appoint an Assistant Deputy Secretary for Human Services who serves at the pleasure of the secretary and is directly responsible to the Deputy Secretary for Human Services.

(b)1. Program offices operate in a staff capacity to the Deputy Secretary for Human Services. Each program office is headed by an assistant secretary who is appointed by, and serves at the pleasure of, the secretary and is directly responsible to the Deputy Secretary for Human Services. The Assistant Secretary for Children's Medical Services is responsible for all programs, activities, and functions of the department relating to all children's medical services programs operated by the department. The Assistant Secretary for Children's Medical Services must be a physician licensed under chapter 458 or chapter 459, and must have specialized training and experience in child health as defined in s. 391.051. The Assistant Secretary for Delinquency Services is responsible for all programs, activities, and functions of the department relating to all delinquency services operated by the department. The secretary shall appoint a Deputy Assistant Secretary for Alcohol and Drug Abuse and a Deputy Assistant Secretary for Mental Health, who both report directly to the Assistant Secretary for Alcohol, Drug Abuse, and Mental Health. The Deputy Secretary for Human Services shall delegate to the program offices the following responsibilities, which include, but are not limited to:

a. Establishment of program standards and performance objectives.

b. Development of program policies and rules, and provision of policy interpretations in order to achieve statewide consistency.

c. The review and monitoring of programs and the provision of technical assistance to programs in order to ensure compliance and accountability with statewide program standards, performance objectives, and state and federal laws, rules, and regulations.

d. Outcome evaluation and program effectiveness.

e. Development of staffing and workload standards.

f. Development of budget and resource allocation methodologies and strategies.

g. Compilation of reports, analyses, and assessments of client needs and services on a statewide basis.

h. Staff development and training.

i. General statewide supervision of the administration of service programs.

j. Any other program planning and development duties assigned by the secretary.

2. The following program offices are established and may be consolidated, restructured, or rearranged by the secretary; provided any such consolidation, restructuring, or rearranging is for the purpose of encouraging service integration through more effective and efficient performance of the program offices or parts thereof:

a. Child Support Enforcement Program Office.—The responsibilities of this program office encompass the administration of the child support enforcement program established in Title IV-D of the Social Security Act, 42 U.S.C. s. 1302, in accordance with the provisions of ss. 409.2551-409.2597.

b. Children's Medical Services Program Office.—The responsibilities of this office encompass all children's medical services programs operated by the department.

c. Economic Services Program Office.—The responsibilities of this office encompass all income support programs within the department, such as aid to families with dependent children (AFDC), food stamps, and state supplementation of the supplemental security income (SSI) program.

d. Developmental Services Program Office.—The responsibilities of this office encompass programs operated by the department for developmentally disabled persons. Developmental disabilities include any disability defined in s. 393.063.

~~e. Medicaid Program Office.—The responsibilities of this office include planning and development of policies and programs, program and provider monitoring, provider relations, interprogram planning, and program surveillance and utilization review.~~

e.~~f.~~ Aging and Adult Services Program Office.—The responsibilities of this office encompass all aging and adult programs operated by the department, including SSI-related program eligibility determinations.

f.~~g.~~ Children and Families Program Office.—The responsibilities of this program office encompass intake services for families-in-need-of-services and children-in-need-of-services programs; protective investigation services for abandoned, abused, and neglected children; interstate compact on the placement of children programs; children's protective services; adoption; child care; foster care programs; specialized services to families; and programs serving children through the Menninger Foundation, including the CHARLEE Program.

g.~~h.~~ Alcohol, Drug Abuse, and Mental Health Program Office.—The responsibilities of this office encompass all alcohol, drug abuse, and mental health programs operated by the department. In addition, the responsibility for adult forensic programs and children's mental health programs and services, except programs serving children through the Menninger Foundation, including the CHARLEE Program, the Eckerd Family Youth Alternatives, Inc., and the Elaine Gordon Treatment Center, shall be located within this office.

h.~~i.~~ Delinquency Services Program Office.—The responsibilities of this office encompass all delinquency programs and services operated by the department, including, but not limited to, programs serving children through the Eckerd Family Youth Alternatives, Inc.; and the Elaine Gordon Treatment Center.

3. State institutions, other than health institutions, are managed as components of related continuums of care. To that end, it is the intent of the Legislature that institutional resources and community-based resources be managed in a coordinated and flexible manner to facilitate maximum development of community-based continuums of care and minimum use of institutional services. Further, it is the intent of the Legislature that budget management of state institutions include mechanisms to transfer institutional funds to service districts in order to successfully reduce the use by the district of its share of institutional resources. Each civil mental health and developmental services institution must have an advisory board that includes representatives selected by each district served by that institution. The advisory board shall assist in policy development, participate in the institution's quality assurance process, and coordinate the delivery of services provided by the community and the institution.

(11) DEPARTMENTAL BUDGET.—

(f)1. The use of unit cost data as the basis for the department's budget is phased in beginning during the 1991-1992 fiscal year and shall be completed by the 1996-1997 fiscal year.

2. The programs of the department shall begin using this budget process on the following timetable:

a. Fiscal year 1991-1992: Alcohol, drug abuse, and mental health programs and developmental services programs.

b. Fiscal year 1992-1993: Economic services programs and aging and adult services programs.

c. Fiscal year 1993-1994: ~~Medicaid programs and~~ Children's medical services programs.

d. Fiscal year 1994-1995: Children, youth, and families programs, health programs, and all other programs.

3. For the first 2 years after each program begins using this budget process, subparagraph (e)3. does not apply to the program.

Section 8. Paragraph (c) of subsection (5), paragraph (b) of subsection (6), paragraphs (f), (h), and (q) of subsection (8), paragraph (c) of subsection (9), paragraphs (a) and (c) of subsection (12), paragraph (a) of subsection (13), and subsection (17) of section 112.0455, Florida Statutes, 1992 Supplement, are amended to read:

112.0455 Drug-Free Workplace Act.—

(5) DEFINITIONS.—Except where the context otherwise requires, as used in this act:

(c) "Initial drug test" means a sensitive, rapid, and reliable procedure to identify negative and presumptive positive specimens. All initial tests shall use an immunoassay procedure or an equivalent, or shall use a more accurate scientifically accepted method approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ as such more accurate technology becomes available in a cost-effective form.

(6) NOTICE TO EMPLOYEES.—

(b) Prior to testing, all employees and job applicants for employment shall be given a written policy statement from the employer which contains:

1. A general statement of the employer's policy on employee drug use, which shall identify:

a. The types of testing an employee or job applicant may be required to submit to, including reasonable suspicion or other basis; and

b. The actions the employer may take against an employee or job applicant on the basis of a positive confirmed drug test result.

2. A statement advising the employee or job applicant of the existence of this section.

3. A general statement concerning confidentiality.

4. Procedures for employees and job applicants to confidentially report the use of prescription or nonprescription medications both before and after being tested. Additionally, employees and job applicants shall receive notice of the most common medications by brand name or common name, as applicable, as well as by chemical name, which may alter or affect a drug test. A list of such medications shall be developed by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~.

5. The consequences of refusing to submit to a drug test.

6. Names, addresses, and telephone numbers of employee assistance programs and local alcohol and drug rehabilitation programs.

7. A statement that an employee or job applicant who receives a positive confirmed drug test result may contest or explain the result to the employer within 5 working days after written notification of the positive test result. If an employee or job applicant's explanation or challenge is unsatisfactory to the employer, the person may contest the drug test result as provided by subsections (14) and (15).

8. A statement informing the employee or job applicant of his responsibility to notify the laboratory of any administrative or civil actions brought pursuant to this section.

9. A list of all drugs for which the employer will test, described by brand names or common names, as applicable, as well as by chemical names.

10. A statement regarding any applicable collective bargaining agreement or contract and the right to appeal to the Public Employees Relations Commission.

11. A statement notifying employees and job applicants of their right to consult the testing laboratory for technical information regarding prescription and nonprescription medication.

(8) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(f) A person who collects or takes a specimen for a drug test conducted pursuant to this section shall collect an amount sufficient for two drug tests as determined by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~.

(h) Every specimen that produces a positive confirmed result shall be preserved by the licensed laboratory that conducts the confirmation test for a period of at least 210 days from the time the results of the positive confirmation test are mailed or otherwise delivered to the employer. However, if an employee or job applicant undertakes an administrative or legal challenge to the test result, the employee or job applicant shall notify the laboratory and the sample shall be retained by the laboratory until the case or administrative appeal is settled. During the 180-day period after written notification of a positive test result, the employee or job applicant who has provided the specimen shall be permitted by the employer to have a portion of the specimen retested, at the employee or job applicant's expense, at another laboratory, licensed and approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~, chosen by the employee or job applicant. The second laboratory must test at equal or greater sensitivity for the drug in question as the first laboratory. The first laboratory which performed the test for the employer shall be responsible for the transfer of the portion of the specimen to be retested, and for the integrity of the chain of custody during such transfer.

(q) An employer who performs drug testing or specimen collection shall use chain-of-custody procedures as established by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ to ensure proper recordkeeping, handling, labeling, and identification of all specimens to be tested.

(9) CONFIRMATION TESTING.—

(c) All positive initial tests shall be confirmed using gas chromatography/mass spectrometry (GC/MS) or an equivalent or more accurate scientifically accepted method approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ as such technology becomes available in a cost effective form.

(12) DRUG TESTING STANDARDS; LABORATORIES.—

(a) No laboratory may analyze initial or confirmation drug specimens unless:

1. The laboratory is licensed and approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ using criteria established by the National Institute on Drug Abuse as guidelines for modeling the state drug testing program.

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

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

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

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

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

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

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

(13) RULES.—

(a) The *Agency for Health Care Administration may adopt* ~~Department of Health and Rehabilitative Services is hereby authorized to promulgate~~ rules, using criteria established by the National Institute on Drug Abuse as guidelines for modeling the state drug testing program, concerning, but not limited to:

1. Standards for drug testing laboratory licensing, suspension, and revocation of a license.

2. Body specimens and minimum specimen amounts which are appropriate for drug testing.

3. Methods of analysis and procedures to ensure reliable drug testing results, including standards for initial tests and confirmation tests.

4. Minimum cut-off detection levels for drugs or their metabolites for the purposes of determining a positive test result.

5. Chain-of-custody procedures to ensure proper identification, labeling, and handling of specimens being tested.

6. Retention, storage, and transportation procedures to ensure reliable results on confirmation tests and retests.

7. A list of the most common medications by brand name or common name, as applicable, as well as by chemical name, which may alter or affect a drug test.

(17) LICENSE FEE.—Fees from licensure of drug testing laboratories shall be sufficient to carry out the responsibilities of the *Agency for Health Care Administration* ~~department~~ for the regulation of drug testing laboratories. The *agency* ~~department~~ shall collect fees for all licenses issued under this part. ~~The fee schedule for fiscal year 1991-1992 shall not exceed the maximum fees provided herein and such schedule adopted by rule by the department pursuant to this part.~~ Each nonrefundable fee shall be due at the time of application and shall be payable to the *agency* ~~department~~ to be deposited in a trust fund administered by the *agency* ~~department~~ and used only for the purposes of this section. The fee schedule is as follows: For licensure as a drug testing laboratory, an annual fee of not less than $8,000 or more than $10,000 per fiscal year; for late filing of an application for renewal, an additional fee of $500 per day shall be charged.

Section 9. Effective July 1, 1993, subsection (5) of section 154.011, Florida Statutes, is amended to read:

154.011 Primary care services.—

(5) The department shall adopt rules to govern the operation of primary care programs authorized by this section. Such rules shall include, but not be limited to, quality of care *and*, case management, ~~and Medicaid participation~~ and shall be developed by the State Health Officer. Rules governing services to clients under 21 years of age shall be developed in conjunction with children's medical services and shall at a minimum include preventive services as set forth in s. 627.6579.

Section 10. Subsections (1) and (4) of section 154.205, Florida Statutes, are amended to read:

154.205 Definitions.—The following terms, whenever used in this part, shall have the following meanings unless a different meaning clearly appears from the context:

(1) "Areawide council" means *a local* ~~an advisory comprehensive~~ health ~~planning~~ council, as described *in s. 408.033* ~~and approved under all pertinent federal and state laws and rules and regulations~~.

(4) "Certificate of need" means a written advisory statement issued by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~, having as its basis a written advisory statement issued by an areawide council and, where there is no council, by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~, evidencing community need for a new, converted, expanded, or otherwise significantly modified health facility.

Section 11. Section 154.245, Florida Statutes, is amended to read:

154.245 ~~Department of Health and Rehabilitative Services~~ Certificate of need required as a condition to bond validation and project construction.—Notwithstanding any provision of this part to the contrary, before any project authorized by this part and subject to review under ss. *408.031-408.045* ~~381.701-381.715~~ is approved by the authority, and before revenue bonds are validated for the project, the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall issue a certificate of need for such project, which shall be a condition precedent to the validation and issuance of any bonds hereunder, other than bonds for refunding or refinancing purposes, and to the construction of the project. However, any portion of a life care facility not requiring licensure under chapter 395 or part I of chapter 400 shall be exempt from the certificate-of-need requirement.

Section 12. Section 154.304, Florida Statutes, 1992 Supplement, is amended to read:

154.304 Definitions.—For the purpose of this act:

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

(2)~~(1)~~ "Board" means the Health Care Board as established in chapter 408.

(3)~~(2)~~ "Certification determination procedures" means the process used by the county of residence or the *agency* ~~department~~ to determine a person's county of residence.

(4)~~(3)~~ "Certified resident" means a United States citizen or lawfully admitted alien who has been certified as a resident of the county by a person designated by the county governing body to provide certification determination procedures for the county in which the patient resides; by the *agency* ~~department~~ if such county does not make a determination of residency within 60 days of receiving a certified letter from the treating hospital; or by the *agency* ~~department~~ if the hospital appeals the decision of the county making such determination.

(5)~~(4)~~ "Charity care obligation" means the minimum amount of uncompensated charity care as reported to the Health Care ~~Cost Containment~~ Board, based on the hospital's most recent audited actual experience, which must be provided by a participating hospital or a regional referral hospital before the hospital is eligible to be reimbursed by a county under the provisions of this act. That amount shall be the ratio of uncompensated charity care days compared to total acute care inpatient days, which shall be equal to or greater than 2 percent.

(6)~~(5)~~ "Department" means the Department of Health and Rehabilitative Services.

(7)~~(6)~~ "Eligibility determination procedures" means the process used by a county or the *agency* ~~department~~ to evaluate a person's financial eligibility, eligibility for state-funded or federally funded programs, and the availability of insurance, in order to document a person as a qualified indigent for the purpose of this act.

(8)~~(7)~~ "Hospital," for the purposes of this act, means an establishment as defined in s. 395.002 and licensed by the *agency* ~~department~~ which qualifies as either a participating hospital or as a regional referral hospital pursuant to this section; except that, hospitals operated by the department shall not be considered participating hospitals for purposes of this act.

(9)~~(8)~~ "Participating hospital" means a hospital which is eligible to receive reimbursement under the provisions of this act because it has been certified by the board as having met its charity care obligation and has either:

(a) A formal signed agreement with a county or counties to treat such county's indigent patients; or

(b) Demonstrated to the board that at least 2.5 percent of its uncompensated charity care, as reported to the board, is generated by out-of-county residents.

(10)~~(9)~~ "Qualified indigent person" or "qualified indigent patient" means a person who has been determined pursuant to s. 154.308 to have an average family income, for the 12 months preceding the determination, which is below 100 percent of the federal ~~nonfarm~~ poverty level; who is not eligible to participate in any other government program which provides hospital care; who has no private insurance or has inadequate private insurance; and who does not reside in a public institution as defined under the medical assistance program for the needy under Title XIX of the Social Security Act, as amended.

(11)~~(10)~~ "Regional referral hospital" means any hospital which is eligible to receive reimbursement under the provision of this act because it has met its charity care obligation and it meets the definition of teaching hospital as defined in s. 408.07.

Section 13. Section 154.306, Florida Statutes, is amended to read:

154.306 Financial responsibility for certified residents who are qualified indigent patients treated at an out-of-county participating hospital or regional referral hospital.—Ultimate financial responsibility for treatment received at a participating hospital or a regional referral hospital by a qualified indigent patient who is a certified resident of a county in the State of Florida, but is not a resident of the county in which the participating hospital or regional referral hospital is located, shall be the obligation of the county of which the qualified indigent patient is a resident. Each county is directed to reimburse participating hospitals or regional referral hospitals as provided for in this act, and shall provide or arrange for indigent eligibility determination procedures and resident certification determination procedures as provided for in rules developed to implement this act. The *agency* ~~department~~, or any county determining eligibility of a qualified indigent, shall provide to the county of residence, upon request, a copy of any documents, forms, or other information, as determined by rule, which may be used in making an eligibility determination.

(1) A county's financial obligation for each certified resident who qualifies as an indigent patient under this act, and who has received treatment at an out-of-county hospital, shall not exceed 45 days per county fiscal year at a rate of payment equivalent to 100 percent of the per diem reimbursement rate currently in effect for the out-of-county hospital under the medical assistance program for the needy under Title XIX of the Social Security Act, as amended, except that those counties that are at their 10-mill cap on October 1, 1991, shall reimburse hospitals for such services at not less than 80 percent of the hospital Medicaid per diem. However, nothing in this section shall preclude a hospital which has a formal signed agreement with a county to treat such county's indigents from negotiating a higher or lower per diem rate with the county. In addition, no county shall be required by this act to pay more than the equivalent of $4 per capita in the county's fiscal year. The *agency* ~~department~~ shall calculate and certify to each county by March 1 of each year, the maximum amount the county may be required to pay under this act by multiplying the most recent official state population estimate for the total population of the county by $4 per capita. Each county shall certify to the *agency* ~~department~~ within 60 days of the end of the county's fiscal year, or upon reaching the $4 per capita threshold, should that occur before the end of the fiscal year, the amount of reimbursement it paid to all out-of-county hospitals under this act.

(2) No county shall be required to pay for any elective or nonemergency admissions or services at an out-of-county hospital for a qualified indigent who is a certified resident of the county when the county provides funding for such services and the services are available at a local hospital in the county where the indigent resides; or the out-of-county hospital has not obtained prior written authorization and approval for such hospital admission or service, provided that the resident county has established a procedure to authorize and approve such admissions.

(3) The county where the indigent resides shall, in all instances, be liable for the cost of treatment provided to a qualified indigent patient at an out-of-county hospital for any emergency medical condition which will deteriorate from failure to provide such treatment and when such condition is determined and documented by the attending physician to be of an emergency nature; provided that the patient has been certified to be a resident of such county pursuant to s. 154.309.

(4) No county shall be liable for payment for treatment of a qualified indigent who is a certified resident and has received services at an out-of-county participating hospital or regional referral hospital, until such time as that hospital has documented to the board and the board has determined that it has met its charity care obligation based on the most recent audited actual experience.

Section 14. Section 154.308, Florida Statutes, is amended to read:

154.308 Determination of patient's eligibility; spend-down program.—

(1) The *agency* ~~department~~, pursuant to s. 154.3105, shall adopt rules which provide statewide eligibility determination procedures, forms, and criteria which shall be used by all counties for determining whether a person financially qualifies as indigent for the purposes of this act.

(a) The criteria used to determine eligibility shall be uniform statewide and shall include, at a minimum, which assets, if any, may be included in the determination, which verification of income shall be required, which categories of persons shall be eligible, and any other criteria which may be determined as necessary.

(b) The methodology by which to determine financial eligibility shall also be uniform statewide such that any county or the state could determine whether a person would be a qualified indigent under this act.

(2) Determination of financial eligibility as a qualified indigent may occur either prior to a person's admission to a participating hospital or a regional referral hospital or subsequent to such admission.

(3) Determination of whether a hospital patient not already determined eligible meets or does not meet eligibility standards to financially qualify him as indigent for the purpose of this act shall be made within 60 days following notification by the hospital requesting a determination of indigency, by certified letter, to the county known or believed to be the county of residence or to the *agency* ~~department~~. If for any reason, the county or *agency* ~~department~~ is unable to determine a patient's eligibility within the allotted timeframe, the hospital shall be notified in writing of the reason or reasons.

(4) A patient determined eligible as a qualified indigent for the purpose of this act subsequent to his or her admission to a participating hospital or a regional referral hospital shall be considered to have been qualified upon admission. Such determination shall be made by a person designated by the governing board of the county to make such a determination or by the *agency* ~~department~~.

(5) Notwithstanding any other provision within this act, any county may establish thresholds of financial eligibility to qualify indigents under this act which are less restrictive than 100 percent of the federal poverty line. However, no county may establish eligibility thresholds which are more restrictive than 100 percent of the federal poverty line.

(6) Notwithstanding any other provision of this act, there is hereby established a spend-down program for persons who would otherwise qualify as qualified indigent persons, but whose average family income, for the 12 months preceding the determination, is between 100 percent and 150 percent of the federal poverty level. The *agency* ~~department~~ shall adopt, by rule, procedures for the spend-down program. The rule shall require that in order to qualify for the spend-down program, a person must have incurred bills for hospital care which would otherwise have qualified for payment under this part. This subsection does not apply to persons who are residents of counties that are at their 10-mill cap on October 1, 1991.

Section 15. Section 154.309, Florida Statutes, is amended to read:

154.309 Certification of county of residence.—

(1) The *agency* ~~department~~, pursuant to s. 154.3105, shall adopt rules for certification determination procedures which provide criteria to be used for determining a qualified indigent's county of residence. Such criteria shall include, at a minimum, how and to what extent residency shall be verified and how a hospital shall be notified of a patient's certification or the inability to certify a patient.

(2) In all instances, the county known or thought to be the county of residence shall be given first opportunity to certify a resident. If the county known or thought to be the county of residence fails to, or is unable to, make such determination within 60 days following written notification by a hospital, the *agency* ~~department~~ shall determine residency utilizing the same criteria required by rule as the county, and the *agency's* ~~department's~~ determination of residency shall be binding on the county of residence. The county determined as the residence of any qualified indigent under this act shall be liable to reimburse the treating hospital pursuant to s. 154.306. If for any reason a county or the *agency* ~~department~~ is unable to determine an indigent's residency, the hospital shall be notified in writing of such reason or reasons.

Section 16. Section 154.31, Florida Statutes, is amended to read:

154.31 Obligation of participating hospital or regional referral hospital.—As a condition of accepting the procedures of this act, each participating hospital or regional referral hospital in Florida shall be obligated to admit for emergency treatment all Florida residents, without regard to county of residence, who meet the eligibility standards established pursuant to s. 154.308 and who meet the medical standards for admission to such institutions. If the *agency* ~~department~~ determines that a participating hospital or a regional referral hospital has failed to meet the requirements of this section, the *agency* ~~department~~ may impose an administrative fine, not to exceed $5,000 per incident, and suspend the hospital from eligibility for reimbursement under the provisions of this act.

Section 17. Section 154.3105, Florida Statutes, is amended to read:

154.3105 Rules.—Rules governing the Health Care Responsibility Act of 1988 shall be developed by the *agency* ~~department~~ based on recommendations of a work group consisting of equal representation by the *agency* ~~department~~, the hospital industry, and the counties. County representatives to this work group shall be appointed by the Florida Association of Counties. Hospital representatives to this work group shall be appointed by the associations representing those hospitals which best represent the positions of the hospitals most likely to be eligible for reimbursement. *The agency shall adopt* rules governing the various aspects of this act ~~shall be adopted by the department~~. Such rules shall address, at a minimum:

(1) Eligibility determination procedures and criteria.

(2) Certification determination procedures and methods of notification to hospitals.

Section 18. Section 154.312, Florida Statutes, is amended to read:

154.312 Procedure for settlement of disputes.—All disputes among counties, the board, the *agency* ~~department~~, a participating hospital, or a regional referral hospital shall be resolved by order as provided in chapter 120. Hearings held under this provision shall be conducted in the same manner as provided in s. 120.57, except that the hearing officer's order shall be final agency action. Cases filed under chapter 120 may combine all disputes between parties. Notwithstanding any other provisions of this part, when a county alleges that a residency determination or eligibility determination made by the *agency* ~~department~~ is incorrect, the burden of proof shall be on the county to demonstrate that such determination is, in light of the total record, not supported by the evidence.

Section 19. Subsection (16) of section 159.27, Florida Statutes, is amended to read:

159.27 Definitions.—The following words and terms, unless the context clearly indicates a different meaning, shall have the following meanings:

(16) "Health care facility" means property operated in the private sector, whether operated for profit or not, used for or useful in connection with the diagnosis, treatment, therapy, rehabilitation, housing, or care of or for aged, sick, ill, injured, infirm, impaired, disabled, or handicapped persons, without discrimination among such persons due to race, religion, or national origin; or for the prevention, detection, and control of disease, including, without limitation thereto, hospital, clinic, emergency, outpatient, and intermediate care, including, but not limited to, facilities for the elderly such as adult congregate living facilities, facilities defined in *s. 154.205(7)* ~~s. 154.205(8)~~, day care and share-a-home facilities, nursing homes, and the following related property when used for or in connection with the foregoing: laboratory; research; pharmacy; laundry; health personnel training and lodging; patient, guest, and health personnel food ser-

vice facilities; and offices and office buildings for persons engaged in health care professions or services; provided, if required by *ss. 408.031-408.045* ~~ss. 381.701-381.715~~ and ss. 400.601-400.614, a certificate of need therefor is obtained prior to the issuance of the bonds.

Section 20. Subsection (9) of section 186.003, Florida Statutes, 1992 Supplement, is amended to read:

186.003 Definitions.—As used in ss. 186.001-186.031 and 186.801-186.911, the term:

(9) "Statewide Health Council" means the Statewide Health Council established pursuant to *s. 408.033* ~~s. 381.703~~.

Section 21. Effective October 1, 1993, subsection (3) of section 189.415, Florida Statutes, is amended to read:

189.415 Special district public facilities report.—

(3) A special district proposing to build, improve, or expand a public facility which requires a certificate of need pursuant to chapter *408* ~~381~~ shall elect to notify the appropriate local general-purpose government of its plans either in its 5-year plan or at the time the letter of intent if filed with the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ pursuant to *s. 408.039* ~~s. 381.709~~.

Section 22. Subsection (2) of section 196.1975, Florida Statutes, is amended to read:

196.1975 Exemption for property used by nonprofit homes for the aged.—Nonprofit homes for the aged are exempt to the extent that they meet the following criteria:

(2) A facility will not qualify as a "home for the aged" unless at least 75 percent of the occupants are over the age of 62 years or totally and permanently disabled. For homes for the aged which are exempt from paying income taxes to the United States as specified in subsection (1), licensing by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ is required for ad valorem tax exemption hereunder only if the home:

(a) Furnishes medical facilities or nursing services to its residents, or

(b) Qualifies as an adult congregate living facility under part II, chapter 400.

Section 23. Section 205.1965, Florida Statutes, is amended to read:

205.1965 Adult congregate living facilities.—No county or municipality shall issue an occupational license for the operation of an adult congregate living facility pursuant to part II of chapter 400 without first ascertaining that the applicant has been licensed by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ to operate such facility at the specified location or locations. The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall furnish to local agencies responsible for issuing occupational licenses sufficient instructions for making the above required determinations.

Section 24. Paragraph (q) of subsection (4) of section 215.20, Florida Statutes, 1992 Supplement, is amended to read:

215.20 Certain income and certain trust funds to contribute to the General Revenue Fund.—

(4) The income of a revenue nature deposited in the following described trust funds, by whatever name designated, is that from which the deductions authorized by subsection (3) shall be made:

(q) The Health Care ~~Cost Containment~~ Trust Fund established pursuant to s. 408.20.

The enumeration of the foregoing moneys or trust funds shall not prohibit the applicability thereto of s. 215.24 should the Governor determine that for the reasons mentioned in s. 215.24 the money or trust funds should be exempt herefrom, as it is the purpose of this law to exempt all trust funds from its force and effect when, by the operation of this law, federal matching funds or contributions to any trust fund would be lost to the state.

Section 25. Paragraph (a) of subsection (2) of section 240.4067, Florida Statutes, 1992 Supplement, is amended, and paragraphs (d) and (e) are added to that subsection, to read:

240.4067 Medical Education Reimbursement and Loan Repayment Program.—

(2) From the funds available, the Department of Health and Rehabilitative Services shall make payments to selected medical professionals as follows:

(a) Up to $4,000 per year for licensed practical nurses and registered nurses, up to $10,000 per year for advanced registered nurse practitioners and physician's assistants, and up to $20,000 per year for physicians. *Penalties for noncompliance shall be the same as those in the National Health Services Corps Loan Repayment Program* ~~or an amount equivalent to one-third of the total of loans and other educational expenses that were incurred by the health care professional during his enrollment in medical or nursing school, whichever is less, for a maximum of 3 years~~. Educational expenses include costs for tuition, matriculation, registration, books, laboratory and other fees, other educational costs, and reasonable living expenses as determined by the Department of Health and Rehabilitative Services.

(d) A medical student who enters and completes a 3-year residency program in this state in family practice, general internal medicine, or general pediatrics is eligible for a loan forgiveness for educational loans in the amount of $10,000 upon beginning the practice of primary care in this state.

(e) A physician who practices family medicine, general internal medicine, or general pediatrics full time in an underserved community in this state is eligible for a loan forgiveness for educational loans in the amount of $10,000 per year for up to 10 years following practice in that area for at least 3 years.

Section 26. Subsection (1) and paragraph (a) of subsection (7) of section 240.4075, Florida Statutes, 1992 Supplement, are amended to read:

240.4075 Nursing Student Loan Forgiveness Program.—

(1) To encourage qualified personnel to seek employment in areas of this state in which critical nursing shortages exist, there is established the Nursing Student Loan Forgiveness Program. The primary function of the program is to increase employment and retention of registered nurses and licensed practical nurses in nursing homes and hospitals in the state and in state-operated medical and health care facilities, *birth centers, community mental health centers as defined in chapter 394, licensed alcohol and drug abuse programs as defined in chapter 396 or chapter 397,* federally sponsored community health centers and teaching hospitals by making repayments toward loans received by students from federal or state programs or commercial lending institutions for the support of post-secondary study in accredited or approved nursing programs.

(7)(a) Funds contained in the Nursing Student Loan Forgiveness Trust Fund which are to be used for loan forgiveness for those nurses employed by hospitals, *birth centers, community mental health centers as defined in chapter 394, licensed alcohol and drug abuse programs as defined in chapter 396 or chapter 397,* and nursing homes must be matched on a dollar-for-dollar basis by contributions from the employing institutions except that this provision shall not apply to state-operated medical and health care facilities, county public health units, federally sponsored community health centers, or teaching hospitals as defined in s. 408.07.

Section 27. Subsection (7) is added to section 381.026, Florida Statutes, 1992 Supplement, to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(7) REMEDIES.—Any facility licensed pursuant to chapter 395 which violates any portion of this section shall be subject to a fine not to exceed $1,000, which shall be imposed, fixed, and collected by the Agency for Health Care Administration.

Section 28. Section 381.0261, Florida Statutes, is amended to read:

381.0261 Distribution of summary.—The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall have printed and made continuously available to health care facilities licensed under chapter 395, physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, and podiatrists licensed under chapter 461 a summary of the Florida Patient's Bill of Rights and Responsibilities. In adopting and making public the summary of the Florida Patient's Bill of Rights and Responsibilities, health care providers and health care facilities are not limited to the format in which the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ prints and distributes the summary.

Section 29. Section 381.0302, Florida Statutes, 1992 Supplement, is amended to read:

381.0302 Florida Health Services Corps.—

(1) To encourage qualified medical professionals to practice in underserved locations where there are shortages of such personnel, the Legislature establishes the Florida Health Services Corps.

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

(a) "Department" means the Department of Health and Rehabilitative Services.

(b) "Florida Health Services Corps" means a program authorized by this section which:

1. Offers scholarships to *allopathic, osteopathic,* ~~medical,~~ chiropractic, *podiatric, optometric,* dental, *physician assistant,* and nursing students, *and loan repayment assistance and travel and relocation expenses to allopathic and osteopathic residents and physicians, chiropractors, podiatrists, optometrists, nurse practitioners, dentists, and physician assistants,* in return for service in a public health care program *or in a medically underserved area.*

2. Offers membership on a voluntary basis to physicians and other health care personnel who provide uncompensated care.

(c) "Medically underserved area" means:

1. A geographic area, a special population, or a facility that has a shortage of health professionals as defined by federal regulations;

2. A county public health unit, community health center, or migrant health center; or

3. A geographic area or facility designated by rule by the department that has a shortage of health care practitioners who serve Medicaid and other low-income patients.

(d) "Medically indigent person" means a person who lacks public or private health insurance, is unable to pay for care, and is a member of a family with an income at or below 185 percent of the federal poverty level.

(e) "Public health program" means a county public health unit, a children's medical services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded *or nonprofit* health care program designated by the department.

(f) "Primary care" means family and general practice, general pediatrics, general geriatrics, obstetrics/gynecology, primary medical eye care, and general internal medicine.

(3) The Florida Health Services Corps shall be developed by the State Health Office in cooperation with the programs in the area Health Education Center network as defined in s. 381.0402 and the state's health care education and training institutions. The State Health Officer shall be the director of the Florida Health Services Corps.

(4) Corps members shall be supervised by the State Health Officer, or his physician designee, for the purpose of practice guidelines, continuing education, and other matters pertaining to professional conduct.

(5) The department may award scholarships to students studying medicine, *osteopathic medicine,* chiropractic, *podiatric medicine, optometry,* nursing, or dentistry.

(a) The program shall require a student who receives a scholarship to accept an assignment in a public health care program or work in a specific community located in a medically underserved area upon *completion of primary care training* ~~graduation~~. The department shall determine assignments. If a practitioner is assigned to a medically underserved area, the practitioner must treat Medicaid patients and other patients with low incomes.

(b) An eligible student must *be pursuing* ~~pursue~~ a full-time course of study in:

1. Allopathic or osteopathic medicine, including physician assistants;

2. Dentistry;

3. Podiatric medicine;

4. ~~3.~~ Nursing, including registered nurses, nurse midwives, and other nurse practitioners; ~~or~~

5. ~~4.~~ Chiropractic medicine*; or*.

6. Optometry.

(c) In selecting students to participate in the scholarship program, priority shall be given to students who indicate a desire to practice a primary care specialty in a medically underserved area after their obligation is completed and who indicate an intent to practice medical specialties for which the department has a need.

(d) Scholarship assistance shall consist of reimbursement for tuition and other educational costs such as books, supplies, equipment, transportation, and monthly living expense stipends. The department shall pay the same amount for living expense stipends as is paid by the National Health Services Corps. Each monthly living expense stipend shall be for a 12-month period beginning with the first month of each school year in which the student is a participant. The department may reimburse a participant for books, supplies, and equipment based on average costs incurred by participants for these items. The department shall prescribe, by rule, eligible expenses for reimbursement and allowable amounts.

(e) For *an allopathic or osteopathic* a medical student *or optometry student,* enrollment in the corps may begin in the second year of medical school or in any year thereafter. For a nursing student or other student, enrollment may occur in any year.

(f) For a student who receives scholarship assistance, participation in the corps after *completion of training* ~~graduation~~ shall be 1 year for each school year of *scholarship* ~~financial~~ assistance, up to a maximum of 3 years. The period of obligated service shall begin when the participant is assigned by the department to a public health program or to a medically underserved area.

(6) The department may provide loan repayment assistance and travel and relocation reimbursement to allopathic and osteopathic medical residents with primary care specialties during their last 2 years of residency training or upon completion of residency training, and to physician assistants and nurse practitioners with primary care specialties, in return for an agreement to serve a minimum of 2 years in the Florida Health Services Corps. During the period of service, the maximum amount of annual financial payments shall not be greater than the annual total of loan repayment assistance and tax subsidies authorized by the National Health Services Corps loan repayment program.

(7)~~(6)~~ The financial penalty for noncompliance with participation requirements *for persons who have received financial payments under subsection (5) or subsection (6)* shall be determined in the same manner as in the National Health Services Corps scholarship program. In addition, noncompliance with participation requirements shall also result in ineligibility for professional licensure *or renewal of licensure* under chapter 458, chapter 459, chapter 460, *chapter 463,* chapter 464, chapter 465, or chapter 466. For a participant who is unable to participate for reasons *of* ~~beyond his control, such as~~ disability, the penalty is the actual amount of financial assistance provided to the participant. Financial penalties shall be deposited in the Florida Health Services Corps Trust Fund and shall be used to provide additional scholarship and financial assistance.

(8)~~(7)~~ Membership in the corps may be extended to any licensed physician or other health care practitioner who provides uncompensated care to medically indigent persons referred by the department. Participation in the corps is voluntary and subject to the supervision of the department for the purpose of practice guidelines, continuing education, and other matters pertaining to professional conduct.

(9) Persons who receive loan repayment assistance under s. 240.4067 shall be members of the Florida Health Services Corps.

(10) Corps members shall be enrolled in Medicaid, if eligible, and accept all patients referred by the department pursuant to an agreement with the department.

(11)~~(8)~~ A Florida Health Services Corps member is an agent of the state under s. 768.28(9) while providing uncompensated services to medically indigent persons who are referred by the department.

(12)~~(9)~~ Funds appropriated under this section shall be deposited in the Florida Health Services Corps Trust Fund, which shall be administered by the State Health Office. *The department may use funds appro-*

priated for the Florida Health Services Corps as matching funds for federal service-obligation scholarship programs for health care practitioners, such as the Demonstration Grants to States for Community Scholarship Grants program. If funds appropriated under this section are used as matching funds, federal criteria shall be followed whenever there is a conflict between provisions in this section and federal requirements.

(13)~~(10)~~ The department shall adopt rules to implement the Florida Health Services Corps. The rules must also quantify penalties for noncompliance.

Section 30. Section 381.0406, Florida Statutes, is created to read:

381.0406 Rural health networks.—

(1)(a) The Legislature finds that, in rural areas, access to health care is limited and the quality of health care is negatively affected by inadequate financing, difficulty in recruiting and retaining skilled health professionals, and because of a migration of patients to urban areas for general acute care and specialty services.

(b) The Legislature further finds that the efficient and effective delivery of health care services in rural areas requires the integration of public and private resources and the coordination of health care providers.

(c) The Legislature further finds that the availability of a continuum of quality health care services, including preventive, primary, secondary, tertiary, and long term care, is essential to the economic and social vitality of rural communities.

(d) The Legislature further finds that the creation of rural health networks can help to alleviate these problems. Rural health networks shall, to the extent possible, be structured to provide a continuum of quality health care services for rural residents through the cooperative efforts of rural health network members.

(e) The Legislature further finds that rural health networks shall have the goal of increasing the utilization of statutory rural hospitals for appropriate health care services whenever feasible, which shall help to ensure their survival and thereby support the economy and protect the health and safety of rural residents.

(f) Finally, the Legislature finds that rural health networks may serve as "laboratories" to determine the best way of organizing rural health services, to move the state closer to ensuring that everyone has access to health care, and to promote cost containment efforts. The ultimate goal of rural health networks shall be to ensure that quality health care is available and efficiently delivered to all persons in rural areas.

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

(a) "Rural" means an area with a population density of less than 100 individuals per square mile or an area defined by the United States Census as rural.

(b) "Health care provider" means any individual, group, or entity, public or private, that provides health care, including: preventive health care, primary health care, secondary and tertiary health care, in-hospital health care, public health care, and health promotion and education.

(c) "Rural health network" or "network" means a nonprofit legal entity, consisting of rural and urban health care providers and others, which is organized to plan and deliver health care services on a cooperative basis in a rural area, except for some secondary and tertiary care services, and which, to the extent possible, ensures ethnic minority and gender-proportionate health care provider participation that is proportionate to the population served by the network.

(3) Because each rural area is unique, with a different health care provider mix, health care provider membership may vary, but each network must include members that provide public health, comprehensive primary care, emergency medical care, and acute inpatient care.

(4) Network membership must be available to all health care providers, if they render care to all patients referred to them from other network members.

(5) A network area does not need to conform to local political boundaries or state administrative district boundaries.

(6) Each network must develop provisions for referral to tertiary inpatient care and to other services that are not available in rural areas.

(7) Each network must make available health promotion, disease prevention, and primary care services to improve the health status of rural residents and to contain health care costs.

(8) A network may have multiple points of entry, such as through private physicians, community health centers, county public health units, certified rural health clinics, hospitals, or other providers; or it may have a single point of entry.

(9) Each network must establish standard protocols, coordinate and share patient records, and develop patient information exchange systems.

(10) Each network must develop risk management and quality assurance programs for network providers.

(11)(a) A network must be incorporated under the laws of the state.

(b) Each network must have a board of directors that derives membership from local government, health care providers, businesses, consumers, and others.

(c) Each network board of directors shall determine the content of health care provider agreements that link network members. Each agreement must specify:

1. Who provides what services.

2. The extent to which the health care provider provides care to persons who lack health insurance or are otherwise unable to pay for care.

3. The procedures for transfer of medical records.

4. The method used for the transportation of patients between providers.

5. Referral and patient flow including appointments and scheduling.

6. Payment arrangements for the transfer or referral of patients.

(12)(a) Each network, to the extent feasible, must provide for a continuum of care for all patients served by the network. Each network must include the following core services: disease prevention, health promotion, comprehensive primary care, emergency medical care, and acute inpatient care. Each network must, to the extent feasible, also ensure the availability of the following services either directly, by contract, or through referral agreements:

1. Services available in the home.

a. Home health care.

b. Hospice care.

2. Services accessible within 30 minutes' travel time or less.

a. Emergency medical services, including advanced life support, ambulance, and basic emergency room services.

b. Primary care.

c. Prenatal care.

d. Community-based services for elders and persons with disabilities, such as adult day care and assistance with activities of daily living.

e. Public health services, including communicable disease control, disease prevention, health education, and health promotion.

f. Outpatient psychiatric services or psychotherapeutic services, and substance abuse services.

3. Services accessible within 45 minutes' travel time or less.

a. Hospital acute inpatient care for persons whose illnesses or medical problems are not severe.

b. Level I obstetrical care, which is labor and delivery for low-risk patients.

c. Skilled nursing services and either long-term nursing home care or extended congregate-living care.

d. Dialysis.

e. Osteopathic and chiropractic manipulative therapy.

f. Podiatric services.

4. Services accessible within 2 hours' travel time or less.

a. Specialist physician care.

b. Hospital acute inpatient care for severe illnesses and medical problems.

c. Level II and III obstetrical care, which is labor and delivery care for high-risk patients and neonatal intensive care.

d. Comprehensive medical rehabilitation.

e. Inpatient psychiatric and substance abuse services.

f. Magnetic resonance imaging, lithotripter treatment, advanced radiology, and other technologically advanced services.

g. Subacute care.

(b) Each network must actively participate with area health education center programs, whenever feasible, in developing and implementing recruitment, training, and retention programs directed at positively influencing the supply and distribution of health care professionals serving in, or receiving training in, network areas.

(c) As funds become available, a network must emphasize community care alternatives for elders who would otherwise be placed in nursing homes and community care alternatives for persons with mental illness who would otherwise be placed in institutions.

(13) In a network area that has an established trauma agency approved by the Department of Health and Rehabilitative Services, that trauma agency must be a participant in the network. Trauma services provided within the network area must comply with s. 395.405.

(14) A network may use all sources of public and private funds to support network activities.

(15) As funds become available, each network must be developed and implemented in two phases.

(a) Phase I consists of a network planning and development grant program administered by the Agency for Health Care Administration in consultation with the State Health Officer. Planning grants must be used to organize networks, incorporate network boards, and develop formal provider agreements as provided for in this section. The Agency for Health Care Administration shall develop a request-for-proposal process to solicit grant applications.

(b) Phase II consists of network operations. As funds become available, a certified network is eligible to receive grant funds to be used to help defray the costs of providing patient care. A Phase II award may occur in the same fiscal year as a Phase I award.

(16) For the purpose of certifying networks that are eligible for Phase II funding, the Agency for Health Care Administration, in consultation with the State Health Office, shall certify networks that meet the criteria delineated in this section.

(17) The Agency for Health Care Administration, in consultation with the State Health Office, shall establish rules that govern the creation and certification of networks, including establishing outcome measures for networks.

Section 31. Section 381.0407, Florida Statutes, is created to read:

381.0407 Rural regional hospital systems.—

(1) To foster the development of hospital systems in rural areas, the Agency for Health Care Administration may grant special consideration under the certificate-of-need program to a rural regional hospital system that:

(a) Includes at least three hospitals that are located in a geographic region defined as rural by the United States Census;

(b) Provides for the cooperative delivery of hospital services; and

(c) Forms a legal entity that includes on its board of directors a member of each hospital in the rural hospital system.

(2) Special consideration under the certificate-of-need program includes:

(a) Expedited review of a proposal to transfer beds between hospitals, and

(b) Preference for a regulated bed or service, if need is shown under s. 408.035. However, preference may not be given under this section for the establishment of skilled nursing facility services by a hospital.

(3) Notwithstanding any law to the contrary, a rural regional hospital system may form a tax district that includes the geographic service area of the system, irrespective of county boundaries, if the geographic service area is located entirely in an area defined as rural by the United States Census.

Section 32. Section 381.0408, Florida Statutes, is created to read:

381.0408 Rural health care innovation zones.—

(1) The Agency for Health Care Administration may establish zones of innovation to improve access to health care in isolated rural areas. To be eligible for designation by the Agency for Health Care Administration as a rural health care innovation zone, a geographic area must have:

(a) Concentrations of seasonal workers;

(b) Concentrations of temporarily unemployed and uninsured residents in rural areas; and

(c) A hospital that has the ability to provide a full range of health services, including primary care and consumer education, and that has a record of providing free health care services in the community.

(2) Upon designating a geographic area as a rural health care innovation zone pursuant to agency rules, the agency may grant preference to a certificate-of-need applicant located within the innovation zone.

(3) The Agency for Health Care Administration may seek Medicaid waivers, amend the state Medicaid plan, and seek additional sources of funding to financially support health care facilities and health care providers located within a rural health care innovation zone.

Section 33. Section 381.045, Florida Statutes, is amended to read:

381.045 Hepatitis B or human immunodeficiency carriers.—The Department of Health and Rehabilitative Services shall have the authority to establish procedures to handle, counsel, and provide other services to health care professionals licensed or certified under chapter 401 *or*~~,~~ ~~chapter 467,~~ part IV of chapter 468~~, and chapter 483~~ who are infected with hepatitis B or the human immunodeficiency virus.

Section 34. Section 381.0602, Florida Statutes, is amended to read:

381.0602 Organ Transplant Advisory Council; membership; responsibilities.—

(1) There is hereby created within the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ a statewide technical Organ Transplant Advisory Council consisting of eight members to represent the interests of the public and the clients of the Department *of Health and Rehabilitative Services*. The members shall be physicians licensed according to chapter 458 or chapter 459. In no case shall a person employed by the *agency* ~~department~~ be appointed as a member of the council.

(2) All members of the council shall be appointed by the *Director of Health Care Administration* ~~Secretary of Health and Rehabilitative Services~~ to serve a term of 2 years.

(3) The *Director of Health Care Administration* ~~Secretary of Health and Rehabilitative Services~~ shall fill each vacancy on the council for the balance of the unexpired term. Priority consideration shall be given to the appointment of an individual whose primary interest, experience, or expertise lies with clients of the Department *of Health and Rehabilitative Services*. If an appointment is not made within 120 days after a vacancy occurs on the council, the vacancy shall be filled by the majority vote of the council.

(4) The members of the council shall elect a chairperson. The term of the chairperson shall be for 1 year, and no chairperson shall serve as chairperson for more than two consecutive terms.

(5) Members of the council shall receive no compensation, but shall be reimbursed for per diem and travel expenses by the *agency* ~~department~~ in accordance with the provisions of s. 112.061 while engaged in the performance of their duties.

(6) The responsibilities of the council shall be to recommend to the *agency* ~~department~~ indications for adult and pediatric organ transplants. The council shall also formulate guidelines and standards for organ transplants and for the development of End Stage Organ Disease and Tissue/Organ Transplant programs. Such recommendations, guidelines, and standards developed by the council shall be applicable only to those health programs funded through the Department of Health and Rehabilitative Services.

(7) The council shall meet at least annually or upon the call of the chairperson or the *Director of Health Care Administration* ~~Secretary of Health and Rehabilitative Services~~.

Section 35. Section 381.0605, Florida Statutes, is renumbered as section 408.055, Florida Statutes, and amended to read:

408.055 ~~381.0605~~ Survey of state hospital facilities; *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~.—

(1) The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ is hereby designated as the sole agency of the state to carry out the purposes of and administer the Federal Hospital and Medical Facilities Amendments of 1964 (Pub. L. No. 88-443).

(2) The Governor is authorized to provide for carrying out such purposes in accordance with the standards prescribed by the Surgeon General.

Section 36. Section 381.6021, Florida Statutes, is amended to read:

381.6021 Certification of organizations engaged in the practice of cadaveric organ and tissue procurement.—The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall:

(1) Establish a program for the certification of organizations, agencies, or other entities engaged in the procurement of organs, tissues, and eyes for transplantation;

(2) Adopt rules that set forth appropriate standards and guidelines for the program. These standards and guidelines must be substantially based on the existing laws of the Federal Government and this state and the existing standards and guidelines of the United Network for Organ Sharing (UNOS), the American Association of Tissue Banks (AATB), the South-Eastern Organ Procurement Foundation (SEOPF), the North American Transplant Coordinators Organization (NATCO), and the Eye Bank Association of America (EBAA). However, all tissue banking standards, except for eye banking standards, shall be adopted from standards of the American Association of Tissue Banks (AATB). In addition, the *agency* ~~department~~ shall, before adopting these standards and guidelines, seek input from all organ procurement organizations, tissue banks, and eye banks based in this state;

(3) Collect, keep, and make available to the Governor and the Legislature information regarding the numbers and disposition of organs and tissues procured by each certified entity;

(4) Monitor participating facilities and agencies for program compliance; and

(5) Provide for the administration of the Organ and Tissue Procurement and Transplantation Advisory Board.

Section 37. Section 381.6022, Florida Statutes, is amended to read:

381.6022 Certification required; provisional certification.—An organization, agency, or other entity may not engage in the practice of organ, tissue, or eye procurement without being appropriately certified by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services, except that all organ procurement organizations, tissue banks, and eye banks that were active in this state before March 1, 1990, and that were reviewed by the Florida State Organ and Tissue Procurement Task Force are granted provisional certification until the department certification process is complete~~.

Section 38. Section 381.6023, Florida Statutes, is amended to read:

381.6023 Organ and Tissue Procurement and Transplantation Advisory Board; creation; duties.—

(1) There is hereby created the Organ and Tissue Procurement and Transplantation Advisory Board which shall consist of 14 members who are appointed by and report directly to the *Director of Health Care Administration* ~~secretary of the Department of Health and Rehabilitative Services~~. The membership must be regionally distributed and must include:

(a) Two representatives who have expertise in vascular organ transplant surgery;

(b) Two representatives who have expertise in vascular organ procurement, preservation, and distribution;

(c) Two representatives who have expertise in musculoskeletal tissue transplant surgery;

(d) Two representatives who have expertise in musculoskeletal tissue procurement, processing, and distribution;

(e) A representative who has expertise in eye and cornea transplant surgery;

(f) A representative who has expertise in eye and cornea procurement, processing, and distribution;

(g) A representative who has expertise in bone marrow procurement, processing, and transplantation;

(h) A representative from the Florida Pediatric Society;

(i) A representative from the Florida Society of Pathologists; and

(j) A representative from the Florida Medical Examiners Commission.

(2) The advisory board members may not be compensated for their services except that they may be reimbursed for their travel expenses as provided by law. Members of the board shall be appointed for 3-year terms of office, except that, initially, five members shall be appointed for 1-year terms, four members shall be appointed for 2-year terms, and four members shall be appointed for 3-year terms.

(3) The board shall:

(a) Assist the *Agency for Health Care Administration* ~~department~~ in the development of necessary professional qualifications, including, but not limited to, the education, training, and performance of persons engaged in the various facets of organ and tissue procurement, processing, preservation, and distribution for transplantation;

(b) Assist the *Agency for Health Care Administration* ~~department~~ in monitoring the appropriate and legitimate expenses associated with organ and tissue procurement, processing, and distribution for transplantation and developing methodologies to assure the uniform statewide reporting of data to facilitate the accurate and timely evaluation of the organ and tissue procurement and transplantation system;

(c) Provide assistance to the Florida Medical Examiners Commission in the development of appropriate procedures and protocols to assure the continued improvement in the approval and release of potential organ and tissue donors by the district medical examiners and associate medical examiners;

(d) Develop with and recommend to the *Agency for Health Care Administration* ~~department~~ the necessary procedures and protocols required to assure that all residents of this state have reasonable access to available organ and tissue transplantation therapy and that residents of this state can be reasonably assured that the statewide procurement transplantation system will be able to fulfill their organ and tissue requirements within the limits of the available supply and according to the severity of their medical condition and need; and

(e) Develop with and recommend to the *Agency for Health Care Administration* ~~department~~ any changes to the laws of this state or administrative rules or procedures required to assure that the statewide organ and tissue procurement and transplantation system will be able to function smoothly, effectively, and efficiently, in accordance with the Federal Anatomical Gift Act and in a manner which assures the residents of this state that no person or entity profits from the altruistic voluntary donation of organs or tissues.

Section 39. Subsections (1) and (2) of section 381.6024, Florida Statutes, are amended to read:

381.6024 Fees; Organ and Tissue Procurement Trust Fund.—

(1) The *Agency for Health Care Administration* ~~department~~ shall assess annual fees to be used for the certification program and the advisory board in the following amounts, which may not exceed $35,000 per organization:

(a) Each general organ procurement organization shall pay the greater of $1,000 or 0.5 percent of its total revenues produced from procurement activity in this state by the certificateholder during its most recently completed fiscal year or operational year.

(b) Each bone and tissue procurement agency or bone and tissue bank shall pay the greater of $1,000 or 0.5 percent of its total revenues from procurement and processing activity in this state by the certificateholder during its most recently completed fiscal year or operational year.

(c) Each eye bank shall pay the greater of $500 or 0.5 percent of its total revenues produced from procurement activity in this state by the certificateholder during its most recently completed fiscal year or operational year.

(2) The *Agency for Health Care Administration* ~~department~~ shall provide by rule for administrative penalties for the purpose of ensuring adherence to the standards of quality and practice required by this chapter and rules of the *agency* ~~department~~ for continued certification.

Section 40. Section 381.6025, Florida Statutes, is amended to read:

381.6025 Physician supervision of cadaveric organ and tissue procurement coordinators.—Organ procurement organizations, tissue banks, and eye banks may employ coordinators, who are registered nurses, physician's assistants, or other medically trained personnel who meet the relevant standards for organ procurement organizations, tissue banks, or eye banks as adopted by the *Agency for Health Care Administration* ~~department~~ under s. 381.6021, to assist in the medical management of organ donors or in the surgical procurement of cadaveric organs, tissues, or eyes for transplantation or research. A coordinator who assists in the medical management of organ donors or in the surgical procurement of cadaveric organs, tissues, or eyes for transplantation or research must do so under the direction and supervision of a licensed physician medical director pursuant to rules and guidelines to be adopted by the *agency* ~~department~~. With the exception of organ procurement surgery, this supervision may be indirect supervision. For purposes of this subsection, the term "indirect supervision" means that the medical director is responsible for the medical actions of the coordinator, that the coordinator is operating under protocols expressly approved by the medical director, and that the medical director or his physician designee is always available, in person or by telephone, to provide medical direction, consultation, and advice in cases of organ, tissue, and eye donation and procurement. Although indirect supervision is authorized under this section, direct physician supervision is to be encouraged when appropriate.

Section 41. Section 381.695, Florida Statutes, is renumbered as section 408.0365, Florida Statutes, and amended to read:

408.0365 ~~381.695~~ Certificate-of-need exemption.—Any inmate health care facility built by or for the exclusive use of the Department of Corrections pursuant to *ss. 945.601-945.6035* ~~this act~~ is exempt from the certificate-of-need requirements of this chapter. This exemption expires when the facility is converted to other purposes.

Section 42. Section 381.698, Florida Statutes, 1992 Supplement, is renumbered as section 483.70, Florida Statutes, and amended to read:

483.70 ~~381.698~~ Blood transfusions.—

(1) SHORT TITLE.—This section shall be known and may be cited as "The Florida Blood Transfusion Act."

(2) DEFINITIONS.—As used in this section, unless the context clearly requires otherwise:

(a) ~~(f)~~ *"Administration fee" means the fee charged by hospitals to blood recipients to recapture the cost to the hospitals of administering blood or blood products to the recipients.*

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

(c) ~~(a)~~ *"Blood" means whole human blood or components of human blood, including plasma, which components are prepared from whole human blood by physical rather than chemical processes, but does not include blood derivatives manufactured or processed for industrial use.*

(d) ~~(b)~~ *"Donation" means any transaction involving the person from whom blood is withdrawn, whether he presents himself for the withdrawal of blood on his own initiative or on the initiative of another person, in which he receives no consideration other than credit through blood assurance programs or other intangible benefits.*

(e) ~~(d)~~ *"Industrial use" means a use of blood in which the blood is modified by physical or chemical means to produce derivatives for therapeutic or pharmaceutic biologicals and laboratory reagents or controls.*

(f) ~~(g)~~ *"Nonreplacement fee" means the fee charged by blood banks for failure to redeposit or replace blood units received by patients, which fee is also known as "recruitment deposit fee," "discount fee," "penalty fee," and "assurance fee."*

(g) ~~(h)~~ *"Paid donor" means a person who donates blood and who receives payment in return.*

(h) ~~(i)~~ *"Payment" means the transfer by a blood bank to any person of money or any other valuable consideration which can be converted to money by the recipient, except that payment does not include the following:*

1. Cancellation or refund of nonreplacement fees or related blood transfusion charges.

2. Time away from employment in order to donate blood, granted by an employer to an employee.

(i) ~~(j)~~ *"Person" means any individual, blood bank, hospital, firm, or corporation or any other entity.*

(j) ~~(e)~~ *"Processing fee" means the fee charged to recipients of blood or blood products to recapture all or part of the cost to the blood banks of providing the service.*

(k) ~~(c)~~ *"Purchase" means any transaction involving the person from whom blood is withdrawn, whether he presents himself for the withdrawal of blood on his own initiative or on the initiative of another person, in which he receives a monetary consideration.*

(l) ~~(k)~~ *"Transfusion" means a use of blood in which the blood is administered to a human being for treatment of sickness or injury.*

~~(l) "Department" means the Department of Health and Rehabilitative Services.~~

(3) LABEL; PURCHASE OR DONATION TO BE INDICATED.—

(a) Every person who withdraws blood from an individual, or separates blood into components by physical processes, shall affix to each container of such blood or components a label in a form specified by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~, which form shall include an indication of whether the blood was obtained by purchase or donation.

(b) Any person who receives blood in this state from a blood bank in another state shall label such blood as donated blood only if he has a certificate, in a form approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~, from such blood bank that the particular shipment of blood was acquired by donation or that all blood processed by that blood bank is acquired by donation. If there is no such certificate, such blood shall be labeled as blood acquired by purchase.

(c) ~~After January 1, 1983,~~ No blood obtained from a paid donor shall be used in any transfusion unless other blood of a type compatible with the blood type of the patient cannot be obtained for the transfusion.

(4) BLOOD AND BLOOD COMPONENTS.—It is the policy of the state to encourage the maintenance of an adequate supply of voluntarily donated blood of the highest quality accessible to all in need of blood. The state seeks with this policy to assure for its residents and visitors a system of blood supply, transfer, and replacement that can supply all of the requirements for blood without unduly burdening persons who, due to age, illness, or other circumstances, are unable to replace or arrange for blood replacement.

(5) RECIPROCAL EXCHANGE OF BLOOD.—All blood banks as well as hospitals, clinics, nursing homes, and other users of blood and blood products operating within the state will make reciprocal exchange of blood as required by the blood needs of the transfusing bank. Reimbursement shall be based upon the fee of the transfusing blood bank or

the schedules determined by the exchange or cooperative system serving the majority of the blood banks, hospitals, and clinics. Geographical location or blood bank affiliation shall not be considered in determining the rate of reimbursement.

(6) ADMINISTRATION OF ACT.—

(a) The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall *adopt* ~~promulgate~~ rules necessary to carry out the provisions of this section. Such rules shall be *adopted* ~~promulgated~~ in accordance with the provisions of chapter 120.

(b) The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ may inspect the collecting, labeling, and storage facilities of any blood bank, hospital, or other entity that withdraws or stores blood, at any reasonable time, to assure compliance with this section.

(7) VIOLATION; PENALTY.—A violation of any provision of subsection (3) shall be a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. A second or subsequent violation of any provision of subsection (3) shall be a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(8) VIOLATION; INJUNCTION.—In addition to any other remedy provided by law, the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ may apply to a circuit court for, and such court shall have jurisdiction upon hearing and for cause shown to grant, a temporary or permanent injunction restraining any person from violating any provision of subsection (3), irrespective of whether or not there exists an adequate remedy at law.

(9) LIMITATION.—Nothing in this section shall require hospitals to file reports or make disclosures beyond those required by s. 408.061.

Section 43. Subsections (1), (2), (3), (4), and (8) of section 383.302, Florida Statutes, are amended to read:

383.302 Definitions of terms used in ss. 383.30-383.335.—As used in ss. 383.30-383.335, unless the context otherwise requires, the term:

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

(2)~~(1)~~ "Birth center" means any facility, institution, or place, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

(3)~~(2)~~ "Clinical staff" means individuals employed full time or part time by a birth center who are licensed or certified to provide care at childbirth.

(4)~~(3)~~ "Consultant" means a physician licensed pursuant to chapter 458 or chapter 459 who agrees to provide advice and services to a birth center and who either:

(a) Is certified or eligible for certification by the American Board of Obstetrics and Gynecology, or

(b) Has hospital obstetrical privileges.

~~(4) "Department" means the Department of Health and Rehabilitative Services.~~

(8) "Low-risk pregnancy" means a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the *agency* ~~department~~, and which is accompanied by adequate prenatal care.

Section 44. Section 383.305, Florida Statutes, is amended to read:

383.305 Licensure; issuance, renewal, denial, suspension, revocation; fees.—

(1)(a) Upon receipt of an application for a license and the license fee, the *agency* ~~department~~ shall issue a license if the applicant and facility have received all approvals required by law and meet the requirements established under ss. 383.30-383.335 and by rules *adopted under those sections* ~~promulgated hereunder~~.

(b) A provisional license may be issued to any birth center that is in substantial compliance with ss. 383.30-383.335 and with the rules of the *agency* ~~department~~. A provisional license may be granted for a period of no more than 1 year from the effective date of rules adopted by the *agency* ~~department~~, shall expire automatically at the end of its term, and may not be renewed.

(c) A license, unless sooner suspended or revoked, automatically expires 1 year from its date of issuance and is renewable upon application for renewal and payment of the fee prescribed, provided the applicant and the birth center meet the requirements established under ss. 383.30-383.335 and by rules *adopted under those sections* ~~promulgated hereunder~~. A complete application for renewal of a license shall be made 90 days prior to expiration of the license on forms provided by the *agency* ~~department~~.

(2) An application for a license, or renewal thereof, shall be made to the *agency* ~~department~~ upon forms provided by it and shall contain such information as the *agency* ~~department~~ reasonably requires, which may include affirmative evidence of ability to comply with applicable laws and rules.

(3)(a) Each application for a birth center license, or renewal thereof, shall be accompanied by a license fee. Fees shall be established by rule of the *agency* ~~department~~. Such fees are payable to the *agency* ~~department~~ and shall be deposited in *the Health Care* a Trust Fund administered by the *agency* ~~department, to be used for the sole purpose of carrying out the provisions of ss. 383.30-383.335~~.

(b) The fees established pursuant to ss. 383.30-383.335 shall be based on actual costs incurred by the *agency* ~~department~~ in the administration of its duties under such sections.

(4) Each license is valid only for the person or governmental unit to whom or which it is issued; is not subject to sale, assignment, or other transfer, voluntary or involuntary; and is not valid for any premises other than those for which it was originally issued.

(5) Each license shall be posted in a conspicuous place on the licensed premises.

(6) Whenever the *agency* ~~department~~ finds that there has been a substantial failure to comply with the requirements established under ss. 383.30-383.335 or in rules *adopted under those sections* ~~promulgated hereunder~~, it is authorized to deny, suspend, or revoke a license.

Section 45. Subsection (5) of section 383.307, Florida Statutes, is amended to read:

383.307 Administration of birth center.—

(5) If a birth center is unable to find a consultant, it may enter into a consultation agreement with the Department *of Health and Rehabilitative Services* upon approval by the State Health Officer.

Section 46. Paragraph (a) of subsection (2) of section 383.308, Florida Statutes, is amended to read:

383.308 Birth center facility and equipment; requirements.—

(2)(a) A birth center shall be equipped with those items needed to provide low-risk maternity care and readily available equipment to initiate emergency procedures in life-threatening events to mother and baby, as defined by rule of the *agency* ~~department~~.

Section 47. Section 383.309, Florida Statutes, is amended to read:

383.309 Minimum standards for birth centers; rules and enforcement.—

(1) The *agency* ~~department~~ shall adopt, amend, promulgate, and enforce rules to implement the provisions of this act, which rules shall include, but are not limited to, reasonable and fair minimum standards for ensuring that:

(a) Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety.

(b) Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented.

(c) Construction, maintenance, repair, and renovation of licensed facilities are governed by rules of the *agency* ~~department~~ which utilize the most recently adopted, nationally recognized codes wherever feasible. Facilities licensed under s. 383.305 are exempt from local construction standards to the extent that those standards are in conflict with the standards adopted by rule of the *agency* ~~department~~.

(d) Licensed facilities are established, organized, and operated consistent with established programmatic standards.

(2) Any licensed facility which is in operation at the time of promulgation of any applicable rule under ss. 383.30-383.335 shall be given a reasonable time under the particular circumstances, not to exceed 1 year from the date of such promulgation, within which to comply with such rule.

Section 48. Section 383.31, Florida Statutes, is amended to read:

383.31 Selection of clients; informed consent.—

(1)(a) A birth center may accept only those patients who are expected to have normal pregnancies, labors, and deliveries.

(b) The criteria for the selection of clients and the establishment of risk status shall be defined by rule of the *agency* ~~department~~.

(2)(a) A patient may not be accepted for care until the patient has signed a client informed-consent form.

(b) The *agency* ~~department~~ shall develop a client informed-consent form to be used by the center to inform the client of the benefits and risks related to childbirth outside a hospital.

Section 49. Subsection (1) of section 383.312, Florida Statutes, is amended to read:

383.312 Prenatal care of birth center clients.—

(1) A birth center shall ensure that its clients have adequate prenatal care, as defined by the *agency* ~~department~~, and shall ensure that serological tests are administered as required by this chapter.

Section 50. Subsection (1) of section 383.313, Florida Statutes, is amended to read:

383.313 Performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—A birth center may collect specimens for those tests that are requested under protocol. A birth center may perform simple laboratory tests, as defined by rule of the *agency* ~~department~~, and is exempt from the requirements of chapter 483, provided no more than five physicians are employed by the birth center and testing is conducted exclusively in connection with the diagnosis and treatment of clients of the birth center.

Section 51. Subsection (1) of section 383.318, Florida Statutes, is amended to read:

383.318 Postpartum care for birth center clients and infants.—

(1) A mother and her infant shall be dismissed from the birth center within 24 hours after the birth of the infant, except in unusual circumstances as defined by rule of the *agency* ~~department~~. If a mother or infant is retained at the birth center for more than 24 hours after the birth, a report shall be filed with the *agency* ~~department~~ within 48 hours of the birth describing the circumstances and the reasons for the decision.

Section 52. Subsection (3) of section 383.32, Florida Statutes, is amended to read:

383.32 Clinical records.—

(3) Clinical records shall be kept confidential in accordance with s. 455.241 and exempt from the provisions of s. 119.07(1). A client's clinical records shall be open to inspection only under the following conditions:

(a) A consent to release information has been signed by the client; or

(b) The review is made by the *agency* ~~department~~ for a licensure survey or complaint investigation.

This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

Section 53. Section 383.324, Florida Statutes, is amended to read:

383.324 Inspections and investigations; inspection fees.—

(1) The *agency* ~~department~~ shall make or cause to be made such inspections and investigations as it deems necessary.

(2) Each facility licensed under s. 383.305 shall pay to the *agency* ~~department~~, at the time of inspection, an inspection fee established by rule of the *agency* ~~department~~.

(3) The *agency* ~~department~~ shall coordinate all periodic inspections for licensure made by the *agency* ~~department~~ to ensure that the cost to the facility of such inspections and the disruption of services by such inspections is minimized.

Section 54. Subsection (3) of section 383.325, Florida Statutes, is amended to read:

383.325 Inspection reports.—

(3) A licensed facility shall, upon the request of any person who has completed a written application with intent to be admitted to such facility or any person who is a patient of such facility, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report issued by the *agency* ~~department~~ or an accrediting organization, whichever is most recent, pertaining to the licensed facility, as provided in subsection (1), provided the person requesting such report agrees to pay a reasonable charge to cover copying costs.

Section 55. Subsection (4) of section 383.327, Florida Statutes, is amended to read:

383.327 Birth and death records; reports.—

(4) A report shall be submitted annually to the *agency* ~~department~~. The contents of the report shall be prescribed by rule of the *agency* ~~department~~.

Section 56. Section 383.33, Florida Statutes, is amended to read:

383.33 Administrative penalties; emergency orders; moratorium on admissions.—

(1)(a) The *agency* ~~department~~ may deny, revoke, or suspend a license, or impose an administrative fine not to exceed $500 per violation per day, for the violation of any provision of ss. 383.30-383.335 or any rule *adopted under those sections* ~~promulgated hereunder~~. Each day of violation constitutes a separate violation and is subject to a separate fine.

(b) In determining the amount of the fine to be levied for a violation, as provided in paragraph (a), the following factors shall be considered:

1. The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted; the severity of the actual or potential harm; and the extent to which the provisions of this act were violated.

2. Actions taken by the licensee to correct the violations or to remedy complaints.

3. Any previous violations by the licensee.

(c) All amounts collected pursuant to this section shall be deposited into a trust fund administered by the *agency* ~~department to be used for the sole purpose of carrying out the provisions of ss. 383.30-383.335~~.

(2) The *agency* ~~department~~ may issue an emergency order immediately suspending or revoking a license when it determines that any condition in the licensed facility presents a clear and present danger to the public health and safety.

(3) The *agency* ~~department~~ may impose an immediate moratorium on elective admissions to any licensed facility, building or portion thereof, or service when the *agency* ~~department~~ determines that any condition in the facility presents a threat to the public health or safety.

Section 57. Section 383.331, Florida Statutes, is amended to read:

383.331 Injunctive relief.—Notwithstanding the existence or pursuit of any other remedy, the *agency* ~~department~~ may maintain an action in the name of the state for injunction or other process to enforce the provisions of ss. 383.30-383.335 and the rules *adopted* ~~promulgated~~ under such sections.

Section 58. Subsection (1) of section 383.335, Florida Statutes, is amended to read:

383.335 Partial exemptions.—

(1) Any facility which was providing obstetrical and gynecological surgical services and was owned and operated by a board-certified obstetrician on June 15, 1984, and which is otherwise subject to licensure under ss. 383.30-383.335 as a birth center, is exempt from the provisions of ss. 383.30-383.335 which restrict the provision of surgical services and outlet forceps delivery and the administration of anesthesia at birth centers. The *agency* ~~department~~ shall adopt rules specifically related to the performance of such services and the administration of anesthesia at such facilities.

Section 59. Paragraph (b) of subsection (1) of section 390.001, Florida Statutes, is amended to read:

390.001 Termination of pregnancies.—

(1) DEFINITIONS.—As used in this section, unless the context clearly requires otherwise:

(b) "Approved facility" means:

1. A hospital licensed by the state; or

2. A medical facility licensed by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ pursuant to rules adopted for that purpose, provided such rules shall require regular evaluation and review procedures.

Section 60. Subsection (1) of section 390.002, Florida Statutes, is amended to read:

390.002 Termination of pregnancies; reporting.—

(1) The director of any medical facility in which any pregnancy is terminated shall submit a monthly report which contains the number of procedures performed, the reason for same, and the period of gestation at the time such procedures were performed to the Department of Health and Rehabilitative Services. The department shall be responsible for keeping such reports in a central place from which statistical data and analysis can be made *and for making the monthly reports available to the Agency for Health Care Administration for the State Center for Health Statistics and for purposes of abortion clinic licensure.*

Section 61. Section 390.011, Florida Statutes, is amended to read:

390.011 Definitions.—As used in this act:

(1) "Abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.

(2) "Abortion clinic" or "clinic" means any facility in which abortions are performed other than a hospital or a physician's office which is not used primarily for the performance of abortions.

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

(4)~~(3)~~ "Department" means the Department of Health and Rehabilitative Services.

(5)~~(4)~~ "Hospital" means a facility licensed under chapter 395.

(6)~~(5)~~ "Physician" means a physician licensed under chapter 458 or chapter 459 or a physician practicing medicine or osteopathy in the employment of the United States or this state.

(7)~~(6)~~ "Third trimester" means the weeks of pregnancy after the 24th week of pregnancy.

Section 62. Subsections (1) and (2) of section 390.012, Florida Statutes, are amended to read:

390.012 Powers of *agency* ~~department~~; rules; disposal of fetal remains.—

(1) The *agency* ~~department~~ shall have the authority to develop and enforce rules for the health, care, and treatment of persons in abortion clinics and for the safe operation of such clinics. These rules shall be comparable to rules which apply to all surgical procedures requiring approximately the same degree of skill and care as the performance of first trimester abortions. The rules shall be reasonably related to the preservation of maternal health of the clients. The rules shall not impose a legally significant burden on a woman's freedom to decide whether to terminate her pregnancy. The rules shall provide for:

(a) The performance of pregnancy termination procedures only by a licensed physician.

(b) The making, protection, and preservation of patient records, which shall be treated as medical records under chapter 458.

(2) The *agency* ~~department~~ may adopt and enforce rules, in the interest of protecting the public health, to ensure the prompt and proper disposal of fetal remains and tissue resulting from pregnancy termination.

Section 63. Subsection (1) of section 390.014, Florida Statutes, is amended to read:

390.014 Licenses; fees, display, etc.—

(1) No abortion clinic shall operate in this state without a currently effective license issued by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~.

Section 64. Subsection (1) of section 390.015, Florida Statutes, is amended to read:

390.015 Application for license.—

(1) An application for a license to operate an abortion clinic shall be made to the *agency* ~~department~~ on a form furnished by it for that purpose. The application shall be accompanied by the applicable license fee.

Section 65. Section 390.016, Florida Statutes, is amended to read:

390.016 Expiration of license; renewal.—

(1) A license issued for the operation of an abortion clinic, unless sooner suspended or revoked, shall expire 1 year from the date of issuance. Sixty days prior to the expiration date, an application for renewal of such license shall be submitted to the *agency* ~~department~~ on a form furnished by the *agency* ~~department~~. The license may be renewed if the applicant has met the requirements of this act and of all rules adopted pursuant to this act.

(2) A licensee against which a revocation or suspension proceeding is pending at the time of license renewal may be issued a conditional license which shall be effective until final disposition of the proceeding by the *agency* ~~department~~. If judicial relief is sought from the order resulting from the revocation or suspension proceeding, the court having jurisdiction may order that the conditional license be continued for the duration of the judicial proceeding.

Section 66. Section 390.017, Florida Statutes, is amended to read:

390.017 Grounds for suspension or revocation of license.—The license of an abortion clinic may be revoked, or may be suspended for a period not to exceed 2 years, or the *agency* ~~department~~ may refuse to renew such license, if it is determined in accordance with the provisions of chapter 120 that the clinic has violated a provision of this act or any rule or lawful order of the *agency* ~~department~~.

Section 67. Section 390.018, Florida Statutes, is amended to read:

390.018 Administrative penalty in lieu of revocation or suspension.—If the *agency* ~~department~~ finds that one or more grounds exist for the revocation or suspension of a license issued to an abortion clinic, the *agency* ~~department~~ may, in lieu of such suspension or revocation, impose a fine upon the clinic in an amount not to exceed $1,000 for each violation. The fine shall be paid to the *agency* ~~department~~ within 60 days from the date of entry of the administrative order. If the licensee fails to pay the fine in its entirety to the *agency* ~~department~~ within the period allowed, the license of the licensee shall stand suspended, revoked, or renewal or continuation may be refused, as the case may be, upon expiration of such period and without any further administrative or judicial proceedings.

Section 68. Section 390.019, Florida Statutes, is amended to read:

390.019 Inspections; investigations.—The *agency* ~~department~~ shall make or shall cause to be made an inspection of an abortion clinic prior to licensing such clinic, and it shall make such additional inspections and investigations as may be necessary to assure compliance with this act.

Section 69. Section 390.021, Florida Statutes, is amended to read:

390.021 Injunction.—In addition to the other powers provided by this act, the *agency* ~~department~~ may institute injunction proceedings in a court of competent jurisdiction to restrain or prevent the establishment

or operation of an abortion clinic which does not have a license or is in violation of any provision of this act or of any rules adopted pursuant to this act.

Section 70. Subsection (2) of section 395.1055, Florida Statutes, 1992 Supplement, is amended to read:

395.1055 Rules and enforcement.—

(2) Separate standards may be provided for general and specialty hospitals, ~~and~~ ambulatory surgical centers, *and statutory rural hospitals as defined in s. 395.602.*

Section 71. Subsection (3) and paragraph (e) of subsection (4) of section 395.403, Florida Statutes, 1992 Supplement, are amended to read:

395.403 Reimbursement of state-sponsored trauma centers.—

(3) To receive state funding, a state-sponsored trauma center shall submit a claim electronically via the Trauma Claims Processing System~~, designed, developed, implemented, and operated by the department's Medicaid program,~~ to the ~~department's~~ Medicaid program *of the Agency for Health Care Administration* upon discharge of a trauma patient. When a hospital stay spans a state fiscal year, a separate hospital claim shall be submitted for the hospital days incurred in each fiscal year.

(4)

(e) The *Agency for Health Care Administration* ~~department's Medicaid Program office~~ shall check each claim to confirm that the patient is not covered under the Medicaid program and *the Department of Health and Rehabilitative Services* shall pay the claim out of the Trauma Services Trust Fund. Trauma patients who are eligible for the Medicaid program shall not be considered eligible for the state-sponsored trauma center program except for Medicaid noncovered services. If a claim is denied by the Trauma Claims Processing System as a result of Medicaid eligibility for Medicaid covered services, the hospital shall submit a claim to the Medicaid fiscal agent for payment.

Section 72. Section 395.606, Florida Statutes, is created to read:

395.606 Rural health network cooperative agreements.—

(1) INTENT.—It is the Legislature's intent that, to the extent necessary to foster the development of rural health networks as provided for in s. 381.0406, competitive market forces shall be replaced with state regulation, as provided for in subsections (2) and (3). It is also the intent of the Legislature that consolidation of hospital services or technologies undertaken pursuant to this section, and cooperative agreements between members of rural health networks, shall not violate the state's antitrust laws when such arrangements improve the quality of health care, moderate cost increases, and are made between members of rural health networks as defined in s. 381.0406. It is also the intent of the Legislature that such arrangements be protected from federal antitrust laws, subject to the approval and supervision of the Agency for Health Care Administration. Such intent is within the public policy of the state to facilitate the provision of quality, cost-efficient medical care to the public.

(2) STATE ACTION APPROVAL.—Providers who are members of certified rural health networks who seek to consolidate services or technologies or enter into cooperative agreements must seek approval from the Agency for Health Care Administration, which may consult with the Department of Legal Affairs. The agency shall determine that the likely benefits resulting from the agreement outweigh any disadvantages attributable to any potential reduction in competition resulting from the agreement and issue a letter of approval if, in its determination, the agreement reduces or moderates costs and meets any of the following criteria:

(a) Consolidates services or facilities in a market area used by rural health network patients to avoid duplication;

(b) Promotes cooperation between rural health network members in the market area;

(c) Encourages cost sharing among rural health network facilities;

(d) Enhances the quality of rural health care; or

(e) Improves utilization of rural health resources and equipment.

(3) STATE OVERSIGHT.—The Agency for Health Care Administration shall review each agreement approved under subsection (2) at least every 2 years. If the agency determines that the likely benefits resulting from its state action approval no longer outweigh any disadvantages attributable to any potential reduction in competition resulting from the agreement, the agency shall initiate proceedings to terminate its state action approval governing the agreement. Such termination proceeding shall be governed by chapter 120.

(4) JUDICIAL REVIEW.—Any applicant aggrieved by a decision of the Agency for Health Care Administration is entitled to both administrative and judicial review thereof in accordance with chapter 120. In such review, the decision of the agency shall be affirmed unless it is arbitrary, capricious, or it is not in compliance with this section.

Section 73. The Division of Statutory Revision is requested to retitle chapter 408, Florida Statutes, as "Health Care Administration."

Section 74. Paragraph (c) of subsection (2), paragraphs (b) and (c) of subsection (3), and subsection (4) of section 408.001, Florida Statutes, 1992 Supplement, are amended to read:

408.001 Florida Health Care Purchasing Cooperative.—

(2) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

(c) The Florida Health Care Purchasing Cooperative shall:

1. Establish administrative and accounting procedures for the operation of the corporation.

2. Secure staff necessary to properly administer the corporation.

3. Develop and implement a plan to publicize the Florida Health Care Purchasing Cooperative, the eligibility requirements for membership, and the procedures for becoming members of the cooperative and to maintain public awareness of the cooperative and its services.

4. Identify third-party payers and health care provider networks that serve members of the cooperative.

5. Collect data on costs and utilization of health care services from members of the cooperative, health care providers that provide services to employees and clients of members of the cooperative, and third-party payers for members of the cooperative. The cooperative shall protect the confidentiality and regulate the disclosure of data and records collected and maintained by the cooperative when such data and records contain information:

a. Of a sensitive, personal or medical nature concerning individuals, the release of which information would be defamatory to such individuals or cause unwarranted damage to the good name or reputation of such individuals or would jeopardize the safety of such individuals; or

b. That is used to protect or further a business advantage over those who do not know or use that information, and the disclosure of which would injure the affected entity in the marketplace.

Notwithstanding s. 119.14, all information obtained prior to October 1, 2001, and determined to be confidential pursuant to this subparagraph is exempt from s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

6. Compare cost and utilization data collected pursuant to subparagraph 5. with data collected by the *Agency for Health Care Administration* ~~Health Care Cost Containment Board~~. Because of the importance of data collection and analysis to the success of the cooperative, the cooperative shall carry out its responsibilities in conjunction with the *Agency for Health Care Administration* ~~Health Care Cost Containment Board~~ and use that *agency's* ~~board's~~ data gathering and analysis capabilities as the board of directors considers appropriate.

7. Establish criteria for evaluating health care provider networks and third-party payers, seeking advice from providers and third-party payers serving members of the cooperative.

8. Evaluate health care provider networks and third-party payers.

9. Inform members of the cooperative about the results of evaluations of health care provider networks and third-party payers.

(3) BOARD OF DIRECTORS.—

(b) The initial board of directors shall consist of:

1. The Director of the *Agency for Health Care Administration or his designee* ~~Division of State Employees Insurance of the Department of Management Services~~;

2. The *Director of the Division of State Health Purchasing of the Agency for Health Care Administration* ~~Assistant Secretary for Medicaid of the Department of Health and Rehabilitative Services~~;

3. The Assistant Secretary for Health Services of the Department of Corrections;

4. Two persons who are responsible for purchasing health benefits for municipal employees and who are appointed by the Florida League of Cities;

5. A person who is responsible for purchasing health care benefits for county employees or health care services for county clients and who is appointed by the Florida Association of Counties; ~~and~~

6. A person who is responsible for purchasing health care benefits for school district employees and who is appointed by the Florida Association of School Administrators; *and*.

7. A person who represents the American Federation of State, County, and Municipal Employees.

~~Appointments to the initial board of directors shall be made by August 1, 1991. The appointed members of the initial board of directors shall be appointed for 2 years and may be reappointed. The Director of the Division of State Employees Insurance shall chair the initial board of directors.~~

(c) The board shall adopt bylaws for the corporation which shall contain provisions for the *election* ~~selection~~ of directors to represent members of the cooperative following the initial appointments *and establish terms of office*. The board of directors may increase the number of its directors to provide for representation by *state and local governments and private employers who voluntarily elect to become* members of the cooperative. *The board must include a representative of the state agency administering the cooperative's contract with the state, if such a contract exists.*

~~(4) STAFF AND ADMINISTRATIVE SUPPORT. The Health Care Cost Containment Board shall provide staff and administrative support to, and shall draft bylaws for, the Florida Health Care Purchasing Cooperative until the board of directors of the cooperative has organized itself and appointed an executive director. The board of directors shall conduct its first meeting on or before September 1, 1991.~~

Section 75. Subsection (5) of section 408.002, Florida Statutes, 1992 Supplement, is amended to read:

408.002 Legislative findings and intent.—

(5) Finally, the Legislature finds that the distribution of health care responsibilities among multiple state agencies has added excessive costs to the health care delivery system. In order to reduce administrative costs and to improve the state's efficiency in addressing the health care crisis, it is the intent of the Legislature to consolidate health care financing, data collection, *planning,* and regulatory functions into a single state agency, *except as otherwise provided by law.* The Legislature intends that this single state agency serve the Governor and the Legislature in ~~all health related~~ matters *related to health care regulation and financing.*

Section 76. Section 408.003, Florida Statutes, 1992 Supplement, is amended to read:

408.003 Health Care Board; appointment of members; terms of office.—

(1) Effective July 1, 1992, and beginning with terms starting on that date, the Health Care Board established pursuant to s. 20.42 shall be composed of 11 members appointed by the Governor, subject to confirmation by the Senate. Four members shall be providers of health care, including one physician licensed under chapter 458 or chapter 459, who shall have professional experience in an ambulatory setting, one representative of nursing homes, and two representatives of hospitals, including one representative of the for-profit hospitals and one representative of the not-for-profit hospitals. Three members shall be representatives of businesses and industries in this state *that are not also providers of health care services,* including one that has fewer than 25 employees. One member shall be a representative from the insurance industry. Three members shall be consumers, one of whom shall represent a major consumer organization. No consumer member shall currently be or in the past have been employed by or affiliated with any provider of health care services. All members of the board shall be permanent residents of the state, and at least one member shall be 60 years of age or older. The Governor shall appoint two members who are not health care providers to the board, who shall serve as alternates for *the* ~~a 2-year period prior to being appointed as~~ regular voting members. An alternate member may only vote in the absence of a regular member *who is from the same appointment category as the alternate.*

(2) Each appointment shall be for a 3-year term, except that the initial appointments of two consumers, one representative of businesses and industries, and the nursing home representative shall be for a term ending on September 30, 1993; the initial appointments of the physician, the representative of the insurance industry, one representative of hospitals, and one representative of businesses and industries shall be for a term ending on September 30, 1994; and the initial appointments of one consumer, one representative of businesses and industries, and one representative of hospitals shall be for a term ending on September 30, 1995. No member is eligible for appointment for more than two full consecutive terms. A vacancy on the board shall be filled within 60 days from the date on which the vacancy occurs, and the appointment shall be made for the remainder of the unexpired term.

(3) The Health Care Board shall be composed of a membership that is reflective of and proportionate to the ethnic minority populations comprising 10 percent or more of the state's population and is proportionate to the gender, geographic, disabled, and demographic populations of the state. Effective January 1, 1994, the Governor shall make appointments to the board that will result in such an ethnically proportionate and gender-proportionate composition by 1995.

(4) The Governor may remove from office any member who no longer meets the qualifications under which he was appointed, who becomes disqualified for neglect of duty, or who misses more than four meetings in any one calendar year.

(5) The board shall meet from time to time to fulfill its responsibilities. Meetings may be called by the Director of Health Care Administration, the chairperson, or any six members and, except in an emergency, shall be called by written notice provided at least 10 working days in advance of the meeting. Meetings shall be open to the public. Six voting members of the board constitute a quorum.

(6) Board members shall be reimbursed for their expenses in accordance with the provisions of s. 112.061, while on official business for the board. The members of ad hoc advisory committees of the board are entitled to reimbursement for expenses incurred, including travel expenses.

Section 77. Subsection (7) of section 408.01, Florida Statutes, 1992 Supplement, is amended to read:

408.01 Voluntary private health insurance coverage and insurance cost containment.—

(7) The agency shall establish an advisory council of employers, *group health care purchasing organizations,* providers, insurers, and consumers to aid in establishing the voluntary private health insurance coverage and cost containment program and to consider administrative and legislative reforms that will assist the private sector in meeting coverage and cost containment targets.

Section 78. Section 408.02, Florida Statutes, 1992 Supplement, is amended to read:

(Substantial rewording of section. See s. 408.02, F.S., 1992 Supp., for present text.)

408.02 Practice parameters.—

(1) The Agency for Health Care Administration, in conjunction with the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Podiatric Association, the Florida Chiropractic Association, and other health professional associations, and in conjunction with the respective boards within the Division of Medical Quality Assurance within the Department of Professional Regulation, shall coordinate the development, adoption or endorsement, implementation, and evaluation of clinically relevant statewide practice parameters. In developing the practice parameters, the agency shall consider the principles and guide-

lines developed by the American Medical Association and other national health professional organizations, practice parameters that have been adopted by other states and the Federal Government, and the data received pursuant to this section. The practice parameters shall be developed for physicians, osteopaths, chiropractors, podiatrists, and other health professionals and may be adopted by rule. The practice parameters shall be clinically relevant and applicable to the day-to-day practice of medicine. The agency shall consult with health professionals and use relevant research findings with respect to patient outcomes in its adoption or endorsement of specific practice parameters.

(2) Practice parameters or guidelines are strategies for patient management, developed to assist physicians and other health professionals in clinical decisionmaking. Practice parameters include standards, guidelines, and other patient management strategies. The standards for practice parameters are accepted principles for patient management which identify a particular management strategy, or a range of management strategies, and provide guidance for the proper management of specific clinical situations. Other strategies for patient management include practice policies and practice options.

(3) The practice parameters adopted or endorsed by the agency shall consider the standards, principles, and guidelines developed by state and national health professional associations, other states, and the Federal Government. The practice parameters adopted by the agency shall include appropriateness criteria related to appropriateness for a condition, recommended frequency of use by age and sex, and exceptions to the parameter based on patient conditions. The practice parameters shall also specifically highlight practice patterns that indicate overuse and add to the costs of health care. The agency shall establish criteria for selecting health professionals and medical treatments, procedures, or other service groupings for the priority development of practice parameters. Such criteria shall include percentage of statewide health care expenditures and services, percentage of malpractice claims, likelihood of promoting primary and preventive health care, extent to which overuse or overutilization is suspected, public interest, and the practicality of evaluating the effects of the parameters on the cost and quality of care. The agency shall target the completion of 50 practice parameters by December 31, 1993. The agency shall prioritize the development of those practice parameters which involve the greatest utilization of resources, either because they are the most costly or because they are the most frequently performed.

(4) The purpose of practice parameters is to improve the quality of medical care by eliminating unwarranted variations in the delivery of medical treatment, fostering the appropriate utilization of health care services, and reducing unnecessary costs due to wrongful and excessive utilization. The practice parameters shall aim at providing quality medical care in the most cost-effective manner possible.

(5) The agency, in consultation with the appropriate professional boards, health professionals, technical experts, and representatives of consumer, insurer, and employer groups, shall develop and adopt state practice parameters, beginning with those which involve the greatest utilization of resources based on frequency and cost.

(6) The agency, in conjunction with the appropriate professional associations and in consultation with the respective boards within the Division of Medical Quality Assurance of the Department of Professional Regulation, shall develop practice parameters for services provided by diagnostic imaging centers, radiation therapy services, clinical laboratory services, physical therapy services, and comprehensive rehabilitative services. Practice parameters applicable to diagnostic imaging services shall be implemented by December 31, 1993.

(7) The practice parameters must establish standards for practice designed both to avoid liability claims altogether and to increase the defensibility of liability claims when they occur, thereby eliminating the need of physicians who use the practice parameters to practice unnecessary defensive medicine.

(8) The agency, in consultation with the appropriate professional boards and associations, shall implement procedures that provide for the periodic review and revision of practice parameters to ensure that the practice parameters are based on the latest scientific findings, outcomes data, other research findings, technological advancements, and clinical experience, but in no case shall the review be less than every 3 years. The agency shall use appropriate clinical, professional, and technical experts to assess the appropriateness of practice parameters adopted by the agency.

(9) The agency shall make the practice parameters available to the public, and to all hospitals, health professionals, health insurers, and other interested parties.

(10) The agency and the appropriate professional boards shall provide for the education of practicing physicians and other health professionals on the use of practice parameters.

(11) The agency shall use practice parameters for the utilization review of Medicaid and primary care services to evaluate the effects of practice parameters on the cost of defensive medicine and professional liability insurance.

(12) Where a practice parameter developed pursuant to this section defines a standard of care under the circumstances of a given case, a physician, an employee of a physician, an employer of a physician, a hospital, or an employee of a hospital, practicing in conformity with the practice paramters, who is subsequently named as a defendant in a lawsuit, may raise compliance with the practice parameter as an affirmative defense to a liability claim. Compiliance or noncompliance with a practice parameter developed under this section is relevant to an affirmative defense based on compliance or relevant to a claim that damages were proximately caused by noncompliance. The factfinder may consider whether any extenuating factors not anticipated by the practice parameters required a different course of care for an individual patient. Noncompliance with a practice parameter does not, in and of itself, create a cause of action.

(13) Practice parameters developed pursuant to this section shall be used in conjunction with the basic health care benefit package developed under this chapter and the health benefit plans authorized under s. 627.6699.

(14) The agency shall require the submission by health care professionals, health care facilities, and health care insurers of data necessary to carry out the agency's duties under this section. To the greatest extent possible, the agency shall coordinate data collection authorized under this subsection with the community health purchasing alliances authorized by ss. 408.701-408.706. The agency shall use the most efficient data collection and reporting process possible, minimizing the workload and the cost of reporting for health care professionals, health care facilities, and health care insurers. To the extent feasible, the agency shall collect required data from one source, such as health insurers. Entities required to report patient data to the agency are subject to the same penalties for failing to report as authorized by s. 408.08(14). Data to be collected and subsequently released to the public under this section shall be developed by the agency with the assistance of the health professional boards, health professional associations, and other interested parties determined by the agency. The agency shall adopt, by rule, the data-reporting requirements of health professionals, health facilities, and health insurers to ensure that the agency has sufficient data to evaluate the practice patterns of health professionals in the state. The data reports shall be provided to the agency quarterly, beginning with the quarter ending December 31, 1993. The agency shall collect data regarding the use of practice parameters, the extent to which health professionals bill for services provided outside the scope of practice parameters, and the effectiveness of practice parameters with regard to the costs of defensive medicine and professional liability insurance. Data collected by the agency shall include such data as patient volume, services provided by procedure and diagnostic grouping, number and type of medications prescribed, number of diagnostic tests ordered, number of consultations, patient outcomes, and total patient charges and sources of payment. These data shall be reported by patient age, sex, diagnosis, and other demographic and condition classifications required by the agency. Data collected and reported to the agency on individual professionals is confidential and exempt from s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(15) The agency shall prepare periodic aggregate reports, but at least annual reports, on health professional practice patterns and on the extent to which health professionals comply with practice parameters, for each type of health professional and geographic area, using the data reported by health professionals, health care facilities, and health insurers pursuant to this section. These reports shall be disseminated to the appropriate health professional boards, health professional associations, individual practitioners, insurers, and other interested parties. The agency shall also provide information to the public on health professional practice patterns and compliance with practice parameters in a way that is useful and meaningful to the public. The agency shall also establish a process for educating health care professionals about the use of practice parameters.

(16) In consultation with health professional boards, associations, and representatives of consumers, employers, and insurers, the agency shall conduct a study to assess:

(a) The acceptance and use of practice parameters within various health professional communities;

(b) The feasibility of using various incentives, including additional education, to promote health professional compliance with practice parameters;

(c) Ways in which payers, such as Medicaid, health maintenance organizations, other managed care organizations, and other third-party payers, can link health professional reimbursement to an overall pattern of adherence to adopted or endorsed practice parameters;

(d) Ways in which health professional licensure protocols can be used to promote adherence to practice parameters;

(e) Methods that hospitals and other health facilities that employ or offer staff privileges to health professionals should be able to use to promote compliance with practice standards, such as reimbursement methods and the continuation of staff privileges;

(f) Methods for evaluating the effectiveness of practice parameters in reducing the costs and incidence of defensive medicine and the costs of professional liability insurance; and

(g) Means for instituting disciplinary actions against health professionals who consistently practice outside the state practice parameters.

(17) The agency shall include a progress report on the development of practice parameters in the final Florida Health Plan due to the Legislature by December 31, 1993. The report shall address the criteria used to prioritize the development of practice parameters, a description of the initial set practice parameters adopted by the agency, public and provider information and education activities, data collection activities, a plan for the development of additional state practice parameters and the use of practice parameters by hospitals and health care professionals, and a report on the results of the study required by this section.

Section 79. Section 408.032, Florida Statutes, 1992 Supplement, is amended to read:

408.032 Definitions.—As used in ss. 408.031-408.045, the term:

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

(2)~~(1)~~ "Capital expenditure" means an expenditure, including an expenditure for a construction project undertaken by a health care facility as its own contractor, which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; or an expenditure which exceeds the minimum as specified in *s. 408.036(1)(c)* ~~s. 381.706(1)(c)~~, changes the bed capacity of the facility, or substantially changes the services or service area of the health care facility, health service provider, or hospice, and which includes the cost of the studies, surveys, designs, plans, working drawings, specifications, initial financing costs, and other activities essential to acquisition, improvement, expansion, or replacement of the plant and equipment. The *agency* ~~department~~ shall, by rule, adjust the capital expenditure threshold annually using an appropriate inflation index.

(3)~~(2)~~ "Certificate of need" means a written statement issued by the *agency* ~~department~~ evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.

(4)~~(3)~~ "Commenced construction" means initiation of and continuous activities beyond site preparation associated with erecting or modifying a health care facility, including procurement of a building permit applying the use of *agency-approved* ~~department-approved~~ construction documents, proof of an executed owner/contractor agreement or an irrevocable or binding forced account, and actual undertaking of foundation forming with steel installation and concrete placing.

~~(4) "Department" means the Agency for Health Care Administration.~~

(5) "District" means a health service planning district composed of the following counties:

District 1.—Escambia, Santa Rosa, Okaloosa, and Walton Counties.

District 2.—Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties.

District 3.—Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties.

District 4.—Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties.

District 5.—Pasco and Pinellas Counties.

District 6.—Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.

District 7.—Seminole, Orange, Osceola, and Brevard Counties.

District 8.—Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.

District 9.—Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.

District 10.—Broward County.

District 11.—Dade and Monroe Counties.

(6) "Expedited review" means the process by which certain types of applications are not subject to the review cycle requirements contained in *s. 408.039(1)* ~~s. 381.709(1)~~, and the letter of intent requirements contained in *s. 408.039(2)* ~~s. 381.709(2)~~.

(7) "Health care facility" means a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the developmentally disabled. A facility relying solely on spiritual means through prayer for healing is not included as a health care facility.

(8) "Health maintenance organization" means a health care provider organization defined and authorized in part I of chapter 641.

(9) "Health services" means diagnostic, curative, or rehabilitative services and includes alcohol treatment, drug abuse treatment, and mental health services.

(10) "Home health agency" means an agency that is certified or seeks certification as a Medicare home health service provider as defined in part III of chapter 400.

(11) "Hospice" or "hospice program" means a hospice as defined in part V of chapter 400.

(12) "Hospital" means a health care facility licensed under chapter 395.

(13) "Institutional health service" means a health service which is provided by or through a health care facility and which entails an annual operating cost of $500,000 or more. The *agency* ~~department~~ shall, by rule, adjust the annual operating cost threshold annually using an appropriate inflation index.

(14) "Intermediate care facility" means an institution which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require health-related care and services above the level of room and board.

(15) "Intermediate care facility for the developmentally disabled" means a residential facility licensed under chapter 393 and certified by the Federal Government pursuant to the Social Security Act as a provider of Medicaid services to persons who are mentally retarded or who have a related condition.

(16) "Major medical equipment" means equipment which is used to provide medical and other health services, which has been approved for general usage by the United States Food and Drug Administration for less than 3 years and which costs in excess of $1 million. The *agency* ~~department~~ shall, by rule, adjust the equipment threshold annually using an appropriate inflation index.

(17) "Multifacility project" means an integrated residential and health care facility consisting of independent living units, adult congregate living facility units, and nursing home beds certificated on or after January 1, 1987, where:

(a) The aggregate total number of independent living units and adult congregate living facility units exceeds the number of nursing home beds.

(b) The developer of the project has expended the sum of $500,000 or more on the certificated and noncertificated elements of the project combined, exclusive of land costs, by the conclusion of the 18th month of the life of the certificate of need.

(c) The total aggregate cost of construction of the certificated element of the project, when combined with other, noncertificated elements, is $10 million or more.

(d) All elements of the project are contiguous or immediately adjacent to each other and construction of all elements will be continuous.

(18) "Nursing home geographically underserved area" means:

(a) A county in which there is no existing or approved nursing home;

(b) An area with a radius of at least 20 miles in which there is no existing or approved nursing home; or

(c) An area with a radius of at least 20 miles in which all existing nursing homes have maintained at least a 95 percent occupancy rate for the most recent 6 months or a 90 percent occupancy rate for the most recent 12 months.

(19) "Skilled nursing facility" means an institution, or a distinct part of an institution, which is primarily engaged in providing, to inpatients, skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(20) "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The *agency* ~~department~~ shall establish by rule a list of all tertiary health services.

Section 80. Section 408.033, Florida Statutes, 1992 Supplement, is amended to read:

408.033 Local and state health planning.—

(1) LOCAL HEALTH COUNCILS.—

(a) Local health councils are hereby established as public or private nonprofit agencies serving the counties of a district ~~of the department~~. The members of each council shall be appointed in an equitable manner by the county commissions having jurisdiction in the respective district. Each council shall be composed of a number of persons equal to 1½ times the number of counties which compose the district or 12 members, whichever is greater. Each county in a district shall be entitled to at least one member on the council. The balance of the membership of the council shall be allocated among the counties of the district on the basis of population rounded to the nearest whole number; except that in a district composed of only two counties, no county shall have fewer than four members. The appointees shall be representatives of health care providers, health care purchasers, and nongovernmental health care consumers, but not excluding elected government officials. The members of the consumer group shall include a representative number of persons over 60 years of age. A majority of council members shall consist of health care purchasers and health care consumers. The local health council shall provide each county commission a schedule for appointing council members to ensure that council membership complies with the requirements of this paragraph. The members of the local health council shall elect a chairman. Members shall serve for terms of 2 years and may be eligible for reappointment.

(b) Each local health council shall:

1. Develop a district health plan which is consistent with the objectives and strategies in the state health plan, but which shall permit each local health council to develop strategies and set priorities for implementation based on its unique local health needs. The district health plan must contain preferences for health services' and facilities' development which must be considered by the *agency* ~~department~~ in its review of certificate-of-need applications. The district health plan shall be submitted to the *agency* ~~department~~ and updated periodically. The district health plans shall use a uniform format and be submitted to the *agency* ~~department~~ according to a schedule developed by the *agency* ~~department~~ in conjunction with the Statewide Health Council and the local health councils. The schedule must provide for coordination between the development of the state health plan and the district health plans and for the development of district health plans by major sections over a multiyear period. The elements of a district plan which are necessary to the review of certificate-of-need applications for proposed projects within the district shall be adopted by the *agency* ~~department~~ as a part of its rules.

2. Advise the *agency and the* Department *of Health and Rehabilitative Services* on health care issues and resource allocations.

3. Promote public awareness of community health needs, emphasizing health promotion and cost-effective health service selection.

4. Collect data and conduct analyses and studies related to health care needs of the district, including the needs of medically indigent persons, and assist the *agency* ~~department~~ and other state agencies in carrying out data collection activities that relate to the functions in this subsection.

5. Monitor the onsite construction progress, if any, of certificate-of-need approved projects and report council findings to the *agency* ~~department~~ on forms provided by the *agency* ~~department~~.

6. Advise and assist regional planning councils within each district with the development of the health element of the comprehensive regional policy plan to address the health goals and policies in the State Comprehensive Plan.

7. Advise and assist local governments within each district on the development of an optional health plan element of the comprehensive plan provided in chapter 163, to assure compatibility with the health goals and policies in the State Comprehensive Plan and district health plan. To facilitate the implementation of this section, the local health council shall annually provide the local governments in its service area, upon request, with:

a. A copy and appropriate updates of the district health plan;

b. A report of hospital and nursing home utilization statistics for facilities within the local government jurisdiction; and

c. Applicable *agency* ~~department~~ rules and calculated need methodologies for health facilities and services regulated under *s. 408.034* ~~s. 381.704~~ for the district served by the local health council.

8. Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of local, state, federal, and private funds distributed to meet the needs of the medically indigent and other underserved population groups.

9. In conjunction with the Department of Health and Rehabilitative Services and Statewide Health Council, plan for services at the local level for persons infected with the human immunodeficiency virus.

10. Provide technical assistance to encourage and support activities by providers, purchasers, consumers, and local, regional, and state agencies in meeting the health care goals, objectives, and policies adopted by the local health council.

11. Provide the *agency* ~~department~~ with data required by rule for the review of certificate-of-need applications and the projection of need for health services and facilities in the district.

(c) Local health councils may conduct public hearings pursuant to *s. 408.039(3)(b)* ~~s. 381.709(3)(b)~~.

(d) Each local health council shall enter into a memorandum of agreement with each regional planning council in its district. In addition, each local health council shall enter into a memorandum of agreement with each local government that includes an optional health element in its comprehensive plan. Each memorandum of agreement must specify the manner in which each local government, regional planning council, and local health council will coordinate its activities to ensure a unified approach to health planning and implementation efforts.

(e) Local health councils may employ personnel to carry out the councils' purposes. Such personnel shall possess qualifications and be compensated in a manner commensurate with comparable positions in the Career Service System. However, such personnel shall not be deemed to be state employees.

(f) Personnel of the local health councils shall provide an annual orientation to council members about council member responsibilities. The orientation shall include presentations and participation by *agency* ~~department~~ staff.

(g) Each local health council is authorized to accept and receive, in furtherance of its health planning functions, funds, grants, and services from governmental agencies and from private or civic sources and to perform studies related to local health planning in exchange for such funds, grants, or services. Each local health council shall, no later than January 30 of each year, render an accounting of the receipt and disbursement of such funds received by it to the *agency* ~~department~~. The *agency* ~~department~~ shall consolidate all such reports and submit such consolidated report to the Legislature no later than March 1 of each year. Funds received by a local health council pursuant to this paragraph shall not be deemed to be a substitute for, or an offset against, any funding provided pursuant to subsection (3).

(2) STATEWIDE HEALTH COUNCIL.—The Statewide Health Council is hereby established as a state-level comprehensive health planning and policy advisory board. For administrative purposes, the council shall be located within the *agency* ~~department~~. The Statewide Health Council shall be composed of: the State Health Officer ~~and the Assistant Secretary for Medicaid~~ of the Department of Health and Rehabilitative Services; the *Division* ~~Deputy~~ Director for Health Policy and *Cost Control,* ~~Planning and~~ the *Division* ~~Deputy~~ Director for Health Quality Assurance, *and the Division Director of State Health Purchasing* of the *agency* ~~department; the director of the Health Care Board~~; the Insurance Commissioner or his designee; the Vice Chancellor for Health Affairs of the Board of Regents; three chairmen of regional planning councils, selected by the regional planning councils; five chairmen of local health councils, selected by the local health councils; four members appointed by the Governor, one of whom is a consumer over 60 years of age, one of whom is a representative of organized labor, one of whom is a physician, and one of whom represents the nursing home industry; five members appointed by the President of the Senate, one of whom is a representative of the insurance industry in this state, one of whom is the chief executive officer of a business with more than 300 employees in this state, one of whom represents the hospital industry, one of whom is a primary care physician, and one of whom is a nurse, and five members appointed by the Speaker of the House of Representatives, one of whom is a consumer who represents a minority group in this state, one of whom represents the home health care industry in this state, one of whom is an allied health care professional, one of whom is the chief executive officer of a business with fewer than 25 employees in this state, and one of whom represents a county social services program that provides health care services to the indigent. Appointed members of the council shall serve for 2-year terms commencing October 1 of each even-numbered year. The council shall elect a president from among the members who are not state employees. The Statewide Health Council shall:

(a) Advise the Governor, the Legislature, and the *agency* ~~department~~ on state health policy issues, state and local health planning activities, and state health regulation programs;

(b) Prepare a state health plan that specifies subgoals, quantifiable objectives, strategies, and resource requirements to implement the goals and policies of the health element of the State Comprehensive Plan. The plan must assess the health status of residents of this state; evaluate the adequacy, accessibility, and affordability of health services and facilities; assess government-financed programs and private health care insurance coverages; and address other topical local and state health care issues. Within 2 years after the health element of the State Comprehensive Plan is amended, and by July 1 of every 3rd year, if it is not amended, the Statewide Health Council shall submit the state health plan to the Executive Office of the Governor, the *director* ~~secretary~~ of the *agency* ~~department~~, the President of the Senate, and the Speaker of the House of Representatives;

(c) Promote public awareness of state health care issues and, in conjunction with the local health councils, conduct public forums throughout the state to solicit the comments and advice of the public on the adequacy, accessibility, and affordability of health care services in this state and other health care issues;

(d) Consult with local health councils, the Health Care ~~Cost Containment~~ Board, the Department of Insurance, the Department of Health and Rehabilitative Services, and other appropriate public and private entities, including health care industry representatives regarding the development of health policies;

(e) Serve as a forum for the discussion of local health planning issues of concern to the local health councils and regional planning councils;

(f) Review district health plans for consistency with the State Comprehensive Plan and the state health plan;

(g) Review the health components of agency functional plans for consistency with the health element of the State Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to agency functional plans to make them consistent with the State Comprehensive Plan;

(h) Review the comprehensive regional plans for consistency with the health element of the State Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to comprehensive regional policy plans to make them consistent with the State Comprehensive Plan;

(i) Assist the Department of Community Affairs in the review of local government comprehensive plans to ensure consistency with policy developed in the district health plans;

(j) With the assistance of the local health councils, conduct public forums and use other means to determine the opinions of health care consumers, providers, payers, and insurers regarding the state's health care goals and policies and develop suggested revisions to the health element of the State Comprehensive Plan. The council shall submit the proposed revisions to the health element of the State Comprehensive Plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1993, and shall widely circulate the proposed revisions to affected parties. The council shall periodically assess the progress made in achieving the goals and policies contained in the health element of the State Comprehensive Plan and report to the *agency* ~~department~~, the Governor, the President of the Senate, and the Speaker of the House of Representatives; and

(k) Conduct any other functions or studies and analyses falling under the duties listed above.

(3) FUNDING.—

(a) The Legislature intends that the cost of local health councils and the Statewide Health Council be borne by application fees for certificates of need and by assessments on selected health care facilities subject to facility licensure by the *agency* ~~department~~, including abortion clinics, adult congregate living facilities, ambulatory surgical centers, birthing centers, clinical laboratories except community nonprofit blood banks, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, and multiphasic testing centers and by assessments on organizations subject to certification by the *agency* ~~department~~ pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics.

(b)1. A hospital licensed under chapter 395, a nursing home licensed under chapter 400, and an adult congregate living facility licensed under chapter 400 shall be assessed an annual fee based on number of beds.

2. All other facilities and organizations listed in paragraph (a) shall each be assessed an annual fee of $150.

3. Facilities operated by the Department of Health and Rehabilitative Services or the Department of Corrections and any hospital which meets the definition of rural hospital pursuant to s. 395.602 are exempt from the assessment required in this subsection.

(c)1. The *agency* ~~department~~ shall, by rule, establish fees for hospitals and nursing homes based on an assessment of $2 per bed. However, no such facility shall be assessed more than a total of $500 under this subsection.

2. The *agency* ~~department~~ shall, by rule, establish fees for adult congregate living facilities based on an assessment of $1 per bed. However, no such facility shall be assessed more than a total of $150 under this subsection.

3. The *agency* ~~department~~ shall, by rule, establish an annual fee of $150 for all other facilities and organizations listed in paragraph (a).

(d) The *agency* ~~department~~ shall, by rule, establish a facility billing and collection process for the billing and collection of the health facility fees authorized by this subsection.

(e) A health facility which is assessed a fee under this subsection is subject to a fine of $100 per day for each day in which the facility is late in submitting its annual fee up to maximum of the annual fee owed by the facility. A facility which refuses to pay the fee or fine is subject to the forfeiture of its license.

(f) There is created in the State Treasury the Local and State Health Trust Fund. Moneys in the fund shall be appropriated only to the *agency* ~~department~~ for the purposes of subsections (1) and (2) of this section.

(g) The *agency* ~~department~~ shall deposit in the Local and State Health Trust Fund all health care facility assessments that are assessed under this subsection and proceeds from the certificate-of-need application fees which are sufficient to maintain the aggregate funding level for the local health councils and the Statewide Health Council as specified in the General Appropriations Act for the 1990-1991 fiscal year, plus any increase specifically mandated by the Legislature for the Statewide Health Council. The remaining certificate-of-need application fees shall be deposited in a trust account administered by the *agency* ~~department~~ and may be used only for the purpose of administering the Health Facility and Services Development Act.

(4) DUTIES AND RESPONSIBILITIES OF THE *AGENCY* ~~DEPARTMENT~~.—

(a) The *agency* ~~department~~, in conjunction with the Statewide Health Council and the local health councils, is responsible for the planning of all health care services in the state and for assisting the Statewide Health Council in the preparation of the state health plan.

(b) The *agency* ~~department~~ shall develop and maintain a comprehensive health care data base for the purpose of health planning and for certificate-of-need determinations. The *agency* ~~department~~ or its contractor is authorized to require the submission of information from health facilities, health service providers, and licensed health professionals which is determined by the *agency* ~~department~~, through rule, to be necessary for meeting the *agency's* ~~department's~~ responsibilities as established in this section.

(c) The *agency* ~~department~~ shall assist personnel of the local health councils in providing an annual orientation to council members about council member responsibilities.

(d) The *agency* ~~department~~ shall contract with the local health councils for the services specified in subsection (1). All contract funds shall be distributed according to an allocation plan developed by the *agency* ~~department~~ that provides for a minimum and equal funding base for each local health council. Any remaining funds shall be distributed based on adjustments for workload. The *agency* ~~department~~ may also make grants to or reimburse local health councils from federal funds provided to the state for activities related to those functions set forth in this section. The *agency* ~~department~~ may withhold funds from a local health council or cancel its contract with a local health council which does not meet performance standards agreed upon by the *agency* ~~department~~ and local health councils.

Section 81. Section 408.034, Florida Statutes, 1992 Supplement, is amended to read:

408.034 Duties and responsibilities of *agency* ~~department~~; rules.—

(1) The *agency* ~~department~~ is designated as the single state agency to issue, revoke, or deny certificates of need and to issue, revoke, or deny exemptions from certificate-of-need review in accordance with the district plans, the statewide health plan, and present and future federal and state statutes. The *agency* ~~department~~ is designated as the state health planning agency for purposes of federal law.

(2) In the exercise of its authority to issue licenses to health care facilities and health service providers, as provided under chapters 393, 395, and 400, and to hospices, the *agency* ~~department~~ shall not issue a license to any health care facility, health service provider, hospice, or part of a health care facility which fails to receive a certificate of need for the licensed facility or service.

(3) The *agency* ~~department~~ shall establish, by rule, uniform need methodologies for health services and health facilities. In developing uniform need methodologies, the *agency* ~~department~~ shall, at a minimum, consider the demographic characteristics of the population, the health status of the population, service use patterns, standards and trends, geographic accessibility, and market economics.

(4) The *agency* ~~department~~ shall establish by rule a nursing home bed need methodology which reduces the community nursing home bed need for the areas of the state where the Department *of Health and Rehabilitative Services or the Department of Elderly Affairs* establishes pilot community diversion programs through the Title XIX aging waiver program.

(5) The *agency* ~~department~~ may adopt rules necessary to implement *ss. 408.031-408 045* ~~ss. 381.701-381.715~~.

Section 82. Section 408.035, Florida Statutes, 1992 Supplement, is amended to read:

408.035 Review criteria.—

(1) The *agency* ~~department~~ shall determine the reviewability of applications and shall review applications for certificate-of-need determinations for health care facilities and services, hospices, and health maintenance organizations in context with the following criteria:

(a) The need for the health care facilities and services and hospices being proposed in relation to the applicable district plan and state health plan, except in emergency circumstances which pose a threat to the public health.

(b) The availability, quality of care, efficiency, appropriateness, accessibility, extent of utilization, and adequacy of like and existing health care services and hospices in the service district of the applicant.

(c) The ability of the applicant to provide quality of care and the applicant's record of providing quality of care.

(d) The availability and adequacy of other health care facilities and services and hospices in the service district of the applicant, such as outpatient care and ambulatory or home care services, which may serve as alternatives for the health care facilities and services to be provided by the applicant.

(e) Probable economies and improvements in service that may be derived from operation of joint, cooperative, or shared health care resources.

(f) The need in the service district of the applicant for special equipment and services which are not reasonably and economically accessible in adjoining areas.

(g) The need for research and educational facilities, including, but not limited to, institutional training programs and community training programs for health care practitioners and for doctors of osteopathy and medicine at the student, internship, and residency training levels.

(h) The availability of resources, including health manpower, management personnel, and funds for capital and operating expenditures, for project accomplishment and operation; the effects the project will have on clinical needs of health professional training programs in the service district; the extent to which the services will be accessible to schools for health professions in the service district for training purposes if such services are available in a limited number of facilities; the availability of alternative uses of such resources for the provision of other health services; and the extent to which the proposed services will be accessible to all residents of the service district.

(i) The immediate and long-term financial feasibility of the proposal.

(j) The special needs and circumstances of health maintenance organizations.

(k) The needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the service district in which the entities are located or in adjacent service districts. Such entities may include medical and other health professions, schools, multidisciplinary clinics, and specialty services such as open-heart surgery, radiation therapy, and renal transplantation.

(l) The probable impact of the proposed project on the costs of providing health services proposed by the applicant, upon consideration of factors including, but not limited to, the effects of competition on the supply of health services being proposed and the improvements or innovations in the financing and delivery of health services which foster competition and service to promote quality assurance and cost-effectiveness.

(m) The costs and methods of the proposed construction, including the costs and methods of energy provision and the availability of alternative, less costly, or more effective methods of construction.

(n) The applicant's past and proposed provision of health care services to Medicaid patients and the medically indigent.

(o) The applicant's past and proposed provision of services that promote a continuum of care in a multilevel health care system, including, but not limited to, acute care, skilled nursing care, home health care, and adult living facilities.

(2) In cases of capital expenditure proposals for the provision of new health services to inpatients, the *agency* ~~department~~ shall also reference each of the following in its findings of fact:

(a) That less costly, more efficient, or more appropriate alternatives to such inpatient services are not available and the development of such alternatives has been studied and found not practicable.

(b) That existing inpatient facilities providing inpatient services similar to those proposed are being used in an appropriate and efficient manner.

(c) In the case of new construction, that alternatives to new construction, for example, modernization or sharing arrangements, have been considered and have been implemented to the maximum extent practicable.

(d) That patients will experience serious problems in obtaining inpatient care of the type proposed, in the absence of the proposed new service.

(e) In the case of a proposal for the addition of beds for the provision of skilled nursing or intermediate care services, that the addition will be consistent with the plans of other agencies of the state responsible for the provision and financing of long-term care, including home health services.

(3) For any application authorized by *s. 408.036(2)(j) or (k)* ~~s. 381.706(2)(j) or (k)~~ involving an approved facility based on a certificate-of-need application filed prior to December 31, 1984, the *agency* ~~department~~ shall approve such application unless the proposed consolidation or division would result in a facility or facilities not meeting the criterion of financial feasibility or unless the consolidation or division would result in beds or services being moved more than 15 miles from their original certificated location.

Section 83. Section 408.036, Florida Statutes, 1992 Supplement, is amended to read:

408.036 Projects subject to review.—

(1) APPLICABILITY.—Unless exempt pursuant to subsection (3), all health-care-related projects, as described in paragraphs (a)-(n), are subject to review and must file an application for a certificate of need with the *agency* ~~department~~. The *agency* ~~department~~ is exclusively responsible for determining whether a health-care-related project is subject to review under *ss 408.031-408.045* ~~ss. 381.701-381.715~~.

(a) The addition of beds by new construction or alteration.

(b) The new construction or establishment of additional health care facilities.

(c) A capital expenditure of $1 million or more by or on behalf of a health care facility or hospice for a purpose directly related to the furnishing of health services at such facility; provided that a certificate of need shall not be required for an expenditure to provide an outpatient health service, or to acquire equipment or refinance debt, for which a certificate of need is not otherwise required pursuant to this subsection. The *agency* ~~department~~ shall, by rule, adjust the capital expenditure threshold annually using an appropriate inflation index.

(d) The conversion from one type of health care facility to another, including the conversion from one level of care to another, in a skilled or intermediate nursing facility, if such conversion effects a change in the level of care of 10 beds or 10 percent of total bed capacity of such skilled or intermediate nursing facility within a 2-year period. If such nursing facility is certified for both skilled and intermediate nursing care, the provisions of this paragraph do not apply.

(e) Any change in licensed bed capacity.

(f) The establishment of a home health agency or hospice, or the direct provision of such services by a health care facility or health maintenance organization for those other than the subscribers of the health maintenance organization.

(g) An acquisition by or on behalf of a health care facility or health maintenance organization, by any means, which acquisition would have required review if the acquisition had been by purchase, including an acquisition at less than fair market value if the fair market value is greater than the capital expenditure threshold.

(h) The establishment of inpatient institutional health services by a health care facility, or a substantial change in such services, or the obligation of capital expenditures for the offering of, or a substantial change in, any such services which entails a capital expenditure in any amount, or an annual operating cost of $500,000 or more. The *agency* ~~department~~ shall, by rule, adjust the annual operating cost threshold annually using an appropriate inflation index.

(i) The acquisition by any means of an existing health care facility by any person, unless such person provides the *agency* ~~department~~ with at least 30 days' written notice of the proposed acquisition, which notice is to include the services to be offered and the bed capacity of the facility, and unless the *agency* ~~department~~ does not determine, within 30 days of receipt of such letter of intent, that the services to be provided and the bed capacity of the facility will be changed.

(j) The acquisition, by any means, of major medical equipment by a health maintenance organization or health care facility to the extent that the health maintenance organization or health care facility is not exempt pursuant to *s. 408.043(1)* ~~s. 381.713(1)~~.

(k) An increase in the cost of a project for which a certificate of need has been issued when such increase in cost exceeds the limits set forth in paragraph (c), paragraph (h), or *s. 408.032* ~~s. 381.702~~, or 10 percent of the originally approved cost of the project, whichever is less, except that no cost overrun review is necessary when the cost overrun is less than $10,000.

(l) A change in the number of psychiatric or rehabilitation beds.

(m) The establishment of tertiary health services.

(n) A transfer of a certificate of need, in which case an expedited review shall be conducted according to rule and in accordance with *s. 408.042* ~~s. 381.712~~.

(2) PROJECTS SUBJECT TO EXPEDITED REVIEW.—Unless exempt pursuant to subsection (3), projects subject to an expedited review shall include, but not be limited to:

(a) Cost overruns, unless such cost overruns are caused by a change in service or scope which the *agency* ~~department~~ determines are otherwise reviewable.

(b) Research, education, and training programs.

(c) Donations, when market value equals or exceeds the applicable capital expenditure thresholds for operating expenditures, or major medical equipment, as defined in this act.

(d) Acquisition of land which is to be used for the construction of a health care facility, or office facilities for health care providers.

(e) Termination of a health care service.

(f) Shared services contracts or projects.

(g) A transfer of a certificate of need.

(h) Emergency projects and unforeseen major public health hazards.

(i) A 50-percent increase in nursing home beds for a facility incorporated and operating in this state for at least 60 years on or before July 1, 1988, which has a licensed nursing home facility located on a campus providing a variety of residential settings and supportive services. The increased nursing home beds shall be for the exclusive use of the campus residents.

(j) Combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict.

(k) Division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. Such division shall not be approved if it would adversely affect the original certificate's approved cost.

The *agency* ~~department~~ shall develop rules to implement the provisions for expedited review, including time schedule, application content, and application processing.

(3) EXEMPTIONS.—Upon request, supported by such documentation as the *agency* ~~department~~ may require, the *agency* ~~department~~ shall grant an exemption from the provisions of subsection (1):

(a) For any expenditure by or on behalf of a health care facility for any part of the physical plant which is not to be directly utilized for providing health services or housing health care providers. This exemption shall apply to expenditures for parking facilities, meeting rooms, cafeterias, administrative data processing facilities, research buildings, landscaping, and similar projects, but shall not apply to expenditures for office facilities for health care providers.

(b) For any expenditure to eliminate or prevent safety hazards as defined by federal, state, or local codes.

(c) For any expenditure to replace any part of a facility or equipment which is destroyed as a result of fire, civil disturbance, or storm or any other act of God.

(d) For any expenditure to acquire major medical equipment which is a substantially identical replacement for existing equipment being taken out of service.

(e) For the initiation or expansion of obstetric services after July 1, 1988.

(f) For any expenditure to replace or renovate any part of a licensed nursing facility, provided that the number of licensed beds will not increase and, in the case of a replacement facility, the project site is the same as the facility being replaced.

(g) For providing respite care services. "Respite care" means short-term care in a licensed health care facility which is personal or custodial in nature and is provided by reason of chronic illness, physical infirmity, or advanced age for the purpose of temporarily relieving family members of the burden of providing care and attendance in the home. In providing respite care, the health care facility shall become the primary caregiver. An individual may be admitted to a respite care program in a hospital without regard to inpatient requirements relating to admitting order and attendance of a member of a medical staff.

(h) For hospice or home health services provided by a rural hospital, as defined in s. 395.602, or for swing beds in such rural hospital in a number that does not exceed one-half of its licensed beds.

(i) For the conversion of licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, if the conversion of the beds does not involve the construction of new facilities. The total number of skilled nursing beds, including swing beds, may not exceed one-half of the total number of licensed beds in the rural hospital on July 1, 1993. Certified skilled nursing beds designated under this paragraph, excluding swing beds, must be included in the community nursing home bed inventory. A rural hospital that subsequently decertifies any acute care beds exempted under this paragraph must notify the agency of the decertification, and the agency shall adjust the community nursing home bed inventory accordingly.

A request for exemption pursuant to this subsection may be made at any time and is not subject to the batching requirements of this section.

Section 84. Paragraph (a) of subsection (2) of section 408.037, Florida Statutes, 1992 Supplement, is amended to read:

408.037 Application content.—An application for a certificate of need shall contain:

(2) A statement of the financial resources needed by and available to the applicant to accomplish the proposed project. This statement shall include:

(a) A complete listing of all capital projects, including new health facility development projects and health facility acquisitions applied for, pending, approved, or underway in any state at the time of application, regardless of whether or not that state has a certificate-of-need program or a capital expenditure review program pursuant to section 1122 of the Social Security Act. The *agency* ~~department~~ may, by rule, require less-detailed information from major health care providers. This listing shall include the applicant's actual or proposed financial commitment to those projects and an assessment of their impact on the applicant's ability to provide the proposed project.

Section 85. Section 408.038, Florida Statutes, 1992 Supplement, is amended to read:

408.038 Fees.—The *agency* ~~department~~ shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the Statewide Health Council, the functions of the local health councils, and the activities of the *agency* ~~department~~ and shall be allocated as provided in *s. 408.033* ~~s. 381.703~~. The fee shall be determined as follows:

(1) A minimum base fee of $5,000.

(2) In addition to the base fee of $5,000, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed $22,000.

Section 86. Section 408.039, Florida Statutes, 1992 Supplement, is amended to read:

408.039 Review process.—The review process for certificates of need shall be as follows:

(1) REVIEW CYCLES.—The *agency* ~~department~~ by rule shall provide for applications to be submitted on a timetable or cycle basis; provide for review on a timely basis; and provide for all completed applications pertaining to similar types of services, facilities, or equipment affecting the same service district to be considered in relation to each other no less often than two times a year.

(2) LETTERS OF INTENT.—

(a) At least 30 days prior to filing an application, a letter of intent shall be filed by the applicant with the local health council and the *agency* ~~department~~, respecting the development of a proposal subject to review. No letter of intent is required for expedited projects as defined by rule by the *agency* ~~department~~.

(b) The *agency* ~~department~~ shall provide a mechanism by which applications may be filed to compete with proposals described in filed letters of intent.

(c) Letters of intent shall describe the proposal with specificity, including proposed capital expenditures, number of beds sought, if any, services, specific subdistrict location, identification of the applicant, including the names of those with controlling interest in the applicant, and such other information as the *agency* ~~department~~ may by rule prescribe. The letter of intent shall contain a certified copy of a resolution by the board of directors of the applicant, or other governing authority if not a corporation, authorizing the filing of the application described in the letter of intent; authorizing the applicant to incur the expenditures necessary to accomplish the proposed project; certifying that if issued a certificate, the applicant shall accomplish the proposed project within the time allowed by law and at or below the costs contained in the application; and certifying that the applicant shall license and operate the facility.

(d) Within 14 days after filing a letter of intent, the applicant shall publish a notice of filing to be published in a newspaper of general circulation in the area affected by the proposal. The notice of filing shall be published once a week for 2 consecutive weeks on forms and in the format and content specified by the *agency* ~~department~~ by rule. Within 21 days after the filing, the *agency* ~~department~~ shall publish notice of the filing of letters of intent in the Florida Administrative Weekly and notice that, if requested, a public hearing shall be held at the local level within 21 days after the application is deemed complete. Notices under this subsection shall contain due dates applicable to the cycle for filing applications and for requesting a hearing.

(3) APPLICATION PROCESSING.—

(a) An applicant shall file an application with the *agency* ~~department~~, and shall furnish a copy of the application to the local health council and the *agency* ~~department~~. Within 15 days after the applicable application

filing deadline established by *agency* ~~department~~ rule, the staff of the *agency* ~~department~~ shall determine if the application is complete. If the application is incomplete, the staff shall request specific information from the applicant necessary for the application to be complete; however, the staff may make only one such request. If the requested information is not filed with the *agency* ~~department~~ within 21 days of the receipt of the staff's request, the application shall be deemed incomplete and deemed withdrawn from consideration.

(b) Upon the request of any applicant or substantially affected person within 14 days after notice that an application has been filed, a public hearing may be held at the *agency's* ~~department's~~ discretion if the *agency* ~~department~~ determines that a proposed project involves issues of great local public interest. The public hearing shall allow applicants and other interested parties reasonable time to present their positions and to present rebuttal information. A recorded verbatim record of the hearing shall be maintained. The public hearing shall be held at the local level within 21 days after the application is deemed complete.

(4) STAFF RECOMMENDATIONS.—

(a) The *agency's* ~~department's~~ review of and final agency action on applications shall be in accordance with the district plan, and statutory criteria, and the implementing administrative rules. In the application review process, the *agency* ~~department~~ shall give a preference, as defined by rule of the *agency* ~~department~~, to an applicant which proposes to develop a nursing home in a nursing home geographically underserved area.

(b) Within 60 days after all the applications in a review cycle are determined to be complete, the *agency* ~~department~~ shall issue its State Agency Action Report and Notice of Intent to grant a certificate of need for the project in its entirety, to grant a certificate of need for identifiable portions of the project, or to deny a certificate of need. The State Agency Action Report shall set forth in writing its findings of fact and determinations upon which its decision is based. If a finding of fact or determination by the *agency* ~~department~~ is counter to the district plan of the local health council, the *agency* ~~department~~ shall provide in writing its reason for its findings, item by item, to the local health council and the Statewide Health Council. If the *agency* ~~department~~ intends to grant a certificate of need, the State Agency Action Report or the Notice of Intent shall also include any conditions which the *agency* ~~department~~ intends to attach to the certificate of need. The *agency* ~~department~~ shall designate by rule a senior staff person, other than the person who issues the final order, to issue State Agency Action Reports and Notices of Intent.

(c) The *agency* ~~department~~ shall publish its proposed decision set forth in the Notice of Intent in the Florida Administrative Weekly within 14 days after the Notice of Intent is issued.

(d) If no administrative hearing is requested pursuant to subsection (5), the State Agency Action Report and the Notice of Intent shall become the final order of the *agency* ~~department~~. The *agency* ~~department~~ shall provide a copy of the final order to the appropriate local health council.

(5) ADMINISTRATIVE HEARINGS.—

(a) Within 21 days after publication of notice of the State Agency Action Report and Notice of Intent, any person authorized under paragraph (b) to participate in a hearing may file a request for an administrative hearing; failure to file a request for hearing within 21 days of publication of notice shall constitute a waiver of any right to a hearing and a waiver of the right to contest the final decision of the *agency* ~~department~~. A copy of the request for hearing shall be served on the applicant.

(b) Hearings shall be held in Tallahassee unless the hearing officer determines that changing the location will facilitate the proceedings. In administrative proceedings challenging the issuance or denial of a certificate of need, only applicants considered by the *agency* ~~department~~ in the same batching cycle are entitled to a comparative hearing on their applications. Existing health care facilities may initiate or intervene in such administrative hearing upon a showing that an established program will be substantially affected by the issuance of a certificate of need to a competing proposed facility or program within the same district, provided that existing health care providers, other than the applicant, have no standing or right to initiate or intervene in an administrative hearing involving a health care project which is subject to certificate-of-need review solely on the basis of *s. 408.036(1)(c)* ~~s. 381.706(1)(c)~~. The *agency* ~~department~~ *shall assign* proceedings requiring hearings to the Division of Administrative Hearings of the Department of Management Services within 10 days after the time has run to request a hearing. Except upon unanimous consent of the parties or upon the granting by the hearing officer of a motion of continuance, hearings shall commence within 60 days after the hearing officer has been assigned. All non-state-agency parties shall bear their own expense of preparing a transcript. In any application for a certificate of need which is referred to the Division of Administrative Hearings for hearing, the hearing officer shall complete and submit to the parties a recommended order as provided in s. 120.57(1)(b). The recommended order shall be issued within 30 days after the receipt of the proposed recommended orders or the deadline for submission of such proposed recommended orders, whichever is earlier. The division shall adopt procedures for administrative hearings which shall maximize the use of stipulated facts and shall provide for the admission of prepared testimony.

(c) The *agency* ~~department~~ shall issue its final order within 45 days after receipt of the recommended order.

(d) If the *agency* ~~department~~ fails to take action within the time specified in paragraph (4)(a) or paragraph (5)(c), or as otherwise agreed to by the applicant and the *agency* ~~department~~, the applicant may take appropriate legal action to compel the *agency* ~~department~~ to act. When making a determination on an application for a certificate of need, the *agency* ~~department~~ is specifically exempt from the time limitations provided in s. 120.60(2).

(6) JUDICIAL REVIEW.—

(a) A party to an administrative hearing for an application for a certificate of need has the right, within not more than 30 days after the date of the final order, to seek judicial review in the District Court of Appeal pursuant to s. 120.68. The *agency* ~~department~~ shall be a party in any such proceeding.

(b) In such judicial review, the court shall affirm the final order of the *agency* ~~department~~, unless the decision is arbitrary, capricious, or not in compliance with *ss. 408.031-408.045* ~~ss. 381.701-381.715~~.

(c) The court, in its discretion, may award reasonable attorney's fees and costs to the prevailing party if the court finds that there was a complete absence of a justiciable issue of law or fact raised by the losing party.

Section 87. Section 408.040, Florida Statutes, is amended to read:

408.040 Conditions and monitoring.—

(1)(a) The *agency* ~~department~~ may issue a certificate of need predicated upon statements of intent expressed by an applicant in the application for a certificate of need. Any certificate of need issued for construction of a new hospital or for the addition of beds to an existing hospital shall include a statement of the number of beds approved by category of service, including rehabilitation or psychiatric service, for which the *agency* ~~department~~ has adopted by rule a specialty-bed-need methodology. All beds which are approved, but are not covered by any specialty-bed-need methodology, shall be designated as general. If the holder of a certificate of need demonstrates good cause why the certificate should be modified, the *agency* ~~department~~ shall reissue the certificate of need with such modifications as may be appropriate. The *agency* ~~department~~ shall by rule define the factors constituting good cause for modification.

(b) If the holder of a certificate of need fails to comply with a condition upon which the issuance of the certificate was predicated, the *agency* ~~department~~ may assess an administrative fine against the certificate-holder in an amount not to exceed $1,000 per failure per day. In assessing the penalty, the *agency* ~~department~~ shall take into account as mitigation the relative lack of severity of a particular failure. Proceeds of such penalties shall be deposited in the Public Medical Assistance Trust Fund.

(2)(a) Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 1 year after the date of issuance, except in the case of a multifacility project, as defined in *s. 408.032(17)* ~~s. 381.702(17)~~, where the certificate of need shall terminate 2 years after the date of issuance. The *agency* ~~department~~ may extend the period of validity of the certificate for an additional period of up to 6 months, upon a showing of good cause, as defined by rule, by the applicant for the extension. The *agency* ~~department~~ shall monitor the progress of the holder of

the certificate of need in meeting the timetable for project development specified in the application with the assistance of the local health council as specified in *s. 408.033* ~~s. 381.703(1)(b)7.~~, and may revoke the certificate of need, if the holder of the certificate is not meeting such timetable and is not making a good faith effort, as defined by rule, to meet it.

(b) A certificate of need issued to an applicant holding a provisional certificate of authority under chapter 651 shall terminate 1 year after the applicant receives a valid certificate of authority from the Department of Insurance. The certificate-of-need validity period may be extended by the *agency* ~~department~~ for an additional period of up to 6 months upon a showing of good cause, as defined by rule, by the applicant for the extension.

(c) The certificate-of-need validity period for a project shall be extended by the *agency* ~~department~~, to the extent that the applicant demonstrates to the satisfaction of the *agency* ~~department~~ that good faith commencement of the project is being delayed by litigation or by governmental action or inaction with respect to regulations or permitting precluding commencement of the project.

(d) If an application is filed to consolidate two or more certificates as authorized by *s. 408.036(2)(j)* ~~s. 381.706(2)(j)~~ or to divide a certificate of need into two or more facilities as authorized by *s. 408.036(2)(k)* ~~s. 381.706(2)(k)~~, the validity period of the certificate or certificates of need to be consolidated or divided shall be extended for the period beginning upon submission of the application and ending when final agency action and any appeal from such action has been concluded. However, no such suspension shall be effected if the application is withdrawn by the applicant.

(3) The *agency* ~~department~~ shall require the submission of an executed architect's certification of final payment for each certificate-of-need project approved by the *agency* ~~department~~. Each project which involves construction shall submit such certification to the *agency* ~~department~~ within 30 days following completion of construction.

Section 88. Section 408.041, Florida Statutes, 1992 Supplement, is amended to read:

408.041 Certificate of need required; penalties.—It is unlawful for any person to undertake a project subject to review under *ss. 408.031-408.045* ~~ss. 381.701-381.715~~ without a valid certificate of need. Any person violating the provisions of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation shall be considered a separate offense.

Section 89. Subsections (1) and (3) of section 408.043, Florida Statutes, 1992 Supplement, are amended, and subsection (4) is added to that section, to read:

408.043 Special provisions.—

(1) OSTEOPATHIC ACUTE CARE HOSPITALS.—When an application is made for a certificate of need to construct or to expand an osteopathic acute care hospital, the need for such hospital shall be determined on the basis of the need for and availability of osteopathic services and osteopathic acute care hospitals in the district. When a prior certificate of need to establish an osteopathic acute care hospital has been issued in a district, and the facility is no longer used for that purpose, the *agency* ~~department~~ may continue to count such facility and beds as an existing osteopathic facility in any subsequent application for construction of an osteopathic acute care hospital.

(3) VALIDITY OF CERTIFICATE OF NEED.—A certificate of need issued by the *agency* ~~department~~ for nursing home facilities of 100 beds or more prior to February 14, 1986, is valid, provided that such facility has expended at least $50,000 in reliance upon such certificate of need, excluding legal fees, prior to the initiation of proceedings under the Administrative Procedure Act subsequent to February 14, 1986, contesting the validity of the certificate of need. If such nursing home certificate of need includes beds that have not yet been licensed as of June 17, 1987, such beds shall not be considered or utilized in the determination of need or included in the inventory of licensed or approved nursing home beds by the *agency* ~~department~~, with respect to applications filed before June 17, 1987. This subsection shall only apply to nursing home beds. Nothing contained herein shall be construed to deny action pursuant to s. 120.69, or to eliminate any conditions of the certificate of need or time requirements to commence construction, including any authorized extensions.

(4) RURAL HEALTH NETWORKS.—Preference shall be given in the award of a certificate of need to a member of a certified rural health network, as provided for in s. 381.0406, subject to the following conditions:

(a) Need must be shown under s. 408.035.

(b) The proposed project must:

1. Strengthen health care services in the rural area through partnerships between rural health care providers; or

2. Increase access to inpatient health care services for Medicaid recipients or other low-income persons who live in the rural area.

(c) No preference shall be given under this section for the establishment of skilled nursing facility services by a hospital other than a rural hospital, as defined in s 395 602.

Section 90. Section 408.044, Florida Statutes, 1992 Supplement, is amended to read:

408.044 Injunction.—Notwithstanding the existence or pursuit of any other remedy, the *agency* ~~department~~ may maintain an action in the name of the state for injunction or other process against any person to restrain or prevent the pursuit of a project subject to review under *ss. 408.031-408.045* ~~ss. 381.701-381.715~~, in the absence of a valid certificate of need.

Section 91. Section 408.045, Florida Statutes, 1992 Supplement, is amended to read:

408.045 Certificate of need; competitive sealed proposals.—

(1) The application, review, and issuance procedures for a certificate of need for an intermediate care facility for the developmentally disabled may be made by the *agency* ~~department~~ by competitive sealed proposals.

(2) The *agency* ~~department~~ shall make a decision regarding the issuance of the certificate of need in accordance with the provisions of s. 287.057(15), rules adopted by the Department *of Health and Rehabilitative Services* relating to intermediate care facilities for the developmentally disabled, and the criteria in *s. 408.035* ~~s. 381.705~~, as further defined by rule.

(3) Notification of the decision shall be issued to all applicants not later than 28 calendar days after the date responses to a request for proposal are due.

(4) The procedures provided for under this section are exempt from the batching cycle requirements and the public hearing requirement of s. 408.039.

(5) The *agency* ~~department~~ may use the competitive sealed proposal procedure for determining a certificate of need for other types of health care facilities and services if the *agency* ~~department~~ identifies an unmet health care need and when funding in whole or in part for such health care facilities or services is authorized by the Legislature.

Section 92. Section 408.05, Florida Statutes, 1992 Supplement, is amended to read:

408.05 State Center for Health Statistics.—

(1) ESTABLISHMENT.—The *agency* ~~department~~ shall establish a State Center for Health Statistics. The center shall establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics. The center shall be staffed with public health experts, biostatisticians, information system analysts, health policy experts, economists, and other staff necessary to carry out its functions.

(2) STATISTICS.—The comprehensive health information system operated by the State Center for Health Statistics shall collect data on:

(a) The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality.

(b) The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state.

(c) Environmental, social, and other health hazards.

(d) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status.

(e) Health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute, long-term care and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities.

(f) Utilization of health care by type of provider.

(g) Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.

(h) Family formation, growth, and dissolution.

(i) The extent of public and private health insurance coverage in this state.

(j) The quality of care provided by various health care providers.

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to produce comparable and uniform health information and statistics, the agency shall perform the following functions:

(a) Coordinate the activities of state agencies involved in the design and implementation of the comprehensive health information system.

(b) Undertake research, development, and evaluation respecting the comprehensive health information system.

(c) Review the statistical activities of the Department of Health and Rehabilitative Services to assure that they are consistent with the comprehensive health information system.

(d) Develop written agreements with local, state, and federal agencies for the sharing of health-care-related data or using the facilities and services of such agencies. State agencies, local health councils, and other agencies under contract with the *agency and the* Department of Health and Rehabilitative Services shall assist the center in obtaining, compiling, and transferring health-care-related data maintained by state and local agencies. Written agreements must specify the types, methods, and periodicity of data exchanges and specify the types of data that will be transferred to the center.

(e) The *agency* ~~department~~ shall establish by rule the types of data collected, compiled, processed, used, or shared. Decisions regarding center data sets should be made based on consultation with the Comprehensive Health Information System Advisory Council and other public and private users regarding the types of data which should be collected and their uses.

(f) The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the *agency* ~~department~~.

(g) Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data. The agency shall periodically review ongoing health care data collections of the Department of Health and Rehabilitative Services and other state agencies to determine if the collections are being conducted in accordance with the established minimum sets of data.

(h) Establish advisory standards to assure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations.

(i) Prescribe standards for the publication of health-care-related data reported pursuant to this section which ensure the reporting of accurate, valid, reliable, complete, and comparable data. Such standards should include advisory warnings to users of the data regarding the status and quality of any data reported by or available from the center.

(j) Prescribe standards for the maintenance and preservation of the center's data. This should include methods for archiving data, retrieval of archived data, and data editing and verification.

(k) Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests.

(4) TECHNICAL ASSISTANCE.—The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the center. The center shall also provide the following additional technical assistance services:

(a) Establish procedures identifying the circumstances under which, the places at which, the persons from whom, and the methods by which a person may secure data from the center, including procedures governing requests, the ordering of requests, timeframes for handling requests, and other procedures necessary to facilitate the use of the center's data. To the extent possible, the center should provide current data timely in response to requests from public or private agencies.

(b) Provide assistance to data sources and users in the areas of data base design, survey design, sampling procedures, statistical interpretation, and data access to promote improved health-care-related data sets.

(c) Identify health care data gaps and seek cooperative agreements with other public or private organizations for meeting documented health care data needs.

(d) Assist other organizations in developing statistical abstracts of their data sets that could be used by the center.

(e) Provide statistical support to state agencies with regard to the use of data bases maintained by the center.

(f) To the extent possible, respond to multiple requests for information not currently collected by the center or available from other sources by initiating data collection.

(g) Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center.

(h) Respond to requests for data which are not available in published form by initiating special computer runs on data sets available to the center.

(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.—The center shall provide for the widespread dissemination of data which it collects and analyzes. The center shall have the following publication, reporting, and special study functions:

(a) The center shall publish and make available periodically to agencies and individuals health statistics publications of general interest, publications providing health statistics on topical health policy issues, publications which provide health status profiles of the people in this state, and other topical health statistics publications.

(b) The center shall publish, make available, and disseminate, promptly and as widely as practicable, the results of special health surveys, health care research, and health care evaluations conducted or supported under this section. Any publication by the center must include a statement of the limitations on the quality, accuracy, and completeness of the data.

(c) The center shall provide indexing, abstracting, translation, publication, and other services leading to a more effective and timely dissemination of health care statistics.

(d) The agency shall prepare and furnish a status report on the establishment of the center by April 1, 1993, to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report shall include an inventory of health data available in this state, implementation plans and progress made in implementing the functions assigned to the center, and recommendations for further legislation or resources needed to fulfill legislative intent with regard to the center, particularly with regard to establishing a statewide comprehensive health information system. The center shall thereafter be responsible for publishing and disseminating an annual report on the center's activities.

(e) The center shall be responsible, to the extent resources are available, for conducting a variety of special studies and surveys to expand the health care information and statistics available for health policy analyses, particularly for the review of public policy issues. The center shall develop a process by which users of the center's data are periodically surveyed regarding critical data needs and the results of the survey considered in determining which special surveys or studies will be conducted. The center shall select problems in health care for research, policy analy-

ses, or special data collections on the basis of their local, regional, or state importance; the unique potential for definitive research on the problem; and opportunities for application of the study findings.

(6) CONFIDENTIALITY.—

(a) The center shall protect the confidentiality of, and regulate the disclosure of, data and records maintained by the center when such records and data contain information of a sensitive personal nature concerning individuals, the release of which information would be defamatory or cause unwarranted damage to the good name or reputation of such individuals. Such records and data are confidential and exempt from the provisions of s. 119.07(1). Therefore, the center shall ensure that such data which is disclosed will not identify a person by name, address, number, symbol, or any other identifying information. The records of the center which contain the name, address, number, symbol, or other identifier of a person shall be confidential and shall not be subject to disclosure under s. 119.07(1) unless otherwise provided by law.

(b) The center may permit authorized representatives of recognized organizations to have access to the records of the center in order to compile statistics for approved purposes and to make abstracts from official records, under the conditions regarding use and disposition of the statistics and abstracts deemed proper by the center.

(c) A violation of this subsection or rules adopted by the *agency* ~~department~~ under this subsection is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Any employee of the *agency* ~~department~~ who is found guilty of violating this subsection or the rules adopted by the *agency* ~~department~~ under this subsection is subject to immediate dismissal.

(d) This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(7) PROVIDER DATA REPORTING.—This section does not confer on the *agency* ~~department~~ the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law.

(8) BUDGET; FEES; TRUST FUND.—

(a) The Legislature intends that funding for the State Center for Health Statistics be appropriated from the General Revenue Fund.

(b) The State Center for Health Statistics may apply for and receive and accept grants, gifts, and other payments, including property and services, from any governmental or other public or private entity or person and make arrangements as to the use of same, including the undertaking of special studies and other projects relating to health-care-related topics. Funds obtained pursuant to this paragraph may not be used to offset annual appropriations from the General Revenue Fund.

(c) The center may charge such reasonable fees for services as the *agency* ~~department~~ prescribes by rule. The established fees shall not exceed the reasonable cost for such services. Fees collected may not be used to offset annual appropriations from the General Revenue Fund.

(d) The *agency* ~~department~~ shall establish a Comprehensive Health Information System Trust Fund as the repository of all funds appropriated to, and fees and grants collected for, services of the State Center for Health Statistics. Any funds, other than funds appropriated to the center from the General Revenue Fund, which are raised or collected by the *agency* ~~department~~ for the operation of the center and which are not needed to meet the expenses of the center for its current fiscal year shall be available to the *agency* ~~board~~ in succeeding years.

(9) STATE COMPREHENSIVE HEALTH INFORMATION SYSTEM ADVISORY COUNCIL.—

(a) There is established in the agency the State Comprehensive Health Information System Advisory Council to assist the center in reviewing the comprehensive health information system and to recommend improvements for such system. The council shall consist of the following members:

1. An employee of the Executive Office of the Governor, to be appointed by the Governor.

2. An employee of the Department of Insurance, to be appointed by the Insurance Commissioner.

3. An employee of the Department of Education, to be appointed by the Commissioner of Education.

4. Ten persons, to be appointed by the Director of Health Care Administration, representing other state and local agencies, state universities, the Florida Association of Business/Health Coalitions, local health councils, professional health-care-related associations, consumers, and purchasers.

(b) Each member of the council shall be appointed to serve for a term of 4 years from the date of his appointment, except that a vacancy shall be filled by appointment for the remainder of the term and except that:

1. Three of the members initially appointed by the Director of Health Care Administration shall each be appointed for a term of 3 years.

2. Two of the members initially appointed by the Director of Health Care Administration shall each be appointed for a term of 2 years.

3. Two of the members initially appointed by the Director of Health Care Administration shall each be appointed for a term of 1 year.

(c) The council may meet at the call of its chairman, at the request of the *agency* ~~department~~, or at the request of a majority of its membership, but at least quarterly.

(d) Members shall elect a chairman annually.

(e) A majority of the members constitutes a quorum, and the affirmative vote of a majority of a quorum is necessary to take action.

(f) The council shall maintain minutes of each meeting and shall make such minutes available to any person.

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

(10) Nothing in this section shall limit, restrict, affect, or control the collection, analysis, release, or publication of data pursuant to the Health Care *Reform Act of 1992* ~~Cost Containment Act of 1988~~ or by any state agency pursuant to its statutory authority, duties, or responsibilities.

Section 93. Section 408.061, Florida Statutes, 1992 Supplement, is amended to read:

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

(1) The agency may require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties. Data to be collected and subsequently released to the public under this section shall be developed by the agency with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency. Data from health care facilities, providers, or insurers *may* ~~shall not~~ include specific provider ~~contract reimbursement~~ information~~, and such data shall be considered proprietary. However, such specific provider reimbursement data shall be reasonably available for onsite inspection necessary to carry out the agency's regulatory duties~~. Any such data obtained by the agency as a result of onsite inspections may not be used by the state for purposes of direct provider contracting and shall not be disclosed to the public.

(a) Such data from health care facilities may include, but are not limited to, case-mix data;~~,~~ patient admission or discharge data with patient and provider-specific identifiers included;~~,~~ *physician-specific, risk-adjusted, patient-outcome-related data; mortality rates; morbidity rates; infection rates; health status; other data needed to fully assess the effects of health care treatment on patient outcomes and health status;* actual charge data by diagnostic groups;~~,~~ financial data;~~,~~ accounting data;~~,~~ operating expenses;~~,~~ expenses incurred for rendering services to patients who cannot or do not pay;~~,~~ interest charges;~~,~~ depreciation expenses based on the expected useful life of the property and equipment involved;~~,~~ and demographic data. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information.

(b) Such data from health care providers may include, but are not limited to, Medicare and Medicaid participation, types of services offered

to patients, amount of revenue and expenses of the health care provider, and such other data which are reasonably necessary to study utilization patterns. The identity of the health care provider who submits any data to the agency under this section which is proprietary business information shall remain confidential and exempt from the provisions of s. 119.07(1). Such proprietary business information may be used in published analysis and reports or otherwise made available for public disclosure in such manner as to preserve the confidentiality of the identity of the provider. However, this exemption shall not limit the use of such data when such data is being used for investigation or enforcement purposes under the provisions of s. 455.225. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(c) Such data from health insurers may include, but are not limited to, claims, premium, administration, and financial information.

(d) A requirement to submit data shall be adopted by rule if the submission of data is being required of all members of any type of health care facility, health care provider, or health insurer. The adoption of rules shall include the development of definitional parameters for proprietary information. The identity of the health care facility or insurer who submits any data to the agency under this section which is proprietary business information shall remain confidential and exempt from the provisions of s. 119.07(1). Such proprietary business information may be used in published analysis and reports or otherwise made available for public disclosure in such manner as to preserve the confidentiality of the identity of the facility or insurer. Rules are not required, however, for the submission of data for a special study mandated by the Legislature or when information is being requested for a single health care facility, health care provider, or health insurer.

(2) The agency shall, by rule, after consulting with appropriate professional and governmental advisory bodies and holding public hearings and considering existing and proposed systems of accounting and reporting utilized by health care facilities, specify a uniform system of financial reporting for each type of facility based on a uniform chart of accounts developed after considering any chart of accounts developed by the national association for such facilities and generally accepted accounting principles. Such systems shall, to the extent feasible, use existing accounting systems and shall minimize the paperwork required of facilities. This provision shall not be construed to authorize the agency to require health care facilities to adopt a uniform accounting system. As a part of such uniform system of financial reporting, the agency may require the filing of any information relating to the cost to the provider and the charge to the consumer of any service provided in such facility, except the cost of a physician's services which is billed independently of the facility.

(3) When more than one licensed facility is operated by the reporting organization, the information required by this section shall be reported for each facility separately.

(4)(a) Within 120 days after the end of its fiscal year, each health care facility shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. *A nursing home that does not participate in the Medicare or Medicaid programs must also submit audited actual experience. Each nursing home must submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health and Rehabilitative Services, shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings. The agency shall include its findings in the final Florida Health Plan that must be submitted to the Legislature by December 31, 1993.*

(b) Each nursing home shall also submit a schedule of the charges in effect at the beginning of the fiscal year and any changes that were made during the fiscal year. A nursing home which is certified under Title XIX of the Social Security Act and files annual Medicaid cost reports may substitute copies of such reports and any Medicaid audits to the agency in lieu of a report and audit required under this subsection. For such facilities, the agency may require only information in compliance with this chapter that is not contained in the Medicaid cost report. Facilities that are certified under Title XVIII, but not Title XIX, of the Social Security Act must submit a report as developed by the agency. This report shall be substantially the same as the Medicaid cost report and shall not require any more information than is contained in the Medicare cost report unless that information is required of all nursing homes. The audit under Title XVIII shall satisfy the audit requirement under this subsection.

(5) In addition to information submitted in accordance with subsection (4), each nursing home, *including Medicare or Medicaid skilled nursing home distinct parts in facilities licensed under chapter 395,* shall track and file with the agency, on a form adopted by the agency, data related to each resident's admission, discharge, or conversion to Medicaid; health and functional status; plan of care; and other information pertinent to the resident's placement in a nursing home.

(6) Any nursing home which assesses residents a separate charge for personal laundry services shall submit to the agency data on the monthly charge for such services, excluding dry cleaning. For facilities that charge based on the amount of laundry, the most recent schedule of charges and the average monthly charge shall be submitted to the agency.

(7) The agency shall collect price and quality information for the 100 most commonly prescribed drugs and their generic equivalents and for durable medical equipment and disposable medical supplies.

(8)~~(7)~~ The agency may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of this chapter.

(9)~~(8)~~ A patient record obtained by the agency, which record contains the name, residence or business address, telephone number, social security or other identifying number, or photograph of any person or the spouse, relative, or guardian of such person, or which record is patient-specific or otherwise identifies the patient, either directly or indirectly, is confidential and exempt from the provisions of s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(10)~~(9)~~ No health care facility, health care provider, health insurer, or other reporting entity or its employees or agents shall be held liable for civil damages or subject to criminal penalties either for the reporting of patient data to the board or for the release of such data by the board as authorized by this chapter.

(11)~~(10)~~ The agency shall be the primary source for collection and dissemination of health care data. *Except as otherwise provided by law,* no other agency of state government may gather data from a health care provider licensed or regulated under this chapter without first determining if the data is currently being collected by the agency and affirmatively demonstrating that it would be more cost-effective for an agency of state government other than the agency to gather the health care data. The *agency director* ~~secretary~~ shall ensure that health care data collected by the divisions within the agency is coordinated. It is the express intent of the Legislature that all health care data be collected by a single source within the agency and that other divisions within the agency, and all other agencies of state government, obtain data for analysis, regulation, and public dissemination purposes from that single source.

~~(11) The agency shall cooperate with local health councils and the state health planning agency with regard to health care data collection and dissemination and shall cooperate with state agencies in any efforts to establish an integrated health care data base.~~

(12) It is the policy of this state that philanthropic support for health care should be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system.

(13) For purposes of determining reasonable costs of services furnished by health care facilities, unrestricted grants, gifts, and income from endowments shall not be deducted from any operating costs of such health care facilities, and, in addition, the following items shall not be deducted from any operating costs of such health care facilities:

(a) An unrestricted grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the health care facility's governing board.

(b) A grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds.

(c) The sale or mortgage of any real estate or other capital assets of the health care facility which the health care facility acquired through a gift or grant and which is not available for use as operating funds under the terms of the gift or grant or because of its designation by the health care facility's governing board, except for recovery of the appropriate share of gains and losses realized from the disposal of depreciable assets.

(14) Except as otherwise provided in this section, all reports filed under this section shall be open to public inspection.

Section 94. Subsections (2) and (3) of section 408.062, Florida Statutes, 1992 Supplement, are amended to read:

408.062 Research, analyses, studies, and reports.—

(2) The board shall evaluate data from nursing home financial reports and shall document and monitor:

(a) Total revenues, annual change in revenues, and revenues by source and classification, including contributions for a *resident's* ~~patient's~~ care from the *resident's* ~~patient's~~ resources and from the family and contributions not directed toward any specific *resident's* ~~patient's~~ care.

(b) Average *resident* ~~patient~~ charges by geographic region, *payer* ~~payer~~, and type of facility ownership.

(c) Profit margins by geographic region and type of facility ownership.

(d) Amount of charity care provided by geographic region and type of facility ownership.

(e) *Resident* ~~Patient~~ days by payer category.

(f) Experience related to Medicaid conversion as reported under s. 408.061.

(g) Other information pertaining to nursing home revenues and expenditures.

The findings of the board shall be included in an annual report to the Governor and Legislature by January 1 each year.

(3) The agency may assess annually the caesarean section rate in Florida hospitals using the analysis methodology that the agency determines most appropriate. To assist the agency in determining the impact of this chapter on Florida hospitals' caesarean section rates, each provider hospital, as defined in s. 383.336, shall notify the agency of the date of implementation of the practice parameters and the date of the first meeting of the hospital peer review board created pursuant to this chapter. The agency shall use these dates in monitoring any change in provider hospital caesarean section rates. An annual report based on this monitoring and assessment shall be submitted to the Governor, the Speaker of the House of Representatives, and the President of the Senate by the agency, with the first annual report due January 1, 1993. *Any hospital that refuses to report, fails to timely report, or files false or incomplete reports or other information required to be reported under this subsection, shall be punished by a fine not to exceed $1,000 a day for each day the violation continues, to be fixed, imposed, and collected by the agency.*

Section 95. Subsection (2) of section 408.063, Florida Statutes, 1992 Supplement, is amended, and present subsections (3), (4), (5), and (6) are redesignated as subsections (5), (6), (7), and (8), respectively, and new subsections (3) and (4) are added to that section, to read:

408.063 Dissemination of health care information.—

(2) The agency shall publish and disseminate information to the public which will enhance informed decisionmaking in the selection of health care providers, facilities, and services. Such publications may identify average charges for specified services, lengths of stay associated with established diagnostic groups, readmission rates, mortality rates, *other patient outcome-related information,* recommended guidelines for selection and use of health care providers, health care facilities, and health care services, and such other information as the agency deems appropriate.

(3) The agency shall collect data on average retail prices, including any dispensing or professional fee, charged for the 100 most commonly prescribed drugs and their generic equivalents by geographic regions and publish a consumer brochure containing that information every 6 months beginning March 31, 1994. The agency shall distribute the brochures to all licensed retail pharmacies, and those pharmacies shall make the brochures available to consumers. The agency shall also send the brochures to the community health purchasing alliances created in s. 408.702 for distribution throughout their regions.

(4) The agency shall collect data on average retail prices charged for durable medical equipment and disposable medical supplies by geographic regions and publish a consumer brochure containing that information. The agency shall distribute the brochures to all retail sellers of such equipment and supplies and the sellers shall make the brochures available to consumers. The agency shall also send the brochures to the community health purchasing alliances created in s. 408.702 for distribution throughout their regions.

Section 96. Subsection (9) of section 408.07, Florida Statutes, 1992 Supplement, is amended to read:

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

(9) "Banked points" means the percentage points earned by a hospital when the actual rate of increase in *gross revenue per adjusted admission (GRAA) is less than the maximum allowable rate of increase (MARI) or the actual rate of increase in the net revenue per adjusted admission (NRAA) is less than the market basket index* ~~gross and net revenue per adjusted admission (GRAA) is less than the maximum allowable rate of increase (MARI)~~.

Section 97. Section 408.072, Florida Statutes, 1992 Supplement, is amended to read:

408.072 Review of hospital budgets.—

(1) At least 90 days prior to the beginning of its fiscal year, each hospital requesting a rate of increase in gross revenue per adjusted admission in excess of the maximum allowable rate of increase for the hospital's next fiscal year, or each hospital utilizing banked percentage points pursuant to paragraph (3)(b), (c), or (d) and requesting a rate of increase in excess of the maximum allowable rate of increase plus the available banked percentage points, shall be subject to detailed budget review and shall file with the board, on forms adopted by the board and based on the uniform system of financial reporting:

(a) Its budget for the next fiscal year, including projected expenditures, projected revenues, and statistical measures necessary for the board to evaluate these projections. Any hospital, the final budget of which requires public review and approval, may submit its budget prior to public review and approval and shall subsequently file any amendments adopted during the public review process at least 45 days prior to the beginning of the fiscal year of the hospital.

(b) Its actual experience for the first 6 months of its current fiscal year, including actual expenditures, actual revenues, and statistical measures necessary for the board to evaluate the actual experience.

(c) Its estimated experience for the last 6 months of its current fiscal year, including estimated expenditures, estimated revenues, and statistical measures necessary for the board to evaluate these estimates.

(d) Information necessary for the board to evaluate the effectiveness of current services and the justification of the hospital for increased costs to continue current services, improve existing services, and provide new services.

(e) Its schedule of projected rates which will be implemented to generate projected revenues.

(2) The projected budget shall be deemed approved unless it is disapproved by the board within 90 days after filing, except that where the hospital requests a hearing, the 90 days shall be tolled until 20 days after the board's receipt of the recommended order from the Division of Administrative Hearings of the Department of *Management Services* ~~Administration~~. Upon agreement by the board and the hospital, the 90-day period may be waived or extended. As part of the review process conducted by the board, the board may approve, disapprove, or disapprove in part the projected budget. Once submitted and reviewed by the board, a detailed budget *or budget amendment* shall not be withdrawn by a hospital unless the increase approved by the board is greater than the maximum allowable rate of increase, the gross revenue per adjusted admission, or the net revenue per adjusted admission.

(3)(a) Except for hospitals filing a budget pursuant to subsection (1), each hospital, at least 90 days prior to the commencement of its next fiscal year, shall file with the board a certified statement, hereafter known as the "budget letter," acknowledging its applicable maximum allowable rate of increase (MARI) in gross and net revenue per adjusted admission. Calculations shall be performed by the hospital using the methodology specified in s. 408.07. Through the budget letter, the hospital shall affirm that the hospital shall not exceed its applicable maximum allowable rate of increase in gross and net revenue per adjusted admission. However, the board shall have *90* ~~30~~ days from receipt of the budget letter to determine if the applicable maximum allowable rates of increase submitted by the hospital are within the levels calculated pursuant to this section. If the board determines that the maximum allowable rates of increase submitted by the hospital are not within the levels calculated by the board, then the budget letter shall be rejected.

(b) If a hospital's gross revenues per adjusted admission, as determined by its audited actual experience in any one year, increase at a percentage rate less than the maximum allowable rate of increase or board-approved rate of increase, whichever is lower, the hospital may carry forward the difference and earn up to a cumulative maximum for ~~both~~ gross ~~and net~~ revenues of 3 "banked" percentage points which may be banked to be used in the future. In no case shall a hospital that exceeds its maximum gross revenue per adjusted admission earn banked points.

(c) If a hospital's net revenue per adjusted admission, as determined by its audited actual experience in any one year, increases at a percentage rate less than the *market basket index* ~~maximum allowable rate of increase~~ or the board-approved rate of change, whichever is lower, the hospital may carry forward the difference and earn up to a cumulative maximum for ~~both gross and~~ net revenues of 3 "banked" percentage points which may be banked to be used in the future.

(d) Earned banked percentage points may be added to the hospital's maximum allowable rate of increase. Such points may be used in the current fiscal year if a budget amendment would have been required to keep the hospital out of a penalty situation. A hospital shall be required to use gross revenue banked percentage points before submitting a budget for detailed review or before submitting a request for a budget amendment. Banked points shall not be transferable from one facility to another and shall only be used by a hospital which earns them as a separately licensed facility. Banked points utilized in budget letters, budget amendments, and detailed budget reviews in the current fiscal year to keep a hospital out of a penalty situation shall not be available for mitigation of penalties pursuant to s. 408.08. The board shall adopt rules which specify procedures for hospitals to bank and use any percentage points as authorized under this section.

(4) For purposes of budget review and comparison and to assist in making determinations pursuant to subsection (8), the board shall:

(a) Establish groupings of hospitals according to characteristics, including, but not limited to, a measure of the nature and range of services provided, teaching hospital status, number of medical specialties represented on the hospital staff, percentage of Medicare inpatient days, average daily census, geographical differences, and case mix. The rule shall provide for the establishment of not more than 15 general groups and for the establishment of additional specialty groups as needed. However, no group shall contain fewer than five hospitals.

(b) Establish statistical indicators per adjusted admission to serve as measures of comparison based on the most recent audited actual experience filed pursuant to s. 408.061(4)(a) for the hospitals in each group. The statistical indicators shall include, but not be limited to, gross revenue, net revenue, and operating expenditures.

(c) For each budget filed pursuant to subsection (1) and amendments filed pursuant to subsection (6), the hospital's most recent audited actual report shall be used as the base for review and comparison purposes.

(5) The board shall review each budget filed pursuant to subsection (1) and amendments filed pursuant to subsection (6) to determine whether the gross revenue per adjusted admission or the net revenue per adjusted admission contained in the budget or amendment is just, reasonable, and not excessive. In making such determination, the board shall consider, and the hospital may use, the following criteria in the following priority, with paragraph (a) the highest priority and paragraph (i) the lowest priority.

(a) The ability of the hospital to earn a reasonable rate of return based on reasonable and justifiable costs.

(b) The impact of patient days attributable to the medically indigent.

(c) The impact of patient days reimbursed by Medicaid.

(d) The impact of patient days reimbursed by Medicare.

(e) The research and educational services provided by the hospital if it is a teaching hospital.

(f) The cost and efficiency of providing the current and proposed services. The cost of proposed services may not be included until these services or facilities have been approved by the designated state agency.

(g) The change in hospital costs as measured by changes in the severity of illness, including changes in the case mix. For psychiatric and other hospitals that would *not* be reimbursed under a prospective payment system by the Federal Government, the impact on hospital costs associated with changes in the average length of stay of patients *or* ~~and~~, when available, case mix shall be considered.

(h) The accuracy of previous budget submissions compared to the actual experience of the hospital.

(i) For psychiatric hospitals, the impact on hospital gross revenues associated with changes in the average length of stay of patients, changes in admissions to hospital units, and changes in admissions to specific services *or* ~~and~~, when available, case mix.

(6) After a hospital budget is approved, approved as amended, or disapproved for a given fiscal year, no amendment to such budget shall be made except in accordance with the following procedures:

(a) A request by a hospital to amend its budget shall be filed in writing with supporting documents no later than 90 days before the end of the hospital's fiscal year. The budget amendment shall be deemed approved unless it is disapproved or disapproved in part by the board within 90 days after the filing, except that where the hospital requests a hearing, the 90 days shall be tolled until 20 days after the board's receipt of the recommended order from the Division of Administrative Hearings of the Department of *Management Services* ~~Administration~~. Upon agreement by the board and the hospital, the 90-day period may be waived or extended.

(b) If approved by the board as part of a budget amendment, the following items shall be applied retroactively for the entire budget year of the hospital:

1. Changes in cost due to changes in case mix, including changes in the severity of illness.

2. Unforeseen and unforeseeable changes in malpractice insurance premiums, prior year Medicare cost report settlements, and retroactive changes in Medicare reimbursement methodology.

(7) The board shall disapprove any budget or amendment or part thereof as excessive that contains a gross revenue per adjusted admission which is not necessary to maintain total hospital costs at a level reasonably related to total services provided and which is not necessary to maintain a prudently managed hospital.

(8) The board shall disapprove, in its entirety or in part, any budget or any budget amendment that contains a rate of increase, a gross revenue per adjusted admission, or a net revenue per adjusted admission which the board finds, pursuant to subsection (3), subsection (5), or subsection (7), to be unjust, unreasonable, or excessive.

(9)(a) The staff of the board shall review the budget or the amendment to the budget, and the executive director or executive staff members designated by the executive director shall make preliminary findings and recommendations in writing as to whether the budget should be approved, disapproved, or disapproved in part. The staff shall send the preliminary findings by certified mail to the hospital. The hospital shall have 14 days from the receipt of the preliminary findings and recommendations to file written objections and request a hearing with the board, if a hearing is desired, or to file written objections if a hearing is not requested by the hospital.

(b) If a hearing is requested, it shall be conducted by the board or, at the election of the board, by a hearing officer of the Division of Administrative Hearings of the Department of *Management Services* ~~Adminis-~~

~~tration~~, pursuant to the provisions of s. 120.57. Hearings shall be held within 30 days of filing the request unless waived by the board and the hospital. All hearings shall be held in Tallahassee unless the board determines otherwise.

(c) Recommended orders shall be issued within 30 days from the close of the hearing unless waived by all parties.

(d) The failure of a hospital to request a hearing within 14 days of the receipt of the preliminary findings of the staff constitutes a waiver of the right of the hospital to contest the final decision of the board, and the board shall enter a final order consistent with the staff's preliminary findings without further proceedings.

(e) During the pendency of any hearing or an appeal of a final order of the board, no hospital shall exceed its current maximum budget level in effect.

(10) The board may publish its findings in connection with any review conducted under this section in the newspaper of the largest circulation in the county in which the hospital is located.

(11) Notwithstanding any other provisions of this chapter:

(a) Any hospital operated by the Department of Health and Rehabilitative Services or the Department of Corrections; any rural hospital as defined in s. 408.07; and any intensive residential treatment program for children and adolescents as defined in s. 395.002(16) which received a certificate of need on or before January 1, 1991, and is licensed under chapter 395 for less than 33 beds, which is not part of a multifacility organization and which is part of a community mental health system, shall be exempt from filing a budget, and shall be exempt from budget review and approval for exceeding the maximum allowable rate of increase and from any penalties arising therefrom. However, each such hospital shall be required to submit to the board its audited actual experience, as required by *s. 408.061(4)(a)* ~~s. 408.061(4)(d)~~.

(b) In addition, the board shall exempt any hospital from filing a budget, from budget review and approval for exceeding the maximum allowable rate of increase, and from any penalties arising therefrom, upon a finding of the board that the hospital, during the hospital's most recent audited actual experience, had a prospective payment arrangement, as defined in s. 408.07, which contained all of the elements set forth in s. 408.50(2)(a)-(e) for at least 90 percent of the hospital's admissions exclusive of Medicare, Medicaid, and any other patients which meet the board's definition for charity care. Such exemption shall be on a year-to-year basis upon a finding by the board that the hospital has met the requirements of this subsection each year. Each hospital exempted from budget review pursuant to this paragraph shall submit to the board its audited actual experience, as required by s. 408.061(4)(a). This paragraph is repealed, and shall be subject to review by the Legislature, upon a finding by the board that at least 25 percent of hospitals which would have otherwise been subject to budget review are excluded from budget review pursuant to this paragraph. Such repeal shall take effect on July 1 following the date on which the board makes a finding that the 25-percent level, as set forth in this paragraph, has been reached.

(12) The review and approval of hospital budgets and budget amendments, and the imposition of fines and penalties, pursuant to this chapter shall apply to hospital budgets for fiscal years which end in calendar year 1994. Notwithstanding any other provision in this chapter to the contrary, any budget for fiscal years ending prior to 1994 shall be filed and reviewed pursuant to chapter 88-394, Laws of Florida, and rules adopted by the board pursuant thereto.

(13) For hospitals in detailed review, in addition to any gross or net revenues for a budget or budget amendment approved pursuant to subsection (5), the board shall also approve gross and net revenues which are necessary to fund any documented direct costs to hospitals arising from assistance provided to expand or supplement the curriculum of a community college, university, or vocational training school for the purpose of training nurses and other health professionals, not including physicians. Assistance would include, but not be limited to, the direct cost of faculty salaries and expenses, books, equipment, recruiting efforts, tuition, hospital internships, and in-kind contributions. It shall be the responsibility of the hospital to document any such increases in costs.

Section 98. Paragraph (c) of subsection (2), paragraph (c) of subsection (3), and subsection (9) of section 408.08, Florida Statutes, 1992 Supplement, are amended to read:

408.08 Inspections and audits; violations; penalties; fines; enforcement.—

(2) The board shall annually compare the audited actual experience of each hospital to the audited actual experience of that hospital for the previous year.

(c) For a hospital submitting a budget letter and for a hospital subject to budget review, the board shall annually compare each hospital's audited actual experience for net revenues per adjusted admission to the hospital's audited actual experience for net revenues per adjusted admission for the previous year. If the rate of increase in net revenues per adjusted admission between the previous year and the current year was less than the market basket index ~~plus 2 percentage points~~, the hospital may carry forward the difference and earn up to a cumulative maximum of 3 banked net revenue percentage points. Such banked net revenue percentage points shall be available to the hospital to offset, in any future year, penalties for exceeding the approved budget or the maximum allowable rate of increase as set forth in subsection (3). Nothing in this paragraph shall be used by a hospital to justify the approval of a budget or a budget amendment by the board in excess of the maximum allowable rate of increase pursuant to s. 408.072.

(3) Penalties shall be assessed as follows:

(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall:

1. Levy a fine against the hospital in the total amount of the excess, to be deposited in the Public Medical Assistance Trust Fund.

2. Notify the agency of the violation, whereupon the agency shall not accept any application for a certificate of need pursuant to ss. 408.031-408.045 from or on behalf of such hospital until such time as the hospital has demonstrated to the satisfaction of the board that, following the date the penalty was imposed under subparagraph 1., the hospital has stayed within its projected or amended budget or its applicable maximum allowable rate of increase for a period of at least 1 year. However, this provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.

3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the agency, whereupon the agency shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.

The determination of the amount of any such excess shall be based upon net revenues per adjusted admission, excluding funds distributed to the hospital from the Public Medical Assistance Trust Fund. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.701 minus the amount of revenues received by the hospital through the Public Medical Assistance Trust Fund. It is the responsibility of the hospital to demonstrate to the satisfaction of the board its entitlement to such reduction. It is the intent of the Legislature that the Health Care Board, in levying any penalty imposed against a hospital for exceeding its maximum allowable rate of increase or its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital and in the hospital's intensity and severity of illness as measured by changes in the hospital's actual proportion of outlier cases to total cases and dollar increases in outlier cases' average charge per case. It is the responsibility of the hospital to demonstrate to the satisfaction of the board any change in its case mix and in its intensity and severity of illness. For psychiatric hospitals *and other hospitals that would not be reimbursed under a prospective payment system by the Federal Government, until a proxy for case mix is available,* the board shall also reduce the amount of excess by ~~utilizing as a proxy for case mix~~ the change in a hospital's audited actual average length of stay ~~as compared to the previous year's audited actual average length of stay~~ without any thresholds or limitations.

(9) In levying any administrative fine against a hospital pursuant to subsection (8), the board shall consider the effect of any changes in the hospital's case mix, and in the hospital's intensity and severity of illness as measured by changes in the hospital's actual proportion of outlier cases to total cases and dollar increases in outlier cases' average charge per case. The board shall adjust the amount of any excess by the changes in the hospital's case mix and in its intensity and severity of illness, based upon certified hospital patient discharge data provided to the board pursuant to s. 408.061. For psychiatric hospitals *and other hospitals that would not be reimbursed under a prospective payment system by the Federal Government, until a proxy for case mix is available,* the board

shall adjust the amount of any excess by ~~utilizing as a proxy for case mix~~ the change in a hospital's audited actual average length of stay *without any thresholds or limitation* ~~as compared to the previous year's audited actual average length of stay~~.

Section 99. Subsection (4) of section 408.09, Florida Statutes, 1992 Supplement, is amended to read:

408.09 Assistance on cost containment strategies.—The agency shall:

(4) Assist existing health *care purchasing* coalitions and local health councils as needed in carrying out their respective goals in an efficient and effective manner.

Section 100. Section 408.20, Florida Statutes, 1992 Supplement, is amended to read:

408.20 Assessments; Health Care ~~Cost Containment~~ Trust Fund.—

(1) The data collection and analysis activities of the agency shall be financed, in part, by an assessment on:

(a) Hospitals in an amount to be determined annually by the agency, but not to exceed 0.04 percent of the gross operating expenses of each hospital for the provision of hospital services for its last fiscal year. Every new hospital shall pay its initial assessment upon being licensed by the state and shall base its assessment payment during the first year of operation upon its projections for gross operating expenses for that year. Each hospital under new ownership shall pay its initial assessment for the first year of operation under new ownership based on its gross operating expenses for the last fiscal year under previous ownership. The assessments shall be levied and collected quarterly.

(b) Nursing homes in an amount set by the agency to cover the agency's approved budget. The agency shall calculate the amount to be collected per bed, rounded to the nearest whole dollar. All assessments collected under this section which are due after the date of notification by the agency shall be at a rate sufficient to cover the agency's approved budget. Assessments shall be levied and collected annually by the agency. Each new nursing home shall pay its initial assessment upon being licensed, and each nursing home under new ownership shall pay its initial assessment under the new ownership based on its number of beds.

(2) All moneys collected are to be deposited into the Health Care ~~Cost Containment~~ Trust Fund, which account is hereby created. The Health Care ~~Cost Containment~~ Trust Fund shall be subject to the service charge imposed pursuant to chapter 215.

(3) Any amounts raised by the collection of assessments provided for in this section which are not required to meet appropriations in the budget act for the current fiscal year shall be available to the agency in succeeding years.

(4) Hospitals operated by the Department of Health and Rehabilitative Services or the Department of Corrections are exempt from the assessments required under this section.

Section 101. Section 408.70, Florida Statutes, is created to read:

408.70 Community health purchasing; legislative findings and intent.—

(1) The Legislature finds that the current health care system in this state does not provide access to affordable health care for all persons in this state. Almost one in five persons is without health insurance. For many, entry into the health care system is through a hospital emergency room rather than a primary care setting. The availability of preventive and primary care and managed, family-based care is limited. Health insurance underwriting practices have led to the avoidance, rather than to the sharing, of insurance risks, limiting access to coverages for small-sized employer groups and high-risk populations. Spiraling premium costs have placed health insurance policies out of the reach of many small-sized and medium-sized businesses and their employees. Lack of outcome and cost information has forced individuals and businesses to make critical health care decisions with little guidance or leverage. Health care resources have not been allocated efficiently, leading to excess and unevenly distributed capacity. These factors have contributed to the high cost of health care. Rural and other medically underserved areas have too few health care resources. Comprehensive, first-dollar coverages have allowed individuals to seek care without regard to cost. Provider competition and liability concerns have led to a medical technology arms race. Rather than competing on the basis of price and patient outcome, health care providers compete for patients on the basis of service, equipping themselves with the latest and best technologies. Managed-care and group-purchasing mechanisms are not widely available to small group purchasers. Health care regulation has placed undue burdens on health care insurers and providers, driving up costs, limiting competition, and preventing market-based solutions to cost and quality problems. Health care costs have been increasing at several times the rate of general inflation, eroding employer profits and investments, increasing government revenue requirements, reducing consumer coverages and purchasing power, and limiting public investments in other vital governmental services.

(2) It is the intent of the Legislature that a structured health care competition model, known as "managed competition," be implemented throughout the state to improve the efficiency of the health care markets in this state. The managed competition model will promote the pooling of purchaser and consumer buying power; ensure informed cost-conscious consumer choice of managed care plans; reward providers for high-quality, economical care; increase access to care for uninsured persons; and control the rate of inflation in health care costs.

(3) The Legislature intends that state-chartered, nonprofit private purchasing organizations, to be known as "community health purchasing alliances," be established. The community health purchasing alliances shall be responsible for assisting alliance members in securing the highest quality of health care, based on current standards, at the lowest possible prices.

Section 102. Section 408.701, Florida Statutes, is created to read:

408.701 Community health purchasing; definitions.—As used in ss. 408.70-408.706, the term:

(1) "Accountable health partnership" means an organization that integrates health care providers and facilities and assumes risk, in order to provide health care services, as certified by the agency under s. 408.704.

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

(3) "Alliance" means a community health-purchasing alliance.

(4) "Alliance member" means:

(a) A small employer as defined in s. 627.6699, or

(b) The state, for the purpose of providing health benefits to state employees and their dependents through the State Group Insurance Program and to Medicaid recipients, participants in the MedAccess program, and participants in the Medicaid buy-in program,

if such entities voluntarily choose to join an alliance.

(5) "Antitrust laws" means federal and state laws intended to protect commerce from unlawful restraints, monopolies, and unfair business practices.

(6) "Associate alliance member" means any purchaser who joins an alliance for the purposes of participating on the alliance board and receiving data from the alliance at no charge as a benefit of membership.

(7) "Benefit standard" means a specified set of health services that are the minimum that must be covered under a basic health benefit plan, as defined in s. 627.6699.

(8) "Business health coalition" means a group of employers organized to share information about health services and insurance coverage, to enable the employers to obtain more cost-effective care for their employees.

(9) "Community health purchasing alliance" means a state-chartered, nonprofit organization that provides detailed information to its members on comparative prices, usage, outcomes, quality, and enrollee satisfaction with accountable health partnerships.

(10) "Consumer" means an individual user of health care services.

(11) "Department" means the Department of Insurance.

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

(13) "Health care provider" or "provider" means a state-licensed facility or practitioner that delivers health care services to individuals.

(14) "Health insurer" or "insurer" means an organization licensed by the department under part III of chapter 624 or part I of chapter 641.

(15) "Health plan" means any hospital or medical policy or contract or certificate, hospital or medical service plan contract, or health maintenance organization contract as defined in the Insurance Code or Health Maintenance Organization Act. The term does not include accident-only, specific disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(16) "Health status" means an assessment of an individual's mental and physical condition.

(17) "Managed care" means systems or techniques generally used by third-party payers or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

(18) "Managed competition" means a process by which purchasers form alliances to obtain information on, and purchase from, competing accountable health partnerships.

(19) "Medical outcome" means a change in an individual's health status after the provision of health services.

(20) "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals.

(21) "Purchaser" means an individual, an organization, or the state that makes health-benefit purchasing decisions on behalf of a group of individuals.

(22) "Self-funded plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for all covered services provided to its enrollees.

(23) "Utilization management" means programs designed to control the overutilization of health services by reviewing their appropriateness relative to established standards or norms.

(24) "24-hour coverage" means the consolidation of such time-limited health care coverage as personal injury protection under automobile insurance into a general health insurance plan.

Section 103. Section 408.702, Florida Statutes, is created to read:

408.702 Community health purchasing alliance; establishment.—

(1) There is hereby created a community health purchasing alliance in each of the 11 health service planning districts established under s. 408.032(5). Each alliance must be operated as a state-chartered, nonprofit private organization organized pursuant to chapter 617.

(2) Three or fewer alliances located in contiguous districts that are not primarily urban may merge into a single alliance upon approval of the agency based upon a showing by the alliance board members that the members of each alliance would be better served under a combined alliance. Board members of each alliance shall serve as the board of the combined alliance.

(3) An alliance is the only entity that is allowed to operate as an alliance in a particular district and must operate for the benefit of its members who are: small employers, as defined in s. 627.6699; the state on behalf of its employees and the dependents of such employees; Medicaid recipients; and associate alliance members. An alliance is the exclusive entity for the oversight and coordination of alliance member purchases. Any health plan offered through an alliance must be offered by an accountable health partnership and an alliance may not directly provide insurance, bear any risk, or form self-insurance plans among its members. An alliance may form a network with other alliances in order to improve services provided to alliance members. Nothing in ss. 408.70-408.706 limits or authorizes the formation of business health coalitions; however, a person or entity that pools together or assists in purchasing health coverage for small employers, as defined in s. 627.6699, may not discriminate in its activities based on the health status or historical or projected claims experience of such employers.

(3) Each alliance shall capitalize on the expertise of existing business health coalitions.

(4) Membership or associate membership in an alliance is voluntary.

(5) Each community health purchasing alliance has the following powers, duties, and responsibilities:

(a) Establishing the conditions of alliance membership in accordance with ss. 408.70-408.706.

(b) Providing to alliance members clear, standardized information on each accountable health partnership and each health plan offered by each accountable health partnership, including information on price, enrollee costs, quality, patient satisfaction, enrollment, and enrollee responsibilities and obligations; and providing accountable health partnership comparison sheets in accordance with agency rule to be used in providing members and their employees with information regarding standard, basic, and specialized coverage that may be obtained through the accountable health partnerships.

(c) Annually offering to all alliance members all accountable health partnerships and health plans offered by the accountable health partnerships which meet the requirements of ss. 408.70-408.706 and which submit a responsive proposal as to information necessary for accountable health partnership comparison sheets, and providing assistance to alliance members in selecting and obtaining coverage through accountable health partnerships that meet those requirements.

(d) Requesting proposals for the standard and basic health plans, as defined in s. 627.6699, from all accountable health partnerships in the district; providing, in the format required by the alliance in the request for proposals, the necessary information for accountable health partnership comparison sheets; and offering to its members health plans of accountable health partnerships which meet those requirements.

(e) Requesting proposals from all accountable health partnerships in the district for specialized benefits approved by the alliance board based on input from alliance members, determining if the proposals submitted by the accountable health partnerships meet the requirements of the request for proposals, and offering them as options through riders to standard plans and basic plans. This paragraph does not limit an accountable health partnership's ability to offer other specialized benefits to alliance members.

(f) Distributing to health care purchasers, placing special emphasis on the elderly, retail price data on prescription drugs and their generic equivalents, durable medical equipment, and disposable medical supplies which is provided by the agency pursuant to s. 408.063(3) and (4).

(g) Establishing administrative and accounting procedures for the operation of the alliance and members' services, preparing an annual alliance budget, and preparing annual program and fiscal reports on alliance operations as required by the agency.

(h) Developing and implementing a marketing plan to publicize the alliance to potential members and associate members and developing and implementing methods for informing the public about the alliance and its services.

(i) Developing grievance procedures to be used in resolving disputes between members and the alliance and disputes between the accountable health partnerships and the alliance. Any member of, or accountable health partnership that serves, an alliance may appeal to the agency any grievance that is not resolved by the alliance.

(j) Ensuring that accountable health partnerships have grievance procedures to be used in resolving disputes between members and an accountable health partnership. A member may appeal to the alliance any grievance that is not resolved by the accountable health partnership. An accountable health partnership that is a health maintenance organization must follow the grievance procedures established in ss. 641.31(5) and 641.311.

(k) Maintaining all records, reports, and other information required by the agency, ss. 408.70-408.706, or other state and local laws.

(l) Receiving and accepting grants, loans, advances, or funds from any public or private agency; and receiving and accepting contributions, from any source, of money, property, labor, or any other thing of value.

(m) Contracting, as authorized by alliance members, with a qualified, independent third party for any service necessary to carry out the powers and duties required by ss. 408.70-408.706.

(n) Developing a plan to facilitate participation of providers in the district in an accountable health partnership, placing special emphasis on ensuring participation by minority physicians in accountable health partnerships if such physicians are available. The use of the term "minority" in ss. 408.70-408.706 is consistent with the definition of "minority person" provided in s. 288.703(3).

(o) Maximizing the choices of health plans available to members and employees of members by offering, at a minimum, the option of choosing between a closed network, such as a health maintenance organization or exclusive provider organization; an open network, such as a preferred provider organization; or a managed care indemnity insurance plan. These options may be provided by a single accountable health partnership if selected by the employer and offered by that partnership, or may be provided by two or more accountable health partnerships selected by the employer from those available in the alliance region.

(p) Petitioning the agency for a determination as to the cost effectiveness of collecting premiums on behalf of participating accountable health partnerships. If determined by the agency to be cost-effective, the alliance may establish procedures for collecting premiums from members and distribute them to the participating accountable health partnerships. This may include the remittance of the share of the group premium paid by both an employer and an enrollee. If an alliance assumes premium collection responsibility, it shall also assume liability for uncollected premium. This liability may be collected through a bad debt surcharge on alliance members to finance the cost of uncollected premiums. The alliance shall pay participating accountable health partnerships their contracting premium amounts on a prepaid monthly basis, or as otherwise mutally agreed upon.

(7) Each alliance shall set reasonable fees for membership in the alliance which will finance all reasonable and necessary costs incurred in administering the alliance.

(8) Each alliance shall annually report on the operations of the alliance, including program and financial operations; and shall provide for annual internal and independent audits.

(9) A community health purchasing alliance may not engage in any activities for which an insurance agent's license is required.

Section 104. Section 408.703, Florida Statutes, is created to read:

408.703 Small employer members of community health purchasing alliances; eligibility requirements.—

(1) The agency shall establish conditions of participation for small employers, as defined in s. 627.6699, which must include, but need not be limited to:

(a) Assurance that the group is a valid small employer and is not formed for the purpose of securing health benefit coverage. This assurance must include requirements for sole proprietors and self-employed individuals which must be based on a specified requirement for the time that the sole proprietor or self-employed individual has been in business, required filings to verify employment status, and other requirements to ensure that the individual is working.

(b) Assurance that the individuals in the small employer group are employees and have not been added for the purpose of securing health benefit coverage.

(2) The agency may not require a small employer to pay any portion of premiums as a condition of participation in an alliance.

(3) The agency may require a small employer seeking membership to agree to participate in the alliance for a specified minimum period of time, not to exceed 1 year.

(4) If a member small employer offers more than one accountable health partnership or health plan and the employer voluntarily contributes to coverage of employees or dependents of employees, the alliance shall require that the employer contribute the same dollar amount for each employee, regardless of the accountable health partnership or benefit plan chosen by the employee.

Section 105. Section 408.704, Florida Statutes, is created to read:

408.704 Agency duties and responsibilities related to community health purchasing alliances.—The agency shall assist in developing a statewide system of community health purchasing alliances. To this end, the agency is responsible for:

(1) Annually certifying that each community health purchasing alliance complies with ss. 408.70-408.706 and rules adopted by the agency. The agency may decertify any community health purchasing alliance if the alliance fails to comply with ss. 408.70-408.706 and rules adopted by the agency. There shall be a rebuttable presumption that an alliance is in compliance if it can show that it is controlling health care costs in the district.

(2) Providing administrative startup funds. Each contract for startup funds is limited to $275,000.

(3) Conducting an annual review of the performance of each alliance to ensure that the alliance is in compliance with ss. 408.70-408.706. To assist the agency in its review, each alliance shall submit, quarterly, data to the agency, including, but not limited to, employer enrollment by employer size, industry sector, previous insurance status, and count; number of total eligible employers in the alliance district participating in the alliance; number of insured lives by county and insured category, including employees, dependents, and other insured categories, represented by alliance members; profiles of potential employer membership by county; premium ranges for each accountable health partnership for alliance member categories; type and resolution of member grievances; membership fees; and alliance financial statements. A summary of this annual review shall be provided to the Legislature and to each alliance.

(4) Developing procedures for implementing carrier comparison sheets established by the agency to be used in providing members and their eligible employees with information regarding accountable health partnerships and health plans offered by accountable health partnerships.

(5) Establishing a data system for accountable health partnerships.

(a) The agency shall establish an advisory data committee comprised of the following representatives of employers, medical providers, hospitals, health maintenance organizations, and insurers:

1. Two representatives appointed by each of the following organizations: Associated Industries of Florida, the Florida Chamber of Commerce, the National Federation of Independent Businesses, and the Florida Retail Federation;

2. One representative of each of the following organizations: the Florida League of Hospitals, the Association of Voluntary Hospitals of Florida, the Florida Hospital Association, the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Chiropractic Association, the Florida Chapter of the National Medical Association, the Association of Managed Care Physicians, the Florida Insurance Council, the Florida Association of Domestic Insurers, the Florida Association of Health Maintenance Organizations; and

3. One representative of governmental health care purchasers and three consumer representatives, to be appointed by the agency.

(b) The advisory data committee shall issue a report and recommendations on each of the following subjects as each is completed. A final report covering all subjects must be included in the final Florida Health Plan to be submitted to the Legislature on December 31, 1993. The report shall include recommendations regarding:

1. Types of data to be collected. Careful consideration shall be given to other data collection projects and standards for electronic data interchanges already in process in this state and nationally, to evaluating and recommending the feasibility and cost-effectiveness of various data collection activities, and to ensuring that data reporting is necessary to support the evaluation of providers with respect to cost containment, access, quality, control of expensive technologies, and customer satisfaction analysis. Data elements to be collected from providers include prices, utilization, patient outcomes, quality, and patient satisfaction. The completion of this task is the first priority of the advisory data committee. The agency shall begin implementing these data collection activities immediately upon receipt of the recommendations, but no later than January 1, 1994. The data shall be submitted by hospitals, other licensed health care facilities, pharmacists, and group practices as defined in s. 455.236(3)(g).

2. A standard data set, a standard cost-effective format for collecting the data, and a standard methodology for reporting the data to the agency, or its designee, and to the alliances. The reporting mechanisms must be designed to minimize the administrative burden and cost to health care providers and carriers. A methodology shall be developed for aggregating data in a standardized format for making comparisons between accountable health partnerships which takes advantage of national models and activities.

3. Methods by which the agency should collect, process, analyze, and distribute the data.

4. Standards for data interpretation. The advisory data committee shall actively solicit broad input from the provider community, carriers, the business community, and the general public.

5. Structuring the data collection process to:

a. Incorporate safeguards to ensure that the health care services utilization data collected is reviewed by experienced, practicing physicians licensed to practice medicine in this state;

b. Require that carrier customer satisfaction data conclusions are validated by the agency;

c. Protect the confidentiality of medical information to protect the patient's identity and to protect the privacy of individual physicians and patients. Proprietary data submitted by insurers, providers, and purchasers are confidential pursuant to s. 408.061(1); and

d. Afford all interested professional medical and hospital associations and carriers a minimum of 60 days to review and comment before data is released to the public.

6. Developing a data collection implementation schedule, based on the data collection capabilities of carriers and providers.

(c) In developing data recommendations, the advisory data committee shall assess the cost-effectiveness of collecting data from individual physician providers. The initial emphasis must be placed on collecting data from those providers with whom the highest percentages of the health care dollars are spent: hospitals, large physician group practices, outpatient facilities, and pharmacies.

(d) The agency shall, to the maximum extent possible, adopt and implement the recommendations of the advisory data committee. The agency shall report all recommendations of the advisory data committee to the Legislature and submit an implementation plan.

(e) The travel expenses of the participants of the advisory data committee must be paid by the participant or by the organization that nominated the participant.

(4) Collecting, compiling, and analyzing data on accountable health partnerships and providing statistical information to alliances.

(5) Receiving appeals by members of an alliance and accountable health partnerships whose grievances were not resolved by the alliance. The agency shall review these appeals pursuant to chapter 120. Records or reports submitted as a part of a grievance proceeding conducted as provided for under this subsection, or patient care quality assurance proceedings, records, or reports obtained or made by any member of a community health purchasing alliance or any member of an accountable health partnership shall be held confidential by the agency and are exempt from s. 119.07(1). The exemption from s. 119.07(1) provided in this subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

Section 106. Section 408.7042, Florida Statutes, is created to read:

408.7042 Purchasing health care for state employees and Medicaid recipients through community health purchasing alliances.—

(1) Pursuant to legislative approval as provided in s. 110.123, and prior to the purchase of health care for state employees and their dependents through community health purchasing alliances, the Division of State Health Purchasing of the Agency for Health Care Administration shall consult with collective bargaining organizations that represent state employees, the Department of Management Services, and the administrator of the State Group Insurance Program. Legislative approval for such purchase of health care is not required, however, if the employee benefit package remains unchanged, or is enhanced, the quality of care is increased, and there is no additional cost to the state or its employees. The purchase of health care for state employees and their dependents through a community health purchasing alliance will be determined by the ability of the alliance to meet or exceed the benefit standard that has been collectively bargained. When purchasing health care for state employees and the dependents of such employees through community health purchasing alliances, the Department of Management Services shall annually offer to all employees the opportunity to select from health plans offered by all accountable health partnerships in the district in which the employee lives. The Department of Management Services shall make available to state employees accountable health partnerships that offer health plans through health maintenance organizations, exclusive provider organizations, preferred provider organizations, and managed-care pure indemnity plans. An accountable health partnership is not required to provide all four types of health plans, but all four types of plans must be made available through multiple accountable health partnerships to state employees, if the Division of State Health Purchasing elects to purchase health care for state employees through community health purchasing alliances. The division shall offer a minimum of five health maintenance organizations and five preferred provider organizations, where available to state employees. The division shall select the accountable health partnerships based upon appropriate objective criteria, including premium price, access to quality care, and member satisfaction. For purposes of the purchase of health care for state employees and their dependents through community health purchasing alliances, the state group health insurance plan is an accountable health partnership.

(2) When purchasing health care for Medicaid, MedAccess, and Medicaid buy-in recipients through community health purchasing alliances, the agency shall ensure that the claims experiences, rates, and charges for such recipients are not commingled with those of other alliance members. The state shall offer to all Medicaid, MedAccess, and Medicaid buy-in recipients the opportunity to select health plans from all accountable health partnerships that have a Medicaid managed-care contract that has been approved by the United States Health Care Financing Administration, or from physicians and facilities that participate in MediPass, in the district in which the recipient lives. For purposes of the purchase of health care for such recipients, the MediPass program and entities with Medicaid managed-care contracts are accountable health partnerships. An entity that provides managed-care for Medicaid recipients pursuant to a contract must obtain a certificate of authority from the agency and begin enrolling non-Medicaid enrollees by July 1, 1994, or within 3 years after the date on which the entity entered into the contract to provide managed care for Medicaid recipients, whichever is sooner. Purchase of health care for Medicaid, MedAccess, and Medicaid buy-in recipients by the agency through community health purchasing alliances may not result in a reduction of benefits or any increased costs for such recipients without prior legislative approval.

Section 107. Section 408.7045, Florida Statutes, is created to read:

408.7045 Community health purchasing alliance marketing requirements.—

(1) Each alliance shall use appropriate, efficient, and standardized means to notify members of the availability of sponsored health coverage from the alliance.

(2) Each alliance shall make available to members marketing materials that accurately summarize the benefit plans that are offered by its accountable health partnerships and the rates, costs, and accreditation information relating to those plans.

(3) Annually, the alliance shall offer each member small employer all accountable health partnerships available in the alliance and provide them with the appropriate materials relating to those plans. The member small employer may choose which health benefit plans shall be offered to eligible employees and may change the selection each year. The employee may be given options with regard to health plans and the type of managed care system under which his benefits will be provided.

(4) An alliance may notify the agency of any marketing practices or materials that it finds are contrary to the fair and affirmative marketing requirements of the program. Upon the request of an alliance, the agency shall request the Department of Insurance to investigate the practices and the Department of Insurance may take any action authorized for a violation of the Insurance Code or the Health Maintenance Organization Act.

Section 108. Section 408.705, Florida Statutes, is created to read:

408.705 Community health purchasing alliances; boards of directors.—

(1) Each community health purchasing alliance shall operate subject to the supervision and approval of a board of directors. The board of directors of each alliance must be composed of 17 members who reside within the alliance district and must be representative of alliance members, consumers, and government purchasers. The initial board members shall be appointed by October 1, 1993, by the Governor, the President of the Senate, and the Speaker of the House of Representatives as follows:

(a) Three consumer members, one appointed by the President of the Senate, one appointed by the Speaker of the House of Representatives, and one appointed by the Governor. A consumer member may not be, or in the past have been, employed by or affiliated with a health insurer, health maintenance organization, or health care provider. The consumer members must be employees of businesses located within the community health purchasing alliance region.

(b) Three members representing state and local governments, one appointed by the President of the Senate, one appointed by the Speaker of the House of Representatives, and one appointed by the Governor. Members representing government must currently be, or in the past have been, in positions of government responsible for the purchasing of health care coverage for government employees.

(c) Eleven members representing business and industry, three appointed by the President of the Senate, three appointed by the Speaker of the House of Representatives, and five appointed by the Governor. Six of the business representatives must be representatives of businesses with 50 or fewer employees, with the appointing officers each appointing two such members.

(2) Each initial appointment is for a 3-year term, except that:

(a) The initial appointment of the consumer member appointed by the Governor, the one consumer member appointed by the Speaker of the House of Representatives, the representative of state or local government appointed by the Governor, one representative of business and industry appointed by the Governor, and two representatives of business and industry appointed by the President of the Senate, shall be for a term of 1 year from the date of initial appointment;

(b) The initial appointment of the consumer member appointed by the President of the Senate, the representative of state or local government appointed by the Speaker of the House of Representatives, one representative of business and industry appointed by the President of the Senate, and two representatives of business and industry appointed by the Speaker of the House of Representatives, shall be for a term of 2 years from the date of initial appointment; and

(c) The initial appointment of the representative of state or local government appointed by the President of the Senate, four representatives of business and industry appointed by the Governor, one representative of business and industry appointed by the President of the Senate, and one representative of business and industry appointed by the Speaker of the House of Representatives, shall be for a term of 3 years from the date of initial appointment.

(3) A member of an alliance board of directors may not be employed by, affiliated with, an agent of, or otherwise a representative of any health care provider or insurance carrier.

(4) The alliance board shall adopt bylaws. The bylaws must include a procedure for establishing qualifications for board membership and electing board members upon the expiration of the initial board members' terms and for the election of board officers. The board shall meet at times and places as it determines necessary to operate the alliance in accordance with ss. 408.70-408.706.

(5) Each board member is accountable to the Governor for proper performance of his duties as a member of the board. The Governor may remove from office any board member for neglect of duty.

(6) To the greatest extent possible, a community health purchasing alliance should be representative of the racial, demographic, and gender mix of the community served by the alliance.

(7) The board may appoint an executive director to serve as the chief operating officer of the alliance, and other staff needed to administer the alliance. The executive director and other alliance staff serve at the pleasure of the board.

(8) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member of the board of directors, or its employees or agents, for any action taken by them in the performance of their powers and duties under ss. 408.70-408.706.

Section 109. Section 408.706, Florida Statutes, is created to read:

408.706 Community health purchasing alliances; accountable health partnerships.—

(1) An accountable health partnership may be created by health care providers, health maintenance organizations, and health insurers, for the purpose of providing health care services to alliance members.

(2) Each accountable health partnership that seeks to offer services to members of an alliance must first obtain agency designation. The agency shall adopt rules in accordance with ss. 408.70-408.706 for designating accountable health partnerships in each district. To qualify as an accountable health partnership, an applicant must submit information considered sufficient by the agency, in a format prescribed by the agency, to satisfactorily demonstrate that the partnership:

(a) Is licensed and in good standing with the department and the licensure agency for participating providers;

(b) Has demonstrated the capacity to administer the health plans it is offering;

(c) Has the ability, experience, and structure to arrange for the appropriate level and type of health care services;

(d) Has the ability, policies, and procedures to conduct utilization management;

(e) Has the ability to achieve, monitor, and evaluate the quality and cost-effectiveness of care provided by its provider network;

(f) Has the ability to assure enrollees adequate access to providers of health care, including geographic availability and adequate numbers and types;

(g) Has the ability and procedures to monitor access to its provider network;

(h) Has a satisfactory grievance procedure and the ability to respond to enrollees' calls, questions, and complaints;

(i) Has the ability to use medical outcome data to educate network providers, update utilization review procedures, and recommend modifications to benefit designs;

(j) Has the ability to recruit and retain health care practitioners who are minorities as defined in s. 288.703(3), with special emphasis on the recruitment and retention of African-American health care providers; and

(k) Has the ability and policies that allow patients to receive care in the most appropriate, least restrictive setting.

If an accountable health partnership is accredited by a nationally recognized accrediting body or federal agency whose standards are acceptable to the agency, or if it is qualified or accredited as a health maintenance organization, the accountable health partnership may be deemed to meet the requirements of paragraphs (a)-(h).

(3) The agency shall establish a designation fee to be paid by each accountable health partnership to cover the agency's cost in performing the designation review.

(4) An accountable health partnership shall:

(a) Require all providers that are part of the partnership to report medical outcomes in accordance with agency standards.

(b) Comply with all rating, underwriting, claims-handling, sales, solicitation, licensing, and unfair trade practices laws and with other provisions of the Florida Insurance Code or of chapter 641.

(5) An accountable health partnership may provide services to more than one community health purchasing alliance.

(6) If an accountable health partnership elects to terminate its contract with an alliance member, the accountable health partnership must provide advance notice of its decision to the alliance at least 120 days prior to the nonrenewal of any health plan by the accountable health partnership.

(7) An accountable health partnership shall maintain records and submit reports to the alliance as required by ss. 408.70-408.706.

(8) An accountable health partnership shall use the services of a licensed agent for the solicitation of insurance or procurement of applications or any other activities for which a health insurance agent's license is required.

(9)(a) The agency shall suspend or revoke its designation of an accountable health partnership that fails to continue to meet the requirements of this section.

(b) The agency shall expedite proceedings to determine whether the designation of the accountable health partnership should be suspended or revoked.

Section 110. Effective July 1, 1993, section 408.90, Florida Statutes, is created to read:

408.90 Legislative findings and intent.—The Legislature finds that 2.5 million Floridians do not have access to health insurance coverage. It is the intent of the Legislature to provide a state health insurance program for those people who are without health insurance so that they may have access to preventive and primary care services. The state health insurance program shall offer basic, affordable health care services to those Floridians who have not had access to the private health insurance market. The Legislature intends that the state program shall target the uninsured and not those who currently have private health insurance coverage.

Section 111. Section 408.901, Florida Statutes, is created to read:

408.901 Definitions.—As used in ss. 408.901-408.908, except as otherwise specifically provided, the term:

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

(2) "Agent" means a person who is licensed to sell health insurance in this state.

(3) "Applicant" means a person who provides a written application to the agency for enrollment in the MedAccess program but whose application has not received final action.

(4) "Eligible person" means any person who meets the residency requirements of ss. 408.901-408.908.

(5) "Employer" means the state, its political subdivisions, any individual, partnership, association, corporation, or business trust, or any person or group of persons, acting in the interest of any employer in relation to an employee.

(6) "Fund" means the Licensure Fees Trust Fund.

(7) "Health services" means a set of basic health services covered by the MedAccess Program.

(8) "Member" means a state resident who has enrolled in the MedAccess program.

(9) "Participating provider" means any person who has a current provider agreement with the agency and who is authorized to furnish covered health services under ss. 408.901-408.908.

(10) "Premium" means the consideration paid or to be paid to the agency for the issuance of health insurance coverage provided by the MedAccess program.

(11) "MedAccess" means the state health program, including the Medicaid buy-in program, created under ss. 408.901-408.908.

Section 112. Section 408.902, Florida Statutes, is created to read:

408.902 MedAccess program; creation; program title.—

(1) Effective July 1, 1994, there is created the MedAccess program to be administered by the Agency for Health Care Administration. The MedAccess program is not subject to the requirements of the Department of Insurance or chapter 627.

(2)(a) The agency shall seek federal statutory or regulatory reforms to establish a Medicaid buy-in program to provide medical assistance to persons ineligible for Medicaid because of current income and categorical restrictions. The agency shall use funds provided by the Robert Wood Johnson Foundation to assist in developing the buy-in program, including, but not limited to, the determination of eligibility and service coverages; cost sharing requirements; managed care provisions; and changes needed to the Medicaid program's claims processing, utilization control, cost control, case management, and provider enrollment systems to operate a buy-in program.

(b) The agency shall seek federal authorization and financial support for a buy-in program that provides federally supported medical assistance coverage for persons with incomes up to 250 percent of the federal poverty level. The agency shall implement the Medicaid buy-in program on January 1, 1994, if the agency has received necessary federal authorization for waivers and has received federal financial participation and state appropriations. The premium subsidy for the Medicaid buy-in program must be structured according to a sliding scale of fees.

(c) If the agency has not received necessary federal waivers and if it has not received federal financial participation at a level equal to 250 percent of the federal poverty level, then the MedAccess program, created under this section, shall be implemented.

(3)(a) The agency shall prepare a report to be included in the Florida Health Plan due to the Legislature by December 31, 1993, on the implementation of the MedAccess program and the Medicaid buy-in program. The report must include the agency's plan for establishing administrative and accounting procedures for the operation of the MedAccess program and the Medicaid buy-in program, securing staff to administer the programs, establishing premiums, determining eligibility, enrolling individuals, billing and collecting premiums, establishing provider networks, enrolling providers, processing claims, marketing the programs, collecting data, establishing a case management program, controlling excess utilization, and containing costs. The report must also include an estimate of total start-up costs, ongoing administrative costs, and claims costs for the programs.

(b) For purposes of purchasing MedAccess services, including the Medicaid buy-in program services, through community health purchasing alliances and accountable health partnerships, it is the intent of the Legislature to maximize the choices of accountable health partnerships available to recipients consistent with the need to aggregate purchasing power in order to reduce costs and maximize access. The agency shall develop recommendations to be included in the Florida Health Plan due to the Legislature by December 31, 1993, which shall specify the procedures and methodologies to be used by the agency or the alliance to select from competing accountable health partnerships. At a minimum, the report must include recommendations on the following:

1. Methods for soliciting proposals from each accountable health partnership in each region;

2. Methods for evaluating each proposal based on quality and price, using objective criteria to be developed and adopted by rule;

3. Parameters for determining the maximum market share that may be awarded to any one accountable health partnership.

Section 113. Section 408.903, Florida Statutes, is created to read:

408.903 Eligibility.—

(1) Each resident of this state who has a gross family income that is equal to or below 250 percent of the federal poverty level and who meets the requirements of this section is eligible to enroll in the MedAccess program. For purposes of ss. 408.901-408.908, the term "resident" means a person who has established a domicile in the state for at least 6 months. As used in this section, the term "resident" means a United States citizen or United States legal permanent resident.

(2) A person or family who applies for enrollment in the MedAccess program must provide documentation that demonstrates he has not been covered by a health insurance policy in the 12-month period before the effective date of enrollment in the program.

(3) A person or family who is currently eligible for health care benefits under Medicare or the Florida Medicaid program is not eligible for enrollment in the MedAccess program. However, a person may convert to the program upon losing eligibility either for Medicare, Medicaid, or the Medicaid buy-in program.

(4) The agency may not use any information related to an applicant's assets in determining eligibility for the program.

(5) Each applicant for the program must complete an application form developed by the agency, provide information related to the family dependents to be enrolled, and supply documentation concerning family income and place of residence.

(6) Applications for enrollment in the MedAccess program must be submitted to the agency during a single 30-day open enrollment period semiannually. The agency shall review all completed applications within 45 days after receipt. Applicants who satisfy the eligibility criteria and have paid their initial premium shall be notified by the agency of the effective date of coverage.

(7) The agency may request verification of continued eligibility from members once every 12 months.

(8) The program may disenroll any member due to failure to meet eligibility criteria, nonpayment of premium, or good cause.

(9) Enrollment in the MedAccess program is subject to eligibility and fiscal limitations and must be renewed annually.

(10) The agency shall, to the extent possible, integrate county public health units and federally funded primary care centers as participating providers in the MedAccess program.

Section 114. Section 408.904, Florida Statutes, is created to read:

408.904 Benefits.—

(1) Each eligible person who enrolls in the MedAccess program may receive benefits for any covered service furnished within this state by a participating provider.

(2) Covered health services include:

(a) Physician services. Those services delivered by a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463 which are medically necessary for the treatment of an injury, illness, or disease. Physician services may not include services that are clinically unproven, experimental, or purely for cosmetic purposes. Each member is limited to 12 physician visits per calendar year, excluding visits related to annual or periodic physical examinations for wellness pursuant to paragraph (h) or for immunizations. The limit on physician visits may be extended by $1,000 in lieu of services authorized under paragraph (c).

(b) Hospital inpatient services. Those services, including psychiatric and comprehensive rehabilitative services, provided for the treatment of a member who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395 up to a limit of 10 days per calendar year per member. In lieu of the 10-day limitation, 3 hospice days may be substituted for 1 inpatient hospital day.

(c) Hospital outpatient services. Those services provided to a member in the outpatient portion of a hospital licensed under part I of chapter 395, up to a limit of $1,000 per calendar year per member, which are preventive, diagnostic, therapeutic, or palliative.

(d) Laboratory services. Professional laboratory services ordered by a licensed physician or other licensed practitioner of the healing arts and provided in a laboratory that meets the requirements for Medicare participation and is licensed under chapter 483.

(e) Birth center services. Those services provided to a member in a birth center licensed under chapter 383, including, but not limited to, prenatal, labor and delivery, postpartum, well-woman gynecological services, annual physicals, family planning, educational services, and any laboratory, drugs, or supplies, as appropriate. These services may be provided by physicians licensed under chapter 458 or chapter 459, nurse practitioners licensed under chapter 464, or midwives licensed under chapter 467, according to their scope of practice.

(f) X-ray services. Radiological services ordered by a licensed physician or other licensed practitioner of the healing arts and that are provided by a licensed professional.

(g) Family planning services. Drugs and supplies that enable a member to plan family size.

(h) Health appraisals, including physician examinations and related tests. Routine annual physical examinations conducted by or under the direction of a licensed physician, without regard to medical necessity, in order to detect disease, disability, or other physical or mental conditions. These services include well-baby and well-child screening and diagnostic services provided periodically to members under the age of 21.

(i) Immunizations.

(j) Advanced registered nurse practitioner services.

(k) Outpatient mental health visits and substance abuse treatment. Outpatient mental health visits provided by a community mental health center as provided in chapter 394 and by a mental health therapist licensed under chapter 490 or chapter 491, and substance abuse treatment provided by a center licensed under chapter 396 or chapter 397, up to a total of five visits per calendar year per member.

(3) Covered health services do not include:

(a) Surgery solely for cosmetic purposes.

(b) Prescribed drugs.

(c) Nursing home services.

(d) Medical examinations conducted and medical reports prepared for either purchasing or renewing life insurance or participating as a plaintiff or defendant in a civil action for the recovery or settlement of damages.

(e) Clinically unproven or experimental procedures.

Section 115. Section 408.905, Florida Statutes, is created to read:

408.905 Limitations and exclusions.—

(1) The MedAccess program does not cover benefits that are provided as part of workers' compensation insurance.

(2) The MedAccess program must exclude coverage for pre- existing conditions, except pregnancy, during a period of 12 months following the effective date of coverage if:

(a) The condition manifested itself within 6 months before the effective date of coverage; or

(b) Medical advice or treatment was recommended or received within 6 months before the effective date of coverage.

(3) In addition to the limitations otherwise provided in ss. 408.901-408.908, the MedAccess program may not include coverage for outpatient prescription drugs, eyeglasses, dental services, custodial care, or emergency services for nonemergency conditions.

(4) Any member of the MedAccess program who is determined to be at high risk by a participating primary care provider must, upon renewal, agree to be placed in a case management system if it is determined by the program to be in the best interest of the member and the MedAccess program.

(5) A person on whose behalf the program has paid out $500,000 in covered benefits is not eligible for continued coverage in the MedAccess program.

Section 116. Section 408.906, Florida Statutes, is created to read:

408.906 Payment of claims.—

(1) The agency is designated as the single state agency authorized to make payments for health services covered under the MedAccess program. These payments shall be made only for services included in the MedAccess program and shall be made only on behalf of eligible members in accordance with ss. 408.901-408.908.

(2) The agency shall pay claims for covered health services provided to members at the same reimbursement rates and fees that are provided under the Florida Medicaid program, pursuant to s. 409.908. If rates for a service have not been established under the Medicaid program, the agency shall develop a reimbursement system for such services.

Section 117. Section 408.907, Florida Statutes, is created to read:

408.907 Collection of premiums.—

(1) Premiums collected from members or from employers on behalf of members must be made in accordance with rules adopted by the agency.

(2) Premiums collected must be deposited into the Licensure Fees Trust Fund administered by the agency. Moneys in this fund shall be used solely for the administration of the MedAccess program.

(3) Employers are encouraged to participate in the payment of all or a portion of their employees' premium obligation. The agency may offer discounts to the premium obligation to employers who pay at least 50 percent of the premium and who collect the premium from the employees on behalf of the agency.

(4) The agency may contract with agents who may refer individuals to the MedAccess program and may pay those agents a referral fee if the individual's application is accepted for enrollment in the MedAccess program.

(5) The agency shall develop strategies for marketing MedAccess to increase public awareness about the state program.

Section 118. Section 408.908, Florida Statutes, is created to read:

408.908 Administration.—The agency shall:

(1) Develop a network of health care providers for providing managed health care services statewide.

(2) Perform all eligibility and administrative functions for claims payment relating to the program.

(3) Evaluate the eligibility of each claim for payment under the program.

(4) Establish a premium-billing-procedure for collecting premiums from insured persons.

(5) Develop a schedule of copayments and deductibles which encourages the use of preventive and primary care services, deters members from overutilizing services, and discourages the use of expensive, technology-driven services.

(6) Market the MedAccess program.

(7) Provide that the direct and indirect expenses of the program are fully covered by the collection of premiums from members of the MedAccess program.

(8) Establish policy and budget guidelines for the MedAccess program.

(9) Adopt rules to carry out ss. 408.901-408.908.

(10) Implement and administer the MedAccess program.

(11) Provide to the public and health care providers information concerning the MedAccess program.

(12) Ensure that the quality of service provided under the MedAccess program meets the standards of the community.

(13) Identify and disqualify health care providers who engage in fraudulent or abusive activities related to the MedAccess program.

(14) Evaluate the adequacy of the services covered by the MedAccess program, the accessibility of the program to the uninsured, and the effectiveness of the MedAccess program in reducing the number of uninsured persons in the state.

Section 119. Effective July 1, 1993, subsections (2) and (3) of section 409.335, Florida Statutes, are amended to read:

409.335 Recovery of payments made due to mistake or fraud.—

(2) When the *Agency for Health Care Administration* ~~department~~ has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the *agency* ~~department~~, after notice to the provider, may:

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the *agency* ~~department~~.

(b) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

Should a provider request an administrative hearing pursuant to chapter 120, such hearing shall be conducted within 90 days following receipt by the provider of the final audit report, absent exceptionally good cause shown as determined by the administrative hearing officer. Upon issuance of a final order, the balance outstanding of the amount determined to constitute the overpayment shall become due. Any withholding of payments by the *Agency for Health Care Administration under* ~~department pursuant to~~ this section shall be limited so that the monthly medical assistance payment shall not be reduced by more than 10 percent.

(3) In all final agency actions and orders issued by hearing officers that relate to recovery of medical assistance overpayments made due to a mistake of the provider or fraud, the *agency* ~~department~~ shall make a motion to impose an interest penalty at 10 percent per year from the date of final agency action or order by a hearing officer until the overpayment is recovered by the *agency* ~~department~~. When the hearing officer's decision is that an overpayment was not made in an amount as great as identified by the *agency* ~~department~~, any collections made by the *agency* ~~department~~ pursuant to subsection (2) shall be reimbursed within 60 days to the provider by the *agency* ~~department~~ with interest at 10 percent per year.

Section 120. Section 409.701, Florida Statutes, is amended to read:

409.701 The Florida Health Access Corporation Act.—

(1) SHORT TITLE.—This section may be cited as the "Florida Health Access Corporation Act."

(2) LEGISLATIVE INTENT.—The Legislature finds that there is insufficient *affordable* ~~group~~ health ~~insurance~~ coverage available to employees of small businesses in Florida, that uninsured employees of small businesses represent a significant portion of the uncompensated costs of health care providers, and that uninsured individuals have impaired access to health care services and correspondingly lower health status. It is the intent of the Legislature that a nonprofit corporation, to be known as the "Florida Health Access Corporation," be organized for the purpose of pooling *the purchasing power of* groups of individuals employed by small businesses, and the dependents of such employees, into larger groups in order to facilitate a program of affordable ~~group~~ health ~~insurance~~ coverage *and establish pooled purchasing arrangements* ~~to uninsured individuals~~. *The health coverage provided by the corporation may be subsidized or nonsubsidized. Subsidies must be available only on a case-by-case basis for individual businesses as determined necessary by the board of directors.*

(3) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

(a) There is authorized the "Florida Health Access Corporation." The Florida Health Access Corporation shall operate in Hillsborough County and a multicounty rural site and such other counties as may be designated by the corporation.

(b) The Florida Health Access Corporation shall:

1. Organize employers of *50* ~~24~~ or fewer full-time *or part-time* employees and facilitate the provision of ~~group~~ health *coverage* ~~insurance~~ to such employers and employees and their dependents;

2. Arrange for the collection of premiums, in an amount to be determined by the board of directors, from all insured individuals to provide for claims paid under ~~group~~ health *coverage* ~~insurance~~ arrangements and for the administrative expenses incurred or estimated to be incurred during the period for which the premium is paid;

3. Establish administrative and accounting procedures for the operation of the corporation;

4. Establish employer and employee eligibility criteria for participation in the program;

5. Establish participation criteria governing eligibility of insurers or any providers of health care services to participate in the program;

6. Establish procedures under which applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board;

7. Contract with an authorized insurer or insurance administrator to provide administrative services to the corporation if desired or when such services are deemed necessary by the board;

8. Contract with authorized insurers or any provider of health care services for the provision of services to individuals covered through the program;

9. Develop and implement a plan to publicize the Florida Health Access Corporation, the eligibility requirements for the program, and the procedures for enrollment in the program, and to maintain public awareness of the corporation and the program;

10. Secure staff necessary to properly administer the corporation. *Administrative* ~~Staff~~ costs shall be funded from grant funds, state and local matching funds, administrative fees collected from employers and insurers, and other sources of funding arranged by the corporation. The board of directors is authorized to determine the number of staff necessary to administer the corporation~~, but shall include, at a minimum, an executive director, an assistant director, and a staff assistant~~; and

11. Enter into contracts with local agencies to provide onsite marketing and enrollment services necessary to the operation of the corporation.

(c) The corporation shall set business and employee eligibility standards which shall define a small business and further identify small businesses eligible for participation in the program. Small businesses eligible for participation *must* ~~shall~~ have *50* ~~24~~ or fewer full-time employees. Employer eligibility standards *for employers who receive direct premium subsidy* shall include a provision that the employer must attest to having offered or provided no other health insurance benefit program in the 6-month period prior to the effective date of participation in the program. *However, this eligibility standard does not apply to an employer who receives nonsubsidized coverage arranged through the program.* The corporation shall make all necessary provisions to prevent the payment of or reimbursement for any claim or expense which may be covered under a separate health insurance or health care services plan under which an individual who participates in the program may be covered. Coverage arranged through the corporation's program is to be considered secondary to any other available coverage held by the individual participating in the program. ~~If such an individual is also eligible for Medicare coverage, the coverage arranged by the corporation shall not pay or reimburse any individual for expenses paid by Medicare.~~ No policy shall be arranged by the corporation which is deemed to be a Medicare supplemental policy as defined in s. 627.672.

(d) The corporation, which shall be operated as a nonprofit private corporation organized pursuant to chapter 617, shall have all powers necessary or convenient to carry out and effectuate the purposes and provisions of this act, including, but not limited to, the power to receive and accept grants, loans, and, notwithstanding the provisions of ss. 215.42 and 215.422, advances of funds from any public or private agency, for, or in aid of, the purpose of this act, and to receive and accept contributions, from any source, of money, property, labor, or any other thing of value, to be held, used, and applied for said purposes.

(4) BOARD OF DIRECTORS.—

(a) The Florida Health Access Corporation shall operate subject to the supervision and approval of a seven-member board of directors, which shall consist of:

1. *Three* ~~Two~~ members~~, one from an urban county and one from a rural county,~~ who shall represent small businesses whose employees are eligible to participate in the Florida Health Access Corporation;

~~2. One member who shall represent consumers eligible to participate in the Florida Health Access Corporation;~~

2.~~3.~~ One member who shall be a representative of a ~~domestic health care insurer or of a~~ private company which offers a self-insured program of health benefits to employees;

3.~~4.~~ One member who shall be the *director* ~~secretary~~ of the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ or his designee;

4.~~5.~~ One member who shall be a representative of *an organized labor or business not-for-profit association* ~~the Florida Chamber of Commerce~~; and

5.~~6.~~ One member who shall be a representative of an employer health coalition.

(b) The board of directors shall be appointed and may be removed by the Governor, *subject to Senate confirmation.* Terms of appointment shall be for 3 years. The board shall appoint the *chief* executive *officer* ~~director~~, who shall be responsible for other staff as authorized by the board.

(c) Board members may be reimbursed from funds of the Florida Health Access Corporation for actual and necessary expenses incurred by them as members, according to state travel and per diem limitations, but may not otherwise be compensated for their services.

(d) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member of the board of directors, or its employees or agents, for any action taken by them in performance of their powers and duties under this act.

(5) LICENSING, FISCAL OPERATION.—

(a) The corporation shall not be deemed to be an insurer. The officers, directors, and employees of the corporation shall not be deemed to be agents of an insurer. Neither the corporation nor the officers, directors, or employees of the corporation shall be subject to the licensing requirements of the insurance code or the rules of the Department of Insurance. However, the Department of Insurance may require that the marketing representative utilized and compensated by the corporation be licensed as representatives of the insurers or health services providers with whom the corporation may contract.

(b) The Florida Health Access Corporation program shall be operated in accordance with sound actuarial principles. The board shall have complete fiscal control over the corporation and shall be responsible for all corporate operations.

~~(c) The Department of Insurance shall assist the program in determining that proposed premium levels will be sufficient to permit the corporation to operate in an actuarially sound manner.~~

(c)~~(d)~~ The corporation may expend funds through direct reinsurance, by purchasing reinsurance, or by other means approved by the board for the program of health care services and benefits arranged through the corporation. The amount of such expenditure shall not exceed funds allocated from the Public Medical Assistance Trust Fund or other sources of funding arranged by the corporation. Notwithstanding the provisions of s. 216.301, any amount so provided, which is not annually required for such purposes, shall remain available to the corporation, to be supplemented by an annual amount equal to the amount expended in the prior year, for the purpose of meeting funding requirements in succeeding years. Any amount remaining upon the liquidation or dissolution of the corporation shall be returned to the Public Medical Assistance Trust Fund.

Section 121. Section 409.7015, Florida Statutes, is amended to read:

409.7015 Unemployment compensation data availability.—

(1) In order to further the research and demonstration objectives of s. 409.701, the Division of Unemployment Compensation, Department of Labor and Employment Security, shall, notwithstanding the provisions of s. 443.171(7), make available to the Florida Health Access Corporation such information as the corporation requests so as to facilitate contact with employers who may be eligible for participation in the program of health insurance benefits arranged through the corporation. Such information as is obtained by the corporation through the provisions of this section is confidential and exempt from the provisions of s. 119.07(1). Neither the corporation nor the staff or agents of the corporation shall release to any state or federal agency, to any private business or person, or to any other entity any information received through the operation of this section. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14. Violation of this section shall be regarded as a violation of s. 443.171(7).

(2) This section *expires* ~~shall stand repealed on~~ October 1, *1995* ~~1993~~.

Section 122. Effective July 1, 1993, section 409.901, Florida Statutes, is amended to read:

409.901 Definitions.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

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

(2)~~(1)~~ "Applicant" means an individual whose written application for medical assistance provided by Medicaid under ss. 409.903-409.906 has been submitted to the *agency* ~~department~~, but has not received final

action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a representative or a person acting for the individual.

(3)~~(2)~~ "Benefit" means any benefit, assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical care, goods, or services.

(4)~~(3)~~ "Claim" means any communication, whether oral, written, or electronic (electronic impulse or magnetic), which is used by any person to apply for payment from the Medicaid program or its fiscal agent for each item or service purported by any person to have been provided by a person to any Medicaid recipient.

(5)~~(4)~~ "Collateral" means:

(a) Any and all causes of action, suits, claims, counterclaims, and demands which accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care, goods, or services which necessitated that Medicaid provide medical assistance.

(b) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

(c) Proceeds, as defined in this section.

(6)~~(5)~~ "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance.

~~(6) "Department" means the Department of Health and Rehabilitative Services. The department is the Medicaid agency for the state, as provided under federal law.~~

(7) "Legal representative" means a guardian, conservator, survivor, or personal representative of a recipient or applicant, or of the property or estate of a recipient or applicant.

(8) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations thereunder, as administered in this state by the *agency* ~~department~~.

(9) "Medicaid agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

(10) "Medicaid program" means the program authorized under Title XIX of the federal Social Security Act that provides for payments for medical items or services, or both, on behalf of any person who is determined by the *agency* ~~department~~ to be eligible on the date of service for Medicaid assistance.

(11) "Medicaid provider" or "provider" means a person or entity that has a Medicaid provider agreement in effect with the *agency* ~~department~~ and is in good standing with the *agency* ~~department~~.

(12) "Medicaid provider agreement" or "provider agreement" means a contract between the *agency* ~~department~~ and a provider for the provision of services or goods, or both, to Medicaid recipients pursuant to Medicaid.

(13) "Medicaid recipient" or "recipient" means an individual whom the *agency* ~~department~~ determines is eligible, pursuant to federal and state law, to receive medical assistance and related services for which the *agency* ~~department~~ may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

(14) "Medicaid-related records" means records that relate to the provider's business or profession and to a Medicaid recipient. Medicaid-related records include records related to non-Medicaid customers, clients, or patients but only to the extent that the documentation is shown by the *agency* ~~department~~ to be necessary to determine a provider's entitlement to payments under the Medicaid program.

(15) "Medical assistance" means any provision of, payment for, or liability for medical services by Medicaid to, or on behalf of, any recipient.

(16) "Medical services" or "medical care" means medical or medically related institutional or noninstitutional care, goods, or services covered by the Medicaid program. The term includes, without limitation, physician services, inpatient hospital services, outpatient hospital services, independent laboratory services, X-ray services, and prescribed drug services, and such other services as are covered by the Medicaid program.

(17) "Payment," as it relates to third-party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. To "pay" means to do any of the acts set forth in this subsection.

(18) "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds thereon and includes insurance payable by reason of loss or damage to the collateral or proceeds. Money, checks, deposit accounts, and the like are "cash proceeds." All other proceeds are "noncash proceeds."

(19) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.

(20) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the *agency* ~~department~~, for any Medicaid-covered injury, illness, goods, or services, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses prior to death. The term includes, without limitation, collateral, as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.

Section 123. Effective July 1, 1993, section 409.902, Florida Statutes, is amended to read:

409.902 Designated single state agency; payment requirements; program title.—The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law This program of medical assistance is designated the "Medicaid program."

Section 124. Effective July 1, 1993, section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.—The *agency* ~~department~~ shall make payments for medical assistance and related services on behalf of the following persons who the *agency* ~~department~~ determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216.

(1) Persons who receive payments from or are determined eligible for the federal and state program known as Aid to Families with Dependent Children (AFDC), and certain persons who were eligible for that program but who became ineligible or who would be eligible but do not meet certain technical requirements. This group includes, but is not limited to:

(a) Low-income, single-parent families and their children.

(b) Low-income, two-parent families in which at least one parent is disabled or otherwise incapacitated.

(c) Certain unemployed two-parent families and their children.

(2) A person who receives payments from, who is determined eligible for, or who was eligible for but lost cash benefits from the federal program known as the Supplemental Security Income program (SSI). This

category includes a low-income person age 65 or over and a low-income person under age 65 considered to be permanently and totally disabled.

(3) A child under age 21 living in a low-income, two-parent family, and a child under age 7 living with a nonrelative, if the income and assets of the family or child, as applicable, do not exceed the cash-assistance limits under the Aid to Families with Dependent Children program.

(4) A child who is eligible under Title IV-E of the Social Security Act for subsidized board payments, foster care, or adoption subsidies, and a child for whom the state has assumed temporary or permanent responsibility and who does not qualify for Title IV-E assistance but is in foster care, shelter or emergency shelter care, or subsidized adoption.

(5) A pregnant woman for the duration of her pregnancy and for the post partum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150 percent of the most current federal poverty level, or, effective January 1, 1992, that has an income which is at or below 185 percent of the most current federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.

(6) A child born after September 30, 1983, living in a family that has an income which is at or below 100 percent of the current federal poverty level, who has attained the age of 6, but has not attained the age of 19. In determining the eligibility of such a child, an assets test is not required.

(7) A child living in a family that has an income which is at or below 133 percent of the current federal poverty level, who has attained the age of 1, but has not attained the age of 6. In determining the eligibility of such a child, an assets test is not required.

(8) A person who is age 65 or over or is determined by the *agency* ~~department~~ to be disabled, whose income is at or below 100 percent of the most current federal poverty level and whose assets do not exceed limitations established by the *agency* ~~department~~. However, the *agency* ~~department~~ may only pay for premiums, coinsurance, and deductibles, as required by federal law, unless additional coverage is provided for any or all members of this group by s. 409.904(1).

Section 125. Effective July 1, 1993, section 409.904, Florida Statutes, is amended to read:

409.904 Optional payments for eligible persons.—The *agency* ~~department~~ may make payments for medical assistance and related services on behalf of the following persons who the *agency* ~~department~~ determines to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216.

(1) A person who is age 65 or older or is determined by the *agency* ~~department~~ to be disabled, whose income is at or below 100 percent of federal poverty level, and whose assets do not exceed limitations established by the *agency* ~~department~~.

(2) A family, a pregnant woman, a child under age 18, a person age 65 or over, or a blind or disabled person who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed limitations established by the *agency* ~~department~~. For a family or person in this group, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person in this group, which group is known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the mentally retarded.

(3) A person who is in need of the services of a licensed nursing facility, a licensed intermediate care facility for the mentally retarded, or a state mental hospital, whose income does not exceed 300 percent of the SSI income standard, and who meets the assets standards established under federal and state law.

(4) A low-income person who meets all other requirements for Medicaid eligibility except citizenship and who is in need of emergency

Section 126. Effective July 1, 1993, section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The *agency* ~~department~~ may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined by the *agency* ~~department~~ to be eligible on the dates on which the services were provided. Any service under this section may be provided only when medically necessary, shall be provided in accordance with state and federal law, and is subject to the availability of moneys and any limitation established by the general appropriations act or chapter 216.

(1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The *agency* ~~department~~ shall pay for services provided to a recipient by a licensed advanced registered nurse practitioner who has a valid collaboration agreement with a licensed physician on file with the Department of Professional Regulation or who provides anesthesia services in accordance with established protocol required by state law and approved by the medical staff of the facility in which the anesthetic service is performed. Reimbursement for such services must be provided in an amount that equals not less than 80 percent of the reimbursement to a physician who provides the same services.

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The *agency* ~~department~~ shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the *agency* ~~department~~ to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

(3) FAMILY PLANNING SERVICES.—The *agency* ~~department~~ shall pay for services necessary to enable a recipient voluntarily to plan family size or to space children. These services include information, education, drugs and supplies, and necessary medical care and followup. Each recipient participating in the family planning portion of the Medicaid program must be provided freedom to choose any alternative method of family planning, as required by federal law.

(4) HOME HEALTH CARE SERVICES.—The *agency* ~~department~~ shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to this subsection shall be licensed under part III of chapter 400 or part II of chapter 499, if appropriate. These services, equipment, and supplies may be limited as provided in the general appropriations act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(5) HOSPITAL INPATIENT SERVICES.—The *agency* ~~department~~ shall pay for all services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, payment for inpatient hospital services in excess of 45 days for a Medicaid recipient 21 years of age or older is dependent upon the availability of sufficient county contributions. A licensed hospital maintained primarily for the care and treatment of patients having mental disorders or mental diseases is not eligible to participate in the hospital inpatient portion of the Medicaid program except as provided in federal law. ~~However, the department shall apply for a waiver, within 9 months after June 5, 1991, designed to provide hospitalization services for mental health reasons to children and adults in the most cost effective and lowest cost setting possible. Such waiver shall include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMD's." The waiver proposal shall propose no additional aggregate cost to the state or federal government, and shall be conducted in District 6 of the Department of Health and Rehabilitative Services. The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. When developing the waiver proposal, the department shall take into account price, quality, accessibility, linkages of the hospital to community services and family support programs, plans of the hospital to ensure the earliest discharge possible, and the comprehensiveness of the mental~~

~~health and other health care services offered by participating providers. The department is directed to monitor and evaluate the implementation of this waiver program if it is granted and report to the chairs of the appropriations committees of the Senate and the House of Representatives by February 1, 1992.~~

(6) HOSPITAL OUTPATIENT SERVICES.—The *agency* ~~department~~ shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,000 per state fiscal year per recipient, unless an exception has been made by the *agency* ~~department~~, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

(7) INDEPENDENT LABORATORY SERVICES.—The *agency* ~~department~~ shall pay for medically necessary diagnostic laboratory procedures ordered by a licensed physician or other licensed practitioner of the healing arts which are provided for a recipient in a laboratory that meets the requirements for Medicare participation and is licensed under chapter 483, if required.

(8) NURSING FACILITY SERVICES.—The *agency* ~~department~~ shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part I of chapter 400 *or in a rural hospital, as defined in s. 395.602,* which are ordered by and provided under the direction of a licensed physician.

(9) PHYSICIAN SERVICES.—The *agency* ~~department~~ shall pay for services and procedures rendered to a recipient by, or under the personal supervision of, a person licensed under state law to practice medicine or osteopathy. These services may be furnished in the physician's office, the Medicaid recipient's home, a hospital, a nursing facility, or elsewhere, but shall be medically necessary for the treatment of an injury, illness, or disease within the scope of the practice of medicine or osteopathy as defined by state law. The *agency* ~~department~~ shall not pay for services that are clinically unproven, experimental, or for purely cosmetic purposes.

(10) PORTABLE X-RAY SERVICES.—The *agency* ~~department~~ shall pay for professional and technical portable radiological services ordered by a licensed physician or other licensed practitioner of the healing arts which are provided by a licensed professional in a setting other than a hospital, clinic, or office of a physician or practitioner of the healing arts, on behalf of a recipient.

(11) RURAL HEALTH CLINIC SERVICES.—The *agency* ~~department~~ shall pay for outpatient primary health care services for a recipient provided by a clinic certified by and participating in the Medicare program which is located in a federally designated, rural, medically underserved area and has on its staff one or more licensed primary care nurse practitioners or physician assistants, and a licensed staff supervising physician or a consulting supervising physician.

(12) TRANSPORTATION SERVICES.—The *agency* ~~department~~ shall ensure that transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for necessary and Medicaid-compensable services. The *agency* ~~department~~ may pay for transportation and other related travel expenses as necessary if these services are not otherwise available.

Section 127. Effective July 1, 1993, section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—The *agency* ~~department~~ may make payments for the following services, which are optional to the state under Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined by the *agency* ~~department~~ to be eligible on the dates on which the services were provided. Any service that is provided under this section may be provided only when medically necessary, must be provided in accordance with state and federal law, and is subject to any limitation established by the general appropriations act or chapter 216.

(1) ADULT DENTURE SERVICES.—The *agency* ~~department~~ may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is age 21 or older.

(2) ADULT HEALTH SCREENING SERVICES.—The *agency* ~~department~~ may pay for an annual routine physical examination, conducted by or under the direction of a licensed physician, for a recipient age 21 or older, without regard to medical necessity, in order to detect and prevent disease, disability, or other health condition or its progression.

(3) AMBULATORY SURGICAL CENTER SERVICES.—The *agency* ~~department~~ may pay for services provided to a recipient in an ambulatory surgical center licensed under part I of chapter 395, by or under the direction of a licensed physician or dentist.

(4) BIRTH CENTER SERVICES.—The *agency* ~~department~~ may pay for examinations and delivery, recovery, and newborn assessment, and related services, provided in a licensed birth center staffed with licensed physicians, certified nurse midwives, and midwives licensed in accordance with chapter 467, to a recipient expected to experience a low-risk pregnancy and delivery.

(5) CASE MANAGEMENT SERVICES.—The *agency* ~~department~~ may pay for primary care case management services rendered to a recipient pursuant to a federally approved waiver, and targeted case management services for specific groups of targeted recipients, which services are rendered pursuant to federal guidelines.

(6) CHILDREN'S DENTAL SERVICES.—The *agency* ~~department~~ may pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist. Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual.

(7) CHIROPRACTIC SERVICES.—The *agency* ~~department~~ may pay for manual manipulation of the spine and initial services, screening, and X rays provided to a recipient by a licensed chiropractic physician.

(8) COMMUNITY MENTAL HEALTH SERVICES.—The *agency* ~~department~~ may pay for rehabilitative services provided to a recipient in a mental health, drug abuse, or alcohol abuse center licensed by and under contract to the *agency* ~~department~~, which are psychiatric in nature and rendered or recommended by a psychiatrist or which are medical in nature and rendered or recommended by a physician or psychiatrist.

(9) DURABLE MEDICAL EQUIPMENT.—The *agency* ~~department~~ may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary.

(10) HEARING SERVICES.—The *agency* ~~department~~ may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(11) HOME AND COMMUNITY-BASED SERVICES.—The *agency* ~~department~~ may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program.

(12) HOSPICE CARE SERVICES.—The *agency* ~~department~~ may pay for all reasonable and necessary services for the palliation or management of a recipient's terminal illness, if the services are provided by a hospice that is licensed under the provisions of part V of chapter 400 and meets Medicare certification requirements.

(13) INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES.—The *agency* ~~department~~ may pay for health-related care and services provided on a 24-hour-a-day basis by a facility licensed under chapter 393, to a recipient who needs such care because of his mental or physical condition.

(14) INTERMEDIATE CARE SERVICES.—The *agency* ~~department~~ may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part I of chapter 400, if the services are ordered by and provided under the direction of a physician.

(15) OPTOMETRIC SERVICES.—The *agency* ~~department~~ may pay for services provided to a recipient, including examination, diagnosis, treatment, and management, related to ocular pathology, if the services are provided by a licensed optometrist or physician.

(16) PODIATRIC SERVICES.—The *agency* ~~department~~ may pay for services, including diagnosis and medical, surgical, palliative, and mechanical treatment, related to ailments of the human foot and lower leg, if provided to a recipient by a podiatrist licensed under state law.

(17) PRESCRIBED DRUG SERVICES.—The *agency* ~~department~~ may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law.

(18) STATE HOSPITAL SERVICES.—The *agency* ~~department~~ may pay for all-inclusive psychiatric inpatient hospital care provided to a recipient age 65 or older in a state mental hospital.

(19) VISUAL SERVICES.—The *agency* ~~department~~ may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient, if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

Section 128. Effective July 1, 1993, section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The *agency* ~~department~~ may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has a provider agreement in effect with the *agency* ~~department~~, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the *agency* ~~department~~.

(1) Each provider agreement shall require the provider to comply fully with all state and federal laws pertaining to the Medicaid program, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts, and shall require the provider to provide services or goods of not less than the scope and quality it provides to the general public.

(2) Each provider agreement shall be a voluntary contract between the *agency* ~~department~~ and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program when furnishing a service or goods to a Medicaid recipient and the *agency* ~~department~~ agrees to pay a sum, determined by fee schedule, payment methodology, or other manner, for the service or goods provided to the Medicaid recipient. Each provider agreement shall be effective for a stipulated period of time, shall be terminable by either party after reasonable notice, and shall be renewable by mutual agreement.

(3) The provider agreement developed by the *agency* ~~department~~, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(a) Have in his possession at the time of signing the provider agreement, and maintain in good standing throughout the period of the agreement's effectiveness, a valid professional or facility license pertinent to the services or goods being provided, if required by the state or locality in which the provider is located, and the Federal Government, if applicable.

(b) Maintain in a systematic and orderly manner all medical and Medicaid-related records as the *agency* ~~department~~ may require and as it determines necessary for the services or goods being provided.

(c) Retain all medical and Medicaid-related records for a period of 5 years to satisfy all necessary inquiries by the *agency* ~~department~~.

(d) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients and comply with all state and federal laws pertaining to confidentiality of patient information.

(e) Permit the *agency* ~~department~~, the Auditor General, the Federal Government, and the authorized agents of each of these entities access to all Medicaid-related information, which may be in the form of records, logs, documents, or computer files, and other information pertaining to services or goods billed to the Medicaid program, including access to all patient records and other provider information if the provider cannot easily separate records for Medicaid patients from other records.

(f) Bill other insurers and third parties, including the Medicare program, before billing the Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person, and comply with all other state and federal requirements in this regard.

(g) Promptly report any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program, and promptly refund such moneys to the *agency* ~~department~~.

(h) Be liable for and indemnify, defend, and hold the *agency* ~~department~~ harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the provider in the course of providing services to a recipient or a person believed to be a recipient.

(i) At the option of the *agency* ~~department~~, provide proof of liability insurance and maintain such insurance in effect for any period during which services or goods are furnished to Medicaid recipients.

(j) Accept Medicaid payment as payment in full, and prohibit the provider from billing or collecting from the recipient or the recipient's responsible party any additional amount except, and only to the extent the *agency* ~~department~~ permits or requires, copayments, coinsurance, or deductibles to be paid by the recipient for the services or goods provided. The Medicaid payment-in-full policy does not apply to services or goods provided to a recipient if the services or goods are not covered by the Medicaid program.

(4) A provider agreement shall provide that, if the provider sells or transfers a business interest or practice that substantially constitutes the entity named as the provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the provider in the provider agreement, the provider is required to maintain and make available to the *agency* ~~department~~ Medicaid-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement.

(5) The *agency* ~~department~~:

(a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim form. The claim form shall require certification that the services or goods have been completely furnished to the recipient and that, with the exception of those services or goods specified by the *agency* ~~department~~, the amount billed does not exceed the provider's usual and customary charge for the same services or goods.

(b) Is prohibited from demanding repayment from the provider in any instance in which the Medicaid overpayment is attributable to *an* ~~departmental~~ error *by the agency* in the determination of eligibility of a recipient.

(c) May adopt, and include in the provider agreement, such other requirements and stipulations on either party as the *agency* ~~department~~ finds necessary to properly and efficiently administer the Medicaid program.

(6) A Medicaid provider agreement may be revoked, at the option of the *agency* ~~department~~, as the result of a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement. A provider shall give the *agency* ~~department~~ 60 days' notice before making any change in ownership of the entity named in the provider agreement as the provider.

(7) The *agency* ~~department~~ may require, as a condition of participating in the Medicaid program and before entering into the provider agreement, that the provider submit information concerning the professional, business, and personal background of the provider. If the provider is a corporation, partnership, association, or other entity, the *agency* ~~department~~ may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater.

(8) Before signing a provider agreement, the *agency* ~~department~~ shall require the provider to submit:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws,

rules, or regulations of this state or of any other state or the Federal Government; any prior violation of the laws, rules, or regulations relating to the Medicare program; any prior violation of the rules or regulations of any other public or private insurer; and any prior violation of the laws, rules, or regulations of any regulatory body of this or any other state. The information required is that which pertains to the entity entering into the provider agreement with the *agency* ~~department~~; to any principal, partner, or shareholder having an ownership interest in the entity of 5 percent or greater; and to any treating provider who participates or intends to participate in Medicaid through the entity acting as a group provider.

(c) Notice of and copies of court documents not sealed by the court of jurisdiction, related to any criminal charge brought in any court in the United States against the provider or the provider entity, or any principal, partner, or major shareholder thereof.

(d) Full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(e) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Medicaid program.

(9) All statements and information furnished by the prospective provider for background information before signing the provider agreement shall be true and complete. The filing of materially incomplete or false information is sufficient cause for immediate termination of the provider from the Medicaid program.

(10) Before signing a provider agreement and at the discretion of the *agency* ~~department~~, other provisions of this section notwithstanding, an entity may become eligible to receive payment from the Medicaid program at the time it first furnishes services or goods, if:

(a) The services or goods provided are otherwise compensable;

(b) The entity meets all other requirements of a Medicaid provider at the time the services or goods were provided; and

(c) The entity agrees to abide by the provisions of the provider agreement effective from the date the services or goods were provided.

(11) A provider may not reenroll in the Medicaid program once suspended or terminated if any fine or overpayment properly assessed has not been repaid, unless the *agency* ~~department~~ has issued a specific letter of forgiveness or has approved a repayment schedule to which the provider agrees to adhere.

(12) A provider who does not adhere to an agreed-upon repayment schedule, whether previously suspended or terminated, may be terminated by the *agency* ~~department~~ for nonpayment or partial payment.

Section 129. Effective July 1, 1993, section 409.908, Florida Statutes, 1992 Supplement, is amended to read:

409.908 Reimbursement of Medicaid providers.—The *agency* ~~department~~ shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the *agency* ~~department~~ and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, and other mechanisms the *agency* ~~department~~ considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited to 45 days per state fiscal year per recipient, except for children under age 21, in which case the only limitation is medical necessity or the payment amount. Reimbursement for hospital outpatient care is limited to $1,000 per state fiscal year per recipient, unless an exception has been made by the *agency* ~~department~~, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

(b) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program, or that participate in the extraordinary disproportionate share program, may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the general appropriations act. The computation of these payments must be made in compliance with all federal regulations and the methodologies described in ss. 409.911, 409.9112, 409.9113, and *409.9116* ~~409.9114~~.

(2)(a) Reimbursement to nursing homes licensed under part I of chapter 400 and intermediate care facilities for the mentally retarded licensed under chapter 393 must be made prospectively. Reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment.

(b) The *agency* ~~department~~ shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care which utilizes a rate-setting mechanism whereby the rates are reasonable and adequate to cover a nursing home's cost which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. In the establishment of any maximum rate of payment, whether overall or component, the *agency* ~~department~~ shall base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(3) The following Medicaid services and goods shall be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the *agency* ~~department~~, whichever amount is less, with the exception of those services or goods for which the *agency* ~~department~~ makes payment using a methodology based on average costs or negotiated fees.

(a) Advanced registered nurse practitioner services.

(b) Birth center services.

(c) Chiropractic services.

(d) Community mental health services.

(e) Dental services, including oral and maxillofacial surgery.

(f) Durable medical equipment.

(g) Hearing services.

(h) Occupational therapy for Medicaid recipients under age 21.

(i) Optometric services.

(j) Orthodontic services.

(k) Personal care for Medicaid recipients under age 21.

(l) Physical therapy for Medicaid recipients under age 21.

(m) Podiatric services.

(n) Portable X-ray services.

(o) Private-duty nursing for Medicaid recipients under age 21.

(p) Respiratory therapy for Medicaid recipients under age 21.

(q) Speech therapy for Medicaid recipients under age 21.

(r) Visual services.

(4) Alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated by the *agency* ~~department~~ and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the *agency* ~~department~~ determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility.

(5) An ambulatory surgical center shall be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.

(6) A provider of early and periodic screening, diagnosis, and treatment services to Medicaid recipients who are children under age 21 shall be reimbursed using an all-inclusive rate stipulated in a fee schedule established by the *agency* ~~department~~. A provider of the visual, dental, and hearing components of such services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the *agency* ~~department~~.

(7) A provider of family planning services shall be reimbursed the lesser of the amount billed by the provider or an all-inclusive amount per type of visit for physicians and advanced registered nurse practitioners, as established by the *agency* ~~department~~ in a fee schedule.

(8) A provider of home-based or community-based services rendered pursuant to a federally approved waiver shall be reimbursed based on an established or negotiated rate for each service. These rates shall be established according to an analysis of the expenditure history and prospective budget developed by each contract provider participating in the waiver program, or under any other methodology adopted by the *agency* ~~department~~ and approved by the Federal Government in accordance with the waiver.

(9) A provider of home health care services or of medical supplies and appliances shall be reimbursed the lesser of the amount billed by the provider or the *agency's* ~~department's~~ established maximum allowable amount, except that, in the case of the rental of durable medical equipment, the total rental payments may not exceed the purchase price of the equipment over its expected useful life or the *agency's* ~~department's~~ established maximum allowable amount, whichever amount is less.

(10) A provider of hospice care services shall be reimbursed through a prospective-cost-reimbursement system for each Medicaid hospice provider.

(11) A provider of independent laboratory services shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the *agency* ~~department~~.

(12)(a) A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the *agency* ~~department~~. ~~Effective October 1, 1991,~~ The *agency* ~~department~~ shall increase fees for surgical and other procedures for which fees have not been increased since 1987 to the median level of Medicare reimbursement in 1986 for Area B in this state.

(b) The agency shall adopt a fee schedule based on a resource-based relative value scale for pricing Medicaid physician services. Under this fee schedule, physicians shall be paid a dollar amount for each service based on the average resources required to provide the service, including, but not limited to, estimates of average physician time and effort, practice expense, and the costs of professional liability insurance. The fee schedule shall provide increased reimbursement for preventive and primary care services and lowered reimbursement for specialty services by using at least two conversion factors, one for cognitive services and another for procedural services. The fee schedule may not increase total Medicaid physician expenditures unless moneys are available, and must be phased in over 2 years, beginning on July 1, 1993.

(c) The agency shall monitor closely the utilization rate for physicians services and identify any trends that indicate an effort to increase the volume of services to counteract any losses that might result from the new fee schedule. The agency shall prepare a report to the Legislature on the overall effect of the resource-based relative value scale fee schedule by December 31, 1996.

(d)~~(b)~~ *Notwithstanding paragraph (b),* reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which includes prenatal, delivery, and postpartum care, shall be at least $1,500 per delivery for a pregnant woman with low medical risk and at least $2,000 per delivery for a pregnant woman with high medical risk, effective April 1, 1992. However, reimbursement to physicians working in Regional Perinatal Intensive Care Centers designated pursuant to chapter 383, for services to certain pregnant Medicaid recipients with a high medical risk, may be made according to obstetrical care and neonatal care groupings and rates established by the *agency* ~~department~~. Nurse midwives licensed under chapter 464 or midwives licensed under chapter 467 shall be reimbursed at no less than 80 percent of the low medical risk fee. However, midwives licensed under chapter 467 shall not receive Medicaid reimbursement for home deliveries conducted for Medicaid recipients, but shall be reimbursed for prenatal and postpartal care provided to such recipients. *Reimbursement for prenatal and postpartal delivery management must be prorated when services are received by a Medicaid recipient in a licensed birth center.* The *agency* ~~department~~ shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman and shall not pay more based solely on the fact that a caesarean section was performed, rather than a vaginal delivery. The *agency* ~~department~~ shall by rule determine a prorated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed.

(13) Premiums, deductibles, and coinsurance for Medicare services rendered to Medicaid eligible persons shall be reimbursed in accordance with fees established by Title XVIII of the Social Security Act.

(14) A provider of prescribed drugs shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the *agency* ~~department~~, plus a dispensing fee.

(15) A provider of primary care case management services rendered pursuant to a federally approved waiver shall be reimbursed by payment of a fixed, prepaid monthly sum for each Medicaid recipient enrolled with the provider.

(16) A provider of rural health clinic services and federally qualified health center services shall be reimbursed a rate per visit based on total reasonable costs of the clinic, as determined by the *agency* ~~department~~ in accordance with federal regulations.

(17) A provider of targeted case management services shall be reimbursed pursuant to an established fee, except where the Federal Government requires a public provider be reimbursed on the basis of average actual costs.

(18) A provider of transportation services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the *agency* ~~department~~, except when the *agency* ~~department~~ has entered into a direct contract with the provider for the provision of an all-inclusive service, or when services are provided pursuant to an agreement negotiated between the *agency* ~~department~~ and the provider.

(19) County public health clinic services may be reimbursed a rate per visit based on total reasonable costs of the clinic, as determined by the *agency* ~~department~~ in accordance with federal regulations under the authority of 42 C.F.R. s. 431.615. However, this cost-based reimbursement shall not be implemented until the State Health Officer has certified that cost accounting systems have been modified and are in place prior to implementation in a specific county in order to ensure accurate and timely reporting of Medicaid-related costs in accordance with established Medicaid reimbursement standards. This section shall be repealed effective June 30, 1995, unless otherwise provided for in the general appropriations act or other provision of law. The *agency* ~~department~~ shall develop a methodology to adequately evaluate the cost-effectiveness of this method of reimbursement and shall make recommendations to the Legislature based on this evaluation prior to the 1995 regular legislative session.

Section 130. Effective July 1, 1993, section 409.910, Florida Statutes, 1992 Supplement, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(1) It is the intent of the Legislature that Medicaid be the payer of last resort for medically necessary goods and services furnished to Medicaid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid. If benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full from, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid. Principles of common law and equity as to assignment, lien, and subrogation are to be abrogated to the extent necessary to ensure full

recovery by Medicaid from third-party resources. It is intended that if the resources of a liable third party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources.

(2) This section may be cited as the "Medicaid Third-Party Liability Act."

(3) Third-party benefits for medical services shall be primary to medical assistance provided by Medicaid.

(4) After the *agency* ~~department~~ has provided medical assistance under the Medicaid program, it shall seek recovery of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid, as to:

(a) Claims for which the *agency* ~~department~~ has a waiver pursuant to federal law; or

(b) Situations in which the *agency* ~~department~~ learns of the existence of a liable third party or in which third-party benefits are discovered or become available after medical assistance has been provided by Medicaid.

(5) An applicant, recipient, or legal representative shall inform the *agency* ~~department~~ of any rights the applicant or recipient has to third-party benefits and shall inform the *agency* ~~department~~ of the name and address of any person that is or may be liable to provide third-party benefits. When the *agency* ~~department~~ provides, pays for, or becomes liable for medical services provided by a hospital, the recipient receiving such medical services or his legal representative shall also provide the information as to third-party benefits, as defined in this section, to the hospital, which shall provide notice thereof to the *agency* ~~department~~ in a manner specified by the *agency* ~~department~~.

(6) When the *agency* ~~department~~ provides, pays for, or becomes liable for medical care under the Medicaid program, it has the following rights, as to which the *agency* ~~department~~ may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits:

(a) The *agency* ~~department~~ is automatically subrogated to any rights that an applicant, recipient, or legal representative has to any third-party benefit for the full amount of medical assistance provided by Medicaid. Recovery pursuant to the subrogation rights created hereby shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but is to provide full recovery by the *agency* ~~department~~ from any and all third-party benefits. Equities of a recipient, his legal representative, a recipient's creditors, or health care providers shall not defeat, reduce, or prorate recovery by the *agency* ~~department~~ as to its subrogation rights granted under this paragraph.

(b) By applying for or accepting medical assistance, an applicant, recipient, or legal representative automatically assigns to the *agency* ~~department~~ any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law.

1. The assignment granted under this paragraph is absolute, and vests legal and equitable title to any such right in the *agency* ~~department~~, but not in excess of the amount of medical assistance provided by the *agency* ~~department~~.

2. The *agency* ~~department~~ is a bona fide assignee for value in the assigned right, title, or interest, and takes vested legal and equitable title free and clear of latent equities in a third person. Equities of a recipient, his legal representative, his creditors, or health care providers shall not defeat or reduce recovery by the *agency* ~~department~~ as to the assignment granted under this paragraph.

3. By accepting medical assistance, the recipient grants to the *agency* ~~department~~ the limited power of attorney to act in his name, place, and stead to perform specific acts with regard to third-party benefits, his assent being deemed to have been given, including:

a. Endorsing any draft, check, money order, or other negotiable instrument representing third-party benefits that are received on behalf of the recipient as a third-party benefit.

b. Compromising claims to the extent of the rights assigned, provided the recipient is not otherwise represented by an attorney as to the claim.

(c) The *agency* ~~department~~ is entitled to, and has, an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness for which a third party is or may be liable, upon the collateral, as defined in s. 409.901.

1. The lien attaches automatically when a recipient first receives treatment for which the *agency* ~~department~~ may be obligated to provide medical assistance under the Medicaid program. The lien is perfected automatically at the time of attachment.

2. The *agency may* ~~department is authorized to~~ file a verified claim of lien. The claim of lien shall be signed by an authorized employee of the *agency* ~~department~~, and shall be verified as to the employee's knowledge and belief. The claim of lien may be filed and recorded with the clerk of the circuit court in the recipient's last known county of residence or in any county deemed appropriate by the *agency* ~~department~~. The claim of lien, to the extent known by the *agency* ~~department~~, shall contain:

a. The name and last known address of the person to whom medical care was furnished.

b. The date of injury.

c. The period for which medical assistance was provided.

d. The amount of medical assistance provided or paid, or for which Medicaid is otherwise liable.

e. The names and addresses of all persons claimed by the recipient to be liable for the covered injuries or illness.

3. The filing of the claim of lien pursuant to this section shall be notice thereof to all persons.

4. If the claim of lien is filed within 1 year after the later of the date when the last item of medical care relative to a specific covered injury or illness was paid, or the date of discovery by the *agency* ~~department~~ of the liability of any third party, or the date of discovery of a cause of action against a third party brought by a recipient or his legal representative, record notice shall relate back to the time of attachment of the lien.

5. If the claim of lien is filed after 1 year after the later of the events specified in subparagraph 4., notice shall be effective as of the date of filing.

6. Only one claim of lien need be filed to provide notice as set forth in this paragraph and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by Medicaid for any specific covered injury or illness. The *agency* ~~department~~ may, in its discretion, file additional, amended, or substitute claims of lien at any time after the initial filing, until the *agency* ~~department~~ has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

7. No release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall be valid or effectual as against a lien created under this paragraph, unless the *agency* ~~department~~ joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the *agency* ~~department~~ is entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the *agency* ~~department~~ may recover from the person accepting the release or satisfaction or making the settlement the full amount of medical assistance provided by Medicaid. Nothing in this section shall be construed as creating a lien or other obligation on the part of an insurer which in good faith has paid a claim pursuant to its contract without knowledge or actual notice that the *agency* ~~department~~ has provided medical assistance for the recipient related to a particular covered injury or illness. However, notice or knowledge that an insured is, or has been a Medicaid recipient within 1 year from the date of service for which a claim is being paid creates a duty to inquire on the part of the insurer as to any injury or illness for which the insurer intends or is otherwise required to pay benefits.

8. The lack of a properly filed claim of lien shall not affect the *agency's* ~~department's~~ assignment or subrogation rights provided in this subsection, nor shall it affect the existence of the lien, but only the effective date of notice as provided in subparagraph 5.

9. The lien created by this paragraph is a first lien and superior to the liens and charges of any provider, and shall exist for a period of 7 years, if recorded, after the date of recording; and shall exist for a period of 7 years after the date of attachment, if not recorded. If recorded, the lien may be extended for one additional period of 7 years by rerecording the claim of lien within the 90-day period preceding the expiration of the lien.

10. The clerk of the circuit court for each county in the state shall endorse on a claim of lien filed under this paragraph the date and hour of filing and shall record the claim of lien in the official records of the county as for other records received for filing. The clerk shall receive as his fee for filing and recording any claim of lien or release of lien under this paragraph the total sum of $2. Any fee required to be paid by the *agency* ~~department~~ shall not be required to be paid in advance of filing and recording, but may be billed to the *agency* ~~department~~ after filing and recording of the claim of lien or release of lien.

11. After satisfaction of any lien recorded under this paragraph, the *agency* ~~department~~ shall, within 60 days after satisfaction, either file with the appropriate clerk of the circuit court or mail to any appropriate party, or counsel representing such party, if represented, a satisfaction of lien in a form acceptable for filing in Florida.

(7) The *agency* ~~department~~ shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits.

(a) Recovery of such benefits shall be collected directly from:

1. Any third party;

2. The recipient or legal representative, if he has received third-party benefits;

3. The provider of a recipient's medical services if third-party benefits have been recovered by the provider; notwithstanding any provision of this section, to the contrary, however, no provider shall be required to refund or pay to the *agency* ~~department~~ any amount in excess of the actual third-party benefits received by the provider from a third-party payor for medical services provided to the recipient; or

4. Any person who has received the third-party benefits.

(b) Upon receipt of any recovery or other collection pursuant to this section, the *agency* ~~department~~ shall distribute the amount collected as follows:

1. To itself, an amount equal to the state Medicaid expenditures for the recipient plus any incentive payment made in accordance with paragraph (14)(a).

2. To the Federal Government, the federal share of the state Medicaid expenditures minus any incentive payment made in accordance with paragraph (14)(a) and federal law, and minus any other amount permitted by federal law to be deducted.

3. To the recipient, after deducting any known amounts owed to the *agency* ~~department~~ for any related medical assistance or to health care providers, any remaining amount. This amount shall be treated as income or resources in determining eligibility for Medicaid.

(8) The *agency* ~~department~~ shall require an applicant or recipient, or the legal representative thereof, to cooperate in the recovery by the *agency* ~~department~~ of third-party benefits of a recipient and in establishing paternity and support of a recipient child born out of wedlock. As a minimal standard of cooperation, the recipient or person able to legally assign a recipient's rights shall:

(a) Appear at an office designated by the *agency* ~~department~~ to provide relevant information or evidence.

(b) Appear as a witness at a court or other proceeding.

(c) Provide information, or attest to lack of information, under penalty of perjury.

(d) Pay to the *agency* ~~department~~ any third-party benefit received.

(e) Take any additional steps to assist in establishing paternity or securing third-party benefits, or both.

(f) Paragraphs (a)-(e) notwithstanding, the *agency* ~~department~~ shall have the discretion to waive, in writing, the requirement of cooperation for good cause shown and as required by federal law.

(9) The *agency* ~~department~~ shall deny or terminate eligibility for any applicant or recipient who refuses to cooperate as required in subsection (8), unless cooperation has been waived in writing by the *agency* ~~department~~ as provided in paragraph (8)(f). However, any denial or termination of eligibility shall not reduce medical assistance otherwise payable by the *agency* ~~department~~ to a provider for medical care provided to a recipient prior to denial or termination of eligibility.

(10) An applicant or recipient shall be deemed to have provided to the *agency* ~~department~~ the authority to obtain and release medical information and other records with respect to such medical care, for the sole purpose of obtaining reimbursement for medical assistance provided by Medicaid.

(11) The *agency* ~~department~~ may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal or administrative proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(a) If either the recipient, or his legal representative, or the *agency* ~~department~~ brings an action against a third party, the recipient, or his legal representative, or the *agency* ~~department~~, or their attorneys, shall, within 30 days after filing the action, provide to the other written notice, by personal delivery or registered mail, of the action, the name of the court in which the case is brought, the case number of such action, and a copy of the pleadings. If an action is brought by either the *agency* ~~department~~, or the recipient or his legal representative, the other may, at any time before trial on the merits, become a party to, or shall consolidate his action with the other if brought independently. Unless waived by the other, the recipient, or his legal representative, or the *agency* ~~department~~ shall provide notice to the other of the intent to dismiss at least 21 days prior to voluntary dismissal of an action against a third party. Notice to the *agency* ~~department~~ shall be sent to an address set forth by rule. Notice to the recipient or his legal representative, if represented by an attorney, shall be sent to the attorney, and, if not represented, then to the last known address of the recipient or his legal representative.

(b) An action by the *agency* ~~department~~ to recover damages in tort under this subsection, which action is derivative of the rights of the recipient or his legal representative, shall not constitute a waiver of sovereign immunity pursuant to s. 768.14.

(c) In the event of judgment, award, or settlement in a claim or action against a third party, the court shall order the segregation of an amount sufficient to repay the *agency's* ~~department's~~ expenditures for medical assistance, plus any other amounts permitted under this section, and shall order such amounts paid directly to the *agency* ~~department~~.

(d) No judgment, award, or settlement in any action by a recipient or his legal representative to recover damages for injuries or other third-party benefits, when the *agency* ~~department~~ has an interest, shall be satisfied without first giving the *agency* ~~department~~ notice and a reasonable opportunity to file and satisfy its lien, and satisfy its assignment and subrogation rights or proceed with any action as permitted in this section.

(e) Except as otherwise provided in this section, notwithstanding any other provision of law, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the *agency's* ~~department's~~ claims for reimbursement of the amount of medical assistance provided and any lien pursuant thereto.

(f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his legal representative is a party and in which the amount of any judgment, award, or settlement from third-party benefits, excluding medical coverage as defined in subparagraph 4., after reasonable costs and expenses of litigation, is an amount equal to or less than 200 percent of the amount of medical assistance provided by Medicaid less any medical coverage paid or payable to the *agency* ~~department~~, then distribution of the amount recovered shall be as follows:

1. Any fee for services of an attorney retained by the recipient or his legal representative shall not exceed an amount equal to 25 percent of the recovery, after reasonable costs and expenses of litigation, from the judgment, award, or settlement.

2. After attorney's fees, two-thirds of the remaining recovery shall be designated for past medical care and paid to the *agency* ~~department~~ for medical assistance provided by Medicaid.

3. The remaining amount from the recovery shall be paid to the recipient.

4. For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, personal injury protection, and casualty.

(g) In the event that the recipient, his legal representative, or his estate brings an action against a third party, notice of institution of legal proceedings, notice of settlement, and all other notices required by this section or by rule shall be given to the *agency* ~~department~~, in Tallahassee, in a manner set forth by rule. All such notices shall be given by the attorney retained to assert the recipient's or legal representative's claim, or, if no attorney is retained, by the recipient, his legal representative, or his estate.

(h) Except as otherwise provided in this section, actions to enforce the rights of the *agency* ~~department~~ under this section shall be commenced within 5 years after the date a cause of action accrues, with the period running from the later of the date of discovery by the *agency* ~~department~~ of a case filed by a recipient or his legal representative, or of discovery of any judgment, award, or settlement contemplated in this section, or of discovery of facts giving rise to a cause of action under this section. Nothing in this paragraph affects or prevents a proceeding to enforce a lien during the existence of the lien as set forth in subparagraph (6)(c)9.

(i) Upon the death of a recipient, and within the time prescribed by ss. 733.702 and 733.710, the *agency* ~~department~~, in addition to any other available remedy, may file a claim against the estate of the recipient for the total amount of medical assistance provided by Medicaid for the benefit of the recipient. Claims so filed shall take priority as class 3 claims as provided by s. 733.707(1)(c). The filing of a claim pursuant to this paragraph shall neither reduce nor diminish the general claims of the *agency* ~~department~~ pursuant to s. 409.345, except that the *agency* ~~department~~ shall not receive double recovery for the same expenditure. Claims under this paragraph shall be superior to those under s. 409.345. The death of the recipient shall neither extinguish nor diminish any right of the *agency* ~~department~~ to recover third-party benefits from a third party or provider. Nothing in this paragraph affects or prevents a proceeding to enforce a lien created pursuant to this section or a proceeding to set aside a fraudulent conveyance as defined in subsection (16).

(12) No action taken by the *agency* ~~department~~ shall operate to deny the recipient's recovery of that portion of benefits not assigned or subrogated to the *agency* ~~department~~, or not secured by the *agency's* ~~department's~~ lien. The *agency's* ~~department's~~ rights of recovery created by this section, however, shall not be limited to some portion of recovery from a judgment, award, or settlement. Only the following benefits are not subject to the rights of the *agency* ~~department~~: benefits not related in any way to a covered injury or illness; proceeds of life insurance coverage on the recipient; proceeds of insurance coverage, such as coverage for property damage, which by its terms and provisions cannot be construed to cover personal injury, death, or a covered injury or illness; proceeds of disability coverage for lost income; and recovery in excess of the amount of medical benefits provided by Medicaid after repayment in full to the *agency* ~~department~~.

(13) No action of the recipient shall prejudice the rights of the *agency* ~~department~~ under this section. No settlement, agreement, consent decree, trust agreement, annuity contract, pledge, security arrangement, or any other device, hereafter collectively referred to in this subsection as a "settlement agreement," entered into or consented to by the recipient or his legal representative shall impair the *agency's* ~~department's~~ rights. However, in a structured settlement, no settlement agreement by the parties shall be effective or binding against the *agency* ~~department~~ for benefits accrued without the express written consent of the *agency* ~~department~~ or an appropriate order of a court having personal jurisdiction over the *agency* ~~department~~.

(14) The *agency may* ~~department is authorized to~~ enter into agreements to enforce or collect medical support and other third-party benefits.

(a) If a cooperative agreement is entered into with any agency, program, or subdivision of the state, or any agency, program, or legal entity of or operated by a subdivision of the state, or with any other state, the *agency* ~~department~~ is authorized to make an incentive payment of up to 15 percent of the amount actually collected and reimbursed to the *agency* ~~department~~, to the extent of medical assistance paid by Medicaid. Such incentive payment is to be deducted from the federal share of that amount, to the extent authorized by federal law. The *agency* ~~department~~ may pay such person an additional percentage of the amount actually collected and reimbursed to the *agency* ~~department~~ as a result of the efforts of the person, but no more than a maximum percentage established by the *agency* ~~department~~. In no case shall the percentage exceed the lesser of a percentage determined to be commercially reasonable or 15 percent, in addition to the 15-percent incentive payment, of the amount actually collected and reimbursed to the *agency* ~~department~~ as a result of the efforts of the person under contract.

(b) If an agreement to enforce or collect third-party benefits is entered into by the *agency* ~~department~~ with any person other than those described in paragraph (a), including any attorney retained by the *agency* ~~department~~ who is not an employee or agent of any person named in paragraph (a), then the *agency* ~~department~~ may pay such person a percentage of the amount actually collected and reimbursed to the *agency* ~~department~~ as a result of the efforts of the person, to the extent of medical assistance paid by Medicaid. In no case shall the percentage exceed a maximum established by the *agency* ~~department~~, which shall not exceed the lesser of a percentage determined to be commercially reasonable or 30 percent of the amount actually collected and reimbursed to the *agency* ~~department~~ as a result of the efforts of the person under contract.

(c) An agreement pursuant to this subsection may permit reasonable litigation costs or expenses to be paid from the *agency's* ~~department's~~ recovery to a person under contract with the *agency* ~~department~~.

(d) Contingency fees and costs incurred in recovery pursuant to an agreement under this subsection may, for purposes of determining state and federal share, be deemed to be administrative expenses of the state. To the extent permitted by federal law, such administrative expenses shall be shared with, or fully paid by, the Federal Government.

(15) Insurance and other third-party benefits may not contain any term or provision which purports to limit or exclude payment or provisions of benefits for an individual if the individual is eligible for, or a recipient of, medical assistance from Medicaid, and any such term or provision shall be void as against public policy.

(16) Any transfer or encumbrance of any right, title, or interest to which the *agency* ~~department~~ has a right pursuant to this section, with the intent, likelihood, or practical effect of defeating, hindering, or reducing recovery by the *agency* ~~department~~ for reimbursement of medical assistance provided by Medicaid, shall be deemed to be a fraudulent conveyance, and such transfer or encumbrance shall be void and of no effect against the claim of the *agency* ~~department~~, unless the transfer was for adequate consideration and the proceeds of the transfer are reimbursed in full to the *agency* ~~department~~, but not in excess of the amount of medical assistance provided by Medicaid.

(17) A recipient or his legal representative or any person representing, or acting as agent for, a recipient or his legal representative, who has notice, excluding notice charged solely by reason of the recording of the lien pursuant to paragraph (6)(c), or who has actual knowledge of the *agency's* ~~department's~~ rights to third-party benefits under this section, who receives any third-party benefit or proceeds therefrom for a covered illness or injury, is required either to pay the *agency* ~~department~~ the full amount of the third-party benefits, but not in excess of the total medical assistance provided by Medicaid, or to place the full amount of the third-party benefits in a trust account for the benefit of the *agency* ~~department~~ pending judicial or administrative determination of the *agency's* ~~department's~~ right thereto. Proof that any such person had notice or knowledge that the recipient had received medical assistance from Medicaid, and that third-party benefits or proceeds therefrom were in any way related to a covered illness or injury for which Medicaid had provided medical assistance, and that any such person knowingly obtained possession or control of, or used, third-party benefits or proceeds and failed either to pay the *agency* ~~department~~ the full amount required by this section or to hold the full amount of third-party benefits or proceeds in trust pending judicial or administrative determination, unless adequately explained, gives rise to an inference that such person knowingly failed to credit the state or its agent for payments received from social security, insurance, or other sources, pursuant to s. 409.325(4)(b), and acted with the intent set forth in s. 812.014(1).

(a) In cases of suspected criminal violations or fraudulent activity, the *agency may* ~~department is authorized to~~ take any civil action permitted at law or equity to recover the greatest possible amount, including, without limitation, treble damages under ss. 772.11 and 812.035(7).

(b) The *agency may* ~~department is authorized to~~ investigate and to request appropriate officers or agencies of the state to investigate suspected criminal violations or fraudulent activity related to third-party benefits, including, without limitation, ss. 409.325 and 812.014. Such requests may be directed, without limitation, to the Medicaid Fraud Control Unit of the Office of the Auditor General, to the Attorney General, or to any state attorney. Pursuant to s. 409.913, the Auditor General has primary responsibility to investigate and control Medicaid fraud.

(c) In carrying out duties and responsibilities related to Medicaid fraud control, the *agency* ~~department~~ may subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(d) All information obtained and documents prepared pursuant to an investigation of a Medicaid recipient, the recipient's legal representative, or any other person relating to an allegation of recipient fraud or theft is confidential and exempt from the provisions of s. 119.07(1):

1. Until such time as the *agency* ~~department~~ takes final agency action;

2. Until such time as the Auditor General refers the case for criminal prosecution;

3. Until such time as an indictment or criminal information is filed by a state attorney in a criminal case; or

4. At all times if otherwise protected by law.

This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(18) In recovering any payments in accordance with this section, the *agency may* ~~department is authorized to~~ make appropriate settlements.

(19) Notwithstanding any provision in this section to the contrary, the *agency* ~~department~~ shall not be required to seek reimbursement from a liable third party on claims for which the *agency* ~~department~~ determines that the amount it reasonably expects to recover will be less than the cost of recovery, or that recovery efforts will otherwise not be cost-effective.

(20) Entities providing health insurance as defined in s. 624.603, and health maintenance organizations and prepaid health clinics as defined in chapter 641, shall provide such records and information as are necessary to accomplish the purpose of this section, unless such requirement results in an unreasonable burden.

(a) The *director* ~~secretary~~ of the *agency* ~~department~~ and the Insurance Commissioner shall enter into a cooperative agreement for requesting and obtaining information necessary to effect the purpose and objective of this section.

1. The *agency* ~~department~~ shall request only that information necessary to determine whether health insurance as defined pursuant to s. 624.603, or those health services provided pursuant to chapter 641, could be, should be, or have been claimed and paid with respect to items of medical care and services furnished to any person eligible for services under this section.

2. All information obtained pursuant to subparagraph 1. is confidential and exempt from s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

3. The cooperative agreement or rules adopted under this subsection may include financial arrangements to reimburse the reporting entities for reasonable costs or a portion thereof incurred in furnishing the requested information. Neither the cooperative agreement nor the rules shall require the automation of manual processes to provide the requested information.

(b) The *agency* ~~department~~ and the Department of Insurance jointly shall adopt rules for the development and administration of the cooperative agreement. The rules shall include the following:

1. A method for identifying those entities subject to furnishing information under the cooperative agreement.

2. A method for furnishing requested information.

3. Procedures for requesting exemption from the cooperative agreement based on an unreasonable burden to the reporting entity.

(21) The *agency may* ~~department is authorized to~~ adopt rules to implement the provisions of this section and federal requirements.

Section 131. Effective July 1, 1993, section 409.911, Florida Statutes, 1992 Supplement, is amended to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the general appropriations act and any limitations established pursuant to chapter 216, the *agency* ~~department~~ shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) Definitions.—As used in this section and s. 409.9112:

(a) "Adjusted patient days" means the sum of acute care patient days and intensive care patient days as reported to the *agency* ~~Department of Health and Rehabilitative Services~~, divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(b) "Actual audited data" or "actual audited experience" means data reported to the *agency* ~~Department of Health and Rehabilitative Services~~ which has been audited in accordance with generally accepted auditing standards by the *agency* ~~department~~ or representatives under contract with the *agency* ~~department~~.

(c) "Base Medicaid per diem" means the hospital's Medicaid per diem rate initially established by the *agency* ~~Department of Health and Rehabilitative Services~~ on January 1, prior to the beginning of each state fiscal year. The base Medicaid per diem rate shall not include any additional per diem increases received as a result of the disproportionate share distribution.

(d) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the *agency* ~~Department of Health and Rehabilitative Services~~ for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity.

(e) "Charity care days" means the sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.

(f) "Disproportionate share percentage" means a rate of increase in the Medicaid per diem rate as calculated under this section.

(g) "Hospital" means a health care institution licensed as a hospital pursuant to chapter 395, but does not include ambulatory surgical centers.

(h) "Medicaid days" means the number of actual days attributable to Medicaid patients as determined by the *agency* ~~Department of Health and Rehabilitative Services~~.

(2) The *agency* ~~Department of Health and Rehabilitative Services~~ shall utilize the following criteria to determine if a hospital qualifies for a disproportionate share payment:

(a) A hospital's total Medicaid days when combined with its total charity care days must equal or exceed 7 percent of its total adjusted patient days.

(b) A hospital's total charity care days weighted by a factor of 4.5, plus its total Medicaid days weighted by a factor of 1, shall be equal to or greater than 10 percent of its total adjusted patient days.

(c) Additionally, in accordance with the seventh federal Omnibus Budget Reconciliation Act, a hospital with a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean or a hospital with a low-income utilization rate of 25 percent or greater shall qualify for reimbursement.

(3) In computing the disproportionate share rate:

(a) Per diem increases earned from disproportionate share shall be applied to each hospital's base Medicaid per diem rate and shall be capped at 170 percent.

(b) The *agency* ~~department~~ shall use the most recent calendar year audited data available at the beginning of each state fiscal year for the calculation of disproportionate share payments under this section.

(c) If the total amount earned by all hospitals under this section exceeds the amount appropriated, each hospital's share shall be reduced on a pro rata basis so that the total dollars distributed from the trust fund do not exceed the total amount appropriated.

(d) The total amount calculated to be distributed under this section shall be made in quarterly payments subsequent to each quarter during the fiscal year.

(4) Hospitals that qualify for a disproportionate share payment solely under paragraph (2)(c) shall have their payment calculated in accordance with the following formulas:

$$TAA = TA \times (1/5.5)$$
$$DSHP = (HMD/TSMD) \times TAA$$

Where:

TAA = total amount available.

TA = total appropriation.

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSMD = total state Medicaid days.

(5) The following formula shall be utilized by the *agency* ~~department~~ to determine the maximum disproportionate share rate to be used to increase the Medicaid per diem rate for hospitals that qualify pursuant to paragraphs (2)(a) and (b):

$$DSR = \left(\frac{CCD}{APD} \times 4.5\right) + \frac{MD}{APD}$$

Where:

APD = adjusted patient days.

CCD = charity care days.

DSR = disproportionate share rate.

MD = Medicaid days.

(6) For fiscal year 1992-1993 only, the following criteria shall be used in determining the disproportionate share percentage:

(a) If the disproportionate share rate is less than 10 percent, the disproportionate share percentage is zero and there is no additional payment.

(b) If the disproportionate share rate is greater than or equal to 10 percent, but less than 20 percent, then the disproportionate share percentage is 1.8478498.

(c) If the disproportionate share rate is greater than or equal to 20 percent, but less than 30 percent, then the disproportionate share percentage is 3.4145488.

(d) If the disproportionate share rate is greater than or equal to 30 percent, but less than 40 percent, then the disproportionate share percentage is 6.3095734.

(e) If the disproportionate share rate is greater than or equal to 40 percent, but less than 50 percent, then the disproportionate share percentage is 11.6591440.

(f) If the disproportionate share rate is greater than or equal to 50 percent, but less than 60 percent, then the disproportionate share percentage is 73.5642254.

(g) If the disproportionate share rate is greater than or equal to 60 percent, but less than 72.5 percent, then the disproportionate share percentage is 135.9356391.

(h) If the disproportionate share rate is greater than or equal to 72.5 percent, then the disproportionate share percentage is 170.00.

(7)(a) To calculate the total amount earned by all hospitals under this section, hospitals with a disproportionate share rate less than 50 percent shall divide their Medicaid days by four, and hospitals with a disproportionate share rate greater than or equal to 50 percent and with greater than 40,000 Medicaid days shall multiply their Medicaid days by 1.5, and the following formula shall be used by the *agency* ~~department~~ to calculate the total amount earned by all hospitals under this section:

$$TAE = BMPD \times MD \times DSP$$

Where:

TAE = total amount earned.

BMPD = base Medicaid per diem.

MD = Medicaid days.

DSP = disproportionate share percentage.

(b) In no case shall total payments to a hospital under this section, with the exception of state facilities, exceed the total amount of uncompensated charity care of the hospital, as determined by the *agency* ~~department~~ according to the most recent calendar year audited data available at the beginning of each state fiscal year.

(8) For fiscal year 1991-1992 and all years other than 1992-1993, the following criteria shall be used in determining the disproportionate share percentage:

(a) If the disproportionate share rate is less than 10 percent, the disproportionate share percentage is zero and there is no additional payment.

(b) If the disproportionate share rate is greater than or equal to 10 percent, but less than 20 percent, then the disproportionate share percentage is 2.1544347.

(c) If the disproportionate share rate is greater than or equal to 20 percent, but less than 30 percent, then the disproportionate share percentage is 4.6415888766.

(d) If the disproportionate share rate is greater than or equal to 30 percent, but less than 40 percent, then the disproportionate share percentage is 10.0000001388.

(e) If the disproportionate share rate is greater than or equal to 40 percent, but less than 50 percent, then the disproportionate share percentage is 21.544347299.

(f) If the disproportionate share rate is greater than or equal to 50 percent, but less than 60 percent, then the disproportionate share percentage is 46.41588941.

(g) If the disproportionate share rate is greater than or equal to 60 percent, then the disproportionate share percentage is 100.

(9) The following formula shall be used by the *agency* ~~department~~ to calculate the total amount earned by all hospitals under this section:

$$TAE = BMPD \times MD \times DSP$$

Where:

TAE = total amount earned.

BMPD = base Medicaid per diem.

MD = Medicaid days.

DSP = disproportionate share percentage.

(10) The *agency may* ~~department is authorized to~~ receive funds from local governments and other local political subdivisions for the purpose of making payments, including federal matching funds, through the Med-

icaid disproportionate share program. Funds received from local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(11) In addition to the other requirements specified in this section, payments may not be made to a hospital unless the hospital agrees to:

(a) Cooperate with a Medicaid prepaid health plan, if one exists in the community.

(b) Assure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

(c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level, except that eligibility may be limited to persons who reside within a more limited area, as agreed by the agency and the hospital.

(d) Contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate.

(e) Cooperate with the agency, the county, and other entities to assure the provision of certain public health services, case-management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

(f) In cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program and who reside within the area.

(g) Provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space. However, the hospital may establish a bill collection program based on a person's ability to pay.

(h) Work with the Florida Healthy Kids Corporation, the Florida Health Care Purchasing Cooperative, the Florida Health Access Corporation, and business health coalitions as appropriate, to develop a feasibility study and plan to provide a low-cost, comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan.

(i) Work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services

(j) Work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.

Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not receive payments under this section until full compliance is achieved.

(12)~~(11)~~ Payments made by the *agency* ~~department~~ to hospitals eligible to participate in this program shall be made in accordance with federal rules and regulations.

(a) If the Federal Government prohibits, restricts, or changes in any manner the methods by which funds are distributed for this program, the *agency may* ~~department shall~~ not distribute any additional funds and shall return all funds to the local government from which the funds were received, except as provided in paragraph (b).

(b) If the Federal Government imposes a restriction that still permits a partial or different distribution, the *agency* ~~department~~ may continue to disburse funds to hospitals participating in the disproportionate share program in a federally approved manner, provided:

1. Each local government which contributes to the disproportionate share program agrees to the new manner of distribution as shown by a written document signed by the governing authority of each local government; and

2. The Executive Office of the Governor, the Office of Planning and Budgeting, the House of Representatives, and the Senate are provided at least 7 days' prior notice of the proposed change in the distribution, and do not disapprove such change.

(c) No distribution shall be made under the alternative method specified in paragraph (b) unless all parties agree or unless all funds of those parties that disagree which are not yet disbursed have been returned to those parties.

(13)~~(12)~~ Notwithstanding the provisions of chapter 216, the Executive Office of the Governor is hereby authorized to establish sufficient trust fund authority to implement the disproportionate share program.

Section 132. Effective July 1, 1993, section 409.9112, Florida Statutes, is amended to read:

409.9112 Disproportionate share program for regional perinatal intensive care centers.—In addition to the payments made under s. 409.911, the *agency* ~~Department of Health and Rehabilitative Services~~ shall design and implement a system of making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center program established pursuant to chapter 383 This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) The following formula shall be used by the *agency* ~~department~~ to calculate the total amount earned for hospitals that participate in the regional perinatal intensive care center program:

$$TAE = DSR \times BMPD \times MD$$

Where:

TAE = total amount earned by a regional perinatal intensive care center.

DSR = disproportionate share rate.

BMPD = base Medicaid per diem.

MD = Medicaid days.

(2) The total additional payment for hospitals that participate in the regional perinatal intensive care center program shall be calculated by the *agency* ~~department~~ as follows:

$$TAP = \left(\frac{TAE \times TA}{STAE}\right)$$

Where:

TAP = total additional payment for a regional perinatal intensive care center.

TAE = total amount earned by a regional perinatal intensive care center.

STAE = sum of total amount earned by each hospital that participates in the regional perinatal intensive care center program.

TA = total appropriation for the regional perinatal intensive care disproportionate share program.

(3) In order to receive payments under this section, a hospital must be participating in the regional perinatal intensive care center program pursuant to chapter 383 and must meet the following additional requirements:

(a) Agree to conform to all *agency* ~~departmental~~ requirements to ensure high quality in the provision of services, including criteria adopted by *agency* ~~departmental~~ rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the *agency* ~~department~~ deems appropriate as specified by rule.

(b) Agree to provide information to the *agency* ~~department~~, in a form and manner to be prescribed by rule of the *agency* ~~department~~, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

(c) Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

(d) Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

(e) Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the *agency* ~~department~~.

(f) Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

(g) Agree to provide backup and referral services to the ~~department's~~ county public health units *of the Department of Health and Rehabilitative Services* and other low-income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

(h) Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

(4) Hospitals which fail to comply with any of the conditions in subsection (3) or the applicable rules of the *agency may* ~~department shall~~ not receive any payments under this section until full compliance is achieved. A hospital which is not in compliance in two or more consecutive quarters shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating regional perinatal intensive care center program hospitals.

Section 133. Effective July 1, 1993, section 409.9113, Florida Statutes, 1992 Supplement, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.—In addition to the payments made under ss. 409.911 and 409.9112, the *agency* ~~Department of Health and Rehabilitative Services~~ shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) On or before September 15 of each year, the agency ~~for Health Care Administration~~ shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the *agency* ~~department~~ shall distribute to each statutory teaching hospital, as defined in s. 408.07, an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals.

(b) The number of full-time equivalent trainees in the hospital, which comprises two components:

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

2. The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

(c) A service index which comprises three components:

1. The Health Care ~~Cost Containment~~ Board Service Index, computed by applying the standard Service Inventory Scores established by the Health Care ~~Cost Containment~~ Board to services offered by the given hospital, as reported on the Health Care ~~Cost Containment~~ Board Worksheet A-2 for the last fiscal year reported to the board before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Health Care ~~Cost Containment~~ Board Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the Health Care ~~Cost Containment~~ Board to the volume of each service, expressed in terms of the standard units of measure reported on the Health Care ~~Cost Containment~~ Board Worksheet A-2 for the last fiscal year reported to the board before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals.

3. Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all state statutory teaching hospitals.

The primary factor for the service index is computed as the sum of these three components, divided by three.

(2) The following formula shall be utilized by the *agency* ~~department~~ to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

$$TAP = THAF \times A$$

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

(3) The Health Care ~~Cost Containment~~ Board shall report to the *agency* ~~department~~ the statutory teaching hospital allocation fraction prior to October 1 of each year.

(4) To be eligible to receive disproportionate share payments under this section after October 1, 1994, a teaching hospital must demonstrate to the agency that a primary care clerkship experience before the 3rd year has been instituted for all medical students enrolled and:

(a) The total number of full-time equivalent trainees in family practice, general internal medicine, general pediatrics, and general geriatrics increased by 5 percent over the previous year; or

(b) The total number of full-time equivalent trainees in family practice, general internal medicine, general pediatrics, and general geriatrics is at least 50 percent of the total number of full-time equivalent trainees in the hospital under paragraph (1)(b).

Section 134. Effective July 1, 1993, section 409.9115, Florida Statutes, 1992 Supplement, is amended to read:

409.9115 Disproportionate share program for mental health hospitals.—The *agency* ~~Department of Health and Rehabilitative Services~~ shall design and implement a system of making mental health disproportionate share payments to hospitals that qualify for disproportionate share payments under s. 409.911. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for patients.

(1) The following formula shall be used by the *agency* ~~department~~ to calculate the total amount earned for hospitals that participate in the mental health disproportionate share program:

$$TAP = \left(\frac{DSH}{TDSH}\right) \times TA$$

Where:

TAP = total additional payment for a mental health hospital.

DSH = total amount earned by a mental health hospital under s. 409.911.

TDSH = sum of total amount earned by each hospital that participates in the mental health hospital disproportionate share program.

TA = total appropriation for the mental health hospital disproportionate share program.

(2) In order to receive payments under this section, a hospital must participate in the Florida Title XIX program and must:

(a) Agree to serve all individuals referred by the Department *of Health and Rehabilitative Services* who require inpatient psychiatric services, regardless of ability to pay.

(b) Be certified or certifiable to be a provider of Title XVIII services.

(c) Receive all of its inpatient clients from admissions governed by the Baker Act as specified in chapter 394.

Section 135. Effective July 1, 1993, section 409.9116, Florida Statutes, is created to read:

409.9116 Disproportionate share program for rural hospitals.—In addition to the payments made under s. 409.911, the agency shall design and implement a system of making disproportionate share payments to statutory rural hospitals. This system of payments must conform with federal requirements and provide for distributing funds in each fiscal year for which an appropriation is made by quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals that serve a disproportionate share of low-income patients.

(1) The following formula must be used by the agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program:

$$TAERH = ((CCDR + MDR) / APRH) \times BMPD \times MDR$$

Where:

APRH = adjusted patient days for a rural hospital.

BMPD = base Medicaid per diem.

CCDR = charity care days for a rural hospital.

MDR = Medicaid days.

TAERH = total amount earned by a rural hospital.

(2) The total additional payment for hospitals that participate in the rural hospital disproportionate share program shall be calculated by the agency as follows:

$$TAPRH = (TAERH \times TARH) / STAERH$$

Where:

STAERH = sum of total amount earned by each hospital that participates in the rural hospital disproportionate share program.

TAERH = total amount earned by a rural hospital.

TAPRH = total additional payment for a rural hospital.

TARH = total appropriation for the rural hospital disproportionate share program.

(3) In the event the disproportionate share program is not available for providing specific assistance to rural hospitals, there shall be created the Rural Hospital Financial Assistance Program. Funds appropriated to the Rural Hospital Financial Assistance Program shall be allocated to rural hospitals based on the formulas in subsection (1) and subsection (2).

(4) In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602 and must meet the following additional requirements:

(a) Agree to conform to all agency requirements to ensure high quality in the provision of services, including criteria adopted by agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the agency deems appropriate as specified by rule.

(b) Agree to accept all patients, regardless of ability to pay, on a functional space-available basis.

(c) Agree to provide backup and referral services to the county public health units and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital.

Section 136. Effective July 1, 1993, section 2 of chapter 92-33, Laws of Florida, is amended to read:

Section 2. Funding generated through the mental health disproportionate share program shall be expended in accordance with legislatively authorized appropriations. If such funding is not addressed in legislatively authorized appropriations, the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall prepare a plan and submit a request for spending authority in accordance with the applicable provisions of chapter 216, Florida Statutes.

Section 137. Effective July 1, 1993, section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The *agency* ~~department~~ shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The *agency* ~~department~~ shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies designed to facilitate the cost-effective purchase of a case-managed continuum of care. The *agency* ~~department~~ shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(1) The *agency* ~~department~~ may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920.

(2) The *agency* ~~department~~ may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients.

(3) The *agency* ~~department~~ may contract with county public health units and other entities authorized by chapter 154 to provide health care services on a prepaid or fixed-sum basis to recipients, which entities may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services are exempt from the provisions of part I of chapter 641.

(4) The *agency* ~~department~~ may contract with any public or private entity on a prepaid or fixed-sum basis for the provision of health care services to recipients.

(a) An entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:

1. Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;

2. Ensures that services meet the standards set by the *agency* ~~department~~ for quality, appropriateness, and timeliness;

3. Makes provisions satisfactory to the *agency* ~~department~~ for insolvency protection and ensures that neither enrolled Medicaid recipients nor the *agency* ~~department~~ will be liable for the debts of the entity;

4. Submits to the *agency* ~~department~~, if a private entity, a financial plan that the *agency* ~~department~~ finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

5. Furnishes evidence satisfactory to the *agency* ~~department~~ of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;

6. Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the *agency* ~~department~~; and

7. Provides organizational, operational, financial, and other information required by the *agency* ~~department~~.

(b) Entities that provide no prepaid health care services other than Medicaid services under contract with the *agency* ~~department~~ are exempt from the provisions of part I of chapter 641.

(5) The *agency* ~~department~~ may contract on a prepaid or fixed-sum basis with any health insurer that:

(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the *agency* ~~department~~;

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Department of Insurance.

(6) The *agency may* ~~department shall~~ not contract on a prepaid or fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:

(a) Fraud;

(b) Violation of federal or state antitrust statutes, including those prescribing price fixing between competitors and the allocation of customers among competitors;

(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

(7) The *agency* ~~department~~ may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(8) The *agency* ~~department~~ shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse.

(9) The *agency* ~~department~~ shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.

(10) The *agency* ~~department~~ shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use services.

(11) The *agency* ~~department~~ shall identify health care utilization and price patterns within the Medicaid program that are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate.

(12) An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the *agency* ~~department~~ or the Department of Insurance, ~~by January 1, 1992,~~ an amount equal to its monthly prepaid Medicaid revenues *if a public entity*; and ~~by and after January 1, 1993,~~ an amount equal to one-and-one-half times its monthly prepaid Medicaid revenues *if a private entity*. In the event an entity's surplus falls below any applicable statutory requirements, or an entity's total of cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the *agency* ~~department~~ or the Department of Insurance falls below *the entity's monthly prepaid Medicaid revenues if a public entity or* one-and-one-half times *the entity's* ~~its~~ monthly prepaid Medicaid revenues *if a private entity*, the *agency* ~~department~~ shall prohibit the entity from engaging in enrollment activities, shall cease to process new enrollments for the entity, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection shall not apply:

(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or

(b) Where the entity's performance and obligations are guaranteed in writing by a nonprofit guaranteeing organization which:

1. Has been in operation for at least 5 years and has assets in excess of $50 million; or

2. Submits a written guarantee acceptable to the *agency* ~~department~~ which is irrevocable during the term of the contracting entity's contract with the *agency* ~~department~~ and, upon termination of the contract, until the *agency* ~~department~~ receives proof of satisfaction of all outstanding obligations incurred under the contract.

(13) The agency shall include, as a minimum in its definition of a managed care provider, health maintenance organizations licensed and in good standing with the Commissioner of Insurance and the prepaid health plans under contract with the agency.

Section 138. Section 409.9121, Florida Statutes, is created to read:

409.9121 Legislative findings and intent.—The Legislature finds that the Medicaid program has experienced an annual growth rate of approximately 28 percent per year for the past 5 years, and is consuming more than half of all new general revenue growth. The present Medicaid system must be reoriented to emphasize, to the maximum extent possible, the delivery of health care through entities and mechanisms that are designed to contain costs, emphasize preventive and primary care, and promote access and continuity of care. The Legislature further finds that the concept of managed care best encompasses these multiple goals. The Legislature also finds that, with the cooperation of the physician community, the Medicaid primary care case management program, known as MediPass, is responsible for ensuring that there is a sufficient supply of primary care to provide access to preventive and primary care services to Medicaid recipients. Therefore, the Legislature declares its intent that the Medicaid program encourage, to the maximum extent practicable and permitted by federal law, Medicaid recipients be enrolled in a managed care program. It is the further intent of the Legislature that the current level of services provided through the Medicaid program be maintained in any managed care program.

Section 139. Section 409.9122, Florida Statutes, is created to read:

409.9122 Medicaid managed care enrollment.—

(1)(a) It is the intent of the Legislature that the agency apply for a federal freedom-of-choice waiver and any other federal waivers necessary to expand MediPass statewide as soon as is practicable.

(b) The MediPass program may not be expanded unless the agency certifies, for each county where MediPass is to be started, that the necessary resources, including staff, are available to adequately inform recipients of their choice of primary care providers and to enroll them with a provider and that the necessary resources, including staff, are available to adequately recruit providers, ensure access, monitor performance and patient satisfaction, and assess the quality of care provided.

(2)(a) The agency shall encourage Medicaid recipients who receive payments from or are determined eligible for the Supplemental Security Income program, to the maximum extent feasible, to enroll in Medicaid or Medicare managed care plans.

(b) The agency shall work cooperatively with the Social Security Administration to identify beneficiaries who are jointly eligible for Medicare and Medicaid and shall develop cooperative programs to encourage these beneficiaries to enroll in a Medicare participating health maintenance organization or prepaid health plans.

(c) The agency shall work cooperatively with the Department of Elderly Affairs to assess the potential cost effectiveness of providing MediPass to beneficiaries who are jointly eligible for Medicare and Medicaid on a voluntary choice basis. If the agency determines that enrollment of these beneficiaries in MediPass has the potential for being cost-effective for the state, the agency shall offer MediPass to these beneficiaries on a voluntary choice basis in the counties where MediPass operates.

(d) The agency shall encourage the enrollment of Medicaid recipients who are also Medicare beneficiaries but who are not enrolled in MediPass or another managed care program in all counties of the state where MediPass is in operation. Subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216, the agency may develop a special reimbursement rate, which takes into consideration the higher utilization of such Medicaid recipients, for payment to health maintenance organizations or prepaid health plans that agree to enroll these recipients.

(3)(a) The agency shall study the feasibility of establishing managed care programs for various special population groups within the Medicaid program, to the extent permitted by federal law, and report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 1994.

(b) The agency shall investigate the feasibility of developing managed care programs for the following groups of Medicaid recipients:

1. Pregnant women and infants.

2. Chronically ill children.

3. Elderly and disabled recipients, especially those who are at risk of nursing home placement.

4. Persons with developmental disabilities.

5. Qualified Medicare beneficiaries.

6. Adults who have chronic, high-cost medical conditions.

7. Adults and children who have mental health problems. A Medicaid managed care program for adults and children who have mental health problems must include specialized programs that use community mental health centers as preferred providers.

8. Other recipients for whom managed care programs offer the opportunity of more cost-effective care and greater access to qualified providers.

(4)(a) The agency shall encourage the development of public and private partnerships to foster the growth of health maintenance organizations and prepaid health plans that will provide high quality health care to Medicaid recipients.

(b) Subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216, the agency may enter into contracts with traditional providers of health care to low-income persons to assist such providers with the technical aspects of cooperatively developing Medicaid prepaid health plans.

1. The agency may contract with disproportionate share hospitals, county public health units, federally initiated or federally funded community health centers, and counties that operate either a hospital or a community clinic.

2. A contract may not be for more than $100,000 per year, and a contract may not be extended with any particular provider for more than 2 years. The contract is intended only as seed or development funding and requires a commitment from the interested party.

3. A contract must require participation by at least one community health clinic and one disproportionate share hospital.

(5)(a) The agency shall develop and implement a comprehensive plan to ensure that recipients are adequately informed of their choices and rights under all Medicaid managed care programs and that Medicaid managed care programs meet acceptable standards of quality in patient care, patient satisfaction, and financial solvency.

(b) The agency shall provide adequate means for informing patients of their choice and rights under a managed care plan at the time of eligibility determination.

(c) The agency shall:

1. Monitor all managed care plans at least quarterly.

2. Review patient grievances, disenrollment forms, medical records, and financial records.

3. Conduct patient satisfaction surveys.

4. Specifically monitor managed care plans for underutilization of prenatal visits of pregnant women; immunization of children; early and periodic screening, diagnosis, and treatment services; and follow-up treatment.

5. Publish and make available to Medicaid recipients quality assurance information and the results of the agency's monitoring of managed care plans in a format that permits recipients to compare this information among different managed care plans. The agency shall publish this information in a format that permits Medicaid recipients to compare different managed care plans, including, but not limited to, prepaid health plans, MediPass, and other case-management programs.

Section 140. Marketing in government buildings by managed health care providers.—

(1) The secretary or director of each state agency which owns, rents, or leases a building shall permit managed health care providers, as defined and approved by the Agency for Health Care Administration, to market the benefits of managed care plans during regular business hours to persons in the building.

(2) The secretary or director of each state agency, in consultation with the Agency for Health Care Administration, shall develop a plan to assure the orderly, professional, and accurate provision of information on the benefits of managed care plans at each site where such marketing occurs.

(3) The Agency for Health Care Administration must include in its definition of managed health care providers a health maintenance organization licensed and in good standing with the Department of Insurance and a prepaid health plan under contract with the agency.

Section 141. Effective July 1, 1993, section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The *agency* ~~department~~ shall operate a program to oversee the activities of Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible.

(1) The *agency* ~~department~~ shall conduct, or cause to be conducted by contract or otherwise, investigations, analyses, and audits of possible fraud, abuse, and neglect in the Medicaid program and shall report the findings therefrom in *agency* ~~departmental~~ audit reports as appropriate.

(2) The agency may conduct an investigation that consists of an audit, a review, or an analysis, or a combination thereof, of the professional records, medical records, financial records, or business records of a provider. The agency may interview the provider or an employee or associate of the provider concerning particular claim activity by that provider for a recipient. Each year of claim activity must be investigated as a separate investigation.

(3)~~(2)~~ The *agency* ~~department~~ may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing, billing, and provision of care to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the *agency* ~~department~~, without any suspicion or allegation of fraud, abuse, or neglect.

(4)~~(3)~~ Any suspected criminal violation or fraudulent activity by a provider, or by the representative or agent of a provider, identified by the *agency* ~~department~~ shall be referred to the Medicaid fraud control unit of the Office of the Auditor General for investigation.

(5)~~(4)~~ A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer review organization designated by the *agency* ~~department~~.

(6)~~(5)~~ When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services which:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as may be authorized by the *agency* ~~department~~.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(7)(a) The agency may withhold Medicaid payments, in whole or in part, to a provider if the agency has evidence that fraud, willful misrepresentation, or improper recipient solicitation has occurred under the Medicaid program. The agency may withhold payments without first notifying the provider of its intention to withhold the payments. The agency is not obligated to process and adjudicate a claim if the agency has evidence that the claim misrepresents services provided.

(b) The agency must notify the provider that program payments are being withheld within 5 days after taking the action. The notice must set forth the general facts and allegations as to the nature of the withholding action, but need not disclose any other specific information concerning the agency's ongoing investigation. The notice must:

1. State that payments are being withheld in accordance with this subsection.

2. State that the withholding is temporary and cite the circumstances under which the withholding will be terminated.

3. Specify, when appropriate, which types of Medicaid claims are being withheld.

4. State all the facts in reference to the evidence.

5. Inform the provider of his right to submit written evidence for the agency to consider.

(c) An action to withhold payment under this section must be temporary and may not continue after the agency or the prosecuting authorities determine that the legal proceedings related to the provider's alleged fraud or willful misrepresentation are complete. An erroneous payment that the agency finds is based on provider fraud, willful misrepresentation, or illegal recipient solicitation is an inappropriate payment rather than an overpayment and the inappropriate payment is payable in its entirety to the agency upon demand.

(8)~~(6)~~ A Medicaid provider shall retain professional and financial records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods.

(9)~~(7)~~ The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the *agency* ~~department~~ takes final agency action respecting the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Auditor General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(10)~~(8)~~ The *agency* ~~department~~ may impose administrative sanctions against a Medicaid provider if:

(a) The provider has entered into a pretrial intervention or other first-offender agreement respecting a charge of, has pled nolo contendere or guilty to a charge of, has been found guilty regardless of adjudication of, or has been convicted of *any criminal offense that relates to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct* ~~Medicaid fraud or any other Medicaid related crime, such as theft, bribery, giving or receiving a kickback~~, or neglecting or physically abusing a recipient;

(b) The provider has pled guilty to, has been found guilty regardless of adjudication of, or has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession;

(c) The provider is excluded from the Medicare program for cause;

(d) The provider's license has not been renewed, or has been revoked, suspended, or terminated, by the licensing agency of any state;

(e) The provider is excluded from participation in the Medicaid or Medicare program by the Federal Government or any state;

(f) The provider has refused access to Medicaid-related records to an authorized auditor or investigator acting as an employee or agent of the *agency* ~~department~~, the Auditor General, a state attorney, or the Federal Government;

(g) The provider has not furnished, upon reasonable notice, such Medicaid-related records as the *agency* ~~department~~ found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(h) The provider is not in compliance with provisions of *agency* ~~departmental~~ policy manuals or handbooks which have been adopted by reference as rules in the Florida Administrative Code, state laws, federal rules and regulations, a provider agreement between the *agency* ~~department~~ and the provider, or certifications found on claim forms submitted by the provider or authorized representative as such provisions apply to the Medicaid program;

(i) The provider has furnished or ordered the furnishing to a recipient of goods or services that are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality. Such determinations must be based on competent peer judgments and evaluations;

(j) The provider or an authorized representative of the provider has submitted or caused to be submitted false or erroneous Medicaid claims that have resulted in payments to the provider in excess of those to which the provider was entitled under the Medicaid program;

(k) The provider or an authorized representative of the provider has submitted or caused to be submitted a Medicaid provider enrollment application, request for prior authorization for Medicaid services, or Medicaid cost report that contains materially false or incorrect information;

(l) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(m) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan, after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(n) The provider is indicted for fraudulent billing practices. The sanction applied for this reason is limited to suspension of the provider from the Medicaid program for the duration of the indictment;

(o) The provider is found liable for negligent practice resulting in death or injury to the provider's patient; or

(p) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program.

(11)~~(9)~~ The *agency* ~~department~~ may impose any of the following sanctions on a provider for any of the acts described in subsection *(10)*~~(8)~~:

(a) Suspension for a specific period of time of not more than 1 year.

(b) Termination for a specific period of time of from more than 1 year to 20 years.

(c) Imposition of a fine of up to $1,000 for each violation not exceeding a total fine of $25,000 in connection with any one audit or investigation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

(12)~~(10)~~ In determining the appropriate administrative sanction to be applied, the *agency* ~~department~~ shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) Any pain and suffering inflicted by the provider on a recipient.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates.

(f) The extent to which a lesser sanction is sufficient to remedy the violation by the provider, in the best judgment of the *agency* ~~department~~.

(g) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the *agency* ~~department~~.

(13)~~(11)~~ The *agency* ~~department~~ may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group, if it determines such action is in the best interest of Medicaid recipients. *This sanction is in addition to other remedies provided by law and does not constitute double jeopardy.*

(14)~~(12)~~ In making a determination of overpayment to a provider, the *agency* ~~department~~ shall use appropriate and valid auditing, accounting, analytical, statistical, or peer review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period.

(15)~~(13)~~ When making a determination that an overpayment has occurred, the *agency* ~~department~~ shall prepare and issue *an agency a* ~~departmental~~ audit report to the provider showing the calculation of overpayments. *If the agency finds that an erroneous payment was made on the basis of provider fraud, willful misrepresentation, or illegal recipient solicitation, it is an inappropriate payment rather than an overpayment and is payable in its entirety to the agency upon demand.*

(16)~~(14)~~ *The agency* ~~departmental~~ audit report, supported by *agency* ~~department~~ work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, either on direct or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business.

(17)~~(15)~~(a) In an investigation of a violation by a provider pursuant to this section, the *agency may* ~~department is entitled to~~ recover investigative and expert costs not exceeding $15,000 if a material violation is found and the *agency's* ~~department's~~ findings were not contested by the provider or, if contested, the *agency* ~~department~~ ultimately prevailed.

(b) The *agency* ~~department~~ has the burden of documenting the investigative costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of investigative costs that may be recovered must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors.

(c) The provider may pay the investigative costs over a period to be determined by the *agency* ~~department~~ if the *agency* ~~department~~ determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of investigative costs may be collected by any means authorized by law for enforcement of a judgment.

(d) Investigative costs that are recovered must be returned to the *agency* ~~department~~.

(18)~~(16)~~ If the *agency* ~~department~~ imposes an administrative sanction under this section for any of the acts described in subsection *(10)*~~(8)~~ upon any provider who is regulated by a state agency other than the *Agency for Health Care Administration* ~~department~~, the *agency* ~~department~~ shall notify that *state* agency of the imposition of the sanction. Such notification must include the provider's name and license number and the specific reasons for sanction.

(19)~~(17)~~ The *agency* ~~department~~ may withhold Medicaid payments to a provider, up to the amount of the alleged overpayment, pending completion of an investigation under this section if it has reasonable cause to believe that the provider has committed one or more violations in relation to such payments. With the exception of providers terminated under the provisions of s. 120.59(3), in which case all payments shall be immediately terminated, the *agency* ~~department~~ may withhold payments under this provision, the monthly Medicaid payment may not be reduced by more than 10 percent, and the payments withheld must be paid to the provider within 60 days with interest at the rate of 10 percent a year upon determining that no such violation has occurred. If the amount of the alleged overpayment is in excess of $75,000, the *agency* ~~department~~ may reduce the Medicaid payments up to $25,000 per month.

Section 142. Effective July 1, 1993, section 409.914, Florida Statutes, is amended to read:

409.914 Assistance for the uninsured.—The *agency* ~~department~~ shall use the claims payment systems, utilization control systems, cost control systems, case management systems, and other systems and controls that it has developed for the management and control of the Medicaid program to assist other agencies and entities, if appropriate, in paying claims and performing other activities necessary for the conduct of programs of state government, or for working with other public and private agencies to solve problems of lack of insurance, underinsurance, or uninsurability. When conducting these services, the *agency* ~~department~~ shall ensure:

(1) That full payment is received for services provided.

(2) That costs of providing these services are clearly segregated from costs necessary for the conduct of the Medicaid program.

(3) That the program conducted serves the interests of the state in ensuring that effective and quality health care at a reasonable cost is provided to the citizens of the state.

Section 143. Effective July 1, 1993, subsection (4) of section 409.915, Florida Statutes, is amended to read:

409.915 County contributions to Medicaid.—Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program, in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section.

(4) Each county shall pay into the General Revenue Fund, unallocated, its pro rata share of the total county participation based upon statements rendered by the *agency* ~~department~~ in consultation with the counties.

Section 144. Effective July 1, 1993, section 409.916, Florida Statutes, is amended to read:

409.916 Deposit of grants and rebates.—The *agency* ~~department~~ shall deposit any funds received from pharmaceutical manufacturers and all other funds received by the *agency* ~~department~~ from any other person as the result of a cost containment strategy, in the nature of a rebate, grant, or other similar mechanism into the Grants and Donations Trust Fund. Funds received from pharmaceutical manufacturers shall be used as the state portion for funding Medicaid prescribed drug services. However, at least $75,000 may be appropriated from the Grants and Donations Trust Fund for Medicaid research and development activities as specified in the General Appropriations Act.

Section 145. Effective July 1, 1993, section 409.919, Florida Statutes, is amended to read:

409.919 Rules.—The *agency* ~~department~~ shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements.

Section 146. Effective July 1, 1993, paragraph (a) of subsection (1), paragraphs (a), (c), and (d) of subsection (2), subsections (4), (5), and (6), and paragraphs (b), (e), and (f) of subsection (9) of section 409.920, Florida Statutes, are amended to read:

409.920 Medicaid provider fraud.—

(1) For the purposes of this section, the term:

(a) "Fiscal agent" means any individual, firm, corporation, partnership, organization, or other legal entity that has contracted with the *agency* ~~department~~ to receive, process, and adjudicate claims under the Medicaid program.

(2) Any person who:

(a) Knowingly makes, causes to be made, or aids and abets in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the *agency* ~~department~~ or its fiscal agent for payment is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Knowingly charges, solicits, accepts, or receives anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fails to credit the *agency* ~~department~~ or its fiscal agent for any payment received from a third-party source is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(d) Knowingly makes or in any way causes to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the *agency* ~~department~~ to determine a general or specific rate of payment for an item or service provided by a provider is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) All records in the custody of the *agency* ~~department~~ or its fiscal agent which relate to Medicaid provider fraud are business records within the meaning of s. 90.803(6).

(5) Proof that a claim was submitted to the *agency* ~~department~~ or its fiscal agent which contained a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to an inference that the person whose signature appears as the provider's authorizing signature on the claim form, or whose signature appears on *an agency* ~~a department~~ electronic claim submission agreement submitted for claims made to the fiscal agent by electronic means, had knowledge of the false statement or false representation. This subsection applies whether the signature appears on the claim form or the electronic claim submission agreement by means of handwriting, typewriting, facsimile signature stamp, computer impulse, initials, or otherwise.

(6) Proof of submission to the *agency* ~~department~~ or its fiscal agent of a document containing items of income and expense, which document is used or that may be used by the *agency* ~~department~~ or its fiscal agent to determine a general or specific rate of payment and which document contains a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to the inference that the person who signed the certification of the document had knowledge of the false statement or representation. This subsection applies whether the signature appears on the document by means of handwriting, typewriting, facsimile signature stamp, electronic transmission, initials, or otherwise.

(9) The Auditor General shall conduct a statewide program of Medicaid fraud control. To accomplish this purpose, the Auditor General shall:

(b) Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Medicaid program, in coordination with the *agency* ~~department~~.

(e) Refer to the *agency* ~~department~~ all suspected abusive activities not of a criminal nature.

(f) Refer to the *agency* ~~department~~ for collection each instance of overpayment to a provider of health care under the Medicaid program which he discovers during the course of an investigation.

Section 147. Effective July 1, 1993, paragraph (a) of subsection (2) of section 411.222, Florida Statutes, is amended to read:

411.222 Intraagency and interagency coordination; creation of offices; responsibilities; memorandum of agreement; creation of coordinating council; responsibilities.—

(2) DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES.—There is created within the Department of Health and Rehabilitative Services an Office of Prevention, Early Assistance, and Child Development for the purpose of intraagency and interagency planning, policy, and program development and coordination to enhance existing programs and services and to develop new programs and services for high-risk pregnant women and for high-risk preschool children and their families. In order to meet the responsibilities of this chapter, staff shall be assigned to the office no later than September 1, 1989.

(a) Intraagency responsibilities.—

1. Assure planning, policy, and program coordination in programs serving high-risk pregnant women and high-risk preschool children and their families, within the following offices of the Department of Health and Rehabilitative Services:

a. Alcohol, Drug Abuse, and Mental Health.

b. Children's Medical Services.

c. Children, Youth, and Families.

d. Developmental Services.

e. Economic Services.

f. Health.

~~g. Medicaid.~~

g.~~h.~~ Child Support Enforcement.

2. Assure planning, policy, and program coordination in the following interprogram areas:

a. Transportation.

b. Migrant and refugee services.

c. Volunteer services.

d. Child abuse and neglect prevention, early intervention, and treatment.

e. Chapter I of Pub. L. No. 97-35.

3. Ensure, within available resources, the implementation of the continuum of comprehensive services in the service districts.

4. Serve as clearinghouse for the collection and dissemination of information relating to programs and services for high-risk pregnant women and for high-risk preschool children and their families, and programs aimed at preventing sexual activity and teenage pregnancy, including model and exemplary programs that have demonstrated effectiveness and beneficial outcomes.

5. Develop publications, including, but not limited to, directories, newsletters, public awareness documents, and other resource materials which assist agencies, programs, and families in meeting the needs of the high-risk population.

6. Provide technical assistance at the request of program offices, service districts, providers, advisory councils, and advocacy groups, and other agencies or entities with which the Department of Health and Rehabilitative Services has contracts or cooperative agreements.

7. Disseminate information regarding the availability of federal, state, and private grants which target teenagers at risk of pregnancy, high-risk pregnant women, and high-risk preschool children and their families.

8. Perform duties relating to the joint strategic plan as specified in s. 411.221.

Section 148. Paragraphs (a) and (k) of subsection (2) and paragraph (b) of subsection (5) of section 415.107, Florida Statutes, 1992 Supplement, are amended to read:

415.107 Confidentiality of reports and records in cases of abuse, neglect, or exploitation of aged persons or disabled adults.—

(2) Access to such records, excluding the name of the reporter which shall be released only as provided in subsection (4), shall depend on the classification of the report, and shall be granted only to the following persons, officials, and agencies. Access to unfounded reports shall be limited to the persons and for the purposes stated in paragraphs (a), (b), (c), (g), and (h). Access to proposed confirmed reports shall be limited to the persons and for the purposes stated in paragraphs (a) through (i). Access to confirmed reports shall be limited to the persons and for the purposes stated in paragraphs (a) through (m). Access to reports closed without classification shall be limited to the persons and for the purposes stated in paragraphs (a), (b), (c), (e), (f), and (g), as follows:

(a) Employees or agents of the department *or the Agency for Health Care Administration* responsible for carrying out adult or child protective services investigations, ongoing adult or child protective services, or licensure or approval of nursing homes, adult congregate living facilities, adult day care centers, adult foster homes, home care for the elderly, hospices, or other facilities used for the placement of aged persons or disabled adults.

(k) The Department of Professional Regulation when taking disciplinary action against a licensee for actions which resulted in a confirmed report of abuse, neglect, or exploitation which has been upheld following a chapter 120 hearing or a waiver of such proceedings.

(5)

(b) The department shall, upon receipt of an application of a person applying for an initial license or renewal of a license for a facility to provide day or residential care for aged persons or disabled adults, search its central abuse registry and tracking system for the existence of a confirmed report of child or adult abuse, neglect, or exploitation as defined in ss. 415.102(1), (5), (9), and (12) and 415.503(3) and (6) on an owner or administrator who is directly involved in the onsite day-to-day care of the residents of the facility and advise the licensing agent of any report found and the results of the investigation conducted pursuant thereto, including whether the time period has elapsed for requesting an amendment or expunction of the report, and the result of any subsequent administrative hearing held on the report. The department may search its central abuse registry and tracking system for confirmed reports of child or adult abuse, neglect, or exploitation as defined in ss. 415.102(1), (5), (9), and (12) and 415.503(3) and (6) on corporate owners and board of director members, partners, or other owners who are not directly involved in the onsite day-to-day care of the residents of the facility. Such a report shall disqualify an individual from licensure, but the department may grant an exemption from disqualification if the department has clear and convincing evidence to support a reasonable belief that the person is of good character so as to justify an exemption. The person shall bear the burden of setting forth sufficient evidence of rehabilitation, including, but not limited to, the circumstances surrounding the incident, the nature of the harm occasioned to the victim, and the history of the person since the incident, or such other circumstances that shall by the aforementioned standards indicate that the person will not present a danger to the safety or well-being of aged persons or disabled adults. The decision of the department regarding an exemption may be contested through a hearing pursuant to chapter 120. A disqualified person may also request amendment or expunction of the report pursuant to s. 415.103(3)(d). For purposes of a licensure application, these remedies must be requested within 30 days of notification, or be deemed waived. The department *or the Agency for Health Care Administration* shall notify any individual disqualified from licensure of the right to appeal that disqualification, of remedies available, and of the time limit for requesting such remedies pursuant to the provisions of this subsection. The department *or the Agency for Health Care Administration* may issue no license until screening procedures and, if necessary, administrative remedies are complete. However, a conditional or provisional license may be issued in the case of an existing licensed facility for only that time necessary to complete the above screening procedures and administrative remedies. No application for licensure shall be deemed complete until all requested screening information has been correctly submitted pursuant to department procedure.

Section 149. Paragraphs (a) and (j) of subsection (2) and subsection (4) of section 415.51, Florida Statutes, 1992 Supplement, are amended to read:

415.51 Confidentiality of reports and records in cases of child abuse or neglect.—

(2) Access to such records, excluding the name of the reporter which shall be released only as provided in subsection (9), shall depend on the classification of the report, and shall be granted only to the following persons, officials, and agencies. Access to unfounded reports shall be limited to the persons and for the purposes stated in paragraphs (a), (b), (c), (g), and (l). Access to proposed confirmed reports shall be limited to the persons and for the purposes stated in paragraphs (a) through (i) and (l). Access to confirmed reports shall be limited to the persons and for the purposes stated in paragraphs (a) through (n). Access to reports closed without classification shall be limited to the persons and for the purposes stated in paragraphs (a), (b), (c), (e), (f), and (l), as follows:

(a) Employees or agents of the department *or the Agency for Health Care Administration* responsible for carrying out child or adult protective investigations, ongoing child or adult protective services, or licensure or approval of adoptive homes, foster homes, or other homes used to provide for the care and welfare of children.

(j) The Department of Professional Regulation when taking disciplinary action against a licensee for actions which resulted in a confirmed report of abuse, neglect, or exploitation which has been upheld following a chapter 120 hearing or a waiver of such proceedings.

(4) The department shall, upon receipt of the applicable fee, search its central abuse registry and tracking system records pursuant to the requirements of ss. 39.076, 110.1127, 242.335, 393.0655, 394.457, 396.0425, 397.0715, 400.478, 400.497, 402.305(1), 402.3055, 402.313, 409.175,

409.176, and 464.008 for the existence of a confirmed report made on the personnel as defined in the foregoing provisions. The search shall also include indicated reports prior to July 1, 1987. Reports prior to 1978 shall not be included. If the search reveals an indicated or closed report prior to July 1, 1987, the department shall review the report to determine whether the indicated report shall be classified as "proposed confirmed" according to the definitions in s. 415.503. If the report is classified as "proposed confirmed," the department shall notify the individual according to the provisions of s. 415.504(4)(d)1.b. The department shall report the existence of any confirmed report of abuse and advise the authorized licensing agency, applicant for license, or other authorized agency or person of the results of the search and the date of the report. In the case of judicial determination of abuse, the department shall report the procedure for inspection of court records as set forth in s. 39.411(3). The department may not release any information on unfounded reports. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14. Prior to a search being conducted, the department or its designee shall notify such person that an inquiry will be made. The department *or the Agency for Health Care Administration* shall notify each person for whom a search is conducted of the results of the search upon request.

Section 150. Subsections (2), (3), and (6) of section 419.001, Florida Statutes, are amended to read:

419.001 Site selection of community residential homes.—

(2) Homes of six or fewer residents which otherwise meet the definition of a community residential home shall be deemed a single-family unit and a noncommercial, residential use for the purpose of local laws and ordinances. Homes of six or fewer residents which otherwise meet the definition of a community residential home shall be allowed in single-family or multifamily zoning without approval by the local government, provided that such homes shall not be located within a radius of 1,000 feet of another existing such home with six or fewer residents. Such homes with six or fewer residents shall not be required to comply with the notification provisions of this section; provided, however, that the sponsoring agency or the department notifies the local government at the time of home occupancy that the home is licensed by the department *or the Agency for Health Care Administration.*

(3)(a) When a site for a community residential home has been selected by a sponsoring agency in an area zoned for multifamily, the agency shall notify the chief executive officer of the local government in writing and include in such notice the specific address of the site, the residential licensing category, the number of residents, and the community support requirements of the program. Such notice *must* ~~shall also~~ contain a statement from the district administrator of the department indicating the need for *the home. The notice must also contain a statement from the department or the Agency for Health Care Administration indicating* ~~and~~ the licensing status of the proposed community residential home and specifying how the home meets applicable licensing criteria for the safe care and supervision of the clients in the home. The district administrator shall also provide to the local government the most recently published data compiled that identifies all community residential homes in the district in which the proposed site is to be located. The local government shall review the notification of the sponsoring agency in accordance with the zoning ordinance of the jurisdiction.

(b) Pursuant to such review, the local government may:

1. Determine that the siting of the community residential home is in accordance with local zoning and approve the siting. If the siting is approved, the sponsoring agency may establish the home at the site selected.

2. Fail to respond within 60 days. If the local government fails to respond within such time, the sponsoring agency may establish the home at the site selected.

3. Deny the siting of the home.

(c) The local government shall not deny the siting of a community residential home unless the local government establishes that the siting of the home at the site selected:

1. Does not otherwise conform to existing zoning regulations applicable to other multifamily uses in the area.

2. Does not meet applicable licensing criteria established and determined by the department *or the Agency for Health Care Administration,* including requirements that the home be located to assure the safe care and supervision of all clients in the home.

3. Would result in such a concentration of community residential homes in the area in proximity to the site selected, or would result in a combination of such homes with other residences in the community, such that the nature and character of the area would be substantially altered. A home that is located within a radius of 1,200 feet of another existing community residential home in a multifamily zone shall be an overconcentration of such homes that substantially alters the nature and character of the area. A home that is located within a radius of 500 feet of an area of single-family zoning substantially alters the nature and character of the area.

(6) The department *or the Agency for Health Care Administration may* ~~shall~~ not issue a license to a sponsoring agency for operation of a community residential home if the sponsoring agency does not notify the local government of its intention to establish a program, as required by subsection (3). A license issued without compliance with the provisions of this section shall be considered null and void, and continued operation of the home may be enjoined.

Section 151. Section 419.002, Florida Statutes, is amended to read:

419.002 Statewide registry.—

(1) There shall be established in the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ a statewide registry of all licensed community residential homes so as to improve the ability of state and local agencies responsible for planning, administration, licensing, regulating, and operating such homes to effectively identify existing and future needs for persons and services in different areas and to coordinate their planning efforts to meet such needs. The statewide registry shall include, but not be limited to, the following information for each home:

(a) The residential licensing category.

(b) The name and address of the sponsoring agency.

(c) The address of the community residential home.

(d) The total number of department clients authorized to reside in the home.

(2) The department shall provide or provide for technical assistance, within available resources, to local governments to assist in their planning and community education programs with respect to community residential homes and other similar facilities.

(3) Nothing in this section shall be construed to authorize the *Agency for Health Care Administration* ~~department~~ to release any confidential information, except as otherwise authorized by law.

Section 152. Paragraph (a) of subsection (10) of section 440.102, Florida Statutes, is amended to read:

440.102 Drug-free workplace program requirements.—The following shall apply to a drug-free workplace program implemented pursuant to rules adopted by the division:

(10) RULES.—

(a) The Department of Labor and Employment Security shall adopt rules using rules adopted by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative~~ Services pursuant to s. 112.0455 and criteria established by the National Institute on Drug Abuse as guidelines for modeling the state drug testing program, concerning, but not limited to:

1. Standards for drug testing laboratory licensing and suspension and revocation of a license.

2. Body specimens and minimum specimen amounts which are appropriate for drug testing.

3. Methods of analysis and procedures to ensure reliable drug testing results, including standards for initial tests and confirmation tests.

4. Minimum cutoff detection levels for drugs or their metabolites for the purposes of determining a positive test result.

5. Chain-of-custody procedures to ensure proper identification, labeling, and handling of specimens being tested.

6. Retention, storage, and transportation procedures to ensure reliable results on confirmation tests and retests.

Section 153. Section 455.201, Florida Statutes, 1992 Supplement, as amended by section 36 of chapter 92-33, Laws of Florida, and section 6 of chapter 92-149, Laws of Florida, is amended to read:

455.201 Professions and occupations regulated by Department of Professional Regulation ~~or Agency for Health Care Administration~~; legislative intent; requirements.—

(1) It is the intent of the Legislature that persons desiring to engage in any lawful profession regulated by the Department of Professional Regulation ~~or the Agency for Health Care Administration~~ shall be entitled to do so as a matter of right if otherwise qualified.

(2) The Legislature further *intends* ~~believes~~ that such professions *should* ~~shall~~ be regulated only for the preservation of the health, safety, and welfare of the public under the police powers of the state. Such professions shall be regulated when:

(a) Their unregulated practice can harm or endanger the health, safety, and welfare of the public, and when the potential for such harm is recognizable and clearly outweighs any anticompetitive impact *that* ~~which~~ may result from regulation.

(b) The public is not effectively protected by other means, including, but not limited to, other state statutes, local ordinances, or federal legislation.

(c) Less restrictive means of regulation are not available.

(3) It is further *the* legislative intent that the use of the term "profession" with respect to those activities licensed and regulated by the Department of Professional Regulation ~~or the Agency for Health Care Administration~~ shall not be deemed to mean that such activities are not occupations for other purposes in state or federal law.

(4) No board, nor the department, ~~nor the Agency for Health Care Administration~~ shall create unreasonably restrictive and extraordinary standards that deter qualified persons from entering the various professions. No board, nor the department, shall take any action *that* ~~which~~ tends to create or maintain an economic condition that unreasonably restricts competition, except as specifically provided by law.

(5) Policies adopted by the department shall ensure that all expenditures are made in the most cost-effective manner to maximize competition, minimize licensure costs, and maximize public access to meetings conducted for the purpose of professional regulation. The long-range planning function of the department shall be implemented to facilitate effective operations and to eliminate inefficiencies.

Section 154. Section 455.203, Florida Statutes, 1992 Supplement, as amended by section 37 of chapter 92-33, Laws of Florida, and section 7 of chapter 92-149, Laws of Florida, is amended to read:

455.203 Department of Professional Regulation; ~~Agency for Health Care Administration;~~ powers and duties.—The Department of Professional Regulation ~~and the Agency for Health Care Administration, for the boards under their respective jurisdictions,~~ shall:

(1) Adopt rules establishing a procedure for the biennial renewal of licenses; provided, however, the department ~~or the Agency for Health Care Administration~~ may issue up to a 4-year license to selected licensees notwithstanding any other provisions of law to the contrary. Fees for such renewal *may* ~~shall~~ not exceed the fee caps for individual professions on an annualized basis as authorized by law.

(2) Appoint the executive director of each board *within the department*, subject to the approval of the board.

(3) Submit a biennial budget to the Legislature at a time and in the manner provided by law.

(4) Develop a training program for persons newly appointed to membership on any board. The program shall familiarize such persons with the substantive and procedural laws and rules and fiscal information relating to the regulation of the appropriate profession and with the structure of the department ~~or the Agency for Health Care Administration~~.

(5) Adopt all rules necessary to administer this chapter.

(6) Establish by rules procedures by which the department ~~and the Agency for Health Care Administration~~ shall use the expert or technical advice of the appropriate board for the purposes of investigation, inspection, evaluation of applications, other duties of the department, or any other areas the department may deem appropriate.

(7) Require all proceedings of any board or panel thereof *within the department* and all formal or informal proceedings conducted by ~~either~~ the department ~~or the Agency for Health Care Administration~~ or a hearing officer with respect to licensing or discipline to be electronically recorded in a manner sufficient to assure the accurate transcription of all matters so recorded.

(8) Select only those investigators, or consultants who undertake investigations, who meet criteria established with the advice of the respective boards.

Section 155. Section 455.205, Florida Statutes, 1992 Supplement, as amended by section 38 of chapter 92-33, Laws of Florida, is amended to read:

455.205 Contacting boards through department ~~or agency~~.—Each board under the jurisdiction of the Department of Professional Regulation may be contacted through the headquarters of the Department of Professional Regulation in the City of Tallahassee or at any regional office of the department. ~~Each board under the jurisdiction of the Agency for Health Care Administration may be contacted through the headquarters of the Agency for Health Care Administration in the City of Tallahassee.~~

Section 156. Section 455.207, Florida Statutes, 1992 Supplement, as amended by section 39 of chapter 92-33, Laws of Florida, and section 9 of chapter 92-149, Laws of Florida, is amended to read:

455.207 Boards; organization; meetings; compensation and travel expenses.—

(1) Each board within the department ~~and each board within the Agency for Health Care Administration~~ shall comply with the provisions of this section.

(2) The board shall annually elect from among its number a chairperson and vice chairperson.

(3) The board shall meet at least once annually and may meet as often as is necessary. The chairperson or a quorum of the board shall have the authority to call other meetings. A quorum shall be necessary for the conduct of official business by the board or any committee thereof. Unless otherwise provided by law, 51 percent or more of the appointed members of the board or any committee, when applicable, shall constitute a quorum. The vote of a majority of the members of the quorum shall be necessary for any official action by the board or committee. Three consecutive unexcused absences or absences constituting 50 percent or more of the board's meetings within any 12-month period shall cause the board membership of the member in question to become void, and the position shall be considered vacant. The board, or the department when there is no board, shall, by rule, define unexcused absences.

(4) Unless otherwise provided by law, a board member or former board member serving on a probable cause panel shall be compensated $50 for each day in attendance at an official meeting of the board and for each day of participation in any other business involving the board. Each board shall adopt rules defining the phrase "other business involving the board," but the phrase may not routinely be defined to include telephone conference calls. A board member also shall be entitled to reimbursement for expenses pursuant to s. 112.061. Travel out of state shall require the prior approval of the secretary.

(5) When two or more boards have differences between them, the boards may elect to, or the secretary may request that the boards, establish a special committee to settle those differences. The special committee shall consist of three members designated by each board, who may be members of the designating board or other experts designated by the board, and of one additional person designated and agreed to by the members of the special committee. In the event the special committee cannot agree on the additional designee, upon request of the special committee, the secretary may select the designee. The committee shall recommend rules necessary to resolve the differences. If a rule adopted pursuant to this provision is challenged, the participating boards shall share the costs associated with defending the rule or rules. The department shall provide legal representation for any special committee established pursuant to this section

Section 157. Section 455 208, Florida Statutes, 1992 Supplement, as amended by section 40 of chapter 92-33, Laws of Florida, and section 10 of chapter 92-149, Laws of Florida, is amended to read:

455.208 Publication of information.—The department ~~of Professional Regulation, the Agency for Health Care Administration,~~ and the boards shall have the authority to advise licensees periodically, through the publication of a newsletter, about information that the department ~~of Professional Regulation, the Agency for Health Care Administration,~~ or the board determines is of interest to the industry. Unless otherwise prohibited by law, the department and the boards shall publish a summary of final orders resulting in fines, suspensions, or revocations, and any other information the department or the board determines is of interest to the public.

Section 158. Section 455.209, Florida Statutes, 1992 Supplement, as amended by section 41 of chapter 92-33, Laws of Florida, and section 11 of chapter 92-149, Laws of Florida, is amended to read:

455.209 Accountability and liability of board members.—

(1) Each board member shall be accountable to the Governor for the proper performance of duties as a member of the board. The Governor shall investigate any legally sufficient complaint or unfavorable written report received by the Governor or by the department or a board concerning the actions of the board or its individual members. The Governor may suspend from office any board member for malfeasance, misfeasance, neglect of duty, drunkenness, incompetence, permanent inability to perform his official duties, or commission of a felony.

(2) Each board member and each former board member serving on a probable cause panel shall be exempt from civil liability for any act or omission when acting in the member's official capacity, and the department ~~of Professional Regulation or the Agency for Health Care Administration, as appropriate,~~ or the Department of Legal Affairs shall defend any such member in any action against any board or member of a board arising from any such act or omission. In addition, the department or the Department of Legal Affairs may defend the member's company or business in any action against the company or business if the department or the Department of Legal Affairs determines that the actions from which the suit arises are actions taken by the member in the member's official capacity and were not beyond the member's statutory authority. In providing such defense, the department~~, the agency,~~ or the Department of Legal Affairs may employ or utilize the legal services of outside counsel.

Section 159. Section 455.211, Florida Statutes, 1992 Supplement, as amended by section 42 of chapter 92-33, Laws of Florida, and section 12 of chapter 92-149, Laws of Florida, is amended to read:

455.211 Board rules; final agency action; challenges.—

(1) The Secretary of Professional Regulation shall have standing to challenge any rule or proposed rule of a board ~~under its jurisdiction~~ pursuant to ss. 120.54 and 120.56. ~~The Director of Health Care Administration shall have standing to challenge any rule or proposed rule of any board under its jurisdiction, pursuant to ss. 120.54 and 120.56.~~ In addition to challenges for any invalid exercise of delegated legislative authority, the hearing officer, upon such a challenge by the secretary ~~of Professional Regulation or the Director of Health Care Administration,~~ may declare all or part of a rule or proposed rule invalid if it:

(a) Does not protect the public from any significant and discernible harm or damages;

(b) Unreasonably restricts competition or the availability of professional services in the state or in a significant part of the state; or

(c) Unnecessarily increases the cost of professional services without a corresponding or equivalent public benefit.

However, there shall not be created a presumption of the existence of any of the conditions cited in this subsection in the event that the rule or proposed rule is challenged.

(2) In addition, either the secretary ~~of Professional Regulation, the Director of Health Care Administration,~~ or the board shall be a substantially interested party for purposes of s. 120.54(5). The board may, as an adversely affected party, initiate and maintain an action pursuant to s. 120.68 challenging the final agency action.

(3) No board created within the department shall have standing to challenge a rule or proposed rule of another board. However, if there is a dispute between boards concerning a rule or proposed rule, the boards may avail themselves of the provisions of s. 455.207(5).

Section 160. Section 43 of chapter 92-33, Laws of Florida, section 455.2141, Florida Statutes, as created by section 44 of chapter 92-33, Laws of Florida, and section 455.2173, Florida Statutes, as created by section 46 of chapter 92-33, Laws of Florida, are repealed.

Section 161. Section 455.2175, Florida Statutes, 1992 Supplement, as amended by section 47 of chapter 92-33, Laws of Florida, is amended to read:

455.2175 Penalty for theft or reproduction of an examination.—In addition to, or in lieu of, any other discipline imposed *under* ~~pursuant to~~ s. 455.227, the theft of an examination in whole or in part or the act of reproducing or copying any examination administered by the department ~~of Professional Regulation or the Agency for Health Care Administration,~~ whether *the* ~~said~~ examination is reproduced or copied in part or in whole and by any means, shall constitute a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 162. Section 455.218, Florida Statutes, 1992 Supplement, as amended by section 48 of chapter 92-33, Laws of Florida, and section 16 of chapter 92-149, Laws of Florida, is amended to read:

455.218 Foreign-trained professionals; special examination and license provisions.—

(1) When not otherwise provided by law, ~~within their respective jurisdictions, the Agency for Health Care Administration and~~ the department shall, by rule, provide procedures under which exiled professionals may be examined within each practice act. A person shall be eligible for such examination if the person:

(a) Immigrated to the United States ~~after leaving the person's home country because of political reasons,~~ provided *the* ~~such~~ country is located in the Western Hemisphere ~~and lacks diplomatic relations with the United States~~;

(b) Applies to the department ~~of Professional Regulation or the Agency for Health Care Administration, as appropriate,~~ and submits a fee;

(c) Was a Florida resident immediately preceding the person's application;

(d) Demonstrates to the department ~~of Professional Regulation or the Agency for Health Care Administration,~~ through submission of documentation verified by the applicant's respective professional association in exile, that the applicant was graduated with an appropriate professional or occupational degree from a college or university; however, the department ~~of Professional Regulation or the Agency for Health Care Administration~~ may not require receipt of any documentation from the Republic of Cuba as a condition of eligibility under this section;

(e) Lawfully practiced the profession for at least 3 years;

(f) Prior to 1980, successfully completed an approved course of study pursuant to chapters 74-105 and 75-177, Laws of Florida, *except for an applicant who seeks licensure for a profession regulated under chapter 464*; and

(g) Presents a certificate demonstrating the successful completion of a continuing education program which offers a course of study that will prepare the applicant for the examination offered under subsection (2). The department ~~and the Agency for Health Care Administration~~ shall develop rules *that establish the requirements for the content and administration of continuing education programs and rules* for the approval of such programs ~~for their respective boards~~.

(2) Upon request of a person who meets the requirements of subsection (1) and submits an examination fee, the department ~~of Professional Regulation or the Agency for Health Care Administration, for their respective boards,~~ shall provide a written practical examination which tests the person's current ability to practice the profession competently in accordance with the actual practice of the profession. Evidence of meeting the requirements of subsection (1) shall be treated by the department ~~of Professional Regulation or the Agency for Health Care Administration~~ as evidence of the applicant's preparation in the academic and preprofessional fundamentals necessary for successful professional practice, and the applicant shall not be examined by the department ~~of Professional Regulation or the Agency for Health Care Administration~~ on such fundamentals.

(3) The fees charged for the examinations offered under subsection (2) shall be established by the department ~~and the Agency for Health Care Administration, for their respective boards,~~ by rule and shall be sufficient to develop or to contract for the development of the examination and its administration, grading, and grade reviews.

(4) The department ~~of Professional Regulation and the Agency for Health Care Administration~~ shall *examine* ~~license~~ any applicant ~~within their respective boards~~ who meets the requirements of subsections (1) and (2). *Upon passing the examination and issuance of the license by the department, licensees* ~~All licenses so issued~~ are subject to the administrative requirements of this chapter and the respective practice act under which the license is issued. Each applicant so licensed is subject to all provisions of this chapter and the respective practice act under which *the* ~~his~~ license was issued.

(5) Upon a request by an applicant otherwise qualified under this section, the examinations offered under subsection (2) may be given in the applicant's native language, provided that any translation costs are borne by the applicant.

(6) The department ~~and the Agency for Health Care Administration, for their respective boards,~~ shall not issue an initial license to, or renew a license of, any applicant or licensee who is under investigation or prosecution in any jurisdiction for an action *that* ~~which~~ would constitute a violation of this chapter or the professional practice acts administered by the department ~~or agency~~ and the boards until such time as the investigation or prosecution is complete, at which time the provisions of the professional practice acts shall apply.

Section 163. Section 455.220, Florida Statutes, as created by section 49 of chapter 92-33, Laws of Florida, and section 455.2205, Florida Statutes, as created by section 50 of chapter 92-33, Laws of Florida, are repealed.

Section 164. Section 455.221, Florida Statutes, 1992 Supplement, as amended by section 51 of chapter 92-33, Laws of Florida, is amended to read:

455.221 Legal and investigative services.—

(1) The Department of Legal Affairs shall provide legal services to each board within the Department of Professional Regulation ~~or the Agency for Health Care Administration~~, but the primary responsibility of the Department of Legal Affairs *is* ~~shall be~~ to represent the interests of the citizens of the state by vigorously counseling the boards with respect to their obligations under the laws of the state. Subject to the prior approval of the Attorney General, any board may retain independent legal counsel to provide legal advice to the board on a specific matter. Fees and costs of such counsel ~~by the Department of Legal Affairs or independent legal counsel approved by the Attorney General~~ shall be paid from the Professional Regulation Trust Fund ~~or the Health Care Trust Fund, as appropriate~~.

(2) The Department of Professional Regulation ~~or the Agency for Health Care Administration~~ may employ or utilize the legal services of outside counsel and the investigative services of outside personnel. However, no attorney employed or utilized by the department *may* ~~of Professional Regulation or the Agency for Health Care Administration shall~~ prosecute a matter and provide legal services to the board with respect to the same matter.

Section 165. Section 455.223, Florida Statutes, 1992 Supplement, as amended by section 52 of chapter 92-33, Laws of Florida, is amended to read:

455.223 Power to administer oaths, take depositions, and issue subpoenas.—For the purpose of any investigation or proceeding conducted by the department ~~of Professional Regulation or the Agency for Health Care Administration~~, the department ~~or the agency~~ shall have the power to administer oaths, take depositions, make inspections when authorized by statute, issue subpoenas, which *must* ~~shall~~ be supported by affidavit, serve subpoenas and other process, and compel the attendance of witnesses and the production of books, papers, documents, and other evidence. The department ~~of Professional Regulation or the Agency for Health Care Administration~~ shall exercise this power on its own initiative or whenever requested by a board or the probable cause panel of any board. Challenges to, and enforcement of, the subpoenas and orders shall be handled as provided in s. 120.58.

Section 166. Section 455.224, Florida Statutes, 1992 Supplement, as amended by section 53 of chapter 92-33, Laws of Florida, and section 20 of chapter 92-149, Laws of Florida, is amended to read:

455.224 Authority to issue citations.—

(1) Notwithstanding the provisions of s. 455.225, the board, or the department ~~or the Agency for Health Care Administration~~ when there is no board, shall adopt rules to permit the issuance of citations. The citation shall be issued to the subject and shall contain the subject's name and address, *the subject's* ~~his~~ license number if applicable, a brief factual statement, the sections of the law allegedly violated, and the penalty imposed. The citation must clearly state that the subject may choose, in lieu of accepting the citation, to follow the procedure under s. 455.225. If the subject disputes the matter in the citation, the procedures set forth in s. 455.225 must be followed. However, if the subject does not dispute the matter in the citation with the department ~~or the agency, whichever has jurisdiction,~~ within 30 days after the citation is served, the citation shall become a final order of the board, *or the department when there is no board, and shall constitute discipline.* The penalty shall be a fine or other conditions as established by rule.

(2) The board, or the department ~~or the agency~~ when there is no board, shall adopt rules designating violations for which a citation may be issued. Such rules shall designate as citation violations those violations for which there is no substantial threat to the public health, safety, and welfare.

(3) The department ~~of Professional Regulation or the Agency for Health Care Administration~~ shall be entitled to recover the costs of investigation, in addition to any penalty provided according to board *or*~~,~~ department~~, or agency~~ rule, as part of the penalty levied pursuant to the citation.

(4) A citation must be issued within 6 months after the filing of the complaint that is the basis for the citation.

(5) Service of a citation may be made by personal service or certified mail, restricted delivery, to the subject at the subject's last known address.

(6) *The department has* ~~Within their respective jurisdictions, the Department of Professional Regulation and the Agency for Health Care Administration have~~ exclusive authority to, and shall adopt rules to, designate those violations for which the licensee is subject to the issuance of a citation and designate the penalties for those violations if any board fails to incorporate this section into rules by January 1, 1992. *Any board created on or after January 1, 1992, shall have 6 months to enact rules designating violations and penalties appropriate for citation offenses. Failure to enact such rules shall give the department exclusive authority to adopt rules as required for the implementation of this section. A board shall have continuing authority to amend its rules adopted by January 1, 1992, pursuant to this section.*

Section 167. Section 455.225, Florida Statutes, 1992 Supplement, as amended by section 54 of chapter 92-33, Laws of Florida, section 21 of chapter 92-149, Laws of Florida, and section 132 of chapter 92-279, Laws of Florida, is amended to read:

455.225 Disciplinary proceedings.—~~Disciplinary proceedings for each board shall be within the jurisdiction of the Department of Professional Regulation or the Agency for Health Care Administration, as appropriate.~~

(1) The department ~~of Professional Regulation or the Agency for Health Care Administration, for the boards under their respective jurisdictions,~~ shall cause to be investigated any complaint which is filed before it if the complaint is in writing, signed by the complainant, and legally sufficient. A complaint is legally sufficient if it contains ultimate facts *that* ~~which~~ show that a violation of this chapter, of any of the practice acts relating to the professions regulated by the department ~~or the agency~~, or of any rule *adopted* ~~promulgated~~ by the department~~, the agency,~~ or a regulatory board in the department ~~or the agency~~ has occurred. *In order to determine* ~~Prior to finding~~ legal sufficiency, the department ~~or the agency~~ may require supporting information or documentation ~~as necessary to determine legal sufficiency~~. The department ~~or the agency~~ may investigate ~~or continue to investigate~~, and the department~~, the agency,~~ or the appropriate ~~regulatory~~ board may take appropriate final action on, a complaint even though the original complainant withdraws it or otherwise indicates *a* ~~his~~ desire not to cause the com-

plaint to be investigated or prosecuted to completion. The department ~~or the agency~~ may investigate an anonymous complaint if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the department ~~or the agency~~ has reason to believe, after preliminary inquiry, that the alleged violations in the complaint are true. The department ~~or the agency~~ may investigate a complaint made by a confidential informant if the complaint is legally sufficient, if the alleged violation of law or rule is substantial, and if the department ~~or the agency~~ has reason to believe, after preliminary inquiry, that the allegations of the complainant are true. ~~Unless a complaint has been filed with the department or the agency, or the department or the agency has been specifically authorized by statute,~~ The department ~~or the agency~~ may ~~not~~ initiate an investigation *if* ~~unless~~ it has reasonable cause to believe that a licensee or a group of licensees has violated a Florida statute, a rule of the department, ~~a rule of the agency,~~ or a rule of a board. Except as provided in ss. 458.331(9), 459.015(9), 460.413(5), and 461.013(6), when an investigation of any *subject* ~~person~~ is undertaken, the department ~~or the agency~~ shall promptly furnish to the *subject* ~~person~~ or *subject's* ~~his~~ attorney a copy of the complaint or document which resulted in the initiation of the investigation. The *subject* ~~person~~ may submit a written response to the information contained in *the* ~~such~~ complaint or document within 20 days after service to the *subject* ~~person~~ of the complaint or document. The *subject's* ~~person's~~ written response shall be considered by the probable cause panel. *This right to respond shall not prohibit the department from issuing a summary emergency order if necessary to protect the public.* However, if the secretary, or the secretary's designee, and the chairman of the respective board or the chairman of its probable cause panel agree in writing that such notification would be detrimental to the investigation, the department ~~or the agency~~ may withhold notification. The department ~~or the agency~~ may conduct an investigation without notification to any *subject* ~~person~~ if the act under investigation is a criminal offense. ~~The department or the agency may delegate, by rule, its investigative function regarding a given practice act to the regulatory board having regulatory power over the practice.~~

(2) The department ~~of Professional Regulation and the Agency for Health Care Administration~~ shall allocate sufficient and adequately trained staff to expeditiously and thoroughly determine legal sufficiency and investigate all legally sufficient complaints. When its investigation is complete and legally sufficient, the department ~~or the agency~~ shall prepare and submit to the probable cause panel of the appropriate regulatory board the investigative report of the department ~~or the agency~~. The report shall contain the investigative findings and the recommendations of the department ~~or the agency~~ concerning the existence of probable cause. At any time after legal sufficiency is found, the department ~~or the agency~~ may dismiss any case, or any part thereof, if the department ~~or the agency~~ determines that there is insufficient evidence to support the prosecution of allegations contained therein. The department ~~or the agency~~ shall provide a detailed report to the appropriate probable cause panel prior to dismissal of any case or part thereof, and to the subject of the complaint after dismissal of any case or part thereof, under this section. For cases dismissed prior to a finding of probable cause, *the* ~~such~~ report is confidential and exempt from s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14. The probable cause panel shall have access, upon request, to the investigative files pertaining to a case prior to dismissal of *the* ~~such~~ case. If the department ~~or the agency~~ dismisses a case, the probable cause panel may retain independent legal counsel, employ investigators, and continue the investigation and prosecution of the case as it deems necessary.

(3) As an alternative to the provisions of subsections (1) and (2), when a complaint is received, the department ~~or the agency~~ may provide a licensee with a notice of noncompliance for an initial offense of a minor violation. Each board, or the department ~~or the agency~~ if there is no board, shall establish by rule those minor violations under this provision that do not endanger the public health, safety, and welfare and which do not demonstrate a serious inability to practice the profession. Failure of a licensee to take action in correcting the violation within 15 days after notice may result in the institution of regular disciplinary proceedings.

(4) The determination as to whether probable cause exists shall be made by majority vote of a probable cause panel of the board, or by the department ~~of Professional Regulation or the Agency for Health Care Administration~~, as appropriate. Each regulatory board shall provide, by rule, that the determination of probable cause shall be made by a panel of its members or by the department ~~or the agency~~. *Each board may provide by rule for multiple probable cause panels composed of at least two members. Each board may provide by rule that one or more members of the panel or panels may be a former board member. The length of term or repetition of service of any such former board member on a probable cause panel may vary according to the direction of the board when authorized by board rule. Any probable cause panel must include one of the board's former or present consumer members, if one is available, is willing to serve, and is authorized to do so by the board chairman. Any probable cause panel must include a present board member. Any probable cause panel must include a former or present professional board member. However, any former professional board member serving on the probable cause panel must hold an active valid license for that profession.* ~~The panel, if any, shall be composed of board members, but not more than one of the panel members may be a lay member.~~ All proceedings of the panel are exempt from the provisions of s. 286.011 until *10 days after* probable cause has been found to exist by the panel or until the subject of the investigation waives his privilege of confidentiality. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14. ~~In aid of its duty to determine the existence of probable cause,~~ The probable cause panel may make a reasonable request, and upon *the* ~~such~~ request the department ~~or the agency~~ shall provide such additional investigative information as is necessary to the determination of probable cause. A request for additional investigative information shall be made within 15 days from the date of receipt by the probable cause panel of the investigative report of the department ~~or the agency~~. The probable cause panel or the department ~~or the agency~~, as may be appropriate, shall make its determination of probable cause within 30 days after receipt by it of the final investigative report of the department ~~or the agency~~. The secretary may grant extensions of the 15-day and the 30-day time limits. If the probable cause panel does not find probable cause within the 30-day time limit, as may be extended, or if the probable cause panel finds no probable cause, the department ~~or the agency~~ may determine, within 10 days after the panel fails to determine probable cause or 10 days after the time limit has elapsed, that probable cause exists. *In lieu of a finding of probable cause, the probable cause panel, or the department when there is no board, may issue a letter of guidance to the subject.* If the probable cause panel finds that probable cause exists, it shall direct the department ~~or the agency~~ to ~~send the licensee a letter of guidance or to~~ file a formal complaint against the licensee. The department ~~or the agency~~ shall follow the directions of the probable cause panel regarding the filing of a formal complaint. If directed to do so, the department ~~or the agency~~ shall file a formal complaint against the ~~regulated professional or~~ subject of the investigation and prosecute that complaint pursuant to the provisions of chapter 120. However, the department ~~or the agency~~ may decide not to prosecute the complaint if it finds that probable cause had been improvidently found by the panel. In such cases, the department ~~or the agency~~ shall refer the matter to the board. The board may then file a formal complaint and prosecute the complaint pursuant to the provisions of chapter 120. The department ~~or the agency~~ shall also refer to the board any investigation or disciplinary proceeding not before the Division of Administrative Hearings pursuant to chapter 120 or otherwise completed by the department ~~or the agency~~ within 1 year of the filing of a complaint. A probable cause panel or a board may retain independent legal counsel, employ investigators, and continue the investigation as it deems necessary; all costs thereof shall be paid from ~~the Health Care Trust Fund or~~ the Professional Regulation Trust Fund~~, as appropriate~~. All proceedings of the probable cause panel shall be exempt from the provisions of s. 120.53(1)(d).

(5) A formal hearing before a hearing officer from the Division of Administrative Hearings shall be held pursuant to chapter 120 if there are any disputed issues of material fact. The hearing officer shall issue a recommended order pursuant to chapter 120. If any party raises an issue of disputed fact during an informal hearing, the hearing shall be terminated and a formal hearing pursuant to chapter 120 shall be held.

(6) The appropriate board, with those members of the panel, if any, who reviewed the investigation pursuant to subsection (4) being excused, *or the department when there is no board,* shall determine and issue the final order in each disciplinary case. Such order shall constitute final agency action. Any consent order or agreed settlement shall be subject to the approval of the department ~~or the agency~~.

(7) The department ~~of Professional Regulation or the Agency for Health Care Administration, as appropriate,~~ shall have standing to seek judicial review of any final order of the board, pursuant to s. 120.68.

(8) Any proceeding for the purpose of summary suspension of a license, or for the restriction of the license, of a licensee pursuant to s. 120.60(8) shall be conducted by the secretary ~~of Professional Regulation~~ or his designee, ~~or the Director of Health Care Administration or his designee, as appropriate,~~ who shall issue the final summary order.

(9) The department ~~of Professional Regulation or the Agency for Health Care Administration, as appropriate,~~ shall periodically notify the person who filed the complaint of the status of the investigation, whether probable cause has been found, and the status of any civil action or administrative proceeding or appeal.

(10) The complaint and all information obtained pursuant to the investigation by the department ~~of Professional Regulation or the Agency for Health Care Administration~~ shall be confidential and exempt from s. 119.07(1) until 10 days after probable cause has been found to exist by the probable cause panel or by the department ~~or the agency~~, or until the regulated professional or subject of the investigation waives his privilege of confidentiality, whichever occurs first. Upon completion of the investigation *and written request by the subject*, the department ~~or the agency~~ shall *provide the subject an opportunity to inspect or, at the subject's expense,* ~~upon written request,~~ forward *to the subject* a copy of the *department's* investigative file. *Notwithstanding the provisions of s. 455.241, the subject shall be entitled to inspect or receive a copy of any expert witness reports and patient records obtained by the department in connection with the investigation, provided the subject agrees in writing to maintain the confidentiality of any information received pursuant to this section until 10 days after probable cause is found and to maintain the confidentiality of patient records pursuant to s. 455.241. The subject* ~~to the subject, who~~ may file a written response to the information contained in the investigative file. Such response must be filed within 20 days, unless an extension of time has been granted by the department ~~or the agency~~. Nothing in this subsection shall be construed to prohibit the department ~~of Professional Regulation or the Agency for Health Care Administration~~ from providing such information to any law enforcement agency or to any other regulatory agency. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(11) A privilege against civil liability is hereby granted to any complainant or any witness with regard to information furnished with respect to any investigation or proceeding pursuant to this section, unless the complainant or witness acted in bad faith or with malice in providing such information.

(12)(a) No person who reports in any capacity, whether or not required by law, information to the *department* ~~Division of Health Quality Assurance of the Agency for Health Care Administration~~ with regard to the incompetence, impairment, or unprofessional conduct of any health care provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, or chapter 466 shall be held liable in any civil action for reporting against such health care provider if such person acts without intentional fraud or malice.

(b) No facility licensed under chapter 395, health maintenance organization certificated under part I of chapter 641, physician licensed under chapter 458, or osteopathic physician licensed under chapter 459 shall discharge, threaten to discharge, intimidate, or coerce any employee or staff member by reason of such employee's or staff member's report to the *department* ~~division~~ about a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 who may be guilty of incompetence, impairment, or unprofessional conduct so long as such report is given without intentional fraud or malice.

(c) In any civil suit brought outside the protections of paragraphs (a) and (b), where intentional fraud or malice is alleged, the person alleging intentional fraud or malice shall be liable for all court costs and for the other party's reasonable attorney's fees if intentional fraud or malice is not proved.

Section 168. Section 455.227, Florida Statutes, 1992 Supplement, as amended by section 55 of chapter 92-33, Laws of Florida, and section 22 of chapter 92-149, Laws of Florida, is amended to read:

455.227 Grounds for discipline; penalties; enforcement.—

(1) The board shall have the power to revoke, suspend, or deny the renewal of the license, or to reprimand, censure, or otherwise discipline *a licensee, if* the board finds that:

(a) The licensee has made misleading, deceptive, untrue, or fraudulent representations in the practice of his profession;

(b) The licensee has intentionally violated any rule adopted by the board *or*, the department ~~of Professional Regulation, or the Agency for Health Care Administration, as appropriate~~;

(c) The licensee has been convicted of a felony which relates to the practice of his profession;

(d) The licensee has been adjudicated mentally incompetent;

(e) The license has been obtained by fraud or material misrepresentation of a material fact;

(f) The licensee has used a Class III or a Class IV laser device or product, as defined by federal regulations, without having complied with the rules promulgated pursuant to s. 501.122(2) governing the registration of such devices with the Department of Health and Rehabilitative Services;

(g) The licensee has failed to comply with the educational course requirements for human immunodeficiency virus and acquired immune deficiency syndrome; or

(h) The licensee has had a license or the authority to practice the regulated profession revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions, for a violation that would constitute a violation under Florida law. The licensing authority's acceptance of a relinquishment of licensure, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of charges against the license, shall be construed as action against the license.

(2) In addition to, or in lieu of, any other discipline imposed pursuant to this section, the board may impose an administrative fine not to exceed $1,000 for each violation. In any case where the board imposes a civil penalty and the penalty is not paid within a reasonable time, such reasonable time to be prescribed in the rules of the board, the Department of Legal Affairs shall bring, upon request by the board, a civil action to recover the penalty.

(3) In addition to, or in lieu of, any other remedy or criminal prosecution, the department ~~of Professional Regulation or the Agency for Health Care Administration, as appropriate,~~ may file a proceeding in the name of the state seeking issuance of an injunction or a writ of mandamus against any person who violates any of the provisions of this part, or any provisions of law with respect to professions regulated by the department ~~or the agency~~, and any board therein, or the rules adopted pursuant thereto.

(4) In the event the board, or the department when there is no board, determines that revocation of a license is the appropriate penalty, the revocation shall be permanent. However, the board may establish, by rule, requirements for reapplication by applicants whose licenses have been permanently revoked. Such requirements may include, but shall not be limited to, satisfying current requirements for an initial license.

Section 169. Section 455.2273, Florida Statutes, 1992 Supplement, as amended by section 56 of chapter 92-33, Laws of Florida, and section 23 of chapter 92-149, Laws of Florida, is amended to read:

455.2273 Disciplinary guidelines.—

(1) Each board, or the department when there is no board, shall adopt, by rule, and periodically review the disciplinary guidelines applicable to each ground for disciplinary action which may be imposed by the board, or the department when there is no board, pursuant to this chapter, the respective practice acts, and any rule of the board or department.

(2) The disciplinary guidelines shall specify a meaningful range of designated penalties based upon the severity and repetition of specific offenses, it being the legislative intent that minor violations be distinguished from those which endanger the public health, safety, or welfare; that such guidelines provide reasonable and meaningful notice to the public of likely penalties which may be imposed for proscribed conduct; and that such penalties be consistently applied by the board.

(3) A specific finding of mitigating or aggravating circumstances shall allow the board to impose a penalty other than that provided for in such guidelines. If applicable, the board, or the department when there is no board, shall adopt by rule disciplinary guidelines to designate possible mitigating and aggravating circumstances and the variation and range of penalties permitted for such circumstances.

(4) The department ~~of Professional Regulation or the Agency for Health Care Administration, as appropriate,~~ must review such disciplinary guidelines for compliance with the legislative intent as set forth herein to determine whether the guidelines establish a meaningful range of penalties and may also challenge such rules pursuant to ss. 120.54 and 120.56.

(5) The rules provided for in this section shall be promulgated no later than January 1, 1993.

(6) The hearing officer, in recommending penalties in any recommended order, must follow the penalty guidelines established by the board or department and must state in writing the mitigating or aggravating circumstances upon which the recommended penalty is based.

Section 170. Section 455.2275, Florida Statutes, 1992 Supplement, as amended by section 57 of chapter 92-33, Laws of Florida, and section 24 of chapter 92-149, Laws of Florida, is amended to read:

455.2275 Penalty for giving false information.—In addition to, or in lieu of, any other discipline imposed *under* ~~pursuant to~~ s. 455.227, the act of knowingly giving false information in the course of applying for or obtaining a license from the department ~~of Professional Regulation or the Agency for Health Care Administration,~~ or any board *within the department* ~~thereunder~~, with intent to mislead a public servant in the performance of his official duties, or the act of attempting to obtain or obtaining a license from ~~either~~ the department ~~or the agency~~, or any board *within the department* ~~thereunder~~, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 171. Section 455.228, Florida Statutes, 1992 Supplement, as amended by section 58 of chapter 92-33, Laws of Florida, and section 26 of chapter 92-149, Laws of Florida, is amended to read:

455.228 Unlicensed practice of a profession; cease and desist notice; civil penalty; enforcement.—

(1) When the department ~~of Professional Regulation or the Agency for Health Care Administration~~ has probable cause to believe that any person not licensed by the department ~~or the agency~~, or the appropriate regulatory board within the department ~~or the agency~~, has violated any provision of this chapter or any statute that relates to the practice of a profession regulated by the department ~~or the agency~~, or any rule adopted pursuant thereto, the department ~~or the agency~~ may issue and deliver to *the* ~~such~~ person a notice to cease and desist from such violation. In addition, the department ~~or the agency~~ may issue and deliver a notice to cease and desist to any person who aids and abets the unlicensed practice of a profession by employing *an* ~~such~~ unlicensed person. The issuance of a notice to cease and desist shall not constitute agency action for which a s. 120.57 hearing may be sought. For the purpose of enforcing a cease and desist order, the department ~~or the agency~~ may file a proceeding in the name of the state seeking issuance of an injunction or a writ of mandamus against any person who violates any provisions of *the* ~~such~~ order. In addition to the foregoing remedies, the department ~~or the agency~~ may impose an administrative penalty not to exceed $5,000 per incident, *under* ~~pursuant to~~ the provisions of chapter 120. If the department ~~or the agency~~ is required to seek enforcement of the agency order for a penalty *under* ~~pursuant to~~ s. 120.58, it shall be entitled to collect its attorney's fees and costs, together with any cost of collection.

(2) In addition to or in lieu of any remedy provided in subsection (1), the department ~~or the agency~~ may seek the imposition of a civil penalty through the circuit court for any violation for which the department ~~or the agency~~ may issue a notice to cease and desist under subsection (1). The civil penalty shall be no less than $500 and no more than $5,000 for each offense. The court may also award to the prevailing party court costs and reasonable attorney fees and, in the event the department ~~or the agency~~ prevails, may also award reasonable costs of investigation.

(3) The provisions of this section *apply only* ~~only apply~~ to the provisions of s. 455.217 and the professional practice acts administered by the Department of Professional Regulation ~~or the Agency for Health Care Administration~~.

Section 172. Section 455.2285, Florida Statutes, 1992 Supplement, as amended by section 59 of chapter 92-33, Laws of Florida, and section 28 of chapter 92-149, Laws of Florida, is amended to read:

455.2285 Annual report concerning finances, administrative complaints, disciplinary actions, and recommendations.—The Department of Professional Regulation *is* ~~and the Agency for Health Care Administration are each~~ directed to prepare and submit a report to the President of the Senate and Speaker of the House of Representatives by November 1 of each year, beginning in 1993. In addition to finances and any other information the Legislature may require, the report shall include statistics and relevant information, profession by profession, detailing:

(1) The revenues, expenditures, and cash balances for the prior year, and a review of the adequacy of existing fees.

(2) The number of complaints received and investigated.

(3) The number of findings of probable cause made.

(4) The number of findings of no probable cause made.

(5) The number of administrative complaints filed.

(6) The disposition of all administrative complaints.

(7) A description of disciplinary actions taken.

(8) The status of the development and implementation of rules providing for disciplinary guidelines pursuant to s. 455.2273.

(9) Such recommendations for administrative and statutory changes necessary to facilitate efficient and cost-effective operation of the department and the various boards.

Section 173. Section 455.229, Florida Statutes, 1992 Supplement, as amended by section 60 of chapter 92-33, Laws of Florida, and section 29 of chapter 92-149, Laws of Florida, is amended to read:

455.229 Public inspection of information required from applicants; exceptions; examination hearing.—

(1) All information required by the department ~~of Professional Regulation or the Agency for Health Care Administration~~ of any applicant shall be a public record and shall be open to public inspection *under* ~~pursuant to~~ s. 119.07, except financial information, medical information, school transcripts, examination questions, answers, papers, grades, and grading keys, which are confidential and exempt from s. 119.07(1) and shall not be discussed with or made accessible to anyone except members of the board, the department ~~of Professional Regulation or the Agency for Health Care Administration~~, and *its* staff ~~thereof,~~ who have a bona fide need to know such information. Any information supplied to the department ~~of Professional Regulation or the Agency for Health Care Administration,~~ by any other agency which is exempt from the provisions of chapter 119 or is confidential shall remain exempt or confidential *under* ~~pursuant to~~ applicable law while in the custody of the department ~~or the agency~~. These exemptions are subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(2) The department ~~of Professional Regulation or the Agency for Health Care Administration~~ shall establish by rule the procedure by which an applicant, and the applicant's attorney, may review examination questions and answers. Examination questions and answers are not subject to discovery but may be introduced into evidence and considered only in camera in any administrative proceeding under chapter 120. If an administrative hearing is held, the department ~~or the agency~~ shall provide challenged examination questions and answers to the hearing officer. The examination questions and answers provided at the hearing are confidential and exempt from s. 119.07(1), unless invalidated by the hearing officer. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(3) Unless an applicant notifies the department ~~or the agency~~ at least 5 days prior to an examination hearing of the applicant's inability to attend, or unless an applicant can demonstrate an extreme emergency for failing to attend, the department ~~or the agency~~ may require an applicant who fails to attend to pay reasonable attorney's fees, costs, and court costs of the department ~~or the agency~~ for the examination hearing.

Section 174. Section 455.232, Florida Statutes, 1992 Supplement, as amended by section 61 of chapter 92-33, Laws of Florida, and section 30 of chapter 92-149, Laws of Florida, is amended to read:

455.232 Disclosure of confidential information.—

(1) No officer, employee, or person under contract with the department ~~of Professional Regulation or the Agency for Health Care Adminis-~~

~~tration~~, or any board therein, or any subject of an investigation shall convey knowledge or information to any person who is not lawfully entitled to such knowledge or information about any public meeting or public record, which at the time such knowledge or information is conveyed is exempt from the provisions of s. 119.01, s. 119.07(1), or s. 286.011.

(2) Any person who willfully violates any provision of this section is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, and may be subject to discipline pursuant to s. 455.227, and, if applicable, shall be removed from office, employment, or the contractual relationship.

Section 175. Section 455.241, Florida Statutes, 1992 Supplement, as amended by section 62 of chapter 92-33, Laws of Florida, and section 32 of chapter 92-149, Laws of Florida, is amended to read:

455.241 Patient records; report or copies of records to be furnished.—

(1) Any health care practitioner licensed by the department or a board within the department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any person shall, upon request of such person or the person's legal representative, furnish, in a timely manner, without delays for legal review, copies of all reports and records relating to such examination or treatment, including X rays and insurance information. However, when a patient's psychiatric, chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies shall not be conditioned upon payment of a fee for services rendered.

(2) Except as otherwise provided in s. 440.13(2), such records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or *the patient's* ~~his~~ legal representative or other health care providers involved in the care or treatment of the patient, except upon written authorization of the patient. However, such records may be furnished without written authorization to any person, firm, or corporation which has procured or furnished such examination or treatment with the patient's consent or when compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical records shall be furnished to both the defendant and the plaintiff. Such records may be furnished in any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or *the patient's* ~~his~~ legal representative by the party seeking such records. Except in a medical negligence action when a health care provider is or reasonably expects to be named as a defendant, information disclosed to a health care practitioner by a patient in the course of the care and treatment of such patient is confidential and may be disclosed only to other health care providers involved in the care or treatment of the patient, or if permitted by written authorization from the patient or compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given. The Department of Professional Regulation ~~or the Agency for Health Care Administration, as appropriate,~~ may obtain patient records pursuant to a subpoena without written authorization from the patient if the department ~~of Professional Regulation or the Agency for Health Care Administration~~ and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a practitioner has excessively or inappropriately prescribed any controlled substance specified in chapter 893 in violation of *this chapter or of any professional practice act of a profession regulated under the department* ~~s. 458.331(1)(q), s. 459.015(1)(u), s. 461.013(1)(p), s. 462.14(1)(q), s. 466.028(1)(q), or s. 474.214(1)(y), (z), (bb), or (ff)~~ or that a practitioner has practiced his profession below that level of care, skill, and treatment required as defined by *this chapter or by any professional practice act of a board regulated under the department.* ~~s. 458.331(1)(t), s. 459.015(1)(y), s. 460.413(1)(s), s. 461.013(1)(t), s. 462.14(1)(t), s. 463.016(1)(n), s. 464.018(1)(h), s. 466.028(1)(y), or s. 474.214(1)(o) or (r); provided,~~ However, the patient record obtained by the department ~~or the agency~~ pursuant to this subsection shall be used solely for the purpose of the department ~~or the agency~~ and the ~~appropriate regulatory~~ board in disciplinary proceedings. The record shall otherwise be confidential and exempt from s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14. *This* ~~Nothing in this~~ section *does not* ~~shall be construed to~~ limit the assertion of the psychotherapist-patient privilege under s. 90.503 in regard to records of treatment for mental or nervous disorders by a medical practitioner licensed *under* ~~pursuant to~~ chapter 458 or chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency. However, the practitioner shall release records of treatment for medical conditions even if the practitioner has also treated the patient for mental or nervous disorders. If the department ~~or the agency~~ has found reasonable cause under this section and the psychotherapist-patient privilege is asserted, the department ~~or the agency~~ may petition the circuit court for an in camera review of the records by expert medical practitioners appointed by the court to determine if the records or any part thereof are protected under the psychotherapist-patient privilege.

(3) All patient records obtained by the Department of Professional Regulation ~~or the Agency for Health Care Administration~~ and any other documents maintained by the department ~~or the agency~~ which identify the patient by name are confidential and exempt from s. 119.07(1) and shall be used solely for the purpose of the Department of Professional Regulation ~~or the Agency for Health Care Administration~~ and the appropriate regulatory board in its investigation, prosecution, and appeal of disciplinary proceedings. The records shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department ~~or the Agency for Health Care Administration~~ or the appropriate board. These exemptions are subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(4) A health care practitioner furnishing copies of reports or records pursuant to this section shall charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board.

Section 176. Section 455.243, Florida Statutes, 1992 Supplement, as amended by section 63 of chapter 92-33, Laws of Florida, and section 35 of chapter 92-149, Laws of Florida, is amended to read:

455.243 Authority to inspect.—In addition to the authority specified in s. 465.017, duly authorized agents and employees of the department ~~of Professional Regulation and the Agency for Health Care Administration shall~~ have the power to inspect in a lawful manner at all reasonable hours:

(1) Any pharmacy; or

(2) Any establishment at which the services of a *licensee* ~~licensed practitioner~~ authorized to prescribe controlled substances specified in chapter 893 are offered,

for the purpose of determining if any of the provisions of *this* chapter *or any practice act of a professional regulated under the department* ~~458, chapter 459, chapter 461, chapter 466, or chapter 474~~ or any rule *adopted* ~~promulgated~~ thereunder is being violated; or for the purpose of securing such other evidence as may be needed for ~~administrative~~ prosecution ~~under chapter 458, chapter 459, chapter 461, chapter 466, or chapter 474~~.

Section 177. Section 455.245, Florida Statutes, 1992 Supplement, as amended by section 64 of chapter 92-33, Laws of Florida, and section 36 of chapter 92-149, Laws of Florida, is amended to read:

455.245 Health care practitioners; immediate suspension of license.—

(1) The department ~~of Professional Regulation or the Agency for Health Care Administration~~ shall issue an emergency order suspending the license of any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464; chapter 465, chapter 466, chapter 474, or chapter 484 who pleads guilty to, is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication, a felony under chapter 409 or chapter 893 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396.

(2) If the board has previously found any physician or osteopathic physician in violation of the provisions of s. 458.331(1)(t) or s. 459.015(1)(y), in regard to his treatment of three or more patients, and the probable cause panel of the board finds probable cause of an additional violation of that section, then the *secretary* ~~Director of Health Care Administration~~ shall review the matter to determine if an emergency suspension or restriction order is warranted. ~~Nothing in~~ This section *does not* ~~shall be construed so as to~~ limit the *secretary's* authority ~~of the Secretary of Professional Regulation or the Director of Health Care Administration~~ to issue an emergency order.

Section 178. Subsection (2) of section 455.25, Florida Statutes, 1992 Supplement, is amended to read:

455.25 Disclosure of financial interest by production.—

(2) An entity, *except a hospital licensed under chapter 395 or a nursing home licensed under chapter 400,* may not provide items or services to a patient unless, before providing the item or service, the entity obtains the signature of the patient on a written disclosure form informing the patient of:

(a) The existence or nonexistence of any financial relationship with the health care provider who referred the patient;

(b) A schedule of typical fees for items or services usually provided by the entity or, if impracticable because of the nature of the treatment, a written estimate specific to the patient;

(c) The patient's right to obtain the items or services for which the patient has been referred at a location or from a supplier of the patient's choice, including an entity with which the referring health care provider may have a financial relationship; and

(d) The names, addresses, and telephone numbers of at least two reasonable alternative sources of such items or services available to the patient.

Section 179. Section 455.26, Florida Statutes, 1992 Supplement, as amended by section 65 of chapter 92-33, Laws of Florida, and section 37 of chapter 92-149, Laws of Florida, is amended to read:

455.26 Impaired Practitioners Committee; duties.—

(1) There is created the Impaired Practitioners Committee to be composed of one representative *to be appointed by* ~~from~~ each *board* ~~practice licensed~~ under *the jurisdiction of the Division of Medical Quality Assurance within the department* ~~chapter 458, chapter 459, chapter 460, chapter 461, chapter 464, chapter 465, chapter 466, chapter 474, chapter 490, or chapter 491, to be appointed by the board under which the practitioner is licensed,~~ and of one addictionologist, one lay member having an appropriate background in the area of impairment, and a representative of the *department* ~~Agency for Health Care Administration~~, each to be appointed by the ~~Director of Health Care Administration, and of one representative of the Department of Professional Regulation appointed by the~~ Secretary of Professional Regulation. Section 455.207 applies to the activities of the committee.

(2) The committee shall:

(a) Establish policies and guidelines to be used in approving treatment providers for preventive and rehabilitative programs directed to impaired practitioners;

(b) Act as liaison between approved treatment providers and the department ~~of Professional Regulation and the Agency for Health Care Administration~~;

(c) Advise the department ~~and the agency~~ on the continuation and expansion of treatment programs for impaired practitioners; and

(d) Disseminate information concerning the impairment program.

Section 180. Section 464.009, Florida Statutes, is amended to read:

464.009 Licensure by endorsement.—

(1) The department shall issue the appropriate license by endorsement to practice professional or practical nursing to an applicant who, upon applying to the department and remitting a fee set by the board not to exceed $100, demonstrates to the board that he:

(a) Holds a valid license to practice professional or practical nursing in another state of the United States, *another national jurisdiction, or state or territory of another national jurisdiction,* provided that, when the applicant secured his original license, the requirements for licensure were substantially equivalent to or more stringent than those existing in Florida at that time; or

(b) Meets the qualifications for licensure in *s. 464.008(1)(b)-(d)* ~~s. 464.008~~ and has successfully completed a state, *territorial,* regional, or national examination which is substantially equivalent to or more stringent than the examination given by the department.

(2) Such examinations and requirements from other states, *territories, or national jurisdictions* shall be presumed to be substantially equivalent to or more stringent than those in this state. Such presumption shall not arise until January 1, 1980. However, the board may, by rule, specify states, *territories, or nations* the examinations and requirements of which shall not be presumed to be substantially equivalent to those of this state.

(3) The department shall not issue a license by endorsement to any applicant who is under investigation in another state, *territory, or nation* for an act which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 464.018 shall apply.

Section 181. Section 483.610, Florida Statutes, is amended to read:

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

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

(2)~~(1)~~ "Cholesterol screening" means determining the cholesterol level present in an individual's blood by analyzing a drop of blood taken from that individual by means of a fingerstick sample.

(3)~~(2)~~ "Clinical laboratory" means a laboratory licensed under part I.

(4)~~(3)~~ "Clinical staff" means individuals employed full-time or part-time by a cholesterol screening center, who are licensed to provide a medical or health-related service.

~~(4) "Department" means the Department of Health and Rehabilitative Services.~~

(5) "Fingerstick sample" means a quantity of blood taken from an individual by sticking his finger with a needle or lancet.

(6) "Governing body" means any individual, partnership, corporation, or association which is responsible for the overall operation and maintenance of a cholesterol screening center.

(7) "Hospital" means a facility licensed under chapter 395.

(8) "Licensed center" means a facility, institution, or place licensed in accordance with s. 483.613.

(9) "Person" means any individual, firm, partnership, corporation, or association.

(10) "Physician" means a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461.

(11) "Premises" means those buildings and facilities located at the main address of the center and all other buildings and facilities for the performance of cholesterol screening.

(12) "Test site" means any location where cholesterol screening services are performed.

Section 182. Section 483.613, Florida Statutes, is amended to read:

483.613 Licensure; issuance, renewal, denial, suspension, revocation; fees.—

(1)(a) Upon receipt of an application for a license and the license fee, the *agency* ~~department~~ shall issue a license if the applicant and center have received all approvals required by law and meet the requirements established under this part and in rules *adopted* ~~promulgated~~ under this part.

(b) A provisional license may be issued to any cholesterol screening center that is in substantial compliance with this part and with the rules of the *agency* ~~department~~. A provisional license may be granted for a period of no more than 6 months from the effective date of rules adopted by the *agency* ~~department~~, shall expire automatically at the end of its term, and may not be renewed.

(c) A license, unless suspended or revoked sooner, shall automatically expire 1 year from its date of issuance and shall be renewable upon application for renewal and payment of the fee prescribed, provided the applicant and the cholesterol screening center meet the requirements established under this part and in rules *adopted* ~~promulgated~~ under this part. A complete application for renewal of a license shall be made 90 days prior to expiration of the license, on forms provided by the *agency* ~~department~~.

(2) An application for a license, or renewal thereof, shall be made to the *agency* ~~department~~ upon forms provided by the *agency* ~~department~~, shall be under oath, and shall contain such information as the *agency* ~~department~~ reasonably requires, which may include affirmative evidence of ability to comply with applicable laws and rules.

(3)(a) Each application for a cholesterol screening center license, or renewal thereof, shall be accompanied by a license fee. Fees shall be established by rule of the *agency* ~~department~~. Such fees are payable to the *agency* ~~department~~ and shall be deposited in a trust fund administered by the *agency* ~~department~~, to be used for the sole purpose of carrying out the provisions of this part.

(b) The fees established pursuant to this part shall be established by rule at a rate of not less than $750 per licensed center nor more than $1,200 per licensed center, based on the costs incurred by the *agency* ~~department~~ in the administration of its duties under such sections.

(4) Each license shall be valid only for the person to whom or which it is issued; shall not be subject to sale, assignment, or other transfer, voluntary or involuntary; and shall be valid for any premises where screening is conducted under the direct supervision and control of the person to whom it was issued provided such premises meet all other applicable requirements of law and *agency* ~~department~~ rule.

(5) Each license shall be posted in a conspicuous place on the licensed premises and at each test site.

(6) An application for a new license is required when the person holding the license for a cholesterol screening center changes through any means, including, but not limited to, sale, transfer, assignment, or lease. The application for such change shall be made at least 60 days prior to the date of the sale, transfer, assignment, or lease.

Section 183. Subsection (3) of section 483.614, Florida Statutes, is amended to read:

483.614 Administration of cholesterol screening centers.—

(3) All clinical staff shall hold current licenses from the *agency for* ~~appropriate department which is responsible for licensing the practice of~~ their respective disciplines.

Section 184. Paragraph (a) of subsection (2) of section 483.615, Florida Statutes, is amended to read:

483.615 Cholesterol screening center and equipment; requirements.—

(2)(a) A cholesterol screening center shall be equipped with those items needed to provide screenings and readily available equipment to initiate emergency procedures in adverse events to the patient, as defined by rule of the *agency* ~~department~~.

Section 185. Section 483.616, Florida Statutes, is amended to read:

483.616 Standards for operation; *agency* ~~departmental~~ rules.—

(1) The *agency* ~~department~~ shall adopt, amend, promulgate, and enforce rules to implement the provisions of this part, which rules shall include, but are not limited to, reasonable and fair minimum standards for ensuring the health, safety, and welfare of cholesterol screening center patients, as follows:

(a) Sufficient numbers and qualified types of personnel and occupational disciplines shall be available and properly supervised at all times to provide necessary and adequate patient care and safety.

(b) Infection control, housekeeping, sanitary conditions, and medical record procedures that will adequately protect patient care and provide safety shall be established and implemented.

(c) Licensed facilities shall be established, organized, and operated consistent with established programmatic standards.

(d) Instruments shall meet the performance standards established by the Laboratory Standardization Panel of the National Cholesterol Education Program and shall be precise and accurate within 5 percent by January 1, 1991, and within 3 percent by January 1, 1993. Maintenance of each instrument shall be performed according to the manufacturer's guidelines, and each instrument shall have the accuracy of its results traceable to the National Committee for Clinical Laboratory Standards/National Reference System for Cholesterol by following the manufacturer's recommendations for calibration and use of controls.

(e) Protocols shall be written to implement and maintain quality control policies and procedures which include expected outcomes for internal and external quality assurance and which are reviewed by the governing body.

(f) Training programs shall be provided for all staff, which shall include, but are not limited to, the following: professional appearance and conduct, maintaining the confidentiality of health information, coping with emergency patient conditions, and the importance of accurate recording and reporting of screening and followup procedures.

(g) Test sites shall be conducive to handling patient flow of participants and to assuring confidentiality and privacy. Test sites shall be equipped with adequate lighting and essential utilities and with a sink or suitable chemical disinfectant. The temperature of the room in which the analyzer is kept shall be maintained within the manufacturer's recommended specifications.

(h) The governing body shall develop protocols to ensure accurate reporting of screening results, appropriate counseling on the screening results, and referral for any necessary followup action. The protocol shall provide for the distribution of oral and written information to all participants on matters relating to blood cholesterol levels and heart diseases and good health practices that may help achieve or maintain safe cholesterol levels.

(2) Any licensed center which is in operation at the time of promulgation of any applicable rule under this part shall be given a reasonable time under the particular circumstances, not to exceed 1 year from the date of such promulgation, within which to comply with such rule.

Section 186. Paragraph (b) of subsection (3) of section 483.619, Florida Statutes, is amended to read:

483.619 Maintenance of records.—

(3)

(b) A patient's clinical records are considered confidential documents and shall be open to inspection only under the following conditions:

1. If a consent to release information has been signed by the patient; or

2. When review is undertaken by the *agency* ~~department~~ pursuant to a licensure survey or complaint investigation.

Section 187. Section 483.620, Florida Statutes, is amended to read:

483.620 Inspection by the *agency* ~~department~~.—

(1) The *agency* ~~department~~ shall make or cause to be made such announced or unannounced inspections and investigations as it deems necessary. However, there shall be at least one inspection annually to determine that the center and test sites are in compliance with this part and the rules *adopted* ~~promulgated~~ under this part.

(2) The *agency* ~~department~~ shall coordinate all periodic inspections for licensure made by the *agency* ~~department~~ to ensure that the cost to the center of such inspections and the disruption of services by such inspections is minimized.

(3) If the *agency* ~~department~~, through its inspection or through any investigation, has a reasonable belief that conduct by a clinical staff member or any other employee of a cholesterol screening center may constitute grounds for disciplinary action by the appropriate regulatory board, the *agency* ~~department~~ shall report this fact to such regulatory board.

Section 188. Subsections (3) and (4) of section 483.621, Florida Statutes, are amended to read:

483.621 Public access to inspection reports.—

(3) A licensed center shall, upon the request of any person who has completed a written application with intent to be screened by such center or any person who is a patient of such center, or the guardian of any such person, furnish to the requester a copy of the last inspection report issued by the *agency* ~~department~~ pertaining to the licensed center, as provided in subsection (1), provided the person requesting such report agrees to pay a reasonable charge to cover copying costs.

(4) Every center shall post a copy of the latest inspection report of the *agency* ~~department~~ for that center in a prominent location within the center and each test site, so as to be accessible to all patients and to the public. Upon request, the center shall also provide an applicant for screening by the center with a copy of such report.

Section 189. Section 483.622, Florida Statutes, is amended to read:

483.622 Administrative penalties; emergency orders; moratorium on admissions.—

(1)(a) The *agency* ~~department~~ may deny, revoke, or suspend a license, or impose an administrative fine not to exceed $500 per violation per day, for the violation of any provision of this part or any rule *adopted* ~~promulgated~~ under this part. Each day of violation constitutes a separate violation and is subject to a separate fine.

(b) In determining the amount of the fine to be levied for a violation, as provided in paragraph (a), the following factors shall be considered:

1. The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted; the severity of the actual or potential harm; and the extent to which the provisions of this part were violated.

2. Actions taken by the licensee to correct the violations or to remedy complaints.

3. Any previous violations by the licensee.

(c) All amounts collected pursuant to this section shall be deposited into a trust fund administered by the *agency* ~~department~~ to be used for the sole purpose of carrying out the provisions of this part.

(2) Whenever the *agency* ~~department~~ finds that there has been a substantial failure to comply with the requirements established under this part or in rules *adopted* ~~promulgated~~ under this part, it is authorized to deny, suspend, or revoke a license.

(3) The *agency* ~~department~~ may issue an emergency order immediately suspending or revoking a license when it determines that any condition in the licensed center presents a clear and present danger to the public health and safety.

(4) The *agency* ~~department~~ may impose an immediate moratorium on screenings to any licensed center or test site when the *agency* ~~department~~ determines that any condition in the center or test site presents a threat to the public health or safety.

Section 190. Section 483.624, Florida Statutes, is amended to read:

483.624 Injunctive relief.—Notwithstanding the existence or pursuit of any other remedy, the *agency* ~~department~~ may maintain an action in the name of the state for injunction or other process to enforce the provisions of this part and the rules *adopted* ~~promulgated~~ under this part.

Section 191. Paragraph (a) of subsection (4) and subsection (6) of section 624.91, Florida Statutes, are amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

(4) BOARD OF DIRECTORS.—

(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors chaired by the Insurance Commissioner or his designee, and composed of *12* ~~11~~ other members selected for 3-year terms of office as follows:

1. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Administrators;

2. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Boards;

3. One member appointed by the Commissioner of Education from the Office of School Health Programs of the Florida Department of Education;

4. One member appointed by the Governor from among three members nominated by the Florida Pediatric Society;

5. One member, appointed by the Governor, who represents the Children's Medical Services Program;

6. One member appointed by the Insurance Commissioner from among three members nominated by the Florida Hospital Association;

7. Two members, appointed by the Insurance Commissioner, who are representatives of authorized health care insurers or health maintenance organizations;

8. One member, appointed by the Insurance Commissioner, who represents the Institute for Child Health Policy;

9. One member, appointed by the Governor, from among three members nominated by the Florida Academy of Family Physicians; ~~and~~

10. One member, appointed by the Governor, who represents the Agency for Health Care Administration; and

11. ~~10.~~ The State Health Officer or his designee.

In order to provide for staggered terms, the initial term of the members appointed under subparagraphs 1., 4., and 6. shall be for 2 years and the initial term of the members appointed under subparagraphs 2., 5., ~~and~~ 8., *and 10.* shall be for 4 years.

(6) THE FLORIDA HEALTHY KIDS TRUST FUND.—There is created the Florida Healthy Kids Trust Fund in the State Treasury to be administered by the *Agency for Health Care Administration* ~~Department of Insurance~~, to which all appropriations shall be deposited in order to carry out the purposes of this act. Other revenues of the corporation such as grants, contributions, matching funds, and participant payments shall not be considered revenue of the state, but rather shall be funds of the corporation. However, the corporation may designate portions of grants, contributions, matching funds, and participant payments as funds of the state and deposit those funds in the Florida Healthy Kids Trust Fund.

Section 192. Section 626.9545, Florida Statutes, is amended to read:

626.9545 Improper charge identification incentive program.—*Each* ~~No section or provision of the Florida Insurance Code shall be construed as prohibiting an~~ insurer *regulated under the Florida Insurance Code shall establish* ~~from establishing~~ a financial incentive program for remunerating a policyholder or an insured person with a selected percentage or stated portion of any health care charge identified by the policyholder or the insured person as an error or overcharge if the health care charge is recovered by the insurer. The financial incentive program shall be written and shall be available for inspection by the department.

Section 193. Subsection (7) of section 627.613, Florida Statutes, 1992 Supplement, is amended to read:

627.613 Time of payment of claims.—

(7) Upon written notification by an insured, an insurer shall investigate any claim of improper billing by a physician, hospital, or other health care provider. The insurer shall determine if the insured was properly billed for only those procedures and services that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the insured, the insurer shall pay to the insured *50* ~~20~~ percent of the amount of the reduction up to *$1,500* ~~$500~~.

Section 194. Subsection (3) of section 641.21, Florida Statutes, is amended to read:

641.21 Application for certificate.—

(3) Any person or entity which enters into a contract with the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ on a prepaid per capita or prepaid aggregate fixed-sum basis for the provision of health care services or social services, or both, to persons determined eligible for such services shall be exempt from the provisions of this chapter and shall be governed by the standards set forth by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ unless the person or entity provides health care services on a prepaid basis to persons other than those for which the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ has contracted. However, any person or entity which is not certificated under the provisions of this chapter shall not use in its name, logo, contracts, or literature the phrases "health care service plan," "health maintenance organization," or "prepaid health clinic" or the initials "HMO" or "PHC"; imply, directly or indirectly, that it is a health care services plan, health maintenance organization, or prepaid health clinic; or hold itself out to be a health care services plan, health maintenance organization, or prepaid health clinic. A prepaid plan exempt under this subsection shall be subject to regulation by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ in accordance with *s. 641.48(2)* ~~s. 641.48(3)~~.

Section 195. Subsections (3) and (4) of section 641.225, Florida Statutes, are amended to read:

641.225 Surplus requirements.—

(3) An entity providing prepaid capitated services exempt under *s. 641.48(2)* ~~s. 641.48(3)~~ which was providing such services prior to October 1, 1988, and which applies for a certificate of authority is subject to the minimum surplus requirements contained in subsection (1).

(4) An entity that began providing prepaid capitated services exempt under *s. 641.48(2)* ~~s. 641.48(3)~~ after October 1, 1988, has been providing such services for the preceding 12 months, and makes application for a certificate of authority shall meet minimum surplus and enrollment requirements as follows:

(a) At the time the certificate of authority is issued, $100,000 or 5 percent of total liabilities, whichever is greater.

(b) Twelve months from the date a certificate of authority is issued, the greater of $200,000 or 6 percent of total liabilities, and a nonexempt enrollment not to exceed 50 percent of the HMO's exempt enrollment.

(c) Twenty-four months from the date a certificate of authority is issued, the greater of $350,000 or 8 percent of total liabilities, and a nonexempt enrollment not to exceed 75 percent of the HMO's exempt enrollment.

(d) Thirty-six months from the date a certificate of authority is issued, the greater of $500,000 or 10 percent of total liabilities and no limitation on nonexempt enrollment.

An HMO subject to the requirements of this subsection which exceeds the maximum enrollment levels established in this subsection shall then be subject to the minimum surplus requirements set forth in paragraphs (2)(a) and (b).

Section 196. Present subsections (1) through (7) of section 641.47, Florida Statutes, are redesignated as subsections (2) through (8), respectively, and a new subsection (1) is added to that section, to read:

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

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

Section 197. Section 641.48, Florida Statutes, is amended to read:

641.48 Purpose and application of part; exemption.—

(1) The purpose of this part is to ensure that health maintenance organizations and prepaid health clinics deliver high-quality health care to their subscribers. To achieve this purpose, this part requires all health maintenance organizations and prepaid health clinics to obtain a Health Care Provider Certificate from the *agency* ~~Department of Health and Rehabilitative Services~~ as a condition precedent to obtaining a certificate of authority to do business in Florida from the Department of Insurance, pursuant to part I or part II of this chapter.

~~(2) Every health maintenance organization and every prepaid health clinic which possesses a subsisting certificate of authority issued pursuant to part I or part II of this chapter prior to October 1, 1987, shall file an application with the Department of Health and Rehabilitative Services by January 1, 1988, to obtain a Health Care Provider Certificate pursuant to this part. Such application shall be granted unless the department determines that the organization is not in compliance with the requirements of this part and any rules adopted hereunder. For the purposes of this subsection, the 90-day time period for licensing contained in s. 120.60(2) shall be extended to 180 days.~~

(2)~~(3)~~ Any person or entity which enters into a contract with the department on a prepaid per capita or prepaid aggregate fixed-sum basis for the provision of health care services or social services, or both, to persons determined eligible for such services shall be exempt from the provisions of this part and shall be governed by the standards set forth by the department unless the person or entity provides health care service on a prepaid basis to persons other than those for which the department has contracted. However, any person or entity which is not certified under the provisions of this chapter shall not use in its name, logo, contracts, or literature the phrases "health maintenance organization" or "prepaid health clinic" or the initials "HMO" or "PHC"; imply, directly or indirectly, that it is a health maintenance organization or prepaid health clinic; or hold itself out to be a health maintenance organization or prepaid health clinic. Subject to these restrictions, any such person or entity may advertise and market their prepaid health or social services using words or phrases similar to "prepaid health services" or "prepaid social services," so long as the services are accurately described and the advertisement and marketing literature clearly discloses that such services are available only to persons eligible for health care or social services through the department. The department shall set standards or promulgate rules for the conduct of a prepaid plan exempt under this subsection, which shall include provisions whereby the entity shall:

(a) Be organized primarily for the purpose of providing health care or other services of the type regularly offered to the department's enrolled clients.

(b) Ensure that services meet the standards set by the department for quality, appropriateness, and timeliness.

(c) Make provisions satisfactory to the department for insolvency protection and ensure that neither the department's enrolled clients nor the department shall be liable for the debts of the entity.

(d) Submit to the department, if a private entity, a financial plan that the department finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets, excluding revenues from the department premium payments, equal to at least the first 3 months of operating expenses or $200,000, whichever is greater.

(e) Furnish evidence satisfactory to the department of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care.

(f) Provide, through contract or otherwise, for periodic review of its medical facilities, services, and records, as required by the department.

(g) Provide organizational, financial, and other information that may be required to ensure quality of care and financial solvency.

Section 198. Section 641.49, Florida Statutes, is amended to read:

641.49 Certification of health maintenance organization and prepaid health clinic as health care providers; application procedure.—

(1) No person or governmental unit shall establish, conduct, or maintain a health maintenance organization or a prepaid health clinic in this state without first obtaining a Health Care Provider Certificate under this part.

(2) The Department of Insurance shall not issue a certificate of authority under part I or part II of this chapter to any applicant which does not possess a valid Health Care Provider Certificate issued by the *agency* ~~department~~ pursuant to this part.

(3) Each application for a Health Care Provider Certificate shall be on a form prescribed by the *agency* ~~department~~. The following information and documents shall be maintained by the organization and shall be available for inspection or examination at the offices of the organization by the *agency* ~~department~~ at anytime during regular business hours. The *agency* ~~department~~ shall give reasonable notice to the organization prior to any onsite inspection or examination conducted pursuant to this section. The *agency* ~~department~~ may require that the following information or documents be submitted with the application:

(a) A copy of the articles of incorporation and all amendments thereto.

(b) A copy of the bylaws, rules and regulations, or similar form of document, if any, regulating the conduct of the affairs of the applicant.

(c) A list of the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of the affairs of the organization, including all officers and directors of the corporation. Such persons shall fully disclose to the *agency* ~~department~~ and the directors of the organization the extent and nature of any contracts or arrangements between them and the health maintenance organization, including any possible conflicts of interest.

(d) The name and address of the applicant and the name by which the organization is to be known.

(e) A statement generally describing the organization and its operations.

(f) A copy of the form for each group and individual contract, certificate, subscriber handbook, and any other similar documents issued to subscribers.

(g) A statement describing the manner in which health services shall be regularly available.

(h) The locations of the facilities at which health care services shall be regularly available to subscribers.

(i) The type of health care personnel engaged to provide the health care services and the quantity of the personnel of each type.

(j) A statement giving the present and projected number of subscribers to be enrolled yearly for the next 3 years.

(k) A statement indicating the source of emergency care on a 24-hour basis.

(l) A statement that the physicians employed by the applicant have been formally organized as a medical staff and that the applicant's governing body has designated a chief of medical staff.

(m) A statement describing the manner in which the organization assures the maintenance of a medical records system in accordance with accepted medical records' standards and practices.

(n) If general anesthesia is to be administered in a facility not licensed by the *agency* ~~department~~, a copy of architectural plans to meet the requirements for institutional occupancy (NFPA 101 Life Safety Code, current edition as adopted by the State Fire Marshal).

(o) Description of the organization's quality assurance program, including committee structure, criteria and procedures for corrective action which complies with s. 641.51.

(p) For health maintenance organizations only:

1. A description and supporting documentation concerning how the applicant will comply with the internal risk management program requirements.

2. An explanation of how coverage is to be effected outside the health maintenance organization's stated geographic area for emergency services.

(q) A statement and map describing with reasonable accuracy the specific geographic area to be served.

(r) A nonrefundable application fee of $1,000.

(s) Such additional information as the *agency* ~~department~~ may reasonably require.

Section 199. Subsections (1) and (2) of section 641.495, Florida Statutes, are amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(1) The *agency* ~~department~~ shall issue a Health Care Provider Certificate to any entity filing a completed application in conformity with s. 641.48, upon payment of the prescribed fee, and upon the *agency's* ~~department's~~ being satisfied that the applicant has the ability to provide quality of care consistent with the prevailing professional standards of care and which entity otherwise meets the requirements of this part. A certificate, unless sooner suspended or revoked, shall automatically expire 2 years from the date of issuance unless renewed by the organization. The certificate shall be renewed upon application for renewal and payment of a renewal fee of $1,000, provided that the organization is in compliance with the requirements of this part and any rules adopted hereunder. An application for renewal of a certificate shall be made 90 days prior to expiration of the certificate, on forms provided by the *agency* ~~department~~. The renewal application shall not require the resubmission of any documents previously filed with the *agency* ~~department~~ if such documents have remained valid and unchanged since their original filing.

(2) The organization shall demonstrate its capability to provide health care services in the geographic area proposed to service. In addition, each health maintenance organization shall notify the *agency* ~~department~~ of its intent to expand its geographic area at least 60 days prior to the date it begins providing health care services in the new area. Prior to the date the health maintenance organization begins enrolling members in the new area, it must submit a notarized affidavit, signed by two officers of the organization who have the authority to bind the organization, to the *agency* ~~department~~ describing and affirming its existing and projected capability to provide health care services to its projected number of subscribers in the new area. The notarized affidavit shall further assure that, 15 days prior to providing services in the new area, the health maintenance organization shall be able, through documentation or otherwise, to demonstrate that it shall be capable of providing services to its projected subscribers for at least the first 60 days of operation. If the *agency* ~~department~~ determines that the organization is not capable of providing health care services to its projected number of subscribers in the new area, the *agency* ~~department~~ may issue an order pursuant to the procedures of chapter 120 prohibiting the organization from expanding into the new area. In any proceeding pursuant to chapter 120, the *agency* ~~department~~ shall have the burden of establishing that the organization is not capable of providing health care services to its projected number of subscribers in the new area.

Section 200. Section 641.511, Florida Statutes, is amended to read:

641.511 Subscriber grievance reporting and resolution requirements.—

(1) The health maintenance organization shall maintain records of all grievances and shall report annually to the *agency* ~~department~~ a description of the total number of grievances handled, a categorization of the cases underlying the grievances, and the resolution of the grievances.

(2) Each health maintenance organization shall send to the *agency* ~~department~~ a copy of its annual and quarterly grievance reports submitted to the Department of Insurance pursuant to s. 641.311(2).

(3) The *agency* ~~department~~ shall investigate all reports of unresolved quality of care grievances received from:

(a) Annual and quarterly grievance reports submitted by the health maintenance organization to the Department of Insurance.

(b) Appeals of subscribers whose grievances remain unresolved after the subscriber has followed the full grievance procedure of the organization.

(4) The *agency* ~~department~~ shall advise subscribers with grievances to follow the health maintenance organization formal grievance process for resolution prior to review by the *agency* ~~department~~. However, this shall not preclude the *agency* ~~department~~ from investigating any complaint prior to completion of the health maintenance organization's formal grievance process.

(5) A quality of care grievance which remains unresolved after a subscriber has followed the full grievance procedure of the organization, after review by the *agency* ~~department~~, may be presented to the Statewide Subscriber Assistance Program Panel as set forth in s. 641.311.

Section 201. Subsections (1), (3), and (6) of section 641.512, Florida Statutes, are amended to read:

641.512 Accreditation and external quality assurance assessment.—

(1)(a) To promote the quality of health care services provided by health maintenance organizations and prepaid health clinics in this state, the *agency* ~~department~~ shall require each health maintenance organization and prepaid health clinic to be accredited within 1 year of the organization's receipt of its certificate of authority and to maintain accreditation by an accreditation organization approved by the *agency* ~~department~~, as a condition of doing business in the state.

(b) In the event that no accreditation organization can be approved by the *agency* ~~department~~, the *agency* ~~department~~ shall require each health maintenance organization and prepaid health clinic to have an external quality assurance assessment performed by a review organization approved by the *agency* ~~department~~, as a condition of doing business in the state. The assessment shall be conducted within 1 year of the organization's receipt of its certificate of authority and every 2 years thereafter, or when the *agency* ~~department~~ deems additional assessments necessary.

(3) A representative of the *agency* ~~department~~ shall accompany the accreditation or review organization throughout the accreditation or assessment process, but shall not participate in the final accreditation or assessment determination. The accreditation or review organization shall monitor and evaluate the quality and appropriateness of patient care, the

organization's pursuance of opportunities to improve patient care and resolve identified problems, and the effectiveness of the internal quality assurance program required for health maintenance organization and prepaid health clinic certification pursuant to s. 641.49(3)(o).

(6) The accreditation or review organization shall issue a written report of its findings to the health maintenance organization's or prepaid health clinic's board of directors. A copy of the report shall be submitted to the *agency* ~~department~~ by the organization within 30 business days of its receipt by the health maintenance organization or prepaid health clinic.

Section 202. Section 641.515, Florida Statutes, is amended to read:

641.515 Examination by the *agency* ~~department~~.—

(1) The *agency* ~~department~~ shall investigate further any quality of care issue contained in recommendations and reports submitted pursuant to ss. 641.311 and 641.511. The *agency* ~~department~~ shall also investigate further any information that indicates that the organization does not meet accreditation standards or the standards of the review organization performing the external quality assurance assessment pursuant to reports submitted under s. 641.512. Every organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. The *agency* ~~department~~ shall have access to the organization's medical records of individuals and records of employed and contracted physicians, with the consent of the subscriber or by court order, as necessary to carry out the provisions of this part.

(2) The examination report and the records obtained by the *agency* ~~department~~ or by an outside source pursuant to this section and s. 641.512 shall be used solely for the purpose of the *agency* ~~department~~ in enforcing the requirements of this part and in disciplinary proceedings. These records and reports shall be otherwise sealed and shall not be available to the public pursuant to the provisions of s. 119.07 or any other statute providing access to public records. Further, these records and reports shall not be obtainable from the *agency* ~~department~~ through discovery or subpoena in civil actions.

(3) If the *agency* ~~department~~, through its examination or through any investigation, has a reasonable belief that conduct by a staff member or any other employee of an organization may constitute grounds for disciplinary action by the appropriate regulatory board, the *agency* ~~department~~ shall report this fact to such regulatory board.

(4) The *agency* ~~department~~ shall *adopt* ~~promulgate~~ rules imposing upon physicians and hospitals performing services for a health maintenance organization standards of care generally applicable to physicians and hospitals. If the *agency* ~~department~~ determines that any physician or hospital is not adhering to such standards, it may immediately notify any health maintenance organization for which the physician or hospital performs services.

Section 203. Section 641.52, Florida Statutes, is amended to read:

641.52 Suspension, revocation of certificate; administrative fine; notice of action to the Department of Insurance; penalty for use of unlicensed providers.—

(1) The *agency* ~~department~~ may suspend the authority of an organization to enroll new subscribers or revoke the Health Care Provider Certificate of any organization, or order compliance within 60 days, if it finds that any of the following conditions exist:

(a) The organization is in substantial violation of its contracts.

(b) The organization is unable to fulfill its obligations under outstanding contracts entered into with its subscribers.

(c) The organization knowingly utilizes a provider who is furnishing or has furnished health care services and who does not have a subsisting license or other authority to practice or furnish health care services in this state.

(d) The organization no longer meets the requirements for the certificate as originally issued.

(e) The organization has violated any lawful rule or order of the *agency* ~~department~~ or any provision of this part.

(f) The organization has refused to be examined or to produce its accounts, records, and files for examination or to perform any other legal obligation as to such examination, when required by the *agency* ~~department~~.

(g) The organization has not, after given reasonable notice, maintained accreditation or received favorable external quality assurance assessments pursuant to s. 641.512 or following an investigation pursuant to s. 641.515.

(2) Revocation of an organization's certificate shall be for a period of 2 years. After 2 years, the organization may apply for a new certificate by compliance with all application requirements applicable to first-time applicants.

(3) Suspension of an organization's authority to enroll new subscribers shall be for such period, not to exceed 1 year, as is fixed by the *agency* ~~department~~. The *agency* ~~department~~ shall, in its order suspending the authority of an organization to enroll new subscribers, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the organization prior to reinstatement of its authority to enroll new subscribers. The order of suspension is subject to rescission or modification by further order of the *agency* ~~department~~ prior to the expiration of the suspension period. Reinstatement shall not be made unless requested by the organization; however, the *agency* ~~department~~ shall not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(4) Upon expiration of the suspension period the organization's certificate shall automatically reinstate unless the *agency* ~~department~~ finds that the causes of the suspension have not been removed or that the organization is otherwise not in compliance with the requirements of this part. If not so automatically reinstated, the certificate shall be deemed to have expired as of the end of the suspension period.

(5) If the *agency* ~~department~~ finds that one or more grounds exist for the revocation or suspension of a certificate issued under this part, the *agency* ~~department~~ may, in lieu of such revocation or suspension, impose a fine upon the organization. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of a lawful order or rule of the *agency* ~~department~~ or a provision of this part, the *agency* ~~department~~ may impose a fine upon the organization in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.

(6) The *agency* ~~department shall~~ immediately notify the Department of Insurance whenever it issues an administrative complaint or an order or otherwise initiates legal proceedings resulting in or which may result in suspension or revocation of an organization's Health Care Provider Certificate.

(7) Any health maintenance organization which knowingly utilizes the services of a provider who is not licensed or otherwise authorized by law to provide such services is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 204. Subsection (2) of section 641.54, Florida Statutes, is amended to read:

641.54 Hospital and physician information disclosure.—

(2) The list shall be made available, upon request, to the *agency* ~~department~~. The list shall also be made available, upon request:

(a) With respect to negotiation, application, or effectuation of a group health maintenance contract, to the employer or other person who will hold the contract on behalf of the subscriber group. The list may be restricted to include only physicians and hospitals in the group's geographic area.

(b) With respect to an individual health maintenance contract or any contract offered to a person who is entitled to have payments for health care costs made under Medicare, to the person considering or making application to, or under contract with, the health maintenance organization. The list may be restricted to include only physicians and hospitals in the person's geographic area.

Section 205. Subsections (4), (5), (6), (7), (8), (9), (11), and (12) of section 641.55, Florida Statutes, 1992 Supplement, are amended to read:

641.55 Internal risk management program.—

(4) The *agency* ~~Department of Health and Rehabilitative Services~~ shall, after consulting with the Department of Insurance, *adopt* ~~promul-~~

~~gate~~ rules necessary to carry out the provisions of this section, including rules governing the establishment of required internal risk management programs to meet the needs of individual establishments. The Department of Insurance shall assist the *agency* ~~Department of Health and Rehabilitative Services~~ in preparing these rules. Each internal risk management program shall include the use of incident reports to be filed with the risk manager. The risk manager shall have free access to all health maintenance organization or provider medical records. The incident reports shall be considered to be a part of the workpapers of the attorney defending the establishment in litigation relating thereto and shall be subject to discovery, but not be admissible as evidence in court, nor shall any person filing an incident report be subject to civil suit by virtue of the incident report and the matters it contains. As a part of each internal risk management program, the incident reports shall be utilized to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct these problem areas.

(5)(a) Each health maintenance organization subject to this section shall submit an annual report to the *agency* ~~Department of Health and Rehabilitative Services~~ summarizing the incident reports that have been filed in the health maintenance organization for that year pertaining to services rendered on the premises of the health maintenance organization. The report shall be on a form prescribed by rule of the *agency* ~~Department of Health and Rehabilitative Services~~ and shall include with respect to medical services rendered on the premises of the health maintenance organization:

1. The total number of adverse incidents causing injury to patients.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. The name of each provider or a code number utilizing the health care professional's license number and a separate code number identifying all other individuals directly involved in adverse incidents causing injury to patients, the relationship of the individual or provider to the health maintenance organization, and the number of incidents in which each individual or provider has been directly involved. Each health maintenance organization shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

5. A description of all medical malpractice claims filed against the health maintenance organization or its providers, including the total number of pending and closed claims and the nature of the incident which led to, the persons involved in, and the status and disposition of each claim. Each report shall update status and disposition for all prior reports.

6. A report of all disciplinary actions taken against any provider or any medical staff member of the health maintenance organization, including the nature and cause of the action.

(b) The information reported to the *agency* ~~department~~ pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall *be reviewed by the agency to* ~~also be reported to the Department of Professional Regulation quarterly. The Department of Professional Regulation shall review the information and~~ determine whether any of the incidents potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(c) The annual report shall also contain the name of the risk manager of the health maintenance organization, a copy of its policy and procedures which govern the measures taken by the organization and its risk manager to reduce the risk of injuries and adverse or untoward incidents, and the results of these measures. This report and the quarterly reports under paragraph (b) shall be held confidential and shall not be available to the public pursuant to s. 119.07 or any other law providing access to public records, nor shall the report be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the *agency* ~~department, the Department of Professional Regulation,~~ and the appropriate regulatory board. This report shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the *agency* ~~department, the Department of Professional Regulation,~~ or the appropriate regulatory board. However, the *agency* ~~Department of Professional Regulation~~ shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

(6) If an adverse or untoward incident, whether occurring in the facilities of the health maintenance organization or arising from health care prior to admission to the facilities of the organization or in the facility of one of its providers, results in:

(a) The death of a patient;

(b) Severe brain or spinal damage to a patient;

(c) A surgical procedure being performed on the wrong patient; or

(d) A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient,

the organization shall report this incident to the *agency* ~~Department of Health and Rehabilitative Services~~ within 3 working days of its occurrence. A more detailed followup report shall be submitted to the *agency* ~~Department of Health and Rehabilitative Services~~ within 10 days after the first report. The *agency* ~~department~~ may require an additional, final report. ~~Reports under this subsection shall be sent immediately by the department to the Department of Professional Regulation whenever they involve a health care provider licensed under chapter 458, chapter 459, chapter 461, or chapter 466.~~ These reports shall not be available to the public pursuant to s. 119.07 or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the *agency* ~~department, the Department of Professional Regulation,~~ and the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the *agency* ~~department, the Department of Professional Regulation,~~ or the appropriate regulatory board. However, the *agency* ~~Department of Professional Regulation~~ shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The *agency* ~~Department of Health and Rehabilitative Services~~ may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken by the health maintenance organization in response to the incident. The *agency* ~~Department of Professional Regulation~~ shall review each incident and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(7) In addition to any penalty imposed pursuant to s. 641.52, the *agency* ~~department~~ may~~, beginning July 1, 1989,~~ impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of subsection (5) or subsection (6).

(8) The *agency* ~~department and, upon subpoena issued pursuant to s. 455.223, the Department of Professional Regulation~~ shall have access to all health maintenance organization records necessary to carry out the provisions of this section. The records obtained are not available to public access, nor are they discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the *agency* ~~department, the Department of Professional Regulation,~~ and the appropriate regulatory board.~~; nor may records obtained pursuant to s. 455.223 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board.~~ However, the *agency* ~~Department of Professional Regulation~~ shall make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause, except that, with respect to medical review committee records, the provisions of s. 766.101 control.

(9) The *agency* ~~department~~ shall review, no less frequently than annually, the risk management program of each health maintenance organization regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under subsections (5) and (6).

(11) If the *agency* ~~department~~, through its receipt of the annual reports prescribed in subsection (5) or through any investigation, has a reasonable belief that conduct by a provider, staff member, or employee

of a health maintenance organization may constitute grounds for disciplinary action by the appropriate regulatory board, the *agency* ~~department~~ shall report this fact to the regulatory board.

(12) The agency shall send information bulletins to all health maintenance organizations as necessary to disseminate trends and preventive data derived from its actions under this section or under s. 395.0197.

The gross data compiled pursuant to this section or s. 395.0197 shall be furnished by the *agency* ~~department~~ upon request to health maintenance organizations to be utilized for risk management purposes. The *agency* ~~department~~ may *adopt* ~~promulgate~~ rules necessary to carry out the provisions of this section.

Section 206. Section 641.56, Florida Statutes, is amended to read:

641.56 Rulemaking authority.—The *agency may adopt* ~~department is authorized to make~~ rules, not inconsistent with law, which may be necessary to carry out the duties and authority conferred upon the *agency* ~~department~~ by this part and to protect the health, safety, and welfare of the public.

Section 207. Section 641.57, Florida Statutes, is amended to read:

641.57 Disposition of moneys collected under this part.—Fees, administrative penalties, examination expenses, and other sums collected by the *agency* ~~department~~ under this part shall be deposited to the credit of the Health Maintenance Organization Quality Care Trust Fund to be administered by the *agency* ~~department~~ and shall be used to defray the expenses of the department in the discharge of its administrative and regulatory powers and duties as prescribed by this part, including the maintaining of offices and necessary supplies therefor, essential equipment and other materials, salaries and expenses of required personnel, and all other legitimate expenses relating to the discharge of the administrative and regulatory powers and duties imposed under such laws.

Section 208. Section 641.58, Florida Statutes, is amended to read:

641.58 Health maintenance organization and prepaid health clinic regulatory assessment; levy and amount; use of funds; tax returns; penalty for failure to pay.—

(1) In addition to any other license or excise tax now or hereafter imposed, and such taxes as may be imposed under other statutes, there is hereby assessed and imposed upon every health maintenance organization and every prepaid health clinic authorized to engage in business in this state, an annual regulatory assessment not to exceed 0.1 percent of the gross amount of premiums collected by each organization and clinic on contracts or certificates issued to subscribers in this state. For the purpose of this section, "premium" shall include all prepaid per capita fees and prepaid aggregate fees, by whatever name called, *except fees paid by the Division of State Health Purchasing of the agency for the purchase of Medicaid services, which are exempt from this assessment.* The assessment shall be payable annually on or before April 1 to the *agency* ~~department~~ by each organization and clinic on such premiums collected by each during the preceding calendar year, and shall be deposited into the Health Maintenance Organization Quality Care Trust Fund.

(2) The Department of Insurance shall determine the amount of gross premiums for the purposes of the regulatory assessment whereupon the *agency* ~~department~~ shall determine on or before December 1 of each year the regulatory assessment percentage necessary to be imposed for that calendar year, payable on or before the following April 1, as herein prescribed, to provide the funds appropriated to the *agency* ~~department~~ to carry out the provisions of subsection (4).

(3) The *agency* ~~department~~ shall make and issue its order setting the regulatory assessment percentage for that calendar year, payable on or before April 1 of the following year, and shall mail a copy of such order to each health maintenance organization and prepaid health clinic.

(4) The moneys so received and deposited into the Health Maintenance Organization Quality Care Trust Fund shall be used to defray the expenses of the *agency* ~~department~~ are hereby appropriated for use to defray the expenses of the *agency* ~~department~~ in the discharge of its administrative and regulatory powers and duties as prescribed by part III of this chapter, including the maintaining of offices and necessary supplies therefor, essential equipment and other materials, salaries and expenses of required personnel, and all other legitimate expenses relating to the discharge of the administrative and regulatory powers and duties imposed under such part.

(5) If, at the end of any fiscal year, an unencumbered balance of funds received from the regulatory assessment imposed by this section remains in the Health Maintenance Organization Quality Care Trust Fund, such balance shall not revert to the General Revenue Fund of the state, but shall be retained in the Health Maintenance Organization Quality Care Trust Fund to be used for the purposes set forth above. The *agency* ~~department~~ shall take into account the amount of any such remaining funds when determining the regulatory assessment percentage for each calendar year.

(6) Tax returns with respect to the regulatory assessment prescribed by this section shall be made by each entity liable for payment of such tax on forms to be prescribed by the *agency* ~~department~~ and sworn to by one or more of the executive officers or other persons charged under the law with the management of the entity. In the event of an overpayment on account of the assessment, a refund of the overpayment may be made to the remitter.

(7) If any health maintenance organization or prepaid health clinic fails to pay the assessment required by this section on or before April 1 of each year, the *agency* ~~department~~ may suspend or revoke its health care provider certificate or impose any other administrative penalties provided under law.

Section 209. Effective October 1, 1993, section 651.118, Florida Statutes, is amended to read:

651.118 *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~; certificates of need; sheltered beds; community beds.—

(1) The provisions of this section shall control in the case of conflict with the provisions of the Health Facility and Services Development Act, *ss. 408.031-408.045* ~~ss. 381.701-381.715~~; the provisions of chapter 395; or the provisions of parts I and II of chapter 400.

(2) The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall issue a certificate of need to any holder of a provisional certificate of authority pursuant to s. 651.022 to construct nursing home beds for the exclusive use of the prospective residents of the proposed continuing care facility if the holder of the provisional certificate of authority meets the *agency's* ~~Department of Health and Rehabilitative Services'~~ applicable review criteria, utilizing the bed need provisions of subsection (4).

(3) Nursing home beds located within a continuing care facility for which a certificate of need is issued pursuant to subsection (2) shall be known as sheltered nursing home beds.

(4) The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall approve one sheltered nursing home bed for every four proposed residential units in the continuing care facility unless the provider demonstrates the need for a lesser number of sheltered nursing home beds based on proposed utilization by prospective residents or demonstrates the need for additional sheltered nursing home beds based on actual utilization and demand by current residents.

(5) Construction on any sheltered nursing home beds shall not begin until the holder of the provisional certificate of authority has been issued a certificate of authority pursuant to s. 651.021 and a certificate of need from the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~.

(6) Unless the provider already has a component which is to be a part of the continuing care facility and which is licensed pursuant to chapter 395, or part I or part II of chapter 400 at the time of construction of the continuing care facility, the provider shall construct the nonnursing home portion of the facility and the nursing home portion of the facility at the same time. If a provider constructs less than the number of residential units approved in the certificate of authority, the number of licensed sheltered nursing home beds shall be reduced by a proportionate share.

(7) Notwithstanding the provisions of subsection (2), at the discretion of the continuing care provider, sheltered nursing home beds may be used for persons who are not residents of the facility, and who are not parties to a continuing care contract, for a period of up to 5 years from the date of issuance of the initial nursing home license.

(8) This section shall not preclude a continuing care provider from applying to the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ for a certificate of need for commu-

nity nursing home beds or a combination of community and sheltered nursing home beds. Any nursing home bed located in a continuing care facility that is or has been issued for nonrestrictive use shall retain its legal status as a community nursing home bed unless the provider requests a change in status. Any nursing home bed located in a continuing care facility and not issued as a sheltered nursing home bed prior to 1979 shall be classified as a community bed. The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ may require continuing care facilities to submit bed utilization reports for the purpose of determining community and sheltered nursing home bed inventories based on historical utilization by residents and nonresidents.

(9) Whenever the department has been appointed receiver of a provider pursuant to the provisions of part I of chapter 631, the receiver may petition, upon approval of the court having jurisdiction as being in the best interest of the residents, the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ for the conversion of sheltered nursing home beds of the facility to community nursing home beds. The *agency* ~~Department of Health and Rehabilitative Services~~ shall, upon petition of the receiver and through an expedited review, issue a certificate of need converting the sheltered nursing home beds to community nursing home beds. The court having jurisdiction of the delinquency proceeding shall enforce the provisions of this section.

(10) For a provider issued a provisional certificate of authority after July 1, 1986, to operate a facility not previously regulated under this chapter, the following criteria shall be met in order to obtain a certificate of need for sheltered beds pursuant to subsections (2), (3), (4), (5), (6), and (7):

(a) Seventy percent or more of the current residents hold continuing care agreements pursuant to s. 651.011(2) or, if the facility is not occupied, 70 percent or more of the prospective residents will hold continuing care agreements pursuant to s. 651.011(2) as projected in the feasibility study and demonstrated by the provider's marketing practices; and

(b) The continuing care agreements entered into or to be entered into by 70 percent or more of the current residents or prospective residents pursuant to s. 651.011(2) shall provide nursing home care for a minimum of 360 cumulative days, and the holders of the continuing care agreements shall be charged at rates which are 80 percent or less than the rates charged by the provider to persons receiving nursing home care who have not entered into continuing care agreements pursuant to s. 651.011(2).

Section 210. Subsection (3) of section 743.0645, Florida Statutes, is amended to read:

743.0645 Other persons who may consent to medical care or treatment of a minor.—

(3) The Department of Health and Rehabilitative Services caseworker assigned to the child or the administrator of any facility licensed by *the Agency for Health Care Administration or* the department under s. 393.067, s 394.875, or s. 409.175 may consent to the medical care or treatment of any minor committed to it or in its custody under chapter 39, when the person who has the power to consent as otherwise provided by law cannot be contacted and such person has not expressly objected to such consent. There shall be maintained in the records of the minor documentation that a reasonable attempt was made to contact the person who has the power to consent as otherwise provided by law.

Section 211. Effective July 1, 1993, paragraph (d) of subsection (3) of section 766.1115, Florida Statutes, 1992 Supplement, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

(3) DEFINITIONS.—As used in this section, the term:

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician licensed, or physician assistant certified, under chapter 458.

5. An osteopathic physician licensed, or osteopathic physician assistant certified, under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatrist licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under chapter 464 or any facility which employs nurses licensed or registered under chapter 464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association and its employees or a corporate medical group and its employees.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.

13. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(c) of the Internal Revenue Code which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, *a community mental health center as defined in chapter 394,* and any volunteer corporation or volunteer health care provider that delivers health care services.

Section 212. Paragraph (b) of subsection (9) of section 768.28, Florida Statutes, 1992 Supplement, is amended to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions.—

(9)

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, any health care provider when providing services pursuant to s. 766.1115, any member of the Florida Health Services Corps, as defined in s. *381.0302* ~~381.90~~, who provides uncompensated care to medically indigent persons referred by the Department of Health and Rehabilitative Services, and any public defender or his employee or agent, including, among others, an assistant public defender and an investigator.

Section 213. Section 15 of chapter 92-178, Laws of Florida, is amended to read:

Section 15. This act shall apply to referrals for designated health services made on or after the effective date of this act, provided that with respect to an investment interest acquired before May 1, 1992, paragraph (a) of subsection (4) of section 7 shall not apply to referrals for designated health services occurring before *October 1, 1994* ~~October 1, 1995~~, and provided, further, that paragraphs (b)-(g) of subsection (4) of section 7 shall be effective on July 1, 1992, and provided further, that with respect to a facility which is providing a designated health service or other health care items or service which received its certificate of occupancy and began providing that service at that facility after May 1, 1991, and before January 1, 1992, section 7(4)(a)-(g) inclusive of this act shall not apply to referrals for such designated health services and other items or services occurring before October 1, 1996.

Section 214. Effective January 1, 1994, subsection (1) of section 627.410, Florida Statutes, 1992 Supplement, is amended to read:

627.410 Filing, approval of forms.—

(1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the department at its offices in Tallahassee by or in behalf of the insurer which proposes to use such form and has been approved by the department. This provision does not apply to

surety bonds or to specially rated inland marine risks, nor to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to health insurance), or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state *for groups as specified in s. 627.6515(2)* shall be filed with the department for information purposes only.

Section 215. Effective October 1, 1993, paragraph (c) of subsection (2) of section 627.4106, Florida Statutes, 1992 Supplement, is amended to read:

627.4106 Small group health insurance; rates; restrictions.—

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

(c) "Health benefit plan" means any hospital or medical policy or certificate or any health maintenance organization subscriber contract. "Health benefit plan" does not include *specified disease,* accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation and employers' liability or similar insurance, or motor vehicle medical-payment insurance.

Section 216. (1) Effective October 1, 1993, section 627.6699, Florida Statutes, 1992 Supplement, is amended to read:

627.6699 Employee Health Care Access Act.—

(1) SHORT TITLE.—This section may be cited as the "Employee Health Care Access Act."

(2) PURPOSE AND INTENT.—The purpose and intent of this section is to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status, to establish rules regarding renewability of that coverage, to establish limitations on the use of exclusions for preexisting conditions, to provide for development of a standard health benefit plan and a basic health benefit plan to be offered to all small employers, to provide for establishment of a reinsurance program for coverage of small employers, and to improve the overall fairness and efficiency of the small group health insurance market.

(3) DEFINITIONS.—As used in this section, *the term*:

(a) "Actuarial certification" means a written statement, by a member of the American Academy of Actuaries or another person acceptable to the department, that a small employer carrier is in compliance with subsection (6), based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans.

(b)~~(a)~~ "Basic health benefit plan" and "standard health benefit plan" mean low-cost health care plans developed pursuant to subsection *(12)*~~(9)~~.

(c)~~(b)~~ "Board" means the board of directors of the program.

(d)~~(c)~~ "Carrier" means a person who provides health benefit plans in this state, including an authorized insurer, a health maintenance organization, a multiple-employer welfare arrangement, or any other person providing a health benefit plan that is subject to insurance regulation in this state. However, *the term* ~~"carrier"~~ does not include a multiple-employer welfare arrangement established by an association of members ~~of the same profession~~, which multiple-employer welfare arrangement operates solely for the benefit of the members or the members and the employees of such members, *and* was in existence on January 1, 1992~~, and provides coverage for any member of the association with 11 or more employees or any such member and dependents of the member, upon the member's request for such coverage~~.

(e)~~(d)~~ "Case management program" means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the carrier.

(f)~~(e)~~ "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the health benefit plan covering that employee.

(g)~~(f)~~ "Eligible employee" means an employee who works full time, having a normal workweek of *25* ~~30~~ or more hours, and who has met any applicable waiting-period requirements *or other requirements of this act.* The term includes *a self-employed individual,* a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.

(h)~~(g)~~ "Established geographic area" means the county or counties, or any portion of a county or counties, within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(i) "Guarantee-issue basis" means an insurance policy that must be offered to an employer, employee, or dependent of the employee, regardless of health status, preexisting conditions, or claims history.

(j)~~(h)~~ "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(k)~~(i)~~ "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the initial enrollment period provided under the terms of the plan has ended. However, an eligible employee or dependent is not considered a late enrollee if the enrollee:

1. Was covered under another employer health benefit plan at the time the individual was eligible to enroll; lost coverage under that plan as a result of termination of employment, the termination of the other plan's coverage, the death of a spouse, or divorce; and requests enrollment within 30 days after coverage under that plan was terminated;

2. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

3. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(l)~~(j)~~ "Limited benefit policy or contract" means a policy or contract that provides coverage for each person insured under the policy for a specifically named disease or diseases, a specifically named accident, or a specifically named limited market that fulfills an experimental or reasonable need, such as the small group market.

(m) "Modified community rating" means a rating methodology in which the premium for all persons covered in each subgroup is the same and each subgroup is determined solely with respect to the insured's gender, age, tobacco usage, and geographic area.

(n)~~(k)~~ "Participating carrier" means any carrier that issues health benefit plans in this state except a small employer carrier that elects to be a risk-assuming carrier.

(o)~~(l)~~ "Plan of operation" means the plan of operation of the program, including articles, bylaws, and operating rules, adopted by the board *under* ~~pursuant to~~ subsection *(11)*~~(8)~~.

(p)~~(m)~~ "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to:

1. A condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition; or

2. Pregnancy existing on the effective date of coverage.

(q)~~(n)~~ "Program" means the Florida Small Employer Carrier Reinsurance Program created under subsection *(11)*~~(8)~~.

(r)~~(o)~~ "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

1. An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health plan; or

2. An individual health insurance policy, including coverage issued by a health maintenance organization, a fraternal benefit society, or a multiple-employer welfare arrangement, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least 1 year.

(s) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(t)~~(p)~~ "Reinsuring carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection *(11)*~~(8)~~.

(u)~~(q)~~ "Risk-assuming carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection *(10)*~~(7)~~.

(v) "Self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years.

(w)~~(r)~~ "Small employer" means any person, *sole proprietor, self-employed individual, independent contractor,* firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50 percent of its working days during the preceding calendar quarter, employed ~~at least 3, but~~ not more than *50* ~~25~~, eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, may be considered a single employer. *For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.*

(x)~~(s)~~ "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers.

(4) APPLICABILITY AND SCOPE.—

(a) This section applies to a health benefit plan that provides coverage to a small employer in this state, *unless the policy is marketed directly to the individual employee, and the employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy in any manner.* ~~if:~~

~~1. Any portion of the premium or benefits is paid by a small employer;~~

~~2. Any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium; or~~

~~3. The plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of s. 106, s. 125, or s. 162 of the United States Internal Revenue Code.~~

(b) With respect to a group of affiliated carriers or a group of carriers that is eligible to file a consolidated tax return, any restrictions, limitations, or requirements of this section that apply to one of the carriers applies to all of the carriers as if they were one carrier. However, with respect to affiliated companies, all of which are in existence and affiliated on January 1, 1992, the group of affiliated companies is considered one carrier only after one member of the group transfers any small employer business to another member of the group.

(c) An affiliated carrier that is a health maintenance organization having a certificate of authority under part I of chapter 641 may be considered a separate carrier for the purposes of this section.

(d) This section shall not apply to a carrier that does not issue new health benefit plans to small employers on or after January 1, 1994, except that it shall apply to any such carrier that renews a health benefit plan on or after January 1, 1995

(5) AVAILABILITY OF COVERAGE.—

(a) Beginning January 1, 1993, every small employer carrier issuing new health benefit plans to small employers in this state must, as a condition of transacting business in this state, offer to eligible small employers a standard health benefit plan and a basic health benefit plan. Such a small employer carrier shall issue a standard health benefit plan or a basic health benefit plan to every eligible small employer that elects to be covered under such plan, agrees to make the required premium payments under such plan and to satisfy the other provisions of the plan.

(b) In the case of a small employer carrier which does not, on or after January 1, 1993, offer coverage but which does, on or after January 1, 1993, renew or continue coverage in force, such carrier shall be required to provide coverage to newly eligible employees and dependents on the same basis as small employer carriers which are offering coverage on or after January 1, 1993.

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Beginning January 1, 1994, offer and issue basic and standard small employer health benefit plans on a guarantee-issue basis to every eligible small employer, with three to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan.

2. Beginning April 15, 1994, offer and issue basic and standard small employer health benefit plans on a guarantee-issue basis to every eligible small employer, with one or two eligible employees, which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan.

~~(b) In the case of a small employer carrier that establishes more than one class of business, the small employer carrier shall offer, upon request, and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:~~

~~1. The criteria are not intended to discourage or prevent acceptance of small employers from applying for a basic or standard health benefit plan.~~

~~2. The criteria are not related to the health status or claims experience of the small employer.~~

~~3. The criteria are applied consistently to all small employers applying for coverage in the class of business.~~

~~4. The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.~~

(d)~~(c)~~ A small employer carrier must file with the department, in a format and manner prescribed by the committee, a standard health care plan and a basic health care plan to be used by the carrier.

(e)~~(d)~~ The department at any time may, after providing notice and an opportunity for a hearing, disapprove the continued use by the small employer carrier of the standard or basic health benefit plan on the grounds that such plan does not meet the requirements of this section.

(f)~~(e)~~ A health *benefit* ~~care~~ plan covering small employers, issued or renewed on or after October 1, 1992, must comply with the following provisions:

1. Preexisting condition provisions must not exclude coverage for a period beyond 12 months following the individual's effective date of coverage; and

2. *Preexisting condition provisions* may ~~only~~ relate *only* to:

a. Conditions that, during the 6-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(g) A health benefit plan covering small employers, issued or renewed on or after January 1, 1994, must comply with the following conditions:

1. All health benefit plans must be offered and issued on a guarantee-issue basis.

2. The provisions of paragraph (f) apply to health benefit plans issued to a small employer who has three or more eligible employees, and to health benefit plans that are issued to a small employer who has fewer than three eligible employees and that cover an employee who has had qualifying previous coverage continually to a date not more than 30 days before the effective date of the new coverage.

3. With respect to any employee or dependent excluded from coverage due to disease or medical condition or whose coverage had been restricted for certain diseases or medical conditions prior to January 1, 1993, and who has continued to be an eligible employee or dependent as of April 1, 1993, an open enrollment period shall be provided for a 90-day period beginning within 60 days following the effective date of this act, during which period any such employee or dependent shall be entitled to be included within coverage and or issued coverage without restrictions for certain diseases or medical conditions.

4. For health benefit plans that are issued to a small employer who has fewer than three employees and that cover an employee who has not been continually covered by qualifying previous coverage within 30 days before the effective date of the new coverage, preexisting condition provisions must not exclude coverage for a period beyond 24 months following the employee's effective date of coverage and may relate only to:

a. Conditions that, during the 24-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(h) All health benefit plans issued under this section must comply with the following conditions:

1.~~2.~~ In determining whether a preexisting condition provision applies to an eligible employee or dependent, credit must be given for the time the person was covered under qualifying previous coverage if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under the plan.

2.~~3.~~ Late enrollees may be excluded from coverage only for the greater of 18 months or the period of an 18-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months after the effective date of coverage. *For employers who have fewer than three employees, a late enrollee may be excluded from coverage for no longer than 24 months if he was not covered by qualifying previous coverage continually to a date not more than 30 days before the effective date of his new coverage.*

3.~~4.~~ Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

4.~~5.~~a. Except as provided in sub-subparagraph b., in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

b. With respect to a small employer with 10 or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

5.~~6.~~ A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

6.~~7.~~ If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

7.~~8.~~ A small employer carrier *may* ~~shall~~ not modify *any health benefit plan issued to a small employer* ~~a standard or basic health benefit plan~~ with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the ~~standard or basic~~ health benefit plan.

8.~~9.~~ An initial enrollment period of at least 30 days must be provided.

(i)~~(f)~~1. A small employer carrier need not offer coverage or accept applications pursuant to paragraph (a):

a. To a small employer if the small employer is not physically located in an established geographic service area of the small employer carrier, *provided such geographic service area shall not be less than a county*;

b. To an employee if the employee does not work or reside within an established geographic service area of the small employer carrier; or

c. To a small employer group within an area in which the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the department, that it cannot, within its network of providers, deliver service adequately to the members of such groups because of obligations to existing group contract holders and enrollees.

2. A small employer carrier that cannot offer coverage pursuant to sub-subparagraph 1.c. may not offer coverage in the applicable area to new cases of employer groups having more than *50* ~~25~~ eligible employees or small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the department that it has regained its ability to deliver services to small employer groups.

3.a. The department shall, by rule, require each small employer carrier to report, along with its annual statement for calendar year 1992, its gross annual premiums for health benefit plans issued to small employers during calendar year 1992, including both new and renewal business. No later than May 1, 1993, the department shall calculate each carrier's percentage of all small employer carrier premiums for calendar year 1992.

b. During calendar year 1993, a small employer carrier may elect to not offer coverage or accept applications pursuant to paragraph (a):

(I) After its gross annual premiums for all small employer group health benefit plans written or renewed for that year, excluding blocks of business assumed from other carriers, exceeds 25 percent of the total of all small employer carrier premiums for calendar year 1992; or

(II) After its gross annual premiums for small employer group health benefit plans written or renewed for that year, excluding blocks of business assumed from other carriers, exceeds three times that carrier's gross annual premiums for small employer group health benefit plans written or renewed during calendar year 1992, if its share of small employer carrier business for calendar year 1992 calculated under sub-subparagraph a. exceeds 2 percent.

c. The election under sub-subparagraph b. is effective upon filing of a notice of election with the department. The department may, within 30 days after the filing of the notice, disapprove the election if it finds that the carrier does not meet the criteria of sub-subparagraph b. If the department disapproves the election, the carrier is subject to paragraph (a), effective on the date of such disapproval.

d. An election under sub-subparagraph b. expires on December 31, 1993, or upon revocation, whichever occurs earlier.

e. A carrier may file with the department a notice revoking its election under sub-subparagraph b. after the election has been in effect for at least 3 months. Such revocation of an election takes effect on the first day of the calendar quarter following the filing of such notice with the department and subjects the carrier to all requirements of paragraph (a).

f. While a carrier's election under sub-subparagraph b. is in effect, the carrier may not write any further small employer group health benefit plans.

g. A carrier may not make an election under sub-subparagraph b. more than once.

4.a. Beginning in 1994, the department shall, by rule, require each small employer carrier to report, on or before March 1 of each year, its gross annual premiums for all health benefit plans issued to small employers during the previous calendar year, and also to report its gross annual premiums for new, but not renewal, standard and basic health benefit plans subject to this section issued during the previous calendar year. No later than May 1 of each year, the department shall calculate each carrier's percentage of all small employer group health premiums for the previous calendar year and shall calculate the aggregate gross annual premiums for new, but not renewal, standard and basic health benefit plans for the previous calendar year.

b. Beginning with calendar year 1994, a small employer carrier may elect to not offer coverage or accept applications pursuant to paragraph (a):

(I) After its gross annual premiums for new, but not renewal, ~~standard and basic~~ health benefit plans subject to this section for that year, excluding blocks of business assumed from other carriers, exceeds 25 percent of the aggregate gross annual premiums for new, but not renewal, ~~standard and basic~~ health benefit plans subject to this section for the previous calendar year as determined under sub-subparagraph a.; or

(II) After its gross annual premiums for new, but not renewal, ~~standard and basic~~ health benefit plans subject to this section, excluding blocks of business assumed from other carriers, exceeds three times the carrier's percentage of all small employer group premiums for the previous calendar year as determined under sub-subparagraph a., multiplied by the aggregate gross annual premiums for new ~~standard and basic~~ health benefit plans for the previous year as determined under sub-subparagraph a. A carrier may not exercise this option unless its percentage of all small employer group premiums for the previous calendar year as determined under sub-subparagraph a. exceeds 2 percent.

c. The election under sub-subparagraph b. is effective upon filing of a notice of election with the department. The department may, within 30 days after the filing of the notice, disapprove the election if it finds that the carrier does not meet the criteria of sub-subparagraph b. If the department disapproves the election, the carrier is subject to paragraph (a), effective on the date of such disapproval.

d. An election under sub-subparagraph b. expires on December 31 of the year in which the election was made or upon revocation, whichever occurs earlier.

e. A carrier may file with the department a notice revoking its election under sub-subparagraph b. after the election has been in effect for at least 3 months. Such revocation of an election takes effect on the first day of the calendar quarter following the filing of such notice with the department and subjects the carrier to all requirements of paragraph (a).

f. While a carrier's election under sub-subparagraph b. is in effect, the carrier may not write any further new small employer group health benefit plans during the remainder of the calendar year.

g. A carrier may not make an election under sub-subparagraph b. more than once in any calendar year.

(j)~~(g)~~ A small employer carrier may not offer coverage or accept applications pursuant to paragraph (a) if the department finds that the acceptance of an application or applications would endanger the financial condition of the small employer carrier or endanger the interests of the small employer carrier's insureds.

(k) The boundaries of geographic areas used by a small employer carrier must coincide with county lines. A carrier may not apply different geographic rating factors to the rates of small employers located within the same county.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

(a) The department may, by rule, establish regulations to administer this section and to assure that rating practices used by small employer carriers are consistent with the purpose of this section, including assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers on or after January 1, 1994, premium rates for health benefits plans subject to this section are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, tobacco use, or geographic area as determined under paragraph (5)(k).

2. Rating factors related to age, gender, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to department review and approval in accordance with ss. 627.410 and 627.411.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed.

4. Carriers participating in a community health purchasing alliance, in accordance with ss. 408.701-408.705, may apply a different community rate to business written in that program.

(c) For all small employer health benefit plans that are subject to this section, that are issued by small employer carriers before January 1, 1994, and that are renewed on or after January 1, 1995, renewal rates must be based on the same modified community rating standard applied to new business.

(d) Notwithstanding s. 627.401(2), this section and ss. 627.410 and 627.411 apply to any health benefit plan provided by a small employer carrier that provides coverage to one or more employees of a small employer regardless of where the policy, certificate, or contract is issued or delivered, if the health benefit plan covers employees or their covered dependents who are residents of this state.

(7) RENEWABILITY OF COVERAGE.—

(a) Except as provided in paragraph (b), a health benefit plan that is subject to this section is renewable for all eligible employees and dependents at the option of the small employer, except for any of the following reasons:

1. Nonpayment of required premiums;

2. Fraud or misrepresentation by the small employer or fraud or misrepresentation by the insured individual or subscriber or the individual's or subscriber's representative;

3. Noncompliance with plan provisions;

4. Noncompliance with the carrier's minimum participation requirements;

5. Noncompliance with the carrier's employer contribution requirements;

6. The small employer's termination of the business in which it was engaged on the effective date of the plan; or

7. A determination by the department that the continuation of the coverage is not in the best interest of the policyholders or certificateholders or will impair the carrier's ability to meet its contractual obligations. In such instances, the department must assist affected small employers in finding replacement coverage

(8) MAINTENANCE OF RECORDS.—

(a) Each small employer carrier must maintain at its principal place of business a complete and detailed description of its rating practices and renewal practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier must file with the department on or before March 15 of each year an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. The certification must be in a form and manner and contain the information prescribed by the department. The carrier must retain a copy of the certification at its principal place of business.

(c) A small employer carrier must make the information and documentation described in paragraph (a) available to the department upon request. The information constitutes proprietary and trade secret information and may not be disclosed by the department to persons outside the department, except as agreed to by the carrier or as ordered by a court of competent jurisdiction. The exemption from s. 119.07 provided in this paragraph is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(d) Each small employer carrier must file with the department quarterly an enrollment report as directed by the department. Such report shall not constitute proprietary or trade secret information.

(9)~~(6)~~ SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.—

(a) A small employer carrier must elect to become either a risk-assuming carrier or a reinsuring carrier. *Each small employer carrier must make an initial election, binding through January 1, 1994.* ~~The election is binding for a 5-year period, except that~~ The carrier's initial election must be made no later than October 31, 1992~~, and is binding for 2 years~~. *By October 31, 1993, all small employer carriers must file a final election, which is binding for 2 years, from January 1, 1994 through December 31, 1995, after which an election shall be binding for a period of 5 years.* Any carrier that is not a small employer carrier on October 31, 1992, and intends to become a small employer carrier after October 31, 1992, must file its designation when it files the forms and rates it intends to use for small employer group health insurance; such designation shall be binding for 2 years after the date of approval of the forms and rates, and any subsequent designation is binding for 5 years. The department may permit a carrier to modify its election at any time for good cause shown, after a hearing.

(b) The department shall establish an application process for small employer carriers seeking to change their status under this subsection.

(c) An election to become a risk-assuming carrier is subject to approval under subsection *(10)*~~(7)~~.

(d) A small employer carrier that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan *under* ~~pursuant to~~ subsection *(11)*~~(8)~~ as soon as the carrier becomes a risk-assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans under the terms set forth in subsection *(11)*~~(8)~~ and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

(10)~~(7)~~ ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—

(a)1. A small employer carrier may become a risk-assuming carrier by filing with the department a designation of election under subsection *(9)*~~(6)~~ in a format and manner prescribed by the department. The department shall approve the election of a small employer carrier to become a risk-assuming carrier if the department finds that the carrier is capable of assuming that status pursuant to the criteria set forth in paragraph (b).

2. The department must approve or disapprove any designation as a risk-assuming carrier within 60 days after filing.

(b) In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the department shall consider:

1. The carrier's financial ability to support the assumption of the risk of small employer groups.

2. The carrier's history of rating and underwriting small employer groups.

3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable.

4. The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance program provided in subsection *(11)*~~(8)~~.

(c) A small employer carrier that becomes a risk-assuming carrier pursuant to this subsection is not subject to the assessment provisions of subsection *(11)*~~(8)~~.

(d) The department shall provide public notice of a small employer carrier's designation of election under subsection *(9)*~~(6)~~ to become a risk-assuming carrier and shall provide at least a 21-day period for public comment prior to making a decision on the election. The department shall hold a hearing on the election at the request of the carrier.

(e) The department may rescind the approval granted to a risk-assuming carrier under this subsection if the department finds that the carrier no longer meets the criteria of paragraph (b).

~~(f) A risk-assuming carrier shall make available to all small employers in this state, throughout the year and without regard to the health status or industry of the eligible employees and dependents of the small employers, health benefit plans that provide at least that coverage provided by a standard health benefit plan and a basic health benefit plan complying with subsection (9).~~

(11)~~(8)~~ SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—

(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."

(b)1. The program shall operate subject to the supervision and control of the board.

2. Until December 31, 1993, the board shall consist of the commissioner or his designee, who shall serve as chairman, and seven additional members appointed by the commissioner on or before May 1, 1992, as follows:

a. One member shall be a representative of the largest health insurer in the state, as determined by market share as of December 31, 1991.

b. One member shall be a representative of the largest health maintenance organization in the state, as determined by market share as of December 31, 1991.

c. Three members shall be selected from a list of individuals recommended by the Health Insurance Association of America.

d. Two members shall be selected from a list of individuals recommended by the Florida Insurance Council.

The terms of members appointed under this subparagraph expire on December 31, 1993. The appointment of a member under this subparagraph does not preclude the commissioner from appointing the same person to serve as a member under subparagraph 3.

3. Beginning January 1, 1994, the board shall consist of the commissioner or his designee, who shall serve as chairman, and eight additional members who are representatives of carriers and are appointed by the commissioner and serve as follows:

a. The commissioner shall include representatives of small employer carriers subject to assessment under this subsection. If two or more carriers elect to be risk-assuming carriers, the membership must include at least two representatives of risk-assuming carriers; if one carrier is risk-assuming, one member must be a representative of such carrier. At least one member must be a carrier who is subject to the assessments, but is not a small employer carrier. Subject to such restrictions, at least five members shall be selected from individuals recommended by small employer carriers pursuant to procedures provided by rule of the department.

b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the commissioner shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.

4. The commissioner may remove a member for cause.

5. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.

6. The commissioner may require an entity that recommends persons for appointment to submit additional lists of recommended appointees.

(c)1.a. No later than August 15, 1992, the board shall submit to the department a plan of operation to assure the fair, reasonable, and equitable administration of the program. The board may at any time submit to the department any amendments to the plan that the board finds to be necessary or suitable.

b. No later than September 15, 1992, the department shall, after notice and hearing, approve the plan of operation if it determines that the plan submitted by the board is suitable to assure the fair, reasonable, and equitable administration of the program and provides for the sharing of program gains and losses equitably and proportionately in accordance with paragraph (j).

c. The plan of operation, or any amendment thereto, becomes effective upon written approval of the department.

2. If the board fails to submit a suitable plan of operation by August 15, 1992, the department shall, after notice and hearing, adopt a temporary plan of operation by September 15, 1992. The department shall amend or rescind the temporary plan of operation, as appropriate, after it approves a suitable plan of operation submitted by the board.

(d) The plan of operation must, among other things:

1. Establish procedures for handling and accounting for program assets and moneys and for an annual fiscal reporting to the department.

2. Establish procedures for selecting an administering carrier and set forth the powers and duties of the administering carrier.

3. Establish procedures for reinsuring risks.

4. Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses, *other than amounts payable to the administrative carrier*, incurred or estimated to be incurred during the period for which the assessment is made.

5. Provide for any additional matters at the discretion of the board.

(e) The board shall:

1. Recommend to the department market conduct requirements and other requirements for carriers and agents, including requirements relating to:

a. Registration by each carrier with the department of its intention to be a small employer carrier under this section;

b. Publication by the department of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;

c. The availability of a broadly publicized, toll-free telephone number for access by small employers to information concerning this section;

d. Periodic reports by carriers and agents concerning health benefit plans issued; and

e. Methods concerning periodic demonstration by small employer carriers and agents that they are marketing or issuing health benefit plans to small employers.

2. *By January* ~~No later than October~~ 1, 1995, the board shall conduct a study of the effectiveness of this section and may recommend, to the department, improvements to achieve greater rate stability, accessibility, and affordability in the small employer marketplace.

(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals. In addition thereto, the program has specific authority to:

1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.

2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.

3. Take any legal action necessary to avoid the payment of improper claims against the program.

4. Issue reinsurance policies, in accordance with the requirements of this act.

5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.

6. Establish actuarial functions as appropriate for the operation of the program.

7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.

8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.

9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.

10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation.

(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:

1. With respect to a standard and basic health care plan, the program must reinsure the level of coverage provided; and, with respect to any other plan, the program must reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan.

2. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a ~~reinsured~~ small employer may be reinsured within 60 days after the commencement of his coverage.

3. A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan. The carrier may choose to reinsure newly eligible employees and dependents of the reinsured group pursuant to subparagraph 1.

4. The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.

5. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the department approves a lower adjustment factor.

6. A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.

7. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 4., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 4. which may not be ceded to the program.

8. The board may consider adjustments to the premium rates charged

for reinsurance by the program for carriers that use effective cost-containment measures, including high-cost case management, as defined by the board.

9. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed-care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.

(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the department, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan. The premium rates set by the board may vary by geographical *area, as determined under this section,* ~~territory~~ to reflect differences in cost. The multiplying factors *must* ~~shall~~ be established as follows:

a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.

b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.

2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates which shall be subject to the approval of the department.

(i) If a health benefit plan for a small employer issued in accordance with this subsection is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must be consistent with the requirements relating to premium rates set forth in s. 627.4106.

(j)1. *Before* ~~Prior to~~ March 1 of each calendar year, the board shall determine and report to the department the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. *Except as provided in paragraph (n),* risk assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers *for operating losses of the plan* based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year ~~preceding that~~ for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

c. Subject to the approval of the department, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. *Before* ~~Prior to~~ March 1 of each year, the board shall determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the department within 90 days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the department within 90 days following the end of the applicable calendar year, the department may evaluate the operations of the program and implement such amendments to the plan of operation the department deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the commissioner, a deferment, in whole or in part, from any assessment made by the board. The department may defer, in whole or in part, the assessment of a carrier if, in the opinion of the department, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.

(l) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(m) The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the

department any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The department shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the Insurance Code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the department.

(n) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.

(12)~~(9)~~ STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.—

(a)1. *By May 15, 1993* ~~No later than May 15, 1992~~, the commissioner shall appoint a health benefit plan committee composed of four representatives of carriers *which shall include at least two representatives of HMO's, at least one of which is a staff model HMO, two representatives of agents, four* ~~two~~ representatives of small employers, and one employee of a small employer. The carrier members shall be selected from a list of individuals recommended by the board. The commissioner may require the board to submit additional recommendations of individuals for appointment. *As community health purchasing alliances are established under s. 408.703, each such organization shall also appoint an additional member to the committee.*

2. The committee shall develop *changes to* the form and level of coverages for the standard health benefit plan and the basic health benefit plan, and shall submit the forms, and levels of coverages to the department by *September 30, 1993* ~~July 1, 1992~~. The department must approve such forms and levels of coverages by *November 30, 1993* ~~August 1, 1992~~, and may return the submissions to the committee for modification on a schedule that allows the department to grant final approval by *November 30, 1993* ~~August 1, 1992. The committee ceases to exist upon the granting of such final approval~~.

3. The plans shall comply with all of the requirements of this subsection.

4. The plans must be filed with and approved by the department prior to issuance or delivery by any small employer carrier.

5. After approval of the *revised* ~~standard health benefit plan and the basic~~ health benefit *plans* ~~plan~~, if the department determines that modifications to a plan might be appropriate, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the department for approval.

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan and a basic health benefit plan that meets the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan" and "basic health benefit plan" mean policies or contracts that a small employer carrier offers to eligible small employers that contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; and

b. A procedure for preauthorization by the small employer carrier, or its designees.

3. A small employer carrier may include the following managed-care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. *A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.*

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed-care and cost-containment provisions, subject to the approval of the department, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. *The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.*

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for handicapped children pursuant to s. 627.6615; and

h. Emergency or urgent care out of the geographic service area.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan shall include all of the benefits specified in subparagraph *4.* ~~5.~~; however, the basic health benefit plan shall place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.6616, 627.6618, and 627.668 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding said provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.

(c) If a small employer rejects, in writing, the standard health benefit plan and the basic health benefit plan, the small employer carrier may offer the small employer a limited benefit policy or contract.

(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for any small employer, the small employer carrier shall provide such employer group with a written statement that contains, at a minimum:

a. An explanation of those mandated benefits and providers that are not covered by the policy or contract;

b. An explanation of the managed-care and cost-control features of the policy or contract, along with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information or authorization; and

c. An explanation of the primary and preventive care features of the policy or contract.

Such disclosure statement must be presented in a clear and understandable form and format and must be separate from the policy or certificate or evidence of coverage provided to the employer group.

2. Before a small employer carrier issues a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, it must obtain from the prospective policyholder a signed written statement in which the prospective policyholder:

a. Certifies as to eligibility for coverage under the standard health benefit plan, basic health benefit plan, or limited benefit policy or contract;

b. Acknowledges the limited nature of the coverage and an understanding of the managed-care and cost-control features of the policy or contract;

c. Acknowledges that if misrepresentations are made regarding eligibility for coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the person making such misrepresentations forfeits coverage provided by the policy or contract; and

d. *If a limited plan is requested,* acknowledges that the prospective policyholder had been offered, at the time of application for the insurance policy or contract, the opportunity to purchase *any* ~~a standard~~ health benefit plan *offered by the carrier* ~~and a basic health benefit plan~~ and that the prospective policyholder had rejected that coverage.

A copy of such written statement shall be provided to the prospective policyholder no later than at the time of delivery of the policy or contract, and the original of such written statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.

3. Any material statement made by an applicant for coverage under a ~~standard~~ health benefit plan~~, a basic health benefit plan, or a limited benefit policy or contract~~ which falsely certifies as to the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.

4. Each marketing communication that is intended to be used in the marketing of a ~~standard~~ health benefit plan~~, a basic health benefit plan, or a limited benefit policy or contract~~ in this state must be submitted for review by the department prior to use and must contain the disclosures stated in this subsection.

(e)1. A small employer carrier may not use any policy, contract, form, or rate under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the insurer has filed it with the department and the department has approved it under ss. 627.410, 627.4106, and 627.411.

2. A small employer carrier must file with the department *by December 1, 1993,* ~~no later than September 15, 1992,~~ the standard ~~health benefit plan~~ and basic health benefit plan that it intends to initially use to comply with this subsection during calendar year *1994* ~~1993~~, together with the rates therefor, and the department must approve the submissions *by January 1, 1994* ~~no later than November 1, 1992~~.

(13)~~(10)~~ STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, *including any subsequent modifications or additions to those plans,* to eligible small employers in the state. *Before January 1, 1994,* if a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan. *Beginning January 1, 1994, small employer carriers must offer and issue all plans on a guarantee-issue basis.*

(b) No small employer carrier or agent shall, directly or indirectly, engage in the following activities:

1. Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

2. Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(c) The provisions of paragraph (a) shall not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(d) No small employer carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer except if the compensation arrangement provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(e) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for the sale of a basic or standard health benefit plan.

(f) No small employer carrier shall terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent with the small employer carrier unless the agent consistently engages in practices that violate this section or s. 626.9541.

(g) No small employer carrier or agent shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(h) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(i) The department may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(j) A violation of this section by a small employer carrier or an agent shall be an unfair trade practice under s. 626.9541 *or ss. 641.3903 and 641.3907.*

(k) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services relating to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section.

(14)~~(11)~~ APPLICABILITY OF OTHER STATE LAWS.—

(a) Except as expressly provided in this section, a law requiring coverage for a specific health care service or benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to a standard or basic health benefit plan policy or contract or a limited benefit policy or contract offered or delivered to a small employer unless that law is made expressly applicable to such policies or contracts.

(b) Except as provided in this section, a standard or basic health benefit plan policy or contract or limited benefit policy or contract offered to a small employer is not subject to any provision of this code which:

1. Inhibits a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits;

2. Imposes any restriction on a small employer carrier's ability to negotiate with providers regarding the level or method of reimbursing care or services provided under a health benefit plan; or

3. Requires a small employer carrier to either include a specific provider or class of providers when contracting for health care services or benefits or to exclude any class of providers that is generally authorized by statute to provide such care.

(c) Any second tier assessment paid by a carrier pursuant to paragraph *(11)(j)* ~~(8)(j)~~ may be credited against assessments levied against the carrier pursuant to s. 627.6494.

(d) Notwithstanding chapter 641, a health maintenance organization is authorized to issue contracts providing benefits equal to the standard health benefit plan, the basic health benefit plan, and the limited benefit policy authorized by this *section* ~~act~~.

(15)~~(12)~~ RULEMAKING AUTHORITY.—The department may adopt rules *to administer* ~~for the implementation and administration of~~ this section, including *rules governing* compliance by small employer carriers and small employers.

(2) This section shall take effect January 1, 1994, except that subsections (6) and (9) of section 627.6699, Florida Statutes, 1992 Supplement, renumbered as subsections (9) and (12), respectively, of said section and as amended by this section, shall take effect upon becoming law.

Section 217. Present subsections (2), (3), and (4) of section 641.30, Florida Statutes, are renumbered as subsections (3), (4), and (5), respectively, and a new subsection (2) is added to that subsection, to read:

641.30 Construction and relationship to other laws.—

(2) Each health maintenance organization contract that provides coverage to a subscriber must comply with s. 627.6699.

Section 218. The Agency for Health Care Administration shall develop a standardized claims form and an electronic transmission claims format that includes data needed by the agency to perform its duties as provided in chapter 408, Florida Statutes. By April 1, 1994, all health care payers, insurers, and providers must use the standardized claims form or the electronic transmission claims format developed by the agency. The agency shall also develop an electronic medical information and billing system that electronically connects the information and billing systems of health care facilities, health care providers, and health insurers in order to reduce administrative costs and complexities. The agency shall develop a pilot project to test the information and billing system in one or more areas of the state.

Section 219. Notwithstanding any provision of this act to the contrary, if a health care program has entered into a contract with providers or facilities licensed or permitted under chapter 465, Florida Statutes, for the purpose of providing prescribed medicine services, a participant may use a provider who is not a party to the contract, if such provider selected agrees to provide the service at a rate equal to or less than the rate set forth in the contract negotiated by the health care program and such provider's net worth does not exceed $5 million, and such provider is a sole proprietorship, a partnership composed entirely of natural persons, or any other legal entity whose ownership interests are not publicly traded. Nothing in this section applies to any health maintenance organization established under part I of chapter 641, Florida Statutes, which maintains an in-house pharmacy that is permitted under chapter 465, Florida Statutes.

Section 220. The Agency for Health Care Administration shall form a work group for the purpose of examining personnel licensing and training issues related to rural hospitals, as defined in section 395.602, Florida Statutes, and shortages of health care professionals.

(1) The agency work group shall make recommendations for specific statutory and regulatory changes necessary to accomplish the following goals:

(a) Enhancement of the quality and effectiveness of health care in rural areas.

(b) Development of a licensure category and cross-training program that allows rural hospitals, as defined in section 395.602, Florida Statutes, flexibility in utilizing personnel licensed under chapter 464, chapter 483, or part III, part IV, or part V of chapter 468, Florida Statutes, who have at least 3 years' professional experience to perform professional functions in one or more of the other areas of professional practice listed in this paragraph.

(c) Development of standards for a nonrenewable, temporary license to be issued by the appropriate licensing boards that would allow a health care professional licensed in another state to practice in areas of the state designated as areas of critical health professional shortage or in a profession designated as a profession of critical shortage for a period not to exceed 6 months. The agency work group shall make recommendations as to which areas of the state should be designated as areas of critical health professional shortage as well as which health care professions should be designated as professions of critical shortage.

(2) The agency work group shall be composed of:

(a) One member who is a representative of the Division of Health Quality Assurance of the Agency for Health Care Administration, appointed by the Director of Health Care Administration.

(b) One representative of the Agency for Health Care Administration, appointed by the Director of Health Care Administration.

(c) One representative of the Department of Professional Regulation, appointed by the Secretary of Professional Regulation.

(d) One member who is a representative of the Division of Community Colleges of the Department of Education, appointed by the Executive Director of the Division of Community Colleges.

(e) One member appointed by the Board of Medicine.

(f) One member appointed by the Board of Nursing.

(g) One member appointed by the Board of Clinical Laboratory Personnel.

(h) One member who is a representative of the Office of Rural Health, appointed by the Secretary of Health and Rehabilitative Services.

(i) Two members who are representatives of statutory rural hospitals, appointed by the Governor.

(j) Two members who are representatives of statutory rural hospitals, appointed by the President of the Senate.

(k) Two members who are representatives of statutory rural hospitals, appointed by the Speaker of the House of Representatives.

(3) The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives detailing the work group's recommendations no later than December 31, 1993.

Section 221. Interagency Work Group on Health Care Fraud and Abuse.—

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

(a) "Abuse" means a pattern of inappropriate provision of and billing for health care services which, while not fraudulent, reveals a pattern of overutilization intended primarily to increase the income of a health care provider or health care facility.

(b) "Fraud" means the submission of a reimbursement request to a payer for health care services that were not actually provided to a covered individual.

(2) The Agency for Health Care Administration shall establish an Interagency Work Group on Health Care Fraud and Abuse to examine the extent to which fraud and abuse exist, and to research ways in which fraud and abuse in the health care system can be prevented, including the expanded use of civil and criminal penalties. The work group must include representatives of the Agency for Health Care Administration, the Department of Legal Affairs, the Department of Health and Rehabilitative Services, the Office of the Auditor General, the Department of Insurance, and the Department of Law Enforcement. The agency shall also request the participation of a representative of the United States Department of Justice.

(3) The work group shall prepare a report on health care fraud and abuse which includes, but is not limited to:

(a) The development of a comprehensive model program that will enhance and improve the state's ability to detect fraudulent and abusive activities and enforce laws to reduce fraud and abuse.

(b) The identification of the key private and public agencies and organizations that are involved in detecting or prosecuting fraud and abuse and a determination of how these organizations can best coordinate their efforts to reduce fraud and abuse.

(c) An assessment of current laws and regulations to determine if they are adequate to control fraud and abuse, and if not, recommendations for legislation to strengthen current laws and regulation.

(d) An assessment of the feasibility of permitting health insurers to share information regarding the billing of health care providers and

health care facilities and an identification of the most effective methods by which health insurers can aid in investigating health care providers and health care facilities suspected of fraud and abuse.

(e) An evaluation of the potential impact of allowing persons who report fraud to receive a portion of the fine levied against the health care provider or health care facility if the fraud is successfully prosecuted.

(4) The work group must complete its report in time for its recommendations to be included in the final Florida Health Plan that is to be submitted to the Legislature by December 31, 1993, pursuant to section 408.006, Florida Statutes.

Section 222. Community health purchasing alliances; assessment and participation study.—

(1) The Agency on Health Care Administration shall conduct a study that includes, but is not limited to, an assessment of community health purchasing alliances in relation to health care financing issues, the recovery of savings to increase health care coverages, cost shifting, 24-hour coverage, the effects of uninsurance on alliances, employer options under the alliances, accountable health partnership characteristics and requirements, enrollment and marketing requirements, community rating, and risk adjustment in premium allocation to the accountable health partnerships.

(2) The agency shall recommend to the Legislature the steps that must be taken, including federal and state regulatory and statutory reforms, to allow individuals who are not self-employed, self-insured employers, and other employers that are not small employers to participate in community health purchasing alliances.

(3) The agency shall include a report on the progress in implementing community health purchasing alliances, and the results of the study required by this section, in its final Florida Health Plan that is to be submitted to the Legislature by December 31, 1993.

Section 223. Community health purchasing alliances; antitrust study.—

(1) The Legislature recognizes that the health care reforms authorized by sections 408.70-408.706, Florida Statutes, require a different relationship between health insurers, hospitals, physicians, and other providers. The success of community health purchasing alliances depends on accountable health partnerships providing detailed information that can facilitate informed decisions by those who purchase health care. The Legislature intends to research antitrust laws, rules, and case law in order to determine their impact on community health purchasing alliances and accountable health partnerships in this state.

(2) Recognizing the need for more information on which to make future decisions, the Legislature directs the Agency for Health Care Administration, in consultation with the Department of Legal Affairs, the agency advisory council, and health care consumers, purchasers, providers, and insurers, to assess the effects of antitrust laws on community health purchasing alliances and accountable health partnerships. The findings and recommendations from this study must be provided by the agency in its final Florida Health Care Plan that is to be submitted to the Legislature by December 31, 1993.

(3) The antitrust study conducted by the agency must include, but need not be limited to, the following elements:

(a) A methodology, including regulation and state oversight, which would allow physicians, hospitals, insurers, and other providers to form accountable health partnerships in order to offer health care services to community health purchasing alliances and to purchasers of health care who are not alliance members.

(b) A methodology and guidelines that would prevent the formation of monopolies and oligopolies by accountable health partnerships, including limitations on the market share held by one or two accountable health partnerships.

(c) A working definition of a methodology to prevent predatory pricing and other anticompetitive activities such as price fixing and market allocation by insurers, physicians, hospitals, and other providers for the purpose of forcing providers out of business or to unfairly gain market share.

(d) A methodology to allow individual physicians and hospitals to come together in order to jointly offer services as part of an accountable health partnership to an alliance.

(e) Recommendations as to specific changes in federal and state antitrust laws which are required to facilitate the objectives set forth in sections 408.70-408.706, Florida Statutes.

(f) Recommendations on how to ensure a competitive marketplace despite the authorization of antitrust exemptions.

(g) An analysis and report on any other issues related to antitrust exemptions which meet the intent of this section.

Section 224. The Legislature finds that the majority of costs in the health care system are driven by the consumption and utilization of health care resources by health care providers. The Legislature further finds that there is wide variance in the use of health care resources by health care providers with no appreciable difference in the quality of outcomes or the value of health care services provided. Therefore, the Agency for Health Care Administration shall develop and implement a UB-92 based system, with appropriate adjustments for illness severity and acuity, for comparing quality and value of health care services across the state, or, in the alternative, the agency may purchase a data system to accomplish this task. This system shall include, at a minimum, an analysis of the 20 procedures and diagnoses that account for the most significant percentage of total statewide health services and health care costs. The system must take into account all relevant risk factors that contribute to the outcome of a patient's treatment. The agency shall use appropriate data available from the Health Care Board and shall hereby have the authority to collect any necessary statistical data from health care providers, health care facilities, and health insurers. The agency shall make available to the public, on a quarterly basis, the outcome of its analysis of this data. The agency shall specifically target the release of its data to any community health purchasing alliance in the state. The agency shall form a task force of users and providers of this type of data to determine the most useful and efficient means of disseminating the data to the public.

Section 225. There is appropriated from the General Revenue Fund to the Department of Health and Rehabilitative Services the sum of $2 million to be used to provide scholarships and financial assistance, under the Florida Health Services Corps program, section 381.0302, Florida Statutes.

Section 226. There is appropriated from the General Revenue Fund to the Agency for Health Care Administration the sum of $300,000 for the purposes of funding rural health networks as established in section 381.0406, Florida Statutes, as created by this act.

Section 227. (1) Notwithstanding the provisions of section 110.123(6), Florida Statutes, there is appropriated from the General Revenue Fund to the Agency for Health Care Administration the sum of $2 million, for fiscal year 1993-1994, for the purpose of establishing community health purchasing alliances and covering the agency costs associated with implementing the provisions of sections 408.701-408.705, Florida Statutes.

(2) Funds appropriated under this section may be used by the agency to provide grants to community health purchasing alliances for funding administrative start-up costs.

Section 228. Section 409.9114, Florida Statutes, as amended by section 100 of chapter 92-33, Laws of Florida, is repealed.

Section 229. Section 407.60, Florida Statutes, as created by section 11 of chapter 92-178, Laws of Florida, is repealed.

Section 230. Section 3 of chapter 92-304, Laws of Florida, is repealed.

Section 231. Section 9 of chapter 92-178, Laws of Florida, appearing as section 455.238, Florida Statutes, 1992 Supplement, is repealed.

Section 232. Effective January 1, 1994, section 627.4106, Florida Statutes, is repealed.

Section 233. (1) Effective October 1, 1995, sections 458.307, 460.404, 461.004, 464.004, 465.004, 468.1135, 468.1665, 474.204, 484.003, 486.023, 490.004, and 491.004, Florida Statutes; section 457.103, Florida Statutes, as amended by section 1 of chapter 92-38, Laws of Florida; section 459.004, Florida Statutes, as amended by section 85 of chapter 92-149, Laws of Florida; section 463.003, Florida Statutes, as amended by section 43 of chapter 92-149, Laws of Florida; section 466.004, Florida Statutes, as amended by section 97 of chapter 92-149, Laws of Florida; and section 483.805, Florida Statutes, as created by section 32 of chapter 92-58, Laws of Florida, are repealed.

(2) The Legislature shall study the issue of health care delivery and regulation of health care providers. The study must specifically address whether:

(a) The Legislature should create a Department of Health;

(b) The Legislature should create a Department of Health Care Administration and transfer to that department the powers, duties, and functions of the Agency for Health Care Administration;

(c) The Division of Medical Quality Assurance should be transferred to a Department of Health or to a Department of Health Care Administration; and

(d) The Legislature should create a Department of Children and Family Services.

Section 234. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

And the title is amended as follows:

In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to health care; repealing s. 33, ch. 92-33, Laws of Florida; abrogating the transfer of powers, duties, and funds of the Division of Medical Quality Assurance of the Department of Professional Regulation to the Agency for Health Care Administration; amending s. 20.30, F.S.; reinstating the Division of Medical Quality Assurance within the Department of Professional Regulation; reestablishing the Board of Nursing Home Administrators and the Board of Opticianry within the Division of Professions of the Department of Professional Regulation; reestablishing the Board of Medicine, the Board of Osteopathic Medicine, the Board of Acupuncture, the Board of Chiropractic, the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, the Board of Dentistry, the Board of Nursing, the Board of Optometry, the Board of Pharmacy, the Board of Physical Therapy Practice, the Board of Podiatric Medicine, the Board of Psychological Examiners, the Board of Veterinary Medicine, the Board of Speech-Language Pathology and Audiology, and the Board of Clinical Laboratory Personnel within the Division of Medical Quality Assurance; amending s. 20.42, F.S., relating to organization of the Agency for Health Care Administration; creating the Health Care Advisory Commission within the agency; providing for membership of the commission; providing duties of the commission; renaming the Division of Health Policy and Planning as the Division of Health Policy and Cost Control; providing additional responsibilities relating to state and local health planning, certificate-of-need review, hospital budget review, and the administration of specified contracts; providing duties of the Division Director for State Health Purchasing; amending s. 110.123, F.S.; providing requirements for the Agency for Health Care Administration with respect to the state group insurance program; providing rulemaking authority; transferring powers, duties, records, property, and unexpended allocations of funds associated with positions in the State Employees Health Insurance Program to the Division of State Health Purchasing of the Agency for Health Care Administration; transferring powers, duties, records, property, and unexpended allocations of funds of the Medicaid program within the Department of Health and Rehabilitative Services to the Division of State Health Purchasing of the Agency for Health Care Administration; amending s. 20.19, F.S.; conforming provisions to such transfer; amending s. 112.0455, F.S.; providing duties of the agency under the Drug-Free Workplace Act; providing for regulation of drug testing laboratories by the agency; amending ss. 154.011, 154.205, 154.245, 154.304, 154.306, 154.308, 154.309, 154.31, 154.3105, 154.312, F.S., relating to certificates of need and the Health Care Responsibility Act of 1988; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the agency; amending ss. 159.27, 186.003, F.S.; conforming cross-references; amending ss. 189.415, 196.1975, 205.1965, F.S., relating to certificate-of-need review and agency licensure of homes for the aged and adult congregate living facilities; amending s. 215.20, F.S.; conforming terminology relating to the name of a trust fund; amending s. 240.4067, F.S., relating to the Medical Education Reimbursement and Loan Repayment Program; providing for penalties for noncompliance; deleting a limitation on the payment period; providing additional categories of eligibility; amending s. 240.4075, F.S.; adding birth centers, community mental health centers, and alcohol and drug abuse programs to the list of eligible employing institutions for the Nursing Student Loan Forgiveness Program; amending s. 381.026, F.S., relating to the Florida Patient's Bill of Rights and Responsibilities; providing a penalty; amending s. 381.0261, F.S., relating to the distribution of summaries of health care information; conforming provisions to changes made by the act; amending s. 381.0302, F.S.; providing additional membership in the Florida Health Services Corps; authorizing the Department of Health and Rehabilitative Services to provide certain financial assistance to students in additional medical programs; providing additional requirements for corps members; authorizing use of certain appropriated funds as federal matching funds; creating s. 381.0406, F.S., relating to rural health networks; providing legislative findings and intent; providing definitions; providing for organization, administration, and nonprofit corporate status; specifying services to be provided; requiring participation of certain trauma agencies; providing for public and private financing; providing for phased-in implementation; specifying responsibilities of the agency and the State Health Office relating to establishment and certification of rural health networks; providing for rules; creating s. 381.0407, F.S.; authorizing special consideration under the certificate-of-need program for certain rural regional hospital systems; authorizing rural regional hospital systems to establish tax districts that cross county boundaries; creating s. 381.0408, F.S.; providing for designation of rural health care innovation zones by the Agency for Health Care Administration; providing special consideration of certificate-of-need applicants located in rural health care innovation zones; authorizing the Department of Health and Rehabilitative Services to seek funding to support health care facilities and providers in rural health care innovation zones; amending s. 381.045, F.S., relating to procedures and services for certain health care professionals infected with hepatitis B or human immunodeficiency virus; amending s. 381.0602, F.S., relating to the Organ Transplant Advisory Council; amending and renumbering s. 381.0605, F.S., relating to a survey of state hospital facilities; amending ss. 381.6021, 381.6022, 381.6023, 381.6024, 381.6025, F.S., relating to organ and tissue procurement; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the agency; amending and renumbering s. 381.695, F.S., relating to certificate-of-need exemption for health care facilities within the Department of Corrections; amending and renumbering s. 381.698, F.S., relating to the Florida Blood Transfusion Act; amending ss. 383.302, 383.305, 383.307, 383.308, 383.309, 383.31, 383.312, 383.313, 383.318, 383.32, 383.324, 383.325, 383.327, 383.33, 383.331, 383.335, F.S., relating to regulation and licensure of birth centers; amending ss. 390.001, 390.002, 390.011, 390.012, 390.014, 390.015, 390.016, 390.017, 390.018, 390.019, 390.021, F.S., relating to termination of pregnancies; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; amending s. 395.1055, F.S.; providing for separate standards for statutory rural hospitals; amending s. 395.403, F.S.; conforming provisions to changes made by the act; creating s. 395.606, F.S., relating to rural health network cooperative agreements; providing legislative intent with respect to antitrust laws; specifying conditions under which health care providers who are members of rural health networks may consolidate services or enter into cooperative agreements; requiring approval and oversight by the agency; providing for administrative and judicial review; amending s. 408.001, F.S.; revising requirements for the bylaws of the board of directors of the Florida Health Care Purchasing Cooperative; providing additional membership requirements for the board of directors; revising the membership of the board; conforming provisions to changes made by the act; amending s. 408.002, F.S., relating to the Florida Health Plan; amending s. 408.003, F.S., relating to appointment of the Health Care Board; providing for ethnic, geographic, and gender composition; providing for removal of members; providing for meetings, notice, and a quorum; providing for per diem and travel expenses; amending s. 408.01, F.S.; providing for a council advising the agency on health insurance and cost containment to include group health care purchasing organizations; amending s. 408.02, F.S.; revising requirements for the agency in establishing practice parameters; amending ss. 408.032, 408.033, 408.034, 408.035, 408.036, 408.037, 408.038, 408.039, 408.040, 408.041, 408.043, 408.044, 408.045, F.S., relating to certificate of need and authority to license health care facilities and health service providers; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services and the Health Care Board to the agency; providing an additional exemption from certificate-of-need review; providing for preference in certificate-of-need awards to rural health networks under certain conditions; amending s. 408.05, F.S., relating to the State Center for Health Statistics; amending s. 408.061, F.S., relating to health care data collection; providing additional data to be collected from health care facilities by the Agency for Health Care Administration; requiring nursing homes to submit to the agency audited actual experience and statistical profiles of nursing home residents; requiring the agency and the

Department of Health and Rehabilitative Services to review the statistical profiles and include findings in the Florida Health Plan; requiring the agency to collect information on certain drugs and medical equipment and supplies; deleting a requirement with respect to the establishment of a health care data base; amending s. 408.062, F.S.; revising requirements of the Health Care Board in evaluating data from nursing home financial reports; amending s. 408.063, F.S.; requiring the agency to collect data on retail prices of certain drugs and medical equipment and supplies; requiring the agency to distribute brochures to pharmacies and retail sellers of medical equipment and supplies; amending s. 408.07, F.S.; redefining the term "banked points" for purposes of agency review of hospital budgets; amending ss. 408.072, 408.08, F.S.; modifying provisions relating to review of hospital budgets, amending s. 408.09, F.S., relating to assistance on cost containment strategies; clarifying provisions; amending s. 408.20, F.S.; conforming terminology relating to the name of a trust fund; creating s. 408.70, F.S.; providing legislative intent regarding the need to reform the state's health care delivery system; proposing the creation of managed competition throughout the state; proposing the creation of community health purchasing alliances; creating s. 408.701, F.S.; providing definitions; creating s. 408.702, F.S.; establishing community health purchasing alliance regions; providing for the merger of certain alliances; providing for alliance standards; providing for voluntary membership; providing duties, powers, and responsibilities; providing for membership fees; creating s. 408.703, F.S.; providing community health purchasing alliance membership requirements for small employers; creating s. 408.704, F.S.; providing agency responsibilities with respect to community health purchasing alliances; authorizing the agency to contract with alliances and provide startup funds; requiring an annual review; requiring alliances to submit certain data to the agency; establishing an advisory data committee and specifying membership; requiring a report to the Legislature; requiring the submission of data by health care providers; requiring the agency to adopt and implement recommendations of the advisory data committee; establishing an appeals process for grievances; exempting certain records from public disclosure requirements; providing for future legislative review of this exemption under the Open Government Sunset Review Act; creating s. 408.7042, F.S.; providing requirements for the Division of State Health Purchasing of the agency in purchasing health care for state employees and their dependents; providing requirements for the agency in purchasing health care for Medicaid recipients and persons who participate in the MedAccess and Medicaid buy-in programs; creating s. 408.7045, F.S.; establishing community health purchasing alliance marketing requirements; creating s. 408.705, F.S.; providing for boards of directors for community health purchasing alliances; providing for membership, appointment, and terms; providing for staff; creating s. 408.706, F.S.; establishing standards for accountable health partnerships; providing for designation of accountable health partnerships by the agency; specifying standards and requirements; creating s. 408.90, F.S.; providing legislative findings and intent; creating s. 408.901, F.S.; providing definitions; creating s. 408.902, F.S.; creating the MedAccess program within the Agency for Health Care Administration; providing for a report; creating s. 408.903, F.S.; providing eligibility requirements; creating s. 408.904, F.S.; providing health care benefits; creating s. 408.905, F.S.; providing limitations and exclusions; creating s. 408.906, F.S.; providing for the payment of claims; creating s 408.907, F.S.; providing for the collection of premiums; creating s. 408.908, F.S.; providing agency responsibilities for the administration of the MedAccess program; amending s. 409.335, F.S.; conforming provisions to changes made by the act; amending s. 409.701, F.S.; authorizing the Florida Health Access Corporation to provide subsidized or nonsubsidized coverage to small employers; expanding the program statewide; authorizing the corporation to serve businesses with fewer than a specified number of employees; changing the composition of the board of directors of the Florida Health Access Corporation; deleting a requirement that the Department of Insurance provide certain assistance to the corporation; amending s. 409.7015, F.S.; delaying the repeal of the corporation's access to certain data from the Department of Labor and Employment Security; amending ss. 409.901, 409.902, 409.903, 409.904, F.S.; conforming provisions and references to the transfer of responsibilities for the Medicaid program to the agency; amending s. 409.905, F.S.; providing for Medicaid nursing facility services for recipients in rural hospitals; amending ss. 409.906, 409.907, 409.910, F.S.; conforming provisions; amending s. 409.908, F.S.; revising the methodology for reimbursing providers for physician services under Medicaid; amending s. 409.911, F.S.; providing additional requirements for hospitals that receive distributions under the disproportionate share program; amending s. 409.9113, F.S.; providing an additional requirement for teaching hospitals that receive distributions under the disproportionate share program; amending ss. 409.9112, 409.9115, F.S., and s. 2, ch. 92-33, Laws of Florida; conforming provisions; creating s. 409.9116, F.S.; establishing a disproportionate share program for rural hospitals; providing requirements for rural hospitals that receive distributions under the program; amending s. 409.912, F.S.; providing for inclusion of health maintenance organizations and prepaid health plans in the agency's definition of a managed care provider; creating s. 409.9121, F.S.; providing legislative findings and intent; creating s. 409.9122, F.S.; providing for the expansion of the MediPass program; directing the agency to encourage the enrollment of Medicaid recipients in managed care plans; providing for a study of the feasibility of managed care programs for Medicaid recipients with special needs; providing for funds for technical assistance in developing Medicaid prepaid health plans; requiring state agencies to provide access to managed health care providers to market their benefit plans in buildings owned, rented, or leased by the agencies; amending s. 409.913, F.S.; authorizing the agency to conduct certain investigations of Medicaid providers; providing circumstances under which the agency may withhold payments to a provider under the Medicaid program; providing for notice to the provider; providing that certain payments are due to the agency upon demand; amending ss. 409.914, 409.915, 409.916, 409.919, 409.920, 411.222, F.S.; conforming provisions; amending ss. 415.107, 415.51, F.S.; providing duties of the Agency for Health Care Administration with respect to the confidentiality of reports and records in cases of abuse, neglect, or exploitation of aged persons, disabled adults, and children; amending ss. 419.001, 419.002, F.S.; providing duties of the agency with respect to the regulation of community residential homes; amending s. 440.102, F.S., relating to requirements for the drug-free workplace program; conforming provisions to the transfer of certain duties and functions to the agency; amending ss. 455.201, 455.203, 455.205, 455.207, 455.208, 455.209, 455.211, F.S.; conforming provisions to changes made by the act; repealing s. 43, ch. 92-33, Laws of Florida, relating to license renewal for certain medical professions; abrogating the repeal of s. 455.213(6) and (7), F.S.; repealing ss. 455.2141, 455.2173, F.S., relating to duties of the Agency for Health Care Administration with respect to licensing; amending ss. 455.2175, 455.218, F.S.; conforming provisions to changes made by the act; revising licensure requirements for certain foreign-trained professionals; repealing ss. 455.220, 455.2205, F.S., relating to the Health Care Trust Fund; amending ss. 455.221, 455.223, 455.224, 455.225, 455.227, 455.2273, 455.2275, 455.228, 455.2285, 455.229, 455.232, 455.241, 455.243, 455.245, 455.26, F.S.; conforming provisions to changes made by the act; amending s. 464.009, F.S.; revising the requirements for applicants for licensure as a professional or practical nurse with respect to licensure by endorsement; amending ss. 483.610, 483.613, 483.614, 483.615, 483.616, 483.619, 483.620, 483.621, 483.622, 483.624, F.S., relating to the Cholesterol Screening Center Licensure Act; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the agency; amending s. 624.91, F.S.; increasing the membership of the board of directors of the Florida Healthy Kids Corporation; transferring the Florida Healthy Kids Trust Fund to the Agency for Health Care Administration; amending s. 626.9545, F.S.; requiring insurers to establish a financial incentive program for policy holders to report errors or overcharges; amending s. 627.613, F.S.; increasing the amount an insurer must pay to an insured for reporting improper billings that result in a reduction in the amount paid to a provider; amending ss. 641.21, 641.225, F.S.; conforming cross-references to changes made by the act; amending ss. 641.47, 641.48, 641.49, 641.495, 641.511, 641.512, 641.515, 641.52, 641.54, 641.55, 641.56, 641.57, 641.58, F.S., relating to health maintenance organizations and prepaid health clinics; conforming provisions and references to the transfer of responsibilities from the Department of Health and Rehabilitative Services to the agency; providing an exemption from the health maintenance organization and prepaid health clinic regulatory assessment; amending s. 651.118, F.S.; transferring responsibilities of the Department of Health and Rehabilitative Services with respect to certificates of need for sheltered beds and community beds to the Agency for Health Care Administration; amending s. 743.0645, F.S.; providing for consent for medical care of a minor in a facility licensed by the agency; amending s. 766.1115, F.S.; expanding the definition of the term "health care provider" under the Access to Health Care Act; amending s. 768.28, F.S.; conforming a cross-reference to changes made by the act; amending s. 15, ch. 91-178, Laws of Florida; revising the date that the prohibition against referrals by certain investors in designated health services applies; amending s. 627.410, F.S.; providing for filing certificates for certain groups for information purposes; amending s. 627.4106, F.S.; revising a definition; amending s. 627.6699, F.S.; providing definitions; requiring guarantee issue of all health plans to small employers; requiring modified community rating of health plans issued to small employers; revising definition of small employer; revising preexisting conditions requirements

for certain groups; requiring Department of Insurance specification of geographic regions for rating purposes; providing for guaranteed renewability of small group health plans; requiring carriers to maintain records; providing confidentiality; providing for review and repeal; providing for revisions in the standard and basic health benefit plans; requiring the reinsurance board to report complaints of abuse and misrepresentation to the Department of Insurance; providing for alliance membership on the health benefit plan committee; amending s. 627.6515, F.S.; specifying certain groups as out-of-state groups; providing additional requirements; providing application; amending s. 641.30, F.S.; specifying applicability for certain health maintenance organization contracts; requiring the Agency for Health Care Administration to develop a standardized claims form and an electronic claims format; requiring health care payers, insurers, and providers to use such claims form or claims format by a specified date; requiring the agency to develop an electronic medical information and billing system; providing for a pilot project; providing circumstances under which a participant in a health care program may use an alternate provider for the purpose of providing prescribed medicine services; requiring the agency to form a work group to examine licensing and training issues with respect to rural hospitals and health care professional shortages; providing membership of the work group; requiring the agency to establish an Interagency Work Group on Health Care Fraud and Abuse; providing for membership and duties; requiring a report; requiring the agency to conduct an assessment and a participation study of community health purchasing alliances; requiring the agency, in consultation with the Department of Legal Affairs, to assess the effects of antitrust laws on community health purchasing alliances and accountable health partnerships; requiring the agency to develop and implement a UB-92 based system; requiring the Governor to establish an interagency task force to study the most appropriate structure of governmental agencies for the delivery of health care and children's services; requiring a report; providing appropriations; repealing s. 409.9114, F.S., relating to the extraordinary disproportionate share program; repealing s. 407.60, F.S., relating to the Health Care Cost Containment Board; repealing s. 3, ch. 92-304, F.S., relating to directions for preparing a reviser's bill; repealing s. 455.238, F.S., relating to markup provisions; repealing s. 627.4106, F.S., relating to small group health insurance; providing for future repeal of ss. 457.103, 458.307, 459.004, 460.404, 461.004, 463.003, 464.004, 465.004, 466.004, 468.1135, 468.1665, 474.204, 482.805, 484.003, 486.023, 490.004, 491.004, F.S., relating to the Board of Acupuncture, the Board of Medicine, the Board of Osteopathic Medicine, the Board of Chiropractic, the Board of Podiatric Medicine, the Board of Optometry, the Board of Nursing, the Board of Pharmacy, the Board of Dentistry, the Board of Speech-Language Pathology and Audiology, the Board of Nursing Home Administrators, the Board of Veterinary Medicine, the Board of Clinical Laboratory Personnel, the Board of Opticianry, the Board of Physical Therapy Practice, the Board of Psychological Examiners, and the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, respectively; requiring the Legislature to conduct a study and prescribing the elements thereof; providing effective dates.

The vote was:

Yeas—20 Nays—20

Senator Myers moved the following amendment which was adopted:

Amendment 2 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Section 20.42, Florida Statutes, 1992 Supplement, is amended to read:

20.42 Agency for Health Care Administration.—There is created the Agency for Health Care Administration within the Department of Professional Regulation. The agency shall be a separate budget entity, and the director of the agency shall be the agency head for all purposes. The agency shall not be subject to control, supervision, or direction by the Department of Professional Regulation in any manner, including, but not limited to, personnel, purchasing, transactions involving real or personal property, and budgetary matters.

(1) DIRECTOR OF HEALTH CARE ADMINISTRATION.—The head of the agency is the Director of Health Care Administration, who shall be appointed by the Governor. The director shall serve at the pleasure of and report to the Governor.

(2) ORGANIZATION OF THE AGENCY.—The agency shall be organized as follows:

(a) Effective July 1, 1993, the Division of Health Quality Assurance, which shall be responsible for:

1. Health facility licensure and inspection~~; certificate of need~~; *and*

2. Effective July 1, 1994, the Board of Medicine, created under chapter 458; the Board of Osteopathic Medicine, created under chapter 459; the Board of Acupuncture, created under chapter 457; the Board of Chiropractic, created under chapter 460; the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491; the Board of Dentistry, created under chapter 466; the Board of Optometry, created under chapter 463; the Board of Pharmacy, created under chapter 465; the Board of Podiatric Medicine, created under chapter 461; the Board of Nursing, created under chapter 464; the Board of Psychological Examiners, created under chapter 490; the Board of Speech-Language Pathology and Audiology, created under chapter 468; the Board of Nursing Home Administrators, created under part II of chapter 468; occupational therapy, as regulated under part III of chapter 468; respiratory therapy, as regulated under part V of chapter 468; physical therapy, as regulated under chapter 486; *the Board of Clinical Laboratory Personnel, created under part IV of chapter 483; midwifery, as regulated under chapter 467; dietetics and nutrition practice, as regulated under part X of chapter 468; electrolysis, as regulated under chapter 478; nursing assistants, as regulated under s. 400.211;* and the Board of Opticianry, created under part I of chapter 484.

(b) The Division of Health Policy and *Cost Control* ~~Planning~~, which shall be responsible for *health policy,* the State Center for Health Statistics, the development of The Florida Health Plan, *certificate of need, hospital budget review, state and local health planning under s. 408.033,* and research and analysis.

(c) Effective *October* ~~July~~ 1, 1993, the Division of State Health Purchasing, which shall be responsible for *the Medicaid program and the* ~~supervising the purchase of health care by: Medicaid; the Florida Health Access Program; the Pooled Purchasing Cooperative; and~~ state employee health insurance *program functions related to: the procurement of the administrator of the state employee health insurance plan; the development of the plan's benefit design; the establishment of the plan's cost sharing and cost containment requirements; the creation and maintenance of administrative cost controls; the collection and analysis of data; and the monitoring and evaluation of the administrator and provider network performance. The division shall also administer the contracts with the Florida Health Access Corporation program and the Pooled Purchasing Cooperative.*

(d) The Health Care Board, which shall be responsible for hospital budget review, nursing home financial analysis, and special studies as assigned by the secretary or the Legislature.

(e) The Division of Administrative Services, which shall be responsible for revenue management, budget, personnel, and general services.

(3) DEPUTY DIRECTOR FOR HEALTH QUALITY ASSURANCE.—The director shall appoint a Deputy Director for Health Quality Assurance who shall serve at the pleasure of, and be directly responsible to, the director. The Deputy Director for Health Quality Assurance shall be responsible for the Division of Health Quality Assurance.

(4) DEPUTY DIRECTOR FOR HEALTH POLICY AND *COST CONTROL* ~~PLANNING~~.—The director shall appoint a Deputy Director for Health Policy and *Cost Control* ~~Planning~~ who shall serve at the pleasure of, and be directly responsible to, the director. The Deputy Director for Health Policy and *Cost Control* ~~Planning~~ shall be responsible for the Division of Health Policy and *Cost Control* ~~Planning and the Division of State Health Purchasing~~.

(5) DEPUTY DIRECTOR FOR STATE HEALTH PURCHASING.—The director shall appoint a Deputy Director for State Health Purchasing who shall serve at the pleasure of, and be directly responsible to, the director. The Deputy Director for State Health Purchasing shall be responsible for the Division of State Health Purchasing.

(6)~~(5)~~ HEALTH CARE BOARD.—The Health Care Board shall be composed of 11 members appointed by the Governor, subject to confirmation by the Senate. The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall be responsible for hospital budget review, nursing home financial review and analysis, and special studies requested by the Governor, the Legislature, or the director.

(7)~~(6)~~ DEPUTY DIRECTOR OF ADMINISTRATIVE SERVICES.—The director shall appoint a Deputy Director of Administrative Services who shall serve at the pleasure of, and be directly responsible to, the director. The deputy director shall be responsible for the Division of Administrative Services.

Section 2. Section 32 of chapter 92-33, Laws of Florida, is amended to read:

Section 32. Effective July 1, *1994* ~~1993~~, subsections (2), (3), (4), and (5) of section 20.30, Florida Statutes, are amended to read:

20.30 Department of Professional Regulation.—There is created a Department of Professional Regulation.

(2) The following divisions of the Department of Professional Regulation are established:

(a) Division of Examination and Licensure.

(b) Division of Professions.

~~(c) Division of Medical Quality Assurance.~~

~~1. The director of the division shall be appointed by the Secretary of Professional Regulation.~~

~~2. The division shall concentrate sufficient resources and efforts on the investigation and discipline of physicians in violation of the unprofessional conduct provisions of the applicable practice acts as are necessary to meet the challenge of identifying those physicians who are not providing adequate medical care in order to take forceful corrective measures to assure quality medical care throughout the state.~~

~~3. The division shall coordinate closely with the Office of Health Planning and Regulation in the Department of Health and Rehabilitative Services to ensure that the state's regulation of health care facilities and the physicians who practice therein is consistent and offers adequate protection to the public.~~

~~4. The division shall establish and maintain a disciplinary training program for division staff and board members designed to ensure the proper and appropriate administration of medical quality assurance. The program shall provide for initial and periodic training in the grounds for disciplinary action, the actions which may be taken, changes in any relevant law, sanctions which are most appropriate for specified types of unprofessional conduct, guidelines for the conduct of hearings, and any other matters which the division shall determine may be necessary or useful.~~

(c)~~(d)~~ Division of Real Estate.

1. The director of the division shall be appointed by the Secretary of Professional Regulation, subject to approval by a majority of the Florida Real Estate Commission.

2. The offices of the Division of Real Estate shall be located in Orlando.

(d)~~(e)~~ Division of Regulation.

(e)~~(f)~~ Division of Administration.

(3) There shall be a director of the Division of Examination and Licensure, a director of the Division of Professions, ~~a director of the Division of Medical Quality Assurance~~, a director of the Division of Regulation, a director of the Division of Real Estate, and a director of the Division of Administration. Each division director shall directly administer his division and shall be responsible to the secretary of the department.

(4) The following boards are established within the Department of Professional Regulation, Division of Professions:

(a) Board of Accountancy, created under chapter 473.

(b) Board of Architecture and Interior Design, created under part I of chapter 481.

(c) Board of Auctioneers, created under part VI of chapter 468.

(d) Barbers' Board, created under chapter 476.

(e) Construction Industry Licensing Board, created under part I of chapter 489.

(f) Board of Cosmetology, created under chapter 477.

(g) Electrical Contractors' Licensing Board, created under part II of chapter 489.

(h) Board of Professional Engineers, created under chapter 471.

(i) Board of Funeral Directors and Embalmers, created under chapter 470.

(j) Board of Professional Geologists, created under chapter 492.

(k) Board of Hearing Aid Specialists, created under part II of chapter 484.

(l) Board of Professional Land Surveyors, created under chapter 472.

(m) Board of Landscape Architecture, created under part II of chapter 481.

(n) Board of Massage, created under chapter 480.

~~(o) Board of Nursing Home Administrators, created under part II of chapter 468.~~

~~(p) Board of Opticianry, created under part I of chapter 484.~~

(o)~~(q)~~ Board of Pilot Commissioners, created under chapter 310.

(p) Board of Veterinary Medicine, created under chapter 474.

~~(5) The following boards are established within the Department of Professional Regulation, Division of Medical Quality Assurance:~~

~~(a) Board of Medicine, created under chapter 458.~~

~~(b) Board of Osteopathic Medical Examiners, created under chapter 459.~~

~~(c) Board of Acupuncture, created under chapter 457.~~

~~(d) Board of Chiropractic, created under chapter 460.~~

~~(e) Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.~~

~~(f) Board of Dentistry, created under chapter 466.~~

~~(g) Board of Nursing, created under chapter 464.~~

~~(h) Board of Optometry, created under chapter 463.~~

~~(i) Board of Pharmacy, created under chapter 465.~~

~~(j) Board of Physical Therapy Practice, created under chapter 486.~~

~~(k) Board of Podiatric Medicine, created under chapter 461.~~

~~(l) Board of Psychological Examiners, created under chapter 490.~~

~~(m) Board of Veterinary Medicine, created under chapter 474.~~

~~(n) Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.~~

Section 3. Section 33 of chapter 92-33, Laws of Florida, is amended to read:

Section 33. Except as otherwise provided in this act, all powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Division of Medical Quality Assurance of the Department of Professional Regulation, and, except as otherwise provided in this act, the boards established thereunder, are transferred by a type one transfer, as defined in s. 20.06(1), Florida Statutes, to the Agency for Health Care Administration and assigned to the Division of Health Quality Assurance of the agency, as created by this act. Such transfer shall take effect July 1, *1994* ~~1993~~. Any rules promulgated by or for the division or boards are included in such transfer.

Section 4. Subsections (3) and (5) of section 110.123, Florida Statutes, 1992 Supplement, are amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(a) It is the intent of the Legislature to offer a comprehensive package of health insurance benefits for state employees which are provided in a cost-efficient and prudent manner, and to allow state employees the option to choose benefit plans which best suit their individual needs. Therefore, the state group insurance program is established which may include the state group health insurance plan, health maintenance organization plans, group life insurance plans, group accidental death and dismemberment plans, and group disability insurance plans. Furthermore, the department is additionally authorized to establish and provide as part of the state group insurance program any other group insurance plans which are consistent with the provisions of this section.

(b) Notwithstanding any provision in this section to the contrary, it is the intent of the Legislature that the Agency for Health Care Administration shall be responsible for all aspects of the purchase of health care for state employees under the state group health insurance plan and the health maintenance organizations plans. Responsibilities shall include, but not be limited to, the development of requests for proposals for state employee health services, the determination of health care benefits to be provided, and the negotiation of contracts for health care and health care administrative services. Prior to the negotiation of contracts for health care services, the Legislature intends that the Agency for Health Care Administration shall develop, in consultation with the Department of Management Services with respect to state collective bargaining issues, the health benefits and terms to be included in the state group health insurance program. The Agency for Health Care Administration shall adopt rules necessary to perform its responsibilities pursuant to this section. It is the intent of the Legislature that the Department of Management Services shall be responsible for the contract management and day-to-day management of the state employee health insurance program, including, but not limited to, employee enrollment, premium collection, payment to health care providers and other administrative functions related to the program.

(c)~~(b)~~ Except as provided for in subparagraph (d)2., the percentage of state contribution toward the cost of any plan in the state group insurance program shall be uniform with respect to all state employees in state collective bargaining units participating in the same plan or any similar plan. Nothing contained within this section prohibits the development of separate benefit plans for officers and employees exempt from collective bargaining or the development of separate benefit plans for each collective bargaining unit.

(d)~~(c)~~1. Participation by individuals in the program shall be available to all state officers, full-time state employees, and part-time state employees; and such participation in the program or any plan thereof shall be voluntary. Participation in the program shall also be available to retired state officers and employees who elect at the time of retirement to continue coverage under the program, but they may elect to continue all or only part of the coverage they had at the time of retirement. A surviving spouse may elect to continue coverage only under the state group health insurance plan or a health maintenance organization plan.

2. Notwithstanding any previous rejection or cancellation of participation in any group insurance plan or self-insurance plan provided under this section, participation in the insurance plan shall be offered beginning September 1, 1991, to all former employees who retired before September 1, 1991, and to the eligible dependents of these former employees. An employer who provides insurance under this section shall, before September 1, 1991, notify his previously retired former employees and their eligible dependents, in writing, of their eligibility to participate in the group insurance plan or self-insurance plan as provided in this section. The employees and their eligible dependents shall have until October 31, 1991, to accept or reject, in writing, participation in their former employer's group insurance plan or self-insurance plan.

(e)~~(d)~~1. A person eligible to participate in the state group health insurance plan may be authorized by rules *approved by the Agency for Health Care Administration and* adopted by the department, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. *Subject to the approval of and supervision by the Agency for Health Care Administration,* the department shall contract with health maintenance organizations to participate in the state group insurance program through a request for proposal based upon a premium and a minimum benefit package as follows:

a. ~~The department shall establish~~ A minimum benefit package to be provided by a participating HMO ~~which~~ shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO.

b. ~~The department may establish~~ A uniform schedule for deductibles and copayments *may be established* for all participating HMOs.

c. Based upon the minimum benefit package and copayments and deductibles contained in sub-subparagraphs a. and b., the *Agency for Health Care Administration* ~~department~~ shall issue a request for proposal for all HMOs which are interested in participating in the state group insurance program. Upon receipt of all proposals, the *Agency for Health Care Administration* ~~department~~ may, as it deems appropriate, enter into contract negotiations with HMOs submitting bids. As part of the request for proposal process, the *Agency for Health Care Administration* ~~department~~ may require detailed financial data from each HMO which participates in the bidding process for the purpose of determining the financial stability of the HMO.

d. In determining which HMOs to contract with, the *Agency for Health Care Administration* ~~department~~ shall, at a minimum, consider: each proposed contractor's previous experience and expertise in providing prepaid health benefits; each proposed contractor's historical experience in enrolling and providing health care services to participants in the state group insurance program; the cost of the premiums; the plan's ability to adequately provide service coverage and administrative support services as determined by the *Agency for Health Care Administration* ~~department~~; plan benefits in addition to the minimum benefit package; accessibility to providers; and the financial solvency of the plan. Nothing shall preclude the *Agency for Health Care Administration* ~~department~~ from negotiating regional or statewide contracts with health maintenance organization plans when this is cost-effective and when the *Agency for Health Care Administration* ~~department~~ determines the plan has the best overall benefit package for the service areas involved. However, no HMO shall be eligible for a contract if the HMO's retiree Medicare premium exceeds the retiree rate as set by the department for the state group health insurance plan.

e. The department, *subject to the review and approval of the Agency for Health Care Administration,* may limit the number of HMOs that it contracts with in each service area based on the nature of the bids *the Agency for Health Care Administration* ~~it~~ receives, the number of state employees in the service area, and any unique geographical characteristics of the service area. The department, *subject to the review and approval of the Agency for Health Care Administration,* shall establish by rule service areas throughout the state.

f. All persons participating in the state group insurance program who are required to contribute towards a total state group health premium shall be subject to the same dollar contribution regardless of whether the enrollee enrolls in the state group health insurance plan or in an HMO plan.

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

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

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

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

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

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

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

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

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

6. Any HMO participating in the state group insurance program shall, upon the request of the *Agency for Health Care Administration* ~~department~~, submit to the *Agency for Health Care Administration* ~~department~~ standardized data for the purpose of comparison of the appropriateness, quality, and efficiency of care provided by the HMO. Such standardized data shall include: membership profiles; inpatient and outpatient utilization by age and sex, type of service, provider type, and facility; and emergency care experience. Requirements and timetables for submission of such standardized data and such other data as the *Agency for Health Care Administration* ~~department~~ deems necessary to evaluate the performance of participating HMOs shall be promulgated by rule.

7. The department shall, after consultation with *the Agency for Health Care Administration and* representatives from each of the unions representing state and university employees, establish a comprehensive package of insurance benefits including, but not limited to, supplemental health and life coverage, dental care, and vision care to allow state employees the option to choose the benefit plans which best suit their individual needs.

a. Based upon a desired benefit package, the *Agency for Health Care Administration* ~~department~~ shall issue a request for proposal for *health* insurance providers interested in participating in the state group insurance program, *and the department shall issue a request for proposal for insurance providers interested in participating in the non-health-related components of the state group insurance program.* Upon receipt of all proposals, the department *or the Agency for Health Care Administration* may, as *either* ~~it~~ deems appropriate, enter into contract negotiations with insurance providers submitting bids or negotiate a specially designed benefit package. Insurance providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state employees currently enrolled may be included by the department in the supplemental insurance benefit plan established by the department *or the Agency for Health Care Administration* without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans.

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

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans.

(f)~~(e)~~ The benefits of the insurance authorized by this section shall not be in lieu of any benefits payable under chapter 440, the Workers' Compensation Law. The insurance authorized by this law shall not be deemed to constitute insurance to secure workers' compensation benefits as required by chapter 440.

(5) DEPARTMENT OF MANAGEMENT SERVICES; POWERS AND DUTIES.—The Department of Management Services is responsible for the administration of the state group insurance program. The department shall initiate and supervise the program as established by this section and shall adopt such rules as are necessary to perform its responsibilities. To implement this program, the department shall, with prior ~~legislative~~ approval *by the Legislature and, for state employee health insurance, by the Agency for Health Care Administration*:

(a) Determine the benefits to be provided and the contributions to be required for the state group insurance program. Such determinations, whether for a contracted plan or a self-insurance plan pursuant to paragraph (c), do not constitute rules within the meaning of s. 120.52(16) or orders within the meaning of s. 120.52(11). Any physician's fee schedule used in the health and accident plan shall not be available for inspection or copying by medical providers or other persons not involved in the administration of the program. However, in the determination of the design of the program, the department *or the Agency for Health Care Administration* shall consider existing and complementary benefits provided by the Florida Retirement System and the Social Security System.

(b) Prepare, in cooperation with the Department of Insurance *and the Agency for Health Care Administration*, the specifications necessary to implement the program.

(c) Contract on a competitive proposal basis with an insurance carrier or carriers, or professional administrator, determined by the Department of Insurance to be fully qualified, financially sound, and capable of meeting all servicing requirements. Alternatively, the Department of Management Services may self-insure any plan or plans contained in the state group insurance program subject to approval based on actuarial soundness by the Department of Insurance. The department may contract with an insurance company or professional administrator qualified and approved by the Department of Insurance to administer such plan. Before entering into any contract, the Department of Management Services *or, for state employee health insurance, the Agency for Health Care Administration* shall advertise for competitive proposals, and such contract shall be let upon the consideration of the benefits provided in relationship to the cost of such benefits. The department, *subject to the review and approval of the Agency for Health Care Administration,* may contract for medical services which will improve the health or reduce medical costs for employees who participate in the state group insurance plan.

(d) With respect to the state group health insurance plan, be authorized, *subject to the review and approval of the Agency for Health Care Administration,* to require copayments with respect to all providers under the plan.

(e) Have authority to establish, *subject to the review and approval of the Agency for Health Care Administration,* a voluntary program for comprehensive health maintenance, which may include health educational components and health appraisals.

Final decisions concerning the existence of coverage or benefits under the state group health insurance plan shall not be delegated or deemed to have been delegated by the department, *except that such decisions shall be subject to the review and approval of the Agency for Health Care Administration.*

Section 5. Paragraph (c) of subsection (5), paragraph (b) of subsection (6), paragraphs (f), (h), and (q) of subsection (8), paragraph (c) of subsection (9), paragraphs (a) and (c) of subsection (12), paragraph (a) of subsection (13), and subsection (17) of section 112.0455, Florida Statutes, 1992 Supplement, are amended to read:

112.0455 Drug-Free Workplace Act.—

(5) DEFINITIONS.—Except where the context otherwise requires, as used in this act:

(c) "Initial drug test" means a sensitive, rapid, and reliable procedure to identify negative and presumptive positive specimens. All initial tests shall use an immunoassay procedure or an equivalent, or shall use a more accurate scientifically accepted method approved by the *Agency for*

Health Care Administration ~~Department of Health and Rehabilitative Services~~ as such more accurate technology becomes available in a cost-effective form.

(6) NOTICE TO EMPLOYEES.—

(b) Prior to testing, all employees and job applicants for employment shall be given a written policy statement from the employer which contains:

1. A general statement of the employer's policy on employee drug use, which shall identify:

a. The types of testing an employee or job applicant may be required to submit to, including reasonable suspicion or other basis; and

b. The actions the employer may take against an employee or job applicant on the basis of a positive confirmed drug test result.

2. A statement advising the employee or job applicant of the existence of this section.

3. A general statement concerning confidentiality.

4. Procedures for employees and job applicants to confidentially report the use of prescription or nonprescription medications both before and after being tested. Additionally, employees and job applicants shall receive notice of the most common medications by brand name or common name, as applicable, as well as by chemical name, which may alter or affect a drug test. A list of such medications shall be developed by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~.

5. The consequences of refusing to submit to a drug test.

6. Names, addresses, and telephone numbers of employee assistance programs and local alcohol and drug rehabilitation programs.

7. A statement that an employee or job applicant who receives a positive confirmed drug test result may contest or explain the result to the employer within 5 working days after written notification of the positive test result. If an employee or job applicant's explanation or challenge is unsatisfactory to the employer, the person may contest the drug test result as provided by subsections (14) and (15).

8. A statement informing the employee or job applicant of his responsibility to notify the laboratory of any administrative or civil actions brought pursuant to this section.

9. A list of all drugs for which the employer will test, described by brand names or common names, as applicable, as well as by chemical names.

10. A statement regarding any applicable collective bargaining agreement or contract and the right to appeal to the Public Employees Relations Commission.

11. A statement notifying employees and job applicants of their right to consult the testing laboratory for technical information regarding prescription and nonprescription medication.

(8) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(f) A person who collects or takes a specimen for a drug test conducted pursuant to this section shall collect an amount sufficient for two drug tests as determined by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~.

(h) Every specimen that produces a positive confirmed result shall be preserved by the licensed laboratory that conducts the confirmation test for a period of at least 210 days from the time the results of the positive confirmation test are mailed or otherwise delivered to the employer. However, if an employee or job applicant undertakes an administrative or legal challenge to the test result, the employee or job applicant shall notify the laboratory and the sample shall be retained by the laboratory until the case or administrative appeal is settled. During the 180-day period after written notification of a positive test result, the employee or job applicant who has provided the specimen shall be permitted by the employer to have a portion of the specimen retested, at the employee or job applicant's expense, at another laboratory, licensed and approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~, chosen by the employee or job applicant. The second laboratory must test at equal or greater sensitivity for the drug in question as the first laboratory. The first laboratory which performed the test for the employer shall be responsible for the transfer of the portion of the specimen to be retested, and for the integrity of the chain of custody during such transfer.

(q) An employer who performs drug testing or specimen collection shall use chain-of-custody procedures as established by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ to ensure proper recordkeeping, handling, labeling, and identification of all specimens to be tested.

(9) CONFIRMATION TESTING.—

(c) All positive initial tests shall be confirmed using gas chromatography/mass spectrometry (GC/MS) or an equivalent or more accurate scientifically accepted method approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ as such technology becomes available in a cost effective form.

(12) DRUG TESTING STANDARDS; LABORATORIES.—

(a) No laboratory may analyze initial or confirmation drug specimens unless:

1. The laboratory is licensed and approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ using criteria established by the National Institute on Drug Abuse as guidelines for modeling the state drug testing program.

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

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

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

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

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

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

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

(13) RULES.—

(a) The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ is hereby authorized to promulgate rules, using criteria established by the National Institute on Drug Abuse as guidelines for modeling the state drug testing program, concerning, but not limited to:

1. Standards for drug testing laboratory licensing, suspension, and revocation of a license.

2. Body specimens and minimum specimen amounts which are appropriate for drug testing.

3. Methods of analysis and procedures to ensure reliable drug testing results, including standards for initial tests and confirmation tests.

4. Minimum cut-off detection levels for drugs or their metabolites for the purposes of determining a positive test result.

5. Chain-of-custody procedures to ensure proper identification, labeling, and handling of specimens being tested.

6. Retention, storage, and transportation procedures to ensure reliable results on confirmation tests and retests.

7. A list of the most common medications by brand name or common name, as applicable, as well as by chemical name, which may alter or affect a drug test.

(17) LICENSE FEE.—Fees from licensure of drug testing laboratories shall be sufficient to carry out the responsibilities of the *Agency for Health Care Administration* ~~department~~ for the regulation of drug testing laboratories. The *Agency for Health Care Administration* ~~department~~ shall collect fees for all licenses issued under this part. ~~The fee schedule for fiscal year 1991-1992 shall not exceed the maximum fees provided herein and such schedule adopted by rule by the department pursuant to this part.~~ Each nonrefundable fee shall be due at the time of application and shall be payable to the *Agency for Health Care Administration* ~~department~~ to be deposited in a trust fund administered by the *Agency for Health Care Administration* ~~department~~ and used only for the purposes of this section. The fee schedule is as follows: For licensure as a drug testing laboratory, an annual fee of not less than $8,000 or more than $10,000 per fiscal year; for late filing of an application for renewal, an additional fee of $500 per day shall be charged.

Section 6. Effective July 1, 1993, paragraph (b) of subsection (3) and subsection (4) of section 408.001, Florida Statutes, 1992 Supplement, are amended to read:

408.001 Florida Health Care Purchasing Cooperative.—

(3) BOARD OF DIRECTORS.—

(b) The ~~initial~~ board of directors shall consist of:

1. The Director of the *Agency for Health Care Administration* ~~Division of State Employees Insurance of the Department of Management Services~~;

2. The *Deputy Director of the Division of State Health Purchasing of the Agency for Health Care Administration* ~~Assistant Secretary for Medicaid of the Department of Health and Rehabilitative Services~~;

3. The Assistant Secretary for Health Services of the Department of Corrections;

4. Two persons who are responsible for purchasing health benefits for municipal employees and who are appointed by the Florida League of Cities;

5. A person who is responsible for purchasing health care benefits for county employees or health care services for county clients and who is appointed by the Florida Association of Counties; and

6. A person who is responsible for purchasing health care benefits for school district employees and who is appointed by the Florida Association of School Administrators.

~~Appointments to the initial board of directors shall be made by August 1, 1991.~~ The appointed members of the ~~initial~~ board of directors shall be appointed for 2 years and may be reappointed. ~~The Director of the Division of State Employees Insurance shall chair the initial board of directors.~~

~~(4) STAFF AND ADMINISTRATIVE SUPPORT.—The Health Care Cost Containment Board shall provide staff and administrative support to, and shall draft bylaws for, the Florida Health Care Purchasing Cooperative until the board of directors of the cooperative has organized itself and appointed an executive director. The board of directors shall conduct its first meeting on or before September 1, 1991.~~

Section 7. Section 409.701, Florida Statutes, is renumbered as section 408.0014, Florida Statutes, and paragraph (a) of subsection (4) of said section is amended to read:

408.0014 ~~409.701~~ The Florida Health Access Corporation Act.—

(4) BOARD OF DIRECTORS.—

(a) The Florida Health Access Corporation shall operate subject to the supervision and approval of a seven-member board of directors, which shall consist of:

1. Two members, one from an urban county and one from a rural county, who shall represent small businesses whose employees are eligible to participate in the Florida Health Access Corporation;

2. One member who shall represent consumers eligible to participate in the Florida Health Access Corporation;

3. One member who shall be a representative of a domestic health care insurer or of a private company which offers a self-insured program of health benefits to employees;

4. One member who shall be the *Director of Health Care Administration* ~~secretary of the Department of Health and Rehabilitative Services~~ or his designee;

5. One member who shall be a representative of the Florida Chamber of Commerce; and

6. One member who shall be a representative of an employer health coalition.

Section 8. Subsection (2) of section 408.062, Florida Statutes, 1992 Supplement, is amended to read:

408.062 Research, analyses, studies, and reports.—

(2) The board shall evaluate data from nursing home financial reports and shall document and monitor:

(a) Total revenues, annual change in revenues, and revenues by source and classification, including contributions for a *resident's* ~~patient's~~ care from the *resident's* ~~patient's~~ resources and from the family and contributions not directed toward any specific *resident's* ~~patient's~~ care.

(b) Average *resident* ~~patient~~ charges by geographic region, *payer* ~~payor~~, and type of facility ownership.

(c) Profit margins by geographic region and type of facility ownership.

(d) Amount of charity care provided by geographic region and type of facility ownership.

(e) *Resident* ~~Patient~~ days by payer category.

(f) Experience related to Medicaid conversion as reported under s. 408.061.

(g) Other information pertaining to nursing home revenues and expenditures.

The findings of the board shall be included in an annual report to the Governor and Legislature by January 1 each year.

Section 9. Subsection (9) of section 408.07, Florida Statutes, 1992 Supplement, is amended to read:

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

(9) "Banked points" means the percentage points earned by a hospital when the actual rate of increase in *gross revenue per adjusted admission (GRAA) is less than the maximum allowable rate of increase (MARI) or the actual rate of increase in the net revenue per adjusted admission (NRAA) is less than the market basket index* ~~gross and net revenue per adjusted admission (GRAA) is less than the maximum allowable rate of increase (MARI)~~.

Section 10. Paragraph (a) of subsection (4) of section 408.061, Florida Statutes, is amended to read:

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

(4)(a) Within 120 days after the end of its fiscal year, each health care facility shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. *Nursing homes that do not participate in the Medicare or Medicaid programs shall also submit audited actual experience. Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Depart-*

ment of Health and Rehabilitative Services, shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other non-institutional settings. The agency shall include its findings in the final Florida Health Plan which must be submitted to the Legislature by December 31, 1993.

Section 11. Subsection (2), paragraphs (a), (b), and (c) of subsection (3), paragraphs (g) and (i) of subsection (5), paragraph (a) of subsection (6), paragraph (b) of subsection (9), and paragraph (a) of subsection (11) of section 408.072, Florida Statutes, 1992 Supplement, are amended to read:

408.072 Review of hospital budgets.—

(2) The projected budget shall be deemed approved unless it is disapproved by the board within 90 days after filing, except that where the hospital requests a hearing, the 90 days shall be tolled until 20 days after the board's receipt of the recommended order from the Division of Administrative Hearings of the Department of *Management Services* ~~Administration~~. Upon agreement by the board and the hospital, the 90-day period may be waived or extended. As part of the review process conducted by the board, the board may approve, disapprove, or disapprove in part the projected budget. Once submitted and reviewed by the board, a detailed budget *or budget amendment* shall not be withdrawn by a hospital unless the increase approved by the board is greater than the maximum allowable rate of increase, the gross revenue per adjusted admission, or the net revenue per adjusted admission.

(3)(a) Except for hospitals filing a budget pursuant to subsection (1), each hospital, at least 90 days prior to the commencement of its next fiscal year, shall file with the board a certified statement, hereafter known as the "budget letter," acknowledging its applicable maximum allowable rate of increase (MARI) in gross and net revenue per adjusted admission. Calculations shall be performed by the hospital using the methodology specified in s. 408.07. Through the budget letter, the hospital shall affirm that the hospital shall not exceed its applicable maximum allowable rate of increase in gross and net revenue per adjusted admission. However, the board shall have *90* ~~30~~ days from receipt of the budget letter to determine if the applicable maximum allowable rates of increase submitted by the hospital are within the levels calculated pursuant to this section. If the board determines that the maximum allowable rates of increase submitted by the hospital are not within the levels calculated by the board, then the budget letter shall be rejected.

(b) If a hospital's gross revenues per adjusted admission, as determined by its audited actual experience in any one year, increase at a percentage rate less than the maximum allowable rate of increase or board-approved rate of increase, whichever is lower, the hospital may carry forward the difference and earn up to a cumulative maximum for ~~both~~ gross ~~and net~~ revenues of 3 "banked" percentage points which may be banked to be used in the future. In no case shall a hospital that exceeds its maximum gross revenue per adjusted admission earn banked points.

(c) If a hospital's net revenue per adjusted admission, as determined by its audited actual experience in any one year, increases at a percentage rate less than the *market basket index* ~~maximum allowable rate of increase~~ or the board-approved rate of change, whichever is lower, the hospital may carry forward the difference and earn up to a cumulative maximum for ~~both gross and~~ net revenues of 3 "banked" percentage points which may be banked to be used in the future.

(5) The board shall review each budget filed pursuant to subsection (1) and amendments filed pursuant to subsection (6) to determine whether the gross revenue per adjusted admission or the net revenue per adjusted admission contained in the budget or amendment is just, reasonable, and not excessive. In making such determination, the board shall consider, and the hospital may use, the following criteria in the following priority, with paragraph (a) the highest priority and paragraph (i) the lowest priority.

(g) The change in hospital costs as measured by changes in the severity of illness, including changes in the case mix. For psychiatric and other hospitals that would *not* be reimbursed under a prospective payment system by the Federal Government, the impact on hospital costs associated with changes in the average length of stay of patients *or* ~~and~~, when available, case mix shall be considered.

(i) For psychiatric hospitals, the impact on hospital gross revenues associated with changes in the average length of stay of patients, changes in admissions to hospital units, and changes in admissions to specific services *or* ~~and~~, when available, case mix.

(6) After a hospital budget is approved, approved as amended, or disapproved for a given fiscal year, no amendment to such budget shall be made except in accordance with the following procedures:

(a) A request by a hospital to amend its budget shall be filed in writing with supporting documents no later than 90 days before the end of the hospital's fiscal year. The budget amendment shall be deemed approved unless it is disapproved or disapproved in part by the board within 90 days after the filing, except that where the hospital requests a hearing, the 90 days shall be tolled until 20 days after the board's receipt of the recommended order from the Division of Administrative Hearings of the Department of *Management Services* ~~Administration~~. Upon agreement by the board and the hospital, the 90-day period may be waived or extended.

(9)

(b) If a hearing is requested, it shall be conducted by the board or, at the election of the board, by a hearing officer of the Division of Administrative Hearings of the Department of *Management Services* ~~Administration~~, pursuant to the provisions of s. 120.57. Hearings shall be held within 30 days of filing the request unless waived by the board and the hospital. All hearings shall be held in Tallahassee unless the board determines otherwise.

(11) Notwithstanding any other provisions of this chapter:

(a) Any hospital operated by the Department of Health and Rehabilitative Services or the Department of Corrections; any rural hospital as defined in s. 408.07; and any intensive residential treatment program for children and adolescents as defined in s. 395.002(16) which received a certificate of need on or before January 1, 1991, and is licensed under chapter 395 for less than 33 beds, which is not part of a multifacility organization and which is part of a community mental health system, shall be exempt from filing a budget, and shall be exempt from budget review and approval for exceeding the maximum allowable rate of increase and from any penalties arising therefrom. However, each such hospital shall be required to submit to the board its audited actual experience, as required by s. 408.061(4)*(a)*~~(d)~~.

Section 12. Subsection (1), paragraph (c) of subsection (2), paragraph (c) of subsection (3), and subsection (9) of section 408.08, Florida Statutes, 1992 Supplement, are amended to read:

408.08 Inspections and audits; violations; penalties; fines; enforcement.—

(1) The agency may inspect and audit books and records~~, and records~~ of individual or corporate ownership, including books and records of related organizations with which a health care provider or a health care facility had transactions, for compliance with this chapter. Upon presentation of a written request for inspection to a health care provider or a health care facility by the agency or its staff, the health care provider or the health care facility shall make available to the agency or its staff for inspection, copying, and review all books and records relevant to the determination of whether the health care provider or the health care facility has complied with this chapter.

(2) The board shall annually compare the audited actual experience of each hospital to the audited actual experience of that hospital for the previous year.

(c) For a hospital submitting a budget letter and for a hospital subject to budget review, the board shall annually compare each hospital's audited actual experience for net revenues per adjusted admission to the hospital's audited actual experience for net revenues per adjusted admission for the previous year. If the rate of increase in net revenues per adjusted admission between the previous year and the current year was less than the market basket index ~~plus 2 percentage points~~, the hospital may carry forward the difference and earn up to a cumulative maximum of 3 banked net revenue percentage points. Such banked net revenue percentage points shall be available to the hospital to offset, in any future year, penalties for exceeding the approved budget or the maximum allowable rate of increase as set forth in subsection (3). Nothing in this paragraph shall be used by a hospital to justify the approval of a budget or a budget amendment by the board in excess of the maximum allowable rate of increase pursuant to s. 408.072.

(3) Penalties shall be assessed as follows:

(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall:

1. Levy a fine against the hospital in the total amount of the excess, to be deposited in the Public Medical Assistance Trust Fund.

2. Notify the agency of the violation, whereupon the agency shall not accept any application for a certificate of need pursuant to ss. 408.031-408.045 from or on behalf of such hospital until such time as the hospital has demonstrated to the satisfaction of the board that, following the date the penalty was imposed under subparagraph 1., the hospital has stayed within its projected or amended budget or its applicable maximum allowable rate of increase for a period of at least 1 year. However, this provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.

3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the agency, whereupon the agency shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.

The determination of the amount of any such excess shall be based upon net revenues per adjusted admission, excluding funds distributed to the hospital from the Public Medical Assistance Trust Fund. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.701 minus the amount of revenues received by the hospital through the Public Medical Assistance Trust Fund. It is the responsibility of the hospital to demonstrate to the satisfaction of the board its entitlement to such reduction. It is the intent of the Legislature that the Health Care Board, in levying any penalty imposed against a hospital for exceeding its maximum allowable rate of increase or its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital and in the hospital's intensity and severity of illness as measured by changes in the hospital's actual proportion of outlier cases to total cases and dollar increases in outlier cases' average charge per case. It is the responsibility of the hospital to demonstrate to the satisfaction of the board any change in its case mix and in its intensity and severity of illness. For psychiatric hospitals *and other hospitals not reimbursed under a prospective payment system by the Federal Government, until a proxy for case mix is available,* the board shall *adjust* ~~also reduce~~ the amount of excess by ~~utilizing as a proxy for case mix~~ the change in a hospital's audited actual average length of stay ~~as compared to the previous year's audited actual average length of stay~~ without any thresholds or limitations.

(9) In levying any administrative fine against a hospital pursuant to subsection (8), the board shall consider the effect of any changes in the hospital's case mix, and in the hospital's intensity and severity of illness as measured by changes in the hospital's actual proportion of outlier cases to total cases and dollar increases in outlier cases' average charge per case. The board shall adjust the amount of any excess by the changes in the hospital's case mix and in its intensity and severity of illness, based upon certified hospital patient discharge data provided to the board pursuant to s. 408.061. For psychiatric hospitals *and other hospitals not reimbursed under a prospective payment system by the Federal Government, until a proxy for case mix is available,* the board shall adjust the amount of any excess by ~~utilizing as a proxy for case mix~~ the change in a hospital's audited actual average length of stay *without any thresholds or limitation* ~~as compared to the previous year's audited actual average length of stay~~.

Section 13. Subsection (1) of section 409.7015, Florida Statutes, is amended to read:

409.7015 Unemployment compensation data availability.—

(1) In order to further the research and demonstration objectives of s. *408.0014* ~~409.701~~, the Division of Unemployment Compensation, Department of Labor and Employment Security, shall, notwithstanding the provisions of s. 443.171(7), make available to the Florida Health Access Corporation such information as the corporation requests so as to facilitate contact with employers who may be eligible for participation in the program of health insurance benefits arranged through the corporation. Such information as is obtained by the corporation through the provisions of this section is confidential and exempt from the provisions of s. 119.07(1). Neither the corporation nor the staff or agents of the corporation shall release to any state or federal agency, to any private business or person, or to any other entity any information received through the operation of this section. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14. Violation of this section shall be regarded as a violation of s. 443.171(7).

Section 14. Section 408.301, Florida Statutes, is created to read:

408.301 Legislative findings.—The Legislature has found that access to quality, affordable, health care for all Floridians is an important goal for the state. The legislature has charged the Agency for Health Care Administration with the responsibility of developing the Florida Health Plan for assuring access to health care for all Floridians. At the same time, the Legislature recognizes that there are Floridians with special health care and social needs which require particular attention. The people served by the Department of Health and Rehabilitative Services are examples of citizens with special needs. The Legislature further recognizes that the Medicaid Program is an intricate part of the service delivery system for the special needs citizens served by or through the Department of Health and Rehabilitative Services. The Agency for Health Care Administration is not a service provider and does not develop or direct programs for the special needs citizens served by or through the Department of Health and Rehabilitative Services. Therefore, it is the intent of the Legislature that the Agency for Health Care Administration work closely with the Department of Health and Rehabilitative Services in developing plans for assuring access to all Floridians in order to assure that the needs of special citizens are met.

Section 15. Section 408.032, Florida Statutes, is created to read:

(1) The Agency for Health Care Administration shall enter into an inter-agency agreement with the Department of Health and Rehabilitative Services to assure coordination and cooperation in serving special needs citizens. The agreement shall include the requirement that the Secretary of the Department of Health and Rehabilitative Services approve, prior to adoption, any rule developed by the Agency for Health Care Administration where such rule has a direct impact on the mission of the Department of Health and Rehabilitative Services, its program, or its budget.

(2) For rules which indirectly impact on the mission of the Department of Health and Rehabilitative Services, its programs, or its budget, the concurrence of the Secretary of the Department of Health and Rehabilitative Services on the rule is required.

(3) For all other rules developed by the Agency for Health Care Administration, coordination with the Department of Health and Rehabilitative Services is encouraged.

(4) The inter-agency agreement shall also include any other provisions necessary to ensure a continued cooperative working relationship between the Agency for Health Care Administration and the Department of Health and Rehabilitative Services as each strives to meet the needs of the citizens of Florida.

Section 16. Section 455.201, Florida Statutes, 1992 Supplement, is amended to read:

455.201 Professions and occupations regulated by Department of Professional Regulation ~~or Agency for Health Care Administration~~; legislative intent; requirements.—

(1) It is the intent of the Legislature that persons desiring to engage in any lawful profession regulated by the Department of Professional Regulation ~~or the Agency for Health Care Administration~~ shall be entitled to do so as a matter of right if otherwise qualified.

(2) The Legislature further believes that such professions shall be regulated only for the preservation of the health, safety, and welfare of the public under the police powers of the state. Such professions shall be regulated when:

(a) Their unregulated practice can harm or endanger the health, safety, and welfare of the public, and when the potential for such harm is recognizable and clearly outweighs any anticompetitive impact which may result from regulation.

(b) The public is not effectively protected by other means, including, but not limited to, other state statutes, local ordinances, or federal legislation.

(c) Less restrictive means of regulation are not available.

(3) It is further legislative intent that the use of the term "profession" with respect to those activities licensed and regulated by the Department of Professional Regulation ~~or the Agency for Health Care Administration~~ shall not be deemed to mean that such activities are not occupations for other purposes in state or federal law.

(4) No board, nor the department~~, nor the Agency for Health Care Administration~~ shall create unreasonably restrictive and extraordinary standards that deter qualified persons from entering the various professions. No board, nor the department, shall take any action which tends to create or maintain an economic condition that unreasonably restricts competition, except as specifically provided by law.

(5) Policies adopted by the department shall ensure that all expenditures are made in the most cost-effective manner to maximize competition, minimize licensure costs, and maximize public access to meetings conducted for the purpose of professional regulation. The long-range planning function of the department shall be implemented to facilitate effective operations and to eliminate inefficiencies.

Section 17. Paragraph (a) of subsection (4) and subsection (6) of section 624.91, Florida Statutes, are amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

(4) BOARD OF DIRECTORS.—

(a) The Florida Healthy Kids Corporation shall operate subject to the supervision and approval of a board of directors chaired by the Insurance Commissioner or his designee, and composed of *12* ~~11~~ other members selected for 3-year terms of office as follows:

1. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Administrators;

2. One member appointed by the Commissioner of Education from among three persons nominated by the Florida Association of School Boards;

3. One member appointed by the Commissioner of Education from the Office of School Health Programs of the Florida Department of Education;

4. One member appointed by the Governor from among three members nominated by the Florida Pediatric Society;

5. One member, appointed by the Governor, who represents the Children's Medical Services Program;

6. One member appointed by the Insurance Commissioner from among three members nominated by the Florida Hospital Association;

7. Two members, appointed by the Insurance Commissioner, who are representatives of authorized health care insurers or health maintenance organizations;

8. One member, appointed by the Insurance Commissioner, who represents the Institute for Child Health Policy;

9. One member, appointed by the Governor, from among three members nominated by the Florida Academy of Family Physicians; ~~and~~

10. One member, appointed by the Governor, who represents the Agency for Health Care Administration; and

11. ~~10.~~ The State Health Officer or his designee.

In order to provide for staggered terms, the initial term of the members appointed under subparagraphs 1., 4., and 6. shall be for 2 years and the initial term of the members appointed under subparagraphs 2., 5., ~~and~~ 8., *and 10.* shall be for 4 years.

(6) THE FLORIDA HEALTHY KIDS TRUST FUND.—There is created the Florida Healthy Kids Trust Fund in the State Treasury to be administered by the *Agency for Health Care Administration* ~~Department of Insurance~~, to which all appropriations shall be deposited in order to carry out the purposes of this act. Other revenues of the corporation such as grants, contributions, matching funds, and participant payments shall not be considered revenue of the state, but rather shall be funds of the corporation. However, the corporation may designate portions of grants, contributions, matching funds, and participant payments as funds of the state and deposit those funds in the Florida Healthy Kids Trust Fund.

Section 18. Effective July 1, 1993, paragraph (d) of subsection (3) of section 766.1115, Florida Statutes, 1992 Supplement, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

(3) DEFINITIONS.—As used in this section, the term:

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician licensed, or physician assistant certified, under chapter 458.

5. An osteopathic physician licensed, or osteopathic physician assistant certified, under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatrist licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under chapter 464 or any facility which employs nurses licensed or registered under chapter 464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association and its employees or a corporate medical group and its employees.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.

13. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(c) of the Internal Revenue Code which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

Section 19. The provisions of sections 35, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, and 65 of chapter 92-33, Laws of Florida, notwithstanding, the amendments to sections 455.20, 455.203, 455.205, 455.207, 455.208, 455.209, 455.211, 455.214, 455.215, 455.2173, 455.2175, 455.218, 455.220, 455.2205, 455.221, 455.223, 455.224, 455.225, 455.227, 455.2273, 455.2275, 455.228, 455.2285, 455.229, 455.232, 455.241, 455.243, 455.245, and 455.26, Florida Statutes, and the repeal of s. 455.213(6) and (7), Florida Statutes, therein shall not take effect July 1, 1993, but rather shall take effect July 1, 1994

Section 20. Paragraph (a) of subsection (2) of section 240.4067, Florida Statutes, 1992 Supplement, is amended to read:

240.4067 Medical Education Reimbursement and Loan Repayment Program.—

(2) From the funds available, the Department of Health and Rehabilitative Services shall make payments to selected medical professionals as follows:

(a) Up to $4,000 per year for licensed practical nurses and registered nurses, up to $10,000 per year for advanced registered nurse practitioners and physician's assistants, and up to $20,000 per year for physicians. *Penalties for noncompliance shall be the same as those in the National Health Services Corps Loan Repayment Program* ~~or an amount equivalent to one-third of the total of loans and other educational expenses that were incurred by the health care professional during his enrollment in medical or nursing school, whichever is less, for a maximum of 3 years.~~ Educational expenses include costs for tuition, matriculation, registra-

tion, books, laboratory and other fees, other educational costs, and reasonable living expenses as determined by the Department of Health and Rehabilitative Services.

Section 21. Subsection (1) and paragraph (a) of subsection (7) of section 240.4075, Florida Statutes, 1992 Supplement, are amended to read:

240.4075 Nursing Student Loan Forgiveness Program.—

(1) To encourage qualified personnel to seek employment in areas of this state in which critical nursing shortages exist, there is established the Nursing Student Loan Forgiveness Program. The primary function of the program is to increase employment and retention of registered nurses and licensed practical nurses in nursing homes and hospitals in the state and in state-operated medical and health care facilities, *birth centers,* federally sponsored community health centers and teaching hospitals by making repayments toward loans received by students from federal or state programs or commercial lending institutions for the support of postsecondary study in accredited or approved nursing programs.

(7)(a) Funds contained in the Nursing Student Loan Forgiveness Trust Fund which are to be used for loan forgiveness for those nurses employed by hospitals, *birth centers,* and nursing homes must be matched on a dollar-for-dollar basis by contributions from the employing institutions except that this provision shall not apply to state-operated medical and health care facilities, county public health units, federally sponsored community health centers, or teaching hospitals as defined in s. 408.07.

Section 22. Section 381.0302, Florida Statutes, 1992 Supplement, is amended to read:

381.0302 Florida Health Services Corps.—

(1) To encourage qualified medical professionals to practice in underserved locations where there are shortages of such personnel, the Legislature establishes the Florida Health Services Corps.

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

(a) "Department" means the Department of Health and Rehabilitative Services.

(b) "Florida Health Services Corps" means a program authorized by this section which:

1. Offers scholarships to *allopathic, osteopathic,* ~~medical,~~ chiropractic, *podiatric,* dental, *physician assistant,* and nursing students, *and loan repayment assistance and travel and relocation expenses to allopathic and osteopathic residents and physicians, chiropractors, podiatrists, nurse practitioners, dentists, and physician assistants,* in return for service in a public health care program *or in a medically underserved area.*

2. Offers membership on a voluntary basis to physicians and other health care personnel who provide uncompensated care.

(c) "Medically underserved area" means:

1. A geographic area, a special population, or a facility that has a shortage of health professionals as defined by federal regulations;

2. A county public health unit, community health center, or migrant health center; or

3. A geographic area or facility designated by rule by the department that has a shortage of health care practitioners who serve Medicaid and other low-income patients.

(d) "Medically indigent person" means a person who lacks public or private health insurance, is unable to pay for care, and is a member of a family with an income at or below 185 percent of the federal poverty level.

(e) "Public health program" means a county public health unit, a children's medical services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded *or nonprofit* health care program designated by the department.

(f) "Primary care" means family and general practice, general pediatrics, obstetrics/gynecology, and general internal medicine.

(3) The Florida Health Services Corps shall be developed by the State Health Office in cooperation with the programs in the area Health Education Center network as defined in s. 381.0402 and the state's health care education and training institutions. The State Health Officer shall be the director of the Florida Health Services Corps.

(4) Corps members shall be supervised by the State Health Officer, or his physician designee, for the purpose of practice guidelines, continuing education, and other matters pertaining to professional conduct.

(5) The department may award scholarships to students studying medicine, *osteopathic medicine,* chiropractic, *podiatric,* nursing, or dentistry.

(a) The program shall require a student who receives a scholarship to accept an assignment in a public health care program or work in a specific community located in a medically underserved area upon *completion of primary care training* ~~graduation~~. The department shall determine assignments. If a practitioner is assigned to a medically underserved area, the practitioner must treat Medicaid patients and other patients with low incomes.

(b) An eligible student must *be pursuing* ~~pursue~~ a full-time course of study in:

1. Allopathic or osteopathic medicine, including physician assistants;

2. Dentistry;

3. Podiatric medicine;

4. ~~3.~~ Nursing, including registered nurses, nurse midwives, and other nurse practitioners; or

5. ~~4.~~ Chiropractic medicine.

(c) In selecting students to participate in the scholarship program, priority shall be given to students who indicate a desire to practice a primary care specialty in a medically underserved area after their obligation is completed and who indicate an intent to practice medical specialties for which the department has a need.

(d) Scholarship assistance shall consist of reimbursement for tuition and other educational costs such as books, supplies, equipment, transportation, and monthly living expense stipends. The department shall pay the same amount for living expense stipends as is paid by the National Health Services Corps. Each monthly living expense stipend shall be for a 12-month period beginning with the first month of each school year in which the student is a participant. The department may reimburse a participant for books, supplies, and equipment based on average costs incurred by participants for these items. The department shall prescribe, by rule, eligible expenses for reimbursement and allowable amounts.

(e) For *an allopathic or osteopathic* ~~a~~ medical student, enrollment in the corps may begin in the second year of medical school or in any year thereafter. For a nursing student or other student, enrollment may occur in any year.

(f) For a student who receives scholarship assistance, participation in the corps after *completion of training* ~~graduation~~ shall be 1 year for each school year of *scholarship* ~~financial~~ assistance, up to a maximum of 3 years. The period of obligated service shall begin when the participant is assigned by the department to a public health program or to a medically underserved area.

(6) The department may provide loan repayment assistance and travel and relocation reimbursement to allopathic and osteopathic medical residents with primary care specialties during their last 2 years of residency training or upon completion of residency training, and to physician assistants and nurse practitioners with primary care specialties, in return for an agreement to serve a minimum of 2 years in the Florida Health Services Corps. During the period of service, the maximum amount of annual financial payments shall not be greater than the annual total of loan repayment assistance and tax subsidies authorized by the National Health Services Corps loan repayment program.

(7)~~(6)~~ The financial penalty for noncompliance with participation requirements *for persons who have received financial payments under subsection (5) or subsection (6)* shall be determined in the same manner as in the National Health Services Corps scholarship program. In addition, noncompliance with participation requirements shall also result in ineligibility for professional licensure *or renewal of licensure* under chapter 458, chapter 459, chapter 460, chapter 464, chapter 465, or chapter 466. For a participant who is unable to participate for reasons *of* ~~beyond~~

~~his control, such as~~ disability, the penalty is the actual amount of financial assistance provided to the participant. Financial penalties shall be deposited in the Florida Health Services Corps Trust Fund and shall be used to provide additional scholarship and financial assistance.

(8)~~(7)~~ Membership in the corps may be extended to any licensed physician or other health care practitioner who provides uncompensated care to medically indigent persons referred by the department. Participation in the corps is voluntary and subject to the supervision of the department for the purpose of practice guidelines, continuing education, and other matters pertaining to professional conduct.

(9) Persons who receive loan repayment assistance under s. 240.4067 shall be members of the Florida Health Services Corps.

(10) Corps members shall be enrolled in Medicaid and accept all patients referred by the department pursuant to an agreement with the department.

(11)~~(8)~~ A Florida Health Services Corps member is an agent of the state under s. 768.28(9) while providing uncompensated services to medically indigent persons who are referred by the department.

(12)~~(9)~~ Funds appropriated under this section shall be deposited in the Florida Health Services Corps Trust Fund, which shall be administered by the State Health Office. *The department may use funds appropriated for the Florida Health Services Corps as matching funds for federal service-obligation scholarship programs for health care practitioners, such as the Demonstration Grants to States for Community Scholarship Grants program. If funds appropriated under this section are used as matching funds, federal criteria shall be followed whenever there is a conflict between provisions in this section and federal requirements.*

(13)~~(10)~~ The department shall adopt rules to implement the Florida Health Services Corps. The rules must also quantify penalties for noncompliance.

Section 23. Section 381.0406, Florida Statutes, is created to read:

381.0406 Rural health networks.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that, in rural areas, access to health care is limited and the quality of health care is negatively affected by inadequate financing, difficulty in recruiting and retaining skilled health professionals, and because of a migration of patients to urban areas for general acute care and specialty services.

(b) The Legislature further finds that the efficient and effective delivery of health care services in rural areas requires the integration of public and private resources and the coordination of health care providers.

(c) The Legislature further finds that the availability of a continuum of quality health care services, including preventive, primary, secondary, tertiary, and long term care, is essential to the economic and social vitality of rural communities.

(d) The Legislature further finds that the creation of rural health networks can help to alleviate these problems. Rural health networks shall, to the extent possible, be structured to provide a continuum of quality health care services for rural residents through the cooperative efforts of rural health network members.

(e) The Legislature further finds that rural health networks shall have the goal of increasing the utilization of statutory rural hospitals for appropriate health care services whenever feasible, which shall help to ensure their survival and thereby support the economy and protect the health and safety of rural residents.

(f) Finally, the Legislature finds that rural health networks may serve as "laboratories" to determine the best way of organizing rural health services, to move the state closer to ensuring that everyone has access to health care, and to promote cost containment efforts. The ultimate goal of rural health networks shall be to ensure that quality health care is available and efficiently delivered to all persons in rural areas.

(2) DEFINITIONS.—

(a) "Rural" means an area with a population density of less than 100 individuals per square mile or an area defined by the United States Census as rural.

(b) "Health care provider" means any individual, group, or entity, public or private, that provides health care, including: preventive health care, primary health care, secondary and tertiary health care, in-hospital health care, public health care, and health promotion and education.

(c) "Rural health network" or "network" means a nonprofit legal entity, consisting of rural and urban health care providers and others, that is organized to plan and deliver health care services on a cooperative basis in a rural area, except for some secondary and tertiary care services.

(3) Because each rural area is unique, with a different health care provider mix, health care provider membership may vary, but all networks shall include members that provide public health, comprehensive primary care, emergency medical care, and acute inpatient care.

(4) Network membership shall be available to all health care providers, provided that they render care to all patients referred to them from other network members.

(5) Network areas do not need to conform to local political boundaries or state administrative district boundaries.

(6) Networks shall develop provisions for referral to tertiary inpatient care and to other services that are not available in rural areas.

(7) Networks shall make available health promotion, disease prevention, and primary care services to improve the health status of rural residents and to contain health care costs.

(8) Networks may have multiple points of entry, such as through private physicians, community health centers, county public health units, certified rural health clinics, hospitals, or other providers; or they may have a single point of entry.

(9) Networks shall establish standard protocols, coordinate and share patient records, and develop patient information exchange systems.

(10) Networks shall develop risk management and quality assurance programs for network providers.

(11) NETWORK GOVERNANCE AND ORGANIZATION.—

(a) Networks shall be incorporated under the laws of the state.

(b) Networks shall have a board of directors that derives membership from local government, health care providers, businesses, consumers, and others.

(c) Network boards of directors shall have the responsibility of determining the content of health care provider agreements that link network members. The agreements shall specify:

1. Who provides what services.

2. The extent to which the health care provider provides care to persons who lack health insurance or are otherwise unable to pay for care.

3. The procedures for transfer of medical records.

4. The method used for the transportation of patients between providers.

5. Referral and patient flow including appointments and scheduling.

6. Payment arrangements for the transfer or referral of patients.

(12) NETWORK SERVICES.—

(a) Networks, to the extent feasible, shall provide for a continuum of care for all patients served by the network. Each network shall include the following core services: disease prevention, health promotion, comprehensive primary care, emergency medical care, and acute inpatient care. Networks shall, to the extent feasible, also ensure the availability of the following services either directly, by contract, or through referral agreements:

1. Services available in the home.

a. Home health care.

b. Hospice care.

2. Services accessible within 30 minutes or less.

a. Emergency medical services, including advanced life support, ambulance, and basic emergency room services.

b. Primary care.

c. Prenatal care.

d. Community-based services for elders, such as adult day care and assistance with activities of daily living.

e. Public health services, including communicable disease control, disease prevention, health education, and health promotion.

f. Outpatient psychiatric and substance abuse services.

3. Services accessible within 45 minutes or less.

a. Hospital acute inpatient care for persons whose illnesses or medical problems are not severe.

b. Level I obstetrical care, which is labor and delivery for low-risk patients.

c. Skilled nursing services, long-term care, including nursing home care.

d. Dialysis.

e. Osteopathic and chiropractic manipulative therapy.

4. Services accessible within 2 hours or less.

a. Specialist physician care.

b. Hospital acute inpatient care for severe illnesses and medical problems.

c. Level II and III obstetrical care, which is labor and delivery care for high-risk patients and neonatal intensive care.

d. Comprehensive medical rehabilitation.

e. Inpatient psychiatric and substance abuse services.

f. Magnetic resonance imaging, lithotripter treatment, advanced radiology, and other technologically advanced services.

g. Subacute care.

(b) Networks shall actively participate with area health education center programs, whenever feasible, in developing and implementing recruitment, training, and retention programs directed at positively influencing the supply and distribution of health care professionals serving in, or receiving training in, network areas.

(c) As funds become available, networks shall emphasize community care alternatives for elders who would otherwise be placed in nursing homes.

(13) TRAUMA SERVICES.—In those network areas which have an established trauma agency approved by the Department of Health and Rehabilitative Services, that trauma agency must be a participant in the network. Trauma services provided within the network area must comply with s. 395.037.

(14) NETWORK FINANCING. Networks may use all sources of public and private funds to support network activities.

(15) NETWORK IMPLEMENTATION.—As funds become available, networks shall be developed and implemented in two phases.

(a) Phase I shall consist of a network planning and development grant program administered by the Agency for Health Care Administration in consultation with the State Health Officer. Planning grants shall be used to organize networks, incorporate network boards, and develop formal provider agreements as provided for in this section. The Agency for Health Care Administration shall develop a request-for-proposal process to solicit grant applications.

(b) Phase II shall consist of network operations. As funds become available, certified networks shall be eligible to receive grant funds to be used to help defray the costs of providing patient care. A Phase II award may occur in the same fiscal year as a Phase I award.

(16) CERTIFICATION.—For the purpose of certifying networks that are eligible for Phase II funding, the Agency for Health Care Administration, in consultation with the State Health Office, shall certify networks that meet the criteria delineated in this section.

(17) RULES.—The Agency for Health Care Administration, in consultation with the State Health Office, shall establish rules that govern the creation and certification of networks, including establishing outcome measures for networks.

Section 24. Subsection (2) of section 395.1055, Florida Statutes, 1992 Supplement, is amended to read:

395.1055 Rules and enforcement.—

(2) Separate standards may be provided for general and specialty hospitals, ~~and~~ ambulatory surgical centers, and statutory rural hospitals as defined in s. 395.602.

Section 25. Section 395.606, Florida Statutes, is created to read:

395.606 Rural health network cooperative agreements.—

(1) INTENT.—It is the Legislature's intent that, to the extent necessary to foster the development of rural health networks as provided for in s. 381.0406, competitive market forces shall be replaced with state regulation, as provided for in subsections (2) and (3). It is also the intent of the Legislature that consolidation of hospital services or technologies undertaken pursuant to this section, and cooperative agreements between members of rural health networks, shall not violate the state's antitrust laws when such arrangements improve the quality of health care, moderate cost increases, and are made between members of rural health networks as defined in s. 381.0406. It is also the intent of the Legislature that such arrangements be protected from federal antitrust laws, subject to the approval and supervision of the Agency for Health Care Administration. Such intent is within the public policy of the state to facilitate the provision of quality, cost-efficient medical care to its citizens.

(2) STATE ACTION APPROVAL.—Providers who are members of certified rural health networks who seek to consolidate services or technologies or enter into cooperative agreements shall seek approval from the Agency for Health Care Administration, which may consult with the Department of Legal Affairs. The agency shall determine that the likely benefits resulting from the agreement outweigh any disadvantages attributable to any potential reduction in competition resulting from the agreement and issue a letter of approval if, in its determination, the agreement reduces or moderates costs and meets any of the following criteria:

(a) Consolidates services or facilities in a market area used by rural health network patients to avoid duplication;

(b) Promotes cooperation between rural health network members in the market area;

(c) Encourages cost sharing among rural health network facilities;

(d) Enhances the quality of rural health care; or

(e) Improves utilization of rural health resources and equipment.

(3) STATE OVERSIGHT.—The Agency for Health Care Administration shall review each agreement approved under subsection (2) at least every 2 years. If the agency determines that the likely benefits resulting from its state action approval no longer outweigh any disadvantages attributable to any potential reduction in competition resulting from the agreement, the agency shall initiate proceedings to terminate its state action approval governing the agreement. Such termination proceeding shall be governed by chapter 120 of the Florida Administrative Procedure Act.

(4) JUDICIAL REVIEW.—Any applicant aggrieved by a decision of the Agency for Health Care Administration shall be entitled to both administrative and judicial review thereof in accordance with chapter 120. In such review, the decision of the agency shall be affirmed unless it is arbitrary, capricious, or it is not in compliance with this section.

Section 26. Subsection (8) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The department may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined by the department to be eligible on the dates on which the services were provided. Any service under this section may be provided only when medically necessary, shall be provided in accordance with state and federal law, and is subject to the availability of moneys and any limitation established by the general appropriations act or chapter 216.

(8) NURSING FACILITY SERVICES.—The department shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part I of chapter 400 *or in a rural hospital, as defined in s. 395.602,* which are ordered by and provided under the direction of a licensed physician.

Section 27. Section 409.9116, Florida Statutes, is created to read:

409.9116 Disproportionate share program for rural hospitals.—In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to statutory rural hospitals. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program:

$$TAERH = ((CCDR + MDR)/APRH) \times BMPD \times MDR$$

Where:

APRH = adjusted patient days for a rural hospital.

BMPD = base Medicaid per diem.

CCDR = charity care days for a rural hospital.

MDR = Medicaid days.

TAERH = total amount earned by a rural hospital.

(2) The total additional payment for hospitals that participate in the rural hospital disproportionate share program shall be calculated by the agency as follows:

$$TAPRH = (TAERH \times TARH)/STAERH$$

Where:

STAERH = sum of total amount earned by each hospital that participates in the rural hospital disproportionate share program.

TAERH = total amount earned by a rural hospital.

TAPRH = total additional payment for a rural hospital.

TARH = total appropriation for the rural hospital disproportionate share program.

(3) In the event the disproportionate share program is not available for providing specific assistance to rural hospitals, there shall be created the Rural Hospital Financial Assistance Program. Funds appropriated to the rural hospital financial assistance program shall be allocated to rural hospitals based on the formulas in subsection (1) and subsection (2).

(4) In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602 and must meet the following additional requirements:

(a) Agree to conform to all agency requirements to ensure high quality in the provision of services, including criteria adopted by agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the agency deems appropriate as specified by rule.

(b) Agree to accept all patients, regardless of ability to pay, on a functional space-available basis.

(c) Agree to provide backup and referral services to the county public health units and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital.

Section 28. Paragraph (b) of subsection (9) of section 768.28, Florida Statutes, 1992 Supplement, is amended to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions.—

(9)

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, any health care provider when providing services pursuant to s. 766.1115, any member of the Florida Health Services Corps, as defined in s. *381.0302* ~~381.90~~, who provides uncompensated care to medically indigent persons referred by the Department of Health and Rehabilitative Services, and any public defender or his employee or agent, including, among others, an assistant public defender and an investigator.

Section 29. The Agency for Health Care Administration shall establish a workgroup for the purpose of examining personnel licensing and training issues related to rural hospitals, as defined in section 395.602, Florida Statutes, and shortages of health care professionals.

(1) The agency workgroup shall make recommendations for specific statutory and regulatory changes necessary to accomplish the following goals:

(a) Enhancement of the quality and effectiveness of health care in rural areas.

(b) Development of a licensure category and cross-training program that allows rural hospitals, as defined in section 395.602, Florida Statutes, flexibility in utilizing personnel licensed under chapter 464, Florida Statutes, chapter 483, Florida Statutes, or part III, part IV, or part V of chapter 468, Florida Statutes, who have at least 3 years' professional experience, to perform professional functions in one or more of the other areas of professional practice listed in this paragraph.

(c) Development of standards for a nonrenewable, temporary license to be issued by the appropriate licensing boards that would allow a health care professional licensed in another state to practice in areas of the state designated as areas of critical health professional shortage, or in a profession designated as a profession of critical shortage, for a period not to exceed 6 months. The agency workgroup shall make recommendations as to which areas of the state should be designated as areas of critical health professional shortage, as well as which health care professions should be designated as professions of critical shortage.

(2) The agency workgroup shall be composed of the following members:

(a) One member who is a representative of the Office of Licensure and Certification of the agency, appointed by the Director of Health Care Administration.

(b) One representative of the agency appointed by the Director of Health Care Administration.

(c) One representative of the Department of Professional Regulation appointed by the Secretary of Professional Regulation.

(d) One member who is a representative of the Division of Community Colleges of the Department of Education appointed by the Executive Director of the Division of Community Colleges.

(e) One member appointed by the Board of Medicine.

(f) One member appointed by the Board of Nursing.

(g) One member appointed by the Board of Clinical Laboratory Personnel.

(h) One member who is a representative of the Office of Rural Health appointed by the Secretary of Health and Rehabilitative Services.

(i) Two members who are representatives of statutory rural hospitals appointed by the Governor.

(j) Two members who are representatives of statutory rural hospitals appointed by the President of the Senate.

(k) Two members who are representatives of statutory rural hospitals appointed by the Speaker of the House of Representatives.

(3) The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives detailing the workgroup's recommendations no later than December 31, 1993.

Section 30. Section 408.02, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 408.02, F.S., 1992 Supp., for present text.)

408.02 Practice parameters.—

(1) The agency, in conjunction with the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Podiatric Association, and Florida Chiropractic Association, and other health professional associations, and in conjunction with the respective boards within the Division of Medical Quality Assurance, shall coordinate the development, endorsement, implementation, and evaluation of practice parameters, based on the principles and guidelines developed by the American Medical Association and other national organizations that have adopted practice parameters. The practice parameters shall be developed for physicians, osteopathic physicians, chiropractic physicians, podiatrists, and other health professionals and may be adopted by rule, and must be scientifically sound and clinically relevant for each diagnostic-related group and applicable to the day-to-day practice of medicine. Practice parameters adopted by rule do not provide grounds for any administrative action.

(2) Practice parameters mean strategies for patient management that are developed to assist physicians and other health professionals in clinical decisionmaking. Practice parameters include standards, guidelines, and other patient management strategies. Standards are accepted principles for patient management which identify a particular management strategy or range of management strategies. Other strategies for patient management include practice policies and practice options, providing quality medical care. The agency shall prioritize the development of those practice parameters that involve the greatest utilization of resources, because they are the most costly, because they are the most frequently performed, or because they have the greatest potential to increase the quality of health care.

(3) The agency, in consultation with the appropriate professional boards, shall implement existing national practice parameters for physicians, osteopathic physicians, podiatrists, chiropractic physicians and other health professionals until practice parameters are developed and implemented. Practice parameters shall be adopted and implemented beginning with those which involve the greatest utilization of resources based on frequency and cost. Practice parameters must be based on practice parameters developed at the national level, which may be modified by local patterns of practice by health care professionals in this state.

(4) The agency shall use appropriate professional and clinical expertise and reliable methodologies that integrate relevant outcomes research findings in its review and adoption or endorsement of specific practice parameters.

(a) The practice parameters shall provide guidance for the proper management of specific clinical situations.

(b) The agency shall provide for periodic reviews and revisions, where suitable, to ensure that practice parameters are based on the latest scientific findings.

(c) The adoption of practice parameters for services provided by diagnostic imaging centers and radiation services shall be considered a priority by the agency.

(d) The selection of additional areas for the application of practice parameters shall take into account the practicality of evaluating the effects of the parameters on the cost and quality of care.

(5) The agency shall provide for wide distribution of the parameters to practicing physicians and other interested parties for educational purposes.

(6) The agency may use the practice parameters adopted pursuant to this chapter in the utilization review of Medicaid and primary care services for the purpose of determining the effects of practice parameters on the quality of medical care and cost containment.

(7) The agency shall establish a demonstration project to evaluate the effectiveness of practice parameters with regard to the costs of defensive medicine and professional liability insurance.

(a) Under the demonstration project, the agency, in conjunction with the Board of Medicine, shall create advisory committees to advise the agency in the development of and adoption or endorsement of practice parameters. The advisory committees must complete the adoption of as many practice parameters as practical, giving priority to those procedures and diagnoses that account for a significant percentage of total statewide health services and health care costs, no later than January 1, 1994.

(b) The practice parameters must define appropriate clinical indications and methods of treatment.

(c) The practice parameters must establish standards of practice designed to avoid liability claims and to increase the defensibility of liability claims when they occur, thereby eliminating the need for physicians to practice defensive medicine.

(d) The Board of Medicine shall review the practice parameters used in the demonstration project and may adopt them by rule.

(e) Physicians selected by the agency may elect to:

1. Participate in the demonstration project; or

2. Practice in compliance with the practice parameters, beginning no later than January 1, 1994.

(f) A participating physician who is named as a defendant in a cause of action accruing on or after January 1, 1994, but before October 1, 1998, may introduce evidence of compliance with the practice parameters as an affirmative defense to a liability claim.

(8) Practice parameters that have been adopted pursuant to this section shall be studied by the agency to determine their use in conjunction with the basic health care benefit package developed pursuant to this chapter.

(9) The agency shall also evaluate practice parameters in the demonstration project, including the effect on utilization review in Medicaid and primary care; the extent and effect of education concerning parameters for physicians, patients, insurers, and the public; the use of parameters in utilization review; and the impact of parameters on costs. The agency shall report on the development of practice parameters in the Florida Health Care Plan submitted to the Legislature by December 31, 1993.

Section 31. Section 408.700, Florida Statutes, is created to read:

408.700 Legislative findings and intent.—

(1) The Legislature finds that the health care system does not provide access to affordable health care for all Floridians. Almost one in five Floridians are without health insurance. For many, entry into the health care system is through a hospital emergency room rather than a primary care setting. The availability of preventive and primary care and managed, family-based care is limited. Health insurance underwriting practices have led to the avoidance rather than the sharing of insurance risks, limiting access to coverages for smaller employer groups and high-risk populations. Spiraling premium costs have placed health insurance policies out of the reach of many small and medium-sized businesses and their workers. Lack of outcome and cost information has forced individuals and businesses to make critical health care decisions with little guidance or leverage. Health care resources have not been allocated efficiently, leading to excess and unevenly distributed capacity. Rural and other medically underserved areas have too few health care resources. Comprehensive, first-dollar coverages have allowed individuals to seek care without regard to cost. Provider competition and liability concerns have led to a medical technology arms races. Rather than competing on the basis of price and patient outcomes, health care providers compete for patients on the basis of service, equipping themselves with the latest and best technology. Managed care and group purchasing mechanisms are not widely available to small group purchasers. Health care regulation has created undue burdens on health care insurers and providers, driving up costs, limiting competition, and preventing market-based solutions to cost and quality problems. Health care costs have been increasing at several times the rate of general inflation, eroding employer profits and investments, increasing government revenue requirements, reducing consumer coverages and purchasing power, and limiting public investments in other vital governmental services.

(2) It is the intent of the Legislature that there be implemented a structured health care competition model, known as managed competition, throughout the state to improve the efficiency of Florida's health care markets. The managed competition model shall promote the pooling of purchaser and consumer buying power; ensure informed cost-conscious consumer choice of managed care plans; reward providers for high quality, economical care; increase access to care for uninsured Floridians; and control the rate of health inflation.

(3) It is the intent of the Legislature that state-chartered, nonprofit private purchasing organizations, known as community health purchasing alliances, be established. The alliances shall be responsible for assisting alliance members to secure the highest quality health care based on available standards at the lowest possible price.

Section 32. Section 408.701, Florida Statutes, is created to read:

408.701 Definitions.—When used in ss. 408.700-408.707, unless the context otherwise requires, the term:

(1) "Accountable health partnership" means an organization which is in compliance with all statutory standards.

(2) "Agency" means Agency for Health Care Administration.

(3) "Alliance member" means small employer as defined in s. 627.6699, who voluntarily chooses to join an alliance.

(4) "Antitrust" means federal and state laws intended to protect commerce from unlawful restraints, monopolies, and unfair business practices.

(5) "Associate alliance member" means any purchaser who wishes to join an alliance for the purposes of participating on the alliance board, and to receive data from the alliance at no charge as a benefit of membership.

(6) "Benefit standard" means a specified set of health services that are the minimum that must be covered by a basic health benefit plan as defined in s. 627.6699.

(7) "Business health coalition" means a group of employers organized to share information about health services and insurance coverage, and that enables them to obtain more cost-effective care for their employees.

(8) "Community health purchasing alliance" or "alliance" means a state-chartered nonprofit organization that provides detailed information on comparative prices usage, outcomes quality, and enrollee satisfaction of accountable health partnerships to its members.

(9) "Community health purchasing alliance organizational committee" means a committee consisting of two representatives from each of the following organizations: Associated Industries of Florida, Florida Chamber of Commerce, National Federation of Independent Businesses, and the Florida Retail Federation.

(10) "Consumer" means an individual user of health care services.

(11) "Department" means the Department of Insurance.

(12) "Grievance procedure" means an established set of rules that specifies a process to appeal an organizational decision.

(13) "Health care provider" or "provider" means a state licensed facility or practitioner that delivers health care services to individuals.

(14) "Health insurer" or "insurer" means an organization licensed by the department under part III of chapter 624 or part I of chapter 641.

(15) "Health plan" means a health insurance plan that provides health care benefits in accordance with s. 627.419.

(16) "Health status" means an assessment of an individual's mental and physical condition.

(17) "Managed care" means systems or techniques generally used by third-party payers or their agents to affect access to and control payment for health care services. Managed care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care professionals or providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

(18) "Managed competition" means a competing group of publicly accountable health care plans in which providers, insurers, and payers join together to form partnerships that offer health services and insurance coverage as a single product.

(19) "Medical outcome" means a change in an individual's health status after the provision of health services.

(20) "Provider network" means an affiliated group of varied health care providers, including physicians licensed under chapters 458, 459, 460, 461, and 463, midwives licensed under chapter 467, and birth centers, such as an accountable health partnership set up to provide a continuum of health care services to individuals.

(21) "Purchaser" means an individual or organization that makes health benefit purchasing decisions on behalf of a group of individuals, such as the employees of a corporation or the members of a business health care coalition.

(22) "Self-funded plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for all covered services provided to its enrollees.

(23) "24-hour coverage" means the consolidation of such time-limited health care coverage as personal injury protection under automobile insurance into a general health insurance plan.

(24) "Utilization management" means programs designed to control the utilization of health services by reviewing their appropriateness relative to established standards or norms.

Section 33. Section 408.702, Florida Statutes, is created to read:

408.702 Community health purchasing alliance.—

(1) There is hereby created one community health purchasing alliance region in each of the 11 health service planning districts as established in s. 408.032(5). Each alliance shall be operated as a state-chartered, nonprofit private organization organized pursuant to chapter 617.

(2) Three or fewer alliances located in contiguous districts which are not primarily urban may merge into a single alliance upon approval of the agency based upon a showing by the alliance board members that the members of each alliance would be better served under a combined alliance. Board members of each alliance shall serve as the board of the combined alliance.

(3) An alliance shall be the only entity allowed to operate as an alliance in a particular district and shall operate primarily for the benefit of its small employer members. An alliance shall be the exclusive entity for oversight and coordination of alliance member purchases. An alliance may form a network with other alliances in order to improve services to alliance members. Nothing in ss. 408.700-408.707 shall be construed to limit or authorize the formation of business health coalitions; provided that a person or entity that pools together or assists in purchasing health coverage for small employers, as defined in s. 627.6699, may not discriminate in its activities based on the health status or historical or projected claims experience of such employers; and provided, further, that all business health coalitions shall develop a plan to facilitate all providers having a reasonable opportunity to participate in such coverage.

(4) Each alliance shall capitalize on the expertise of existing business health coalitions. Nothing herein shall be construed to limit the formation of business health coalitions.

(5) Employer, individual, government, and other group purchaser membership in an alliance is voluntary.

(6) Community health purchasing alliances shall have the following duties, powers, and responsibilities:

(a) Establishing the conditions of community health purchasing alliance membership in conformance with the requirements of ss. 408.700-408.707.

(b) Providing to alliance members clear, standardized information on each accountable health plan, including information on price, enrollee costs, quality, patient satisfaction, enrollment, and enrollee responsibilities and obligations. The community health purchasing alliance shall develop accountable health partnership comparison sheets to be used in providing members and their employees with information regarding the accountable health partnerships.

(c) Offering to all alliance members all accountable health plans which meet the requirements of ss. 408.700-408.707. The alliance may consult with alliance members in selecting and obtaining coverage through accountable health partnerships that meet the requirements of this act.

(d) Establishing administrative and accounting procedures for the operation of the community health purchasing alliance and member services, preparing an annual alliance budget, and preparing annual program and fiscal reports on alliance operations as required by the agency.

(e) Developing and implementing a marketing plan to publicize the community health purchasing alliance to individual and group purchasers and methods for informing the public about the community health purchasing alliance and its services.

(f) Developing or confirming the existence of member grievance procedures to be used in resolving disputes with a community health purchasing alliance member and disputes between a community health purchasing alliance member and a participating accountable health partnership. Any alliance member may appeal to the agency any grievance which is not resolved by an alliance, provided that a health maintenance organization which is an accountable health partnership shall follow the procedures established in ss. 641.31(5) and 641.311.

(g) Maintaining all records, reports, and other information required by the agency, ss. 408.700-408.707, or other state and local laws.

(h) Receiving and accepting grants, loans, advances or funds from any public or private agency and receiving and accepting contributions from any source, or money, property, labor, or any other thing of value.

(i) Contracting, as authorized by alliance members, with a qualified, independent third party for any service necessary to carry out the powers and duties required by ss. 408.700-408.707.

(j) Developing a plan to facilitate providers and employers in the district having an opportunity to participate in an accountable health partnership. Special emphasis shall be placed on ensuring participation by minority physicians, birth centers, and midwives in accountable health partnerships where minority physicians are available to participate. The use of the term "minority" in ss. 408.700-408.707 shall be consistent with the definition provided in s. 288.703(3).

(k) Maximizing the choice of health plans available to members and employees of members by offering, at a minimum, the option of choosing between health maintenance organizations, exclusive provider organizations, preferred provider organizations, and managed-care pure indemnity plans. These options may be provided by a single accountable health partnership if selected by the employer and offered by that partnership or may be provided by two or more accountable health partnerships selected by the employer from those available in the alliance region.

(7) When purchasing health care for state employees and the dependents of such employees, the agency shall annually offer to all employees the opportunity to enroll in an accountable health partnership of their choice which meets the requirements of s. 408.706 and this section, presented in a standardized format pursuant to s. 408.702(5)(b), so that each recipient of state-sponsored health care services may choose the accountable health partnership from which the recipient will receive health care services. The agency shall make available to its employees and their dependents accountable health partnerships that offer health plans through health maintenance organizations, exclusive provider organizations, preferred provider organizations, and managed-care pure indemnity plans. An accountable health partnership is not required to provide all four health plans, but all four plans must be made available through multiple accountable health partnerships. The agency shall offer a minimum of five health maintenance organizations and five preferred provider organizations, if available, to state employees. The agency shall select the accountable health partnerships based upon appropriate objective criteria, including premium price, access to quality care, and member satisfaction. When purchasing health care for Medicaid, MedAccess, and Medicaid buy-in recipients, the agency shall offer to all recipients the opportunity to enroll in any accountable health partnership that meets the requirements of ss. 408.701-408.706, including MediPass providers and Medicaid-certified health maintenance organizations, presented in a standardized format pursuant to s. 408.702(5)(b), so that each recipient of state-sponsored health care services may choose the accountable health partnership from which the recipient will receive health care services.

(8) The alliance shall set reasonable fees for alliance membership to fund all reasonable and necessary costs incurred in the administration of the alliance.

(9) Each year, the alliance shall report on the operations of the alliance, including program and financial operations, and shall be responsible for internal and independent audits.

Section 34. Section 408.7025, Florida Statutes, is created to read:

408.7025 Agency duties and responsibilities related to community health purchasing alliances.—It is the intent of the Legislature that the agency assist in the development of a statewide system of community health purchasing alliances. The agency shall have no supervisory authority over any alliance, but shall serve to assist the alliances in meeting the requirements set forth for alliances in ss. 408.700-408.707. To this end the agency shall be responsible for the following:

(1) Providing administrative start-up funds. Each contract for start-up funds shall be limited to no more than $275,000.

(2) Conducting an annual review of the performance of each alliance to ensure the alliance is in compliance with the provisions of ss. 408.700-408.707. To assist the agency in its review, the community health purchasing alliance shall submit, on a quarterly basis, data to the agency, including but not limited to, employer enrollment by employer size, industry sector, previous insurance status, and county; number of total eligible employers in the alliance region participating in the alliance; number of insured lives by county and insured category, including employees, dependents, and other insured categories, represented by alliance members; profiles of potential employer membership by county; premium ranges for each accountable health partnership for alliance member categories; type and resolution of member grievances; membership fees; and alliance financial statements. A summary of this annual review shall be provided to the Legislature and to each alliance.

(3) In order to establish a data system for accountable partnerships, the agency shall establish a data committee composed of the following representatives of employers, medical providers, hospitals, health maintenance organizations and insurers:

(a) Two representatives appointed by each of the following organizations: Associated Industries of Florida, the Florida Chamber of Commerce, the National Federation of Independent Businesses, and the Florida Retail Federation.

(b) Two representatives of hospitals, to be appointed by the Florida Hospital Association, the Florida League of Hospitals, and the Association of Voluntary Hospitals of Florida.

(c) Two representatives of physicians, to be appointed by the Florida Medical Association, and one representative of osteopathic physicians to be appointed by the Florida Osteopathic Medical Association.

(d) Two representatives of insurers, to be appointed by the Florida Insurance Council.

(e) Two representatives of health maintenance organizations, to be appointed by the Florida Association of Health Maintenance Organizations.

(f) Two representatives of consumers, to be appointed by the agency.

(4) The data committee shall issue a report and recommendations on each of the following subjects as each is completed. A final report on all subjects must be included in the final Florida Health Plan due to the Legislature on December 31, 1993.

(a) Types of data to be collected, giving careful consideration to other data collection projects already in process in Florida, evaluating and recommending the feasibility and cost-effectiveness of various data collection activities, and ensuring that data reporting is necessary to support the evaluation of providers with respect to cost containment, access, quality, control of expensive technology, and customer satisfaction analysis. Data elements to be collected shall include prices, utilization, patient outcomes, quality, and patient satisfaction to be submitted by providers. The completion of this task is the first priority of the data committee. The agency shall begin the implementation of these data collection activities immediately upon receipt of the recommendations, but no later than January 1, 1994. These data shall be submitted by hospitals, other licensed health care facilities, pharmacists, and group practices as defined in s. 455.236(3)(g).

(b) A standard data set, a standard cost-effective format for collecting the data, and a standard methodology for reporting the data to the agency or its designee, and to the alliances, using reporting mechanisms

designed to minimize the administrative burden and cost to health care providers and carriers; and a methodology for aggregating data in a standardized format for comparison purposes between accountable health plans.

(c) Recommendations concerning whether the agency should contract with a private statistical organization to collect, process, analyze, and distribute the data by the most cost effective method; and whether carriers should be encouraged to continue present proprietary data collection efforts on their own in Florida or on a multistate basis, so long as the Florida standard data elements are collected and reported.

(d) Recommendations for standards for data interpretation, actively soliciting a broad base of input from the provider community, carriers, the business community, and the general public.

(e) Recommendations to structure the data collection process to:

1. Incorporate safeguards to ensure that the health care services utilization data collected is interpreted by experienced, practicing physicians and surgeons licensed to practice medicine in the state.

2. Provide that carrier customer satisfaction data conclusions are validated by an experienced service analysis organization.

3. Protect the confidentiality of medical information to protect the physician's and patient's identities, and to protect the privacy of individual physicians and patients. Such information is exempt from s. 119.07(1). The data submitted by insurers, providers, and purchasers is confidential pursuant to s. 408.061(1).

4. Afford all interested professional medical and hospital associations and carriers a minimum of 60 days to review and comment before any data is released to the public.

(f) Recommendations for developing a data collection implementation schedule, based on carrier and provider data collection capabilities.

(5) The data committee shall develop recommendations concerning the cost-effectiveness of collecting data from individual physicians. The initial emphasis shall be on collecting data from those physicians where the highest percentage of the health care dollars are spent: hospitals, large physician group practices, and outpatient facilities and pharmacies. This subsection does not authorize the agency or the data committee to collect data from individual physicians without further legislative authorization.

(6) The agency shall adopt and implement the recommendations of the committee and shall only modify their recommendations, to the extent necessary, to ensure uniform and valid comparisons of accountable health partnerships and their providers.

(7) Travel costs for the data committee participants shall be paid by the participant or by the organization nominating the participant.

(8) The agency shall collect, compile, and analyze data on accountable health partnerships, and provide statistical information to the alliances.

(9) The agency shall establish enrollee benefit standards that comply with statewide benefit standards.

(10) The agency shall receive appeals by alliance members whose grievances were not resolved by the alliance. The agency shall review such appeals pursuant to the provisions of chapter 120.

(11) The agency shall establish a provider and consumer advisory panel to work with the agency in resolving disputes affecting providers and consumers, including, but not limited to, disputes involving the quality of care, costs, reimbursements, utilization, the appropriateness of care, and operating procedures.

Section 35. Section 408.703, Florida Statutes, is created to read:

408.703 Community health purchasing alliances; boards of directors.—

(1) Each community health purchasing alliance shall operate subject to the supervision and approval of a board of directors. The governing board of each alliance shall be composed of seven members who shall reside within the alliance district and shall be representative of alliance and associate alliance members. The initial board members shall be appointed by the Governor from a list of 21 candidates provided by the community health purchasing alliance organizational committee.

(2) Each appointment shall be for a 3-year term, except that two of the initial appointments shall be for a term of 1 year from the date of the initial appointment; and two of the initial appointments shall be for a term of 2 years from the date of the initial appointment.

(3) An alliance board member may not be employed by, affiliated with, an agent of, or otherwise a representative of any health provider or insurance carrier.

(4) The initial alliance board shall adopt bylaws. The bylaws shall include a mechanism for the election of board members upon the expiration of the initial board members' terms and for the election of board officers. The board shall meet at such times and places as it determines necessary for operation of the alliance in conformance with the requirements of ss. 408.700-408.707.

(5) Each alliance board shall include at least two members who are representatives of employees.

(6) Board members may be reimbursed from alliance funds for actual and necessary expenses incurred by them as members.

(7) The board may appoint an executive director, to serve as the chief operating officer of the alliance, and other staff needed to administer the alliance. The executive director and other alliance staff shall serve at the pleasure of the board.

Section 36. Section 408.704, Florida Statutes, is created to read:

408.704 Community health purchasing alliances; accountable health partnerships.—

(1) Accountable health partnerships may be created by health care providers, health maintenance organizations, and health insurers for the purposes of providing health care services to alliance members, associate alliance members, and other health care purchasers who are not alliance members.

(2) All accountable health partnerships desiring to offer services to alliance members must first obtain agency designation as an accountable health plan. The agency shall adopt rules in accordance with the requirements of ss. 408.700-408.707 for designating accountable health partnerships in each district. To qualify as an accountable health plan, an applicant must submit information deemed sufficient to the agency, in a format prescribed by the agency, to satisfactorily demonstrate that the carrier has all of the following characteristics:

(a) Is licensed and in good standing with the Department of Insurance and the licensure agency for participating providers.

(b) A demonstrated capacity to administer the health benefit plan.

(c) The ability, experience, and structure to arrange for the appropriate level and type of health care service.

(d) The ability, policies, and procedures to conduct utilization management.

(e) The ability to achieve, monitor, and evaluate the quality and cost effectiveness of care provided by its provider network.

(f) The ability to ensure enrollees adequate access to providers of health care, including geographic availability and adequate numbers and types.

(g) The ability and procedures to monitor access to its provider network.

(h) A satisfactory grievance procedure and the ability to respond to enrollees' calls, questions, and complaints.

(i) The ability to utilize medical outcome data to educate network providers, update utilization review procedures, and to recommend modifications to benefit designs.

(3) All accountable health partnerships shall establish a panel of providers, licensed under chapters 458 and 459, from the provider networks to review and make recommendations to the accountable health partnerships on the health plans and issues related to the plans offered by the accountable health partnerships through the community health purchasing alliances.

(4) An accountable health partnership must provide for notice and a hearing for reimbursement and utilization review.

(a) A physician who is subject to a reimbursement review or utilization review must be given a notice that states:

1. A reimbursement review or utilization review has been proposed against the physician.

2. The reasons for the proposed review.

3. The physician's right to request a hearing on the proposed review.

4. A summary of the rights of the physician in the hearing.

(b) If the physician requests a hearing, the physician must be given a notice that states:

1. The place, time, and date of the hearing, which may not be less than 30 days after the date of the notice.

2. The names of the witnesses, if any, expected to testify at the hearing on behalf of the accountable health partnership.

(c) A hearing must be held before an arbitrator mutually acceptable to the physician and the accountable health partnership or before a hearing officer who is appointed by the accountable health partnership and who is not in direct economic competition with the physician. The right to the hearing is forfeited if the physician fails, without good cause, to appear.

(d) In the hearing, the physician may:

1. Be represented by experts on reimbursement and utilization review of the physician's choice.

2. Have a record made of the proceedings, with copies available upon payment of reasonable charges associated with the preparation thereof.

3. Call, examine, and cross-examine witnesses, regardless of the admissibility of the testimony in a court of law.

4. Submit a written statement at the close of the hearing.

(e) Upon completion of the hearing, the arbitrator or hearing officer shall issue a written recommendation, including a statement of the basis for the recommendation. The accountable health partnership shall issue a decision, including a statement of the basis for its decision.

(f) If an accountable health partnership fails to provide for a hearing as required in this subsection, the accountable health partnership may not use any related adverse determination in a reimbursement review or utilization review.

(5) The agency shall establish a designation fee to be paid by each accountable health partnership to cover the agency's cost in performing the designation review.

(6) Accountable health partnerships shall:

(a) Require all providers that are part of the partnership to report medical outcomes in accordance with agency standards.

(b) Comply with all rating, underwriting, claims handling, sales, solicitation, licensing, and unfair trade practices, and other provisions of the Florida Insurance Code or of chapter 641.

(7) An accountable health partnership is authorized to provide services to more than one community health purchasing alliance.

(8) If an accountable health partnership elects to terminate its contract with an alliance member, the accountable health partnership shall provide advance notice of its decision to the alliance and provide notice of the decision at least 120 days prior to the nonrenewal of any health plan by the accountable health partnership.

(9) Accountable health partnerships shall maintain records and submit reports to the alliance as may be required by ss. 408.700-408.707.

(10) An accountable health partnership may not require any greater coverage for professional liability insurance than is currently required by the state law.

(11)(a) The governing body of each accountable health partnership shall set standards and procedures to be applied by the accountable health partnerships in considering and acting upon decisions to offer to providers participation in its provider networks. Such standards and procedures in regard to the provider's eligibility for participation must include the provider's background, experience, health, training and demonstrated competency; the provider's adherence to applicable professional standards; and the applicant's reputation. An accountable health partnership may not deny or terminate a provider from participation solely on the basis of economic criteria unrelated to these standards and procedures. For the purpose of this subsection, the term "economic criteria" does not include determinations with respect to overutilization of medical services or malpractice insurance.

(b) A provider who is made an offer may participate in an accountable health partnership as long as the provider abides by the terms and conditions of the provider network contract and provides services at a rate or price equal to the rate or price negotiated by the accountable health partnership. For purposes of this paragraph, the term "provider" means a health care provider who is licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 465. A community health purchasing alliance must permit any health care provider to participate as a service provider under any health plan offered by the community health purchasing alliance, if the health care provider agrees to the reimbursement rates negotiated by the community health purchasing alliance with other health care providers providing the same services under such plans.

Section 37. Section 408.705, Florida Statutes, is created to read:

408.705 Community health purchasing alliances; study.—

(1) The agency shall conduct a study which shall include, but not be limited to, an assessment of the alliances in relation to health care financing issues, the recovery of savings to increase health care coverages, cost shifting, 24-hour coverage, the effects of uninsurance on the alliances, employer options under the alliances, accountable health partnership characteristics and requirements, enrollment and marketing requirements, community rating, and risk adjustment in premium allocation to the accountable health partnerships.

(2) The agency shall recommend to the Legislature the steps that must be taken, including federal and state regulatory and statutory reforms, to allow the participation of state government purchasers, individuals who are not self-employed, self-insured employers, and other employers who are not small employers in community health purchasing alliances.

(3) The agency shall include a report on the progress in implementing community health purchasing alliances, and the results of the study required by this section, in its final Florida Health Plan, which must be submitted to the Legislature by December 31, 1993.

Section 38. Section 408.707, Florida Statutes is created to read:

408.707 Community health purchasing alliances; antitrust study.—

(1) The Legislature recognizes that health care reforms authorized by ss. 408.700-408.707 will require a different relationship between health insurers, hospitals, physicians, and other providers. The success of community health purchasing alliances depends on accountable health partnerships providing detailed information that can facilitate informed decisions by those who purchase health care. The Legislature intends to research antitrust laws, rules, and case law in order to determine their impact on community health purchasing alliances and accountable health partnerships in Florida.

(2) Recognizing the need for more information on which to make future decisions, the Legislature directs the agency, in consultation with the Department of Legal Affairs, the agency advisory council, and health care consumer, purchasers, providers, and insurers, to assess the impact of antitrust laws on community health purchasing alliances and accountable health partnerships. Findings and recommendations from this study shall be provided to the agency and included in the final Florida Health Plan submitted to the Legislature by December 31, 1993.

(3) The antitrust study conducted by the agency shall include, but not be limited to, the following elements:

(a) A methodology, including regulation and state oversite, which would allow physicians, hospitals, insurers, and other providers to form accountable health partnerships in order to offer health care services to community health purchasing alliances and to purchasers of health care who are not alliance members.

(b) A methodology and guidelines which would prevent the formation of monopolies and oligopolies by accountable health partnerships, including limitations on market share by one or two accountable health plans.

(c) A working definition of a methodology to prevent predatory pricing and other anticompetitive activities by insurers, physicians, hospitals, and other providers for the purpose of forcing providers out of business or to unfairly gain market share.

(d) A methodology to allow individual physicians and hospitals to come together in order to jointly offer services as part of an accountable health partnership to an alliance.

(e) Recommendations as to specific changes in federal and state antitrust laws which are required to facilitate the objectives set forth in ss. 408.700-408.707.

(f) A description of any situation when community health purchasing alliances and accountable health partnerships require exemptions from state and federal antitrust laws.

(g) The criteria that should be used to determine the eligibility of community health partnerships and accountable health partnerships for antitrust exemptions.

(h) Recommendations on how to ensure a competitive market place despite the authorization of antitrust exemptions.

(i) An analysis and report on any other issues related to antitrust exemptions that meet the intent of this section.

Section 39. Provider networks.—

(1) The Agency for Health care Administration shall, by rule, establish criteria and conditions for formation and certification of provider networks that offer provider input into payment, payment procedures, utilization review, administration, coverage, prepayment policies, and other operational and policy decisions to be made by accountable health partnerships.

(2) A provider may not be required to join a provider network in order to negotiate with an accountable health partnership.

(3) This section does not authorize any provider network or any of its members to boycott or threaten to boycott any accountable health partnership that does not accept the proposals made by a provider network.

(4) The agency shall monitor and annually certify that each provider network complies with this section and any implementing rules enacted by the agency. The agency by decertify any provider network that fails to comply with this section or any implementing rules adopted by the agency.

Section 40. Effective July 1, 1993, section 408.90, Florida Statutes, is created to read:

408.90 Legislative findings and intent.—The Legislature finds that 2.5 million Floridians do not have access to health insurance coverage, often because the premiums are unaffordable. It is the intent of the Legislature to provide a state health insurance program for those people who are without health insurance so that they may have access to preventive and primary care services. The state health insurance program shall offer basic, affordable health care services to those Floridians who have not had access to the private health insurance market. The Legislature intends that the state program shall target the uninsured and not those who currently have private health insurance coverage.

Section 41. Section 408.901, Florida Statutes, is created to read:

408.901 Definitions.—As used in ss. 408.901-408.908, except as otherwise specifically provided, the term:

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

(2) "Agent" means a person who is licensed to sell health insurance in this state.

(3) "Applicant" means a person who provides a written application to the agency for enrollment in the MedAccess program but whose application has not received final action.

(4) "Eligible person" means any person who meets the residency requirements of ss. 408.901-408.908.

(5) "Employer" means the state, its political subdivisions, any individual, partnership, association, corporation, or business trust, or any person or group of persons, acting in the interest of any employer in relation to an employee.

(6) "Fund" means the Licensure Fees Trust Fund.

(7) "Health services" means a set of basic health services covered by the MedAcess Program.

(8) "Member" means a Florida resident who has enrolled in the MedAccess program provided in ss. 408.901-408.908.

(9) "Participating provider" means any person who has a current provider agreement with the agency and who is authorized to furnished covered health services pursuant to ss. 408.901-408.908. The agency shall integrate county public health units, federally funded primary care centers and other outpatient clinics as participating providers in the health insurance program.

(10) "Premium" means the consideration paid or to be paid to the agency for the issuance of health insurance coverage provided by the MedAccess program.

(11) "MedAccess" means the state health program created pursuant to ss. 408.901-408.908.

Section 42. Section 408.902, Florida Statutes, is created to read:

408.902 MedAccess program; creation; program title.—

(1) Effective July 1, 1994, there is hereby created the MedAccess program to be administered by the Agency for Health Care Administration. The MedAccess program shall not be subject to the requirements of the Department of Insurance or chapter 627. The director of the agency shall appoint an administrator of the MedAccess program which shall be located in the Division of State Health Purchasing.

(2) If the necessary federal waivers are obtained and state and federal funds are available to establish a Medicaid buy-in program pursuant to s. 409.914, the MedAccess program shall remain available to those members who do not qualify for enrollment or who do not choose to enroll in the Medicaid buy-in program.

Section 43. The Agency for Health Care Administration shall prepare a report on the implementation of the MedAccess program for the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 1993. The report shall include the agency's plan for establishing administrative and accounting procedures for the operation of the MedAccess program, securing staff to administer the program, establishing premiums, determining eligibility, enrolling individuals, billing and collecting premiums, establishing provider networks, enrolling providers, processing claims, marketing the program, collecting data, establishing a case management program, controlling utilization, and containing costs. The report shall also include an estimate of total start-up costs, ongoing administrative costs, and claims costs for the program.

Section 44. Section 408.903, Florida Statutes, is created to read:

408.903 Eligibility.—

(1) Every resident of this state who has a gross family income that is equal to or below 250 percent of the federal poverty level and who meets the requirements of this section is eligible to enroll in the MedAccess program. For purposes of ss. 408.901-408.908, a resident is defined as a person who has established a domicile in the state for a period of at least 6 months. As used in this section, the term "resident" shall mean United States citizens or United States legal permanent residents.

(2) A person or family who applies for enrollment in the MedAccess program must provide documentation that demonstrates he or she has not been been covered by a health insurance policy in the 12-month period prior to the effective date of enrollment in the program.

(3) A person or family who is currently eligible for health care benefits under Medicare or the Florida Medicaid program is not eligible for enrollment in the MedAccess program. However, a person may convert to the program upon losing eligibility either for Medicare or Medicaid or upon disenrolling from the Medicaid buy-in program established pursuant to s. 409.914.

(4) The agency shall not use any information related to an applicant's assets in determining eligibility for the program.

(5) Applicants for the program shall complete an application form developed by the agency and shall provide information related to the family dependents to be enrolled and supply documentation concerning family income and place of residence.

(6) Applications for enrollment in the MedAccess program shall be submitted to the agency during a single month-long open enrollment period each year. The agency shall review all completed applications within 45 days of receipt. Applicants who satisfy the eligibility criteria and have paid their initial premium shall be notified by the agency of the effective date of coverage.

(7) The agency may request verification of continued eligibility from members once every 12 months.

(8) The program may disenroll any member due to failure to meet eligibility criteria, nonpayment of premium, or good cause.

(9) Enrollment in the MedAccess program is subject to eligibility and fiscal limitations and shall be renewed annually.

(10) If the Agency for Health Care Administration obtains the necessary federal waivers to implement a Medicaid buy-in program, members of the MedAccess program who qualify shall be entitled to transfer their enrollment to the Medicaid buy-in program.

Section 45. Section 408.904, Florida Statutes, is created to read:

408.904 Benefits.—

(1) Every eligible person who enrolls in the MedAccess program is entitled to receive benefits for any covered service furnished within this state by a participating provider.

(2) Covered health services include:

(a) Physician services. Those services delivered by a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463 that are medically necessary for the treatment of an injury, illness, or disease. Physician services shall not include those services that are clinically unproven, experimental, or purely for cosmetic purposes. Each member is limited to 12 physician visits per calendar year, excluding those visits related to annual or periodic physical examinations for wellness pursuant to paragraph (g) or for immunizations.

(b) Hospital inpatient services. Those services provided for the treatment of a member who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395 up to a limit of 10 days per calendar year per member.

(c) Hospital outpatient services. Those services provided to a member in the outpatient portion of a hospital licensed under part I of chapter 395, up to a limit of $1,000 per calendar year per member, that are preventive, diagnostic, therapeutic, or palliative.

(d) Laboratory services. Professional laboratory services ordered by a licensed physician or other licensed practitioner of the healing arts and provided in a laboratory that meets the requirements for Medicare participation and is licensed under chapter 483.

(e) X-ray services. Radiological services ordered by a licensed physician or other licensed practitioner of the healing arts and that are provided by a licensed professional.

(f) Family planning services. Drugs and supplies that will enable a member to plan family size.

(g) Health appraisals, including physician examinations and related tests. Routine annual physical examinations conducted by or under the direction of a licensed physician, without regard to medical necessity, in order to detect disease, disability, or other physical or mental conditions. These services include well-baby and well-child screening and diagnostic services provided on a periodic basis to members under the age of 21.

(h) Immunizations.

(i) Advanced registered nurse practitioner services.

(j) Outpatient mental health visits and substance abuse treatment. Outpatient mental health visits provided by community mental health centers as provided in chapter 394 and by a mental health therapist licensed under chapter 490 or chapter 491 and substance abuse treatment provided by a center licensed under chapter 396 or chapter 397, up to a total of five visits per calendar year per member.

(3) Covered health services do not include any of the following:

(a) Surgery solely for cosmetic purposes.

(b) Prescribed drugs.

(c) Nursing home services.

(d) Medical examinations conducted and medical reports prepared for either purchasing or renewing life insurance or participating as a plaintiff or defendant in a civil action for the recover or settlement of damages.

(e) Clinically unproven or experimental procedures.

Section 46. Section 408.905, Florida Statutes, is created to read:

408.905 Limitations and exclusions.—

(1) The MedAccess program shall not cover benefits that are provided as part of workers' compensation insurance.

(2) The MedAccess program shall exclude coverage for preexisting conditions, except pregnancy, during a period of 12 months following the effective date of coverage as long as:

(a) The condition manifested itself within a period of 6 months before the effective date of coverage; or

(b) Medical advice or treatment was recommended or received within 6 months before the effective date of coverage.

(3) In addition to the limitations otherwise provided in ss. 408.901-408.908, the MedAccess program shall not include coverage for outpatient prescription drugs, eyeglasses, dental services, custodial care, or emergency services for nonemergent conditions.

(4) Any member of the MedAccess program who is determined to be at "high risk" by a participating primary care provider shall, upon renewal, agree to be placed in a case management system when it is determined by the program to be in the best interest of the member and the MedAccess program.

(5) No person on whose behalf the program has paid out $500,000 in covered benefits is eligible for continued coverage in the MedAccess program.

Section 47. Section 408.906, Florida Statutes, is created to read:

408.906 Payment of claims.—

(1) The agency is designated as the single state agency authorized to make payments for health services covered under the MedAccess program. These payments shall be made only for services included in the MedAccess program and shall be made only on behalf of eligible members in accordance with the provisions of ss. 408.901-408.908.

(2) The agency shall pay claims for covered health services provided to members at the same reimbursement rates and fees that are provided under the Florida Medicaid program, pursuant to s. 409.908.

Section 48. Section 408.907, Florida Statutes, is created to read:

408.907 Collection of premiums.—

(1) Premiums collected from members or from employers on behalf of members shall be made in accordance with rules adopted by the agency.

(2) Premiums collected shall be deposited in the Licensure Fees Trust Fund of the agency. Moneys in this fund shall be used solely for the administration of the MedAccess program.

(3) Employers are encouraged to participate in the payment of all or a portion of their employees' premium obligation. The agency is authorized to offer discounts to the premium obligation to those employers who pay at least 50 percent of the premium and who collect the premium from the employees on behalf of the agency.

(4) The agency is authorized to contract with agents who may refer individuals to the MedAccess program and may pay those agents a modest referral fee if the individual's application is accepted for enrollment in the MedAccess program.

(5) The agency is directed to develop strategies for marketing MedAccess to increase public awareness about the state program.

Section 49. Section 408.9075, Florida Statutes, is created to read:

408.9075 Administration.—The agency shall be responsible for:

(1) Developing a network of health care providers for providing managed health care services on a statewide basis.

(2) Performing all eligibility and administrative claims payment functions relating to the program.

(3) Evaluating the eligibility of each claim for payment under the program.

(4) Establishing a premium billing procedure for the collection of premiums from insured persons.

(5) Developing a schedule of copayments and deductibles that will encourage the use of preventive and primary care services, will deter members from overutilizing services, and will discourage the use of expensive, technology-driven services.

(6) Marketing the MedAccess program.

(7) Providing that the direct and indirect expenses of the program are fully covered by the collection of premiums from members of the MedAccess program.

(8) Establishing policy and budget guidelines for the MedAccess program.

(9) Adopting rules to carry out the provisions of ss. 408.901-408.908.

(10) Implementing and administering the MedAccess program.

(11) Providing to the public and to health care providers information concerning the MedAccess program.

(12) Ensuring that the quality of service provided under the MedAccess program meets the standards of the community.

(13) Identifying and eliminating health care providers who engage in fraudulent or abusive activities related to the MedAccess program.

(14) Evaluating the adequacy of the services covered by the MedAccess program, the accessibility of the program to the uninsured, and the effectiveness of the MedAccess program in reducing the number of uninsured persons in the state.

Section 50. Subsection (12) of section 409.908, Florida Statutes, 1992 Supplement, is amended to read:

409.908 Reimbursement of Medicaid providers.—The department shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the department and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, and other mechanisms the department considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216.

(12)(a) A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the *agency* ~~department~~. ~~Effective October 1, 1991, the department shall increase fees for surgical and other procedures for which fees have not been increased since 1987 to the median level of Medicare reimbursement in 1986 for Area B in this state.~~

(b) The agency shall adopt a fee schedule based on the resource-based, relative value scale promulgated by the United States Department of Health and Human Services for the Medicare program for pricing Medicaid physician services. Under this fee schedule, physicians shall be paid a dollar amount for each service based on the average resources required to provide the service, including, but not limited to, estimates of average physician time and effort, practice expense, and the costs of professional liability insurance. The fee schedule shall use only one conversion factor that is calculated to ensure that total Medicaid payments to physicians do not exceed anticipated levels had the existing payment system been used, unless additional moneys are available. The fee schedule must be phased in over a 2-year period beginning on October 1, 1993.

(c) The Agency for Health Care Administration shall seek the advice of a 16-member advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under chapters 458 and 459 and shall be composed of 50 percent primary care physicians and 50 percent specialty care physicians.

(d) The agency shall monitor closely the utilization rate for physicians services and identify any trends which may indicate an effort to increase the volume of services to counteract any losses that might result from the new fee schedule. The agency shall prepare a report to the Legislature on the overall effect of the resource-based relative value scale fee schedule by December 31, 1996.

(e)~~(b)~~ *Notwithstanding paragraph (b),* reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which includes prenatal, delivery, and postpartum care, shall be at least $1,500 per delivery for a pregnant woman with low medical risk and at least $2,000 per delivery for a pregnant woman with high medical risk, effective April 1, 1992. However, reimbursement to physicians working in Regional Perinatal Intensive Care Centers designated pursuant to chapter 383, for services to certain pregnant Medicaid recipients with a high medical risk, may be made according to obstetrical care and neonatal care groupings and rates established by the *agency* ~~department~~. Nurse midwives licensed under chapter 464 or midwives licensed under chapter 467 shall be reimbursed at no less than 80 percent of the low medical risk fee. However, midwives licensed under chapter 467 shall not receive Medicaid reimbursement for home deliveries conducted for Medicaid recipients, but shall be reimbursed for prenatal and postpartal care provided to such recipients. The *agency* ~~department~~ shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman and shall not pay more based solely on the fact that a caesarean section was performed, rather than a vaginal delivery. The *agency* ~~department~~ shall by rule determine a prorated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed.

Section 51. Effective July 1, 1993, section 409.9081, Florida Statutes, is created to read:

409.9081 Copayments.—

(1) The agency shall require, subject to federal regulations and limitations, each Medicaid recipient to pay at the time of service a nominal copayment for the following Medicaid services:

(a) Hospital outpatient services: up to $2 for each hospital outpatient visit.

(b) Physician services: up to $2 copayment for each visit with a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461 or chapter 463.

(2) The Agency for Health Care Administration shall study the level of success in collecting copayments from recipients and the administrative costs in attempting to collect copayments. The agency shall report to the Legislature the results of its study by January 1, 1994.

(3) In accordance with federal regulations, the agency shall not require copayments of the following Medicaid recipients:

(a) Children under age 21.

(b) Pregnant women when the services relate to the pregnancy or to any other medical condition which may complicate the pregnancy up to 6 weeks after delivery.

(c) Any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if, as a condition of receiving services in the institution, that individual is required to spend all but a minimal amount of his income required for personal needs for medical care costs.

(d) Any individual who requires emergency services after the sudden onset of a medical condition which, left untreated, would place the individual's health in serious jeopardy.

(e) Any individual when the services or supplies relate to family planning.

(f) Any individual who is enrolled in a Medicaid prepaid health plan or health maintenance organization.

(4) No provider shall impose more than one copayment for any encounter upon a Medicaid recipient.

(5) The agency shall develop a mechanism by which participating providers are able to identify those Medicaid recipients from whom they shall not collect copayments.

Section 52. Effective July 1, 1993, present subsection (11) of s. 409.911, Florida Statutes, 1992 Supplement, is amended, present subsections (11) and (12) are renumbered as subsections (13) and (14), and new subsections (11) and (12) are added to said section, to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the general appropriations act and any limitations established pursuant to chapter 216, the department shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(11) In addition to the other requirements specified in this section, no payments shall be made to a hospital unless the hospital agrees to:

(a) Contract and cooperate with a Medicaid prepaid health plan, if one exists in the community.

(b) Ensure the availability of primary and specialty care physicians to Medicaid recipients not enrolled in a prepaid capitated arrangement who are in need of access to such physicians.

(c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level, and to provide such services on a sliding scale basis to all persons with incomes up to 200 percent of the federal poverty level, except that eligibility may be limited to persons residing within a more limited area, as agreed to by the agency and the hospital.

(d) Contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions as appropriate. The hospital shall agree to provide at an onsite or offsite facility primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.

(e) Cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case finding, referral and acceptance of patients, and sharing of epidemiological data, as the agency and hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

(f) Cooperate with the county in which the hospital resides, to develop a low-cost, outpatient only, prepaid health care program to persons who are not eligible for the Medicaid program, and reside within the area.

(g) Provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and do not have private health insurance, regardless of ability to pay, on a functional space available basis, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay.

(h) Work with the agency, the Healthy Kids Corporation, the Florida Pooled Purchasing Cooperative, and the Florida Health Access Corporation, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons residing within the area who do not have access to such a plan.

(i) Work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate utilization of health services.

(j) Work with the local health council to develop a plan for promoting access to affordable health care services for all persons residing within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.

(12) Any hospital which fails to comply with any of the conditions in subsection (11), or any other contractual conditions, shall not receive any payments under this section until full compliance is achieved.

(13)~~(11)~~ Payments made by the *agency* ~~department~~ to hospitals eligible to participate in this program shall be made in accordance with federal rules and regulations.

(a) If the Federal Government prohibits, restricts, or changes in any manner the methods by which funds are distributed for this program, the *agency* ~~department~~ shall not distribute any additional funds and shall return all funds to the local government from which the funds were received, except as provided in paragraph (b).

(b) If the Federal Government imposes a restriction that still permits a partial or different distribution, the *agency* ~~department~~ may continue to disburse funds to hospitals participating in the disproportionate share program in a federally approved manner, provided:

1. Each local government which contributes to the disproportionate share program agrees to the new manner of distribution as shown by a written document signed by the governing authority of each local government; and

2. The Executive Office of the Governor, the Office of Planning and Budgeting, the House of Representatives, and the Senate are provided at least 7 days' prior notice of the proposed change in the distribution, and do not disapprove such change.

(c) No distribution shall be made under the alternative method specified in paragraph (b) unless all parties agree or unless all funds of those parties that disagree which are not yet disbursed have been returned to those parties.

Section 53. Section 409.9121, Florida Statutes, is created to read:

409.9121 Legislative findings and intent.—The Legislature hereby finds that the Medicaid program has experienced an annual growth rate of approximately 28 percent per year for the past 5 years, and is consuming more than half of all new general revenue growth. The present Medicaid system must be reoriented to emphasize, to the maximum extent possible, the delivery of health care through entities and mechanisms which are designed to contain costs, to emphasize preventive and primary care, and to promote access and continuity of care. The Legislature further finds that the concept of "managed care" best encompasses these multiple goals. The Legislature also finds that, with the cooperation of the physician community, MediPass, the Medicaid primary care case management program, is responsible for ensuring that there is a sufficient supply of primary care to provide access to preventive and primary care services to Medicaid recipients. Therefore, the Legislature declares its intent that the Medicaid program require, to the maximum extent practicable and permitted by federal law, that all Medicaid recipients be enrolled in a managed care program.

Section 54. Section 409.9122, Florida Statutes, is created to read:

409.9122 Mandatory Medicaid managed care enrollment.—

(1)(a) The agency is directed to contract for an independent comprehensive evaluation of the primary care case management program in districts 5 and 6, known as MediPass, and report the findings to the Legislature on or before December 31, 1994. The evaluation shall include, but not be limited to, an assessment of the program's impact on quality of care, access to Medicaid services, cost effectiveness, and provider and recipient satisfaction. It is the intent of the Legislature that the agency apply for a federal freedom of choice waiver and any other federal waivers necessary to expand MediPass to five additional districts by December 31, 1994, and, subject to evaluation findings that the program is cost effective, provides quality health care, and improves access to health services, to the remaining districts in the state by December 31, 1996.

(b) The MediPass program may not be expanded unless the agency certifies, for each county where MediPasss is to be started, that the necessary resources, including staff, are available to adequately inform recipients of their choice of primary care providers and to enroll them with a provider and that the necessary resources, including staff, are available to adequately recruit providers, ensure access, monitor performance and patient satisfaction, and assess the quality of care provided.

(2)(a) The agency shall encourage Medicaid recipients who receive payments from or are determined eligible for the Supplemental Security Income program, to the maximum extent feasible, to enroll in Medicaid or Medicare managed care plans.

(b) The agency shall work cooperatively with the Social Security Administration to identify beneficiaries who are jointly eligible for Medicare and Medicaid and shall develop cooperative programs to encourage these beneficiaries to enroll in a Medicare participating health maintenance organization or prepaid health plans.

(c) The agency shall work cooperatively with the Department of Elderly Affairs to assess the potential cost effectiveness of providing MediPass to beneficiaries who are jointly eligible for Medicare and Medicaid on a voluntary choice basis. If the agency determines that enrollment of these beneficiaries in MediPass has the potential for being cost-effective for the state, the agency shall offer MediPass to these beneficiaries on a voluntary choice basis in the counties where MediPass operates.

(d) The agency shall require the enrollment of Medicaid recipients who are also Medicare beneficiaries but who are not enrolled in MediPass or another managed care program in all counties of the state where MediPass is in operation. Subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216, the agency may develop a special reimbursement rate, which takes into consideration the higher utilization of such Medicaid recipients, for payment to health maintenance organizations or prepaid health plans agreeing to enroll these recipients.

(3)(a) The agency shall conduct a study of the feasibility of establishing managed care programs for various special population groups within the Medicaid program, to the extent permitted by federal law, and report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 1994.

(b) The agency shall investigate the feasibility of developing managed care programs for the following groups of Medicaid recipients:

1. Pregnant women and infants.

2. Chronically ill children.

3. Elderly and disabled recipients, especially those who are at risk of nursing home placement.

4. Persons with developmental disabilities.

5. Qualified Medicare beneficiaries.

6. Adults who have chronic, high-cost medical conditions.

7. Adults and children who have mental health problems.

8. Other recipients for whom managed care programs offer the opportunity of more cost-effective care and greater access to qualified providers.

(4)(a) The agency shall encourage the development of public and private partnerships to foster the growth of health maintenance organizations and prepaid health plans that will provide high quality health care to Medicaid recipients.

(b) Subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216, the agency is authorized to enter into contracts with traditional providers of health care to low-income persons to assist such providers with the technical aspects of cooperatively developing Medicaid prepaid health plans.

1. The agency may contract with disproportionate share hospitals, county public health units, federally initiated or federally funded community health centers, and counties that operate either a hospital or a community clinic.

2. A contract may not be for more than $100,000 per year, and no contract may be extended with any particular provider for more than 2 years. The contract is intended only as seed or development funding and requires a commitment from the interested party.

3. A contract must require participation by at least one community health clinic and one disproportionate share hospital.

(5)(a) The agency shall develop and implement a comprehensive plan to ensure that recipients are adequately informed of their choices and rights under all Medicaid managed care programs and that Medicaid managed care programs meet acceptable standards of quality in patient care, patient satisfaction, and financial solvency.

(b) The agency shall provide adequate means for informing patients of their choice and rights under a managed care plan at the time of eligibility determination.

(c) The agency shall monitor all managed care plans at least quarterly; review patient grievances, disenrollment forms, medical records, and financial records; and require all managed care plans to establish methods for assuring quality and patient satisfaction.

Section 55. Effective July 1, 1993, section 409.914, Florida Statutes, is amended to read:

409.914 Assistance for the uninsured.—

(1) The *agency* ~~department~~ shall use the claims payment systems, utilization control systems, cost control systems, case management systems, and other systems and controls that it has developed for the management and control of the Medicaid program to assist other agencies and entities, if appropriate, in paying claims and performing other activities necessary for the conduct of programs of state government, or for working with other public and private agencies to solve problems of lack of insurance, underinsurance, or uninsurability. When conducting these services, the department shall ensure:

(a)~~(1)~~ That full payment is received for services provided.

(b)~~(2)~~ That costs of providing these services are clearly segregated from costs necessary for the conduct of the Medicaid program.

(c)~~(3)~~ That the program conducted serves the interests of the state in ensuring that effective and quality health care at a reasonable cost is provided to the citizens of the state.

(2)(a) The agency shall seek federal statutory or regulatory reforms to establish a Medicaid buy-in program to provide medical assistance to persons ineligible for Medicaid because of current income and categorical restrictions. The agency shall use funds provided by the Robert Wood Johnson Foundation to assist in developing the buy-in program, including, but not limited to, the determination of eligibility and service coverages; cost sharing requirements; managed care provisions; changes needed to the Medicaid program's claims processing, utilization control, cost control, case management, and provider enrollment systems to operate a buy-in program.

(b) The agency shall seek federal authorization and financial support for a buy-in program that provides federally supported medical assistance coverage for persons with incomes up to 250 percent of the federal poverty level. The agency shall not implement the Medicaid buy-in program until it has received necessary federal authorization and financial participation and state appropriations.

Section 56. Effective July 1, 1993, section 409.9114, Florida Statutes, as created by chapter 91-282, Laws of Florida, and amended by chapter 92-33, Laws of Florida, is repealed.

Section 57. Section 407.60, Florida Statutes, 1992 Supplement, as created by chapter 92-178, Laws of Florida, is repealed.

Section 58. Section 15 of chapter 92-178, Laws of Florida, is amended to read:

Section 15. This act shall apply to referrals for designated health services made on or after the effective date of this act, provided that with respect to an investment interest acquired before May 1, 1992, paragraph (a) of subsection (4) of section 7 shall not apply to referrals for designated health services occurring before October 1, *1994* ~~1995~~, and provided, further, that paragraphs (b)-(g) of subsection (4) of section 7 shall be effective on July 1, 1992, and provided further, that with respect to a facility which is providing a designated health service or other health care items or service which received its certificate of occupancy and began providing that service at that facility after May 1, 1991, and before January 1, 1992, section 7(4)(a)-(g) inclusive of this act shall not apply to referrals for such designated health services and other items or services occurring before October 1, 1996. *This paragraph does not prohibit or limit hospitals and physicians from forming and operating accountable health partnerships.*

Section 59. Section 9 of chapter 92-178, Laws of Florida, appearing as section 455.238, Florida Statutes, 1992 Supplement, is repealed.

Section 60. Health care fraud and abuse study.—

(1) FINDINGS AND INTENT.—The current level of state spending on health care has raised concerns as to whether Florida is getting full value for its health care dollar. One outcome of this concern is increased attention on health care fraud and abuse. A widely used estimate by the federal General Accounting Office is that up to 10 percent of health care expenditures are the result of fraudulent or abusive practices. Significant savings could be realized if coordinated attention were focused on ways to curb fraud and abuse in the health care system. The Legislature intends to establish a workgroup which will look at the nature and extent of health care fraud and abuse in the state and examine ways to systematically address this problem.

(2) DEFINITIONS.—

(a) "Abuse" means the provision of, or billing for, health care services that, while not fraudulent, have marginal medical utility, are inconsistent with acceptable business and medical practices, and are intended primarily to increase the income of a health care provider or facility.

(b) "Fraud" means the representation or omission of material facts with the intent of receiving payment for health care services that were not provided or were provided without medical necessity.

(3) WORKGROUP.—The Agency for Health Care Administration shall establish a workgroup on health care fraud and abuse. The workgroup shall include representatives of the Department of Legal Affairs, the Department of Health and Rehabilitative Services, the Office of the Auditor General, the Department of Insurance, the Department of Law Enforcement, the United States Department of Justice, and the private insurance sector.

(4) REPORT.—The workgroup shall prepare a report on health care fraud and abuse which shall include, but not be limited to, the following elements:

(a) The identification of the major forms of health care fraud and abuse, including an evaluation of present reimbursement procedures which provide opportunities for fraud and invite abusive practices.

(b) An assessment of current laws, rules, and regulations to determine if they are adequate to control fraudulent activities and, if not, recommendations for legislation to strengthen current laws, rules, and regulations.

(c) The identification of the key private and public agencies and organizations involved in the detection or prosecution of fraud, and a determination as to how these organizations can best coordinate their efforts to provide a more effective approach to controlling fraud and abuse.

(d) An assessment of the feasibility of permitting insurance companies to share information regarding provider billing, and an examination of methods to permit insurance companies to collaborate in the investigation of providers suspected of fraud.

(e) An evaluation of the potential impact of allowing persons who report fraud to receive a portion of the fine levied against a provider who is successfully prosecuted.

(f) The workgroup's report shall be included in the final Florida Health Plan, which shall be submitted to the Legislature by December 31, 1993.

Section 61. Section 408.031, Florida Statutes, 1992 Supplement, is amended to read:

408.031 Short title.—Sections *408.031-408.045* ~~381.701-381.715~~ shall be known and may be cited as the "Health Facility and Services Development Act."

Section 62. Section 408.032, Florida Statutes, 1992 Supplement, is amended to read:

408.032 Definitions.—As used in ss. 408.031-408.045, the term:

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

(2) "Approved" means the status of an application for a certificate of need where the agency has either issued a notice of intent to grant the application or entered a final order granting the application or signed a stipulated agreement to grant the application.

(3)~~(1)~~ "Capital expenditure" means an expenditure, including an expenditure for a construction project undertaken by a health care facility as its own contractor, which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; or an expenditure which exceeds the minimum as specified in *s. 408.036(1)(c)* ~~s. 381.706(1)(e)~~, changes the bed capacity of the facility, or substantially changes the services or service area of the health care facility, health service provider, or hospice, and which includes the cost of the studies, surveys, designs, plans, working drawings, specifications, initial financing costs, and other activities essential to acquisition, improvement, expansion, or replacement of the plant and equipment. The *agency* ~~department~~ shall, by rule, adjust the capital expenditure threshold annually using an appropriate inflation index.

(4)~~(2)~~ "Certificate of need" means a written statement issued by the *agency* ~~department~~ evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, *home health agency,* or hospice.

(5)~~(3)~~ "Commenced construction" means initiation of and continuous activities beyond site preparation associated with erecting or modifying a health care facility, including procurement of a building permit applying the use of *agency-approved* ~~department-approved~~ construction documents, proof of an executed owner/contractor agreement or an irrevocable or binding forced account, and actual undertaking of foundation forming with steel installation and concrete placing.

~~(4) "Department" means the Agency for Health Care Administration.~~

(6)~~(5)~~ "District" means a health service planning district composed of the following counties:

District 1.—Escambia, Santa Rosa, Okaloosa, and Walton Counties.

District 2.—Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties.

District 3.—Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties.

District 4.—Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties.

District 5.—Pasco and Pinellas Counties.

District 6.—Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.

District 7.—Seminole, Orange, Osceola, and Brevard Counties.

District 8.—Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.

District 9.—Indian River, Okeechobee, St. Lucie, *and* Martin~~, and Palm Beach~~ Counties.

District 10.—Broward County.

District 11.—Dade and Monroe Counties.

District 12.—Palm Beach County.

(7)~~(6)~~ "Expedited review" means the process by which certain types of applications are not subject to the review cycle requirements contained in *s. 408.039(1)* ~~s. 381.709(1)~~, and the letter of intent requirements contained in *s. 408.039(2)* ~~s. 381.709(2)~~.

(8)~~(7)~~ "Health care facility" means a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the developmentally disabled. A facility relying solely on spiritual means through prayer for healing is not included as a health care facility.

(9)~~(8)~~ "Health maintenance organization" means a health care provider organization defined and authorized in part I of chapter 641.

(10)~~(9)~~ "Health services" means diagnostic, curative, or rehabilitative services and includes alcohol treatment, drug abuse treatment, and mental health services.

(11)~~(10)~~ "Home health agency" means an agency that is certified or seeks certification as a Medicare home health service provider as defined in part III of chapter 400.

(12)~~(11)~~ "Hospice" or "hospice program" means a hospice as defined in part V of chapter 400.

(13)~~(12)~~ "Hospital" means a health care facility licensed under chapter 395.

(14)~~(13)~~ "Institutional health service" means a health service which is provided by or through a health care facility and which entails an annual operating cost of $500,000 or more. The *agency* ~~department~~ shall, by rule, adjust the annual operating cost threshold annually using an appropriate inflation index.

(15)~~(14)~~ "Intermediate care facility" means an institution which provides, on a regular basis, health-related care and services to individuals

who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require health-related care and services above the level of room and board.

(16)~~(15)~~ "Intermediate care facility for the developmentally disabled" means a residential facility licensed under chapter 393 and certified by the Federal Government pursuant to the Social Security Act as a provider of Medicaid services to persons who are mentally retarded or who have a related condition.

(17)~~(16)~~ "Major medical equipment" means equipment which is used to provide medical and other health services, which has been approved for general usage by the United States Food and Drug Administration for less than 3 years and which costs in excess of $1 million. The *agency* ~~department~~ shall, by rule, adjust the equipment threshold annually using an appropriate inflation index.

~~(18) "Multifacility project" means an integrated residential and health care facility consisting of independent living units, adult congregate living facility units, and nursing home beds certificated on or after January 1, 1987, where:~~

~~(a) The aggregate total number of independent living units and adult congregate living facility units exceeds the number of nursing home beds.~~

~~(b) The developer of the project has expended the sum of $500,000 or more on the certificated and noncertificated elements of the project combined, exclusive of land costs, by the conclusion of the 18th month of the life of the certificate of need.~~

~~(c) The total aggregate cost of construction of the certificated element of the project, when combined with other, noncertificated elements, is $10 million or more.~~

~~(d) All elements of the project are contiguous or immediately adjacent to each other and construction of all elements will be continuous.~~

(18) "Nursing home geographically underserved area" means:

(a) A county in which there is no existing or approved nursing home;

(b) An area with a radius of at least 20 miles in which there is no existing or approved nursing home; or

(c) An area with a radius of at least 20 miles in which all existing nursing homes have maintained at least a 95 percent occupancy rate for the most recent 6 months or a 90 percent occupancy rate for the most recent 12 months.

(19) "Regional planning district" means more than one district which has been identified by the agency in rule for the purpose of planning for tertiary health services on a regional basis.

(20)~~(19)~~ "Skilled nursing facility" means an institution, or a distinct part of an institution, which is primarily engaged in providing, to inpatients, skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(21)~~(20)~~ "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The *agency* ~~department~~ shall establish by rule a list of all tertiary health services.

Section 63. Section 408.033, Florida Statutes, 1992 Supplement, is amended to read:

408.033 Local and state health planning.—

(1) LOCAL HEALTH COUNCILS.—

(a) Local health councils are hereby established as public or private nonprofit agencies serving the counties of a district of the *agency* ~~department~~. The members of each council shall be appointed in an equitable manner by the county commissions having jurisdiction in the respective district. Each council shall be composed of a number of persons equal to $1\frac{1}{2}$ times the number of counties which compose the district or 12 members, whichever is greater. Each county in a district shall be entitled to at least one member on the council. The balance of the membership of the council shall be allocated among the counties of the district on the basis of population rounded to the nearest whole number; except that in a district composed of only two counties, no county shall have fewer than four members. The appointees shall be representatives of health care providers, health care purchasers, and nongovernmental health care consumers, but not excluding elected government officials. The members of the consumer group shall include a representative number of persons over 60 years of age. A majority of council members shall consist of health care purchasers and health care consumers. The local health council shall provide each county commission a schedule for appointing council members to ensure that council membership complies with the requirements of this paragraph. The members of the local health council shall elect a chairman. Members shall serve for terms of 2 years and may be eligible for reappointment.

(b) Each local health council shall:

1. Develop a district health plan which is consistent with the objectives and strategies in the state health plan, but which shall permit each local health council to develop strategies and set priorities for implementation based on its unique local health needs. The district health plan must contain *recommendations* ~~preferences~~ for health services' and facilities' development which must be considered by the *agency* ~~department~~ in its review of certificate-of-need applications. The district health plan shall be submitted to the *agency* ~~department~~ and updated periodically. The district health plans shall use a uniform format and be submitted to the *agency* ~~department~~ according to a schedule developed by the *agency* ~~department~~ in conjunction with the Statewide Health Council and the local health councils. The schedule must provide for coordination between the development of the state health plan and the district health plans and for the development of district health plans by major sections over a multiyear period. ~~The elements of a district plan which are necessary to the review of certificate of need applications for proposed projects within the district shall be adopted by the department as a part of its rules.~~

2. Advise the *agency* ~~department~~ on health care issues and resource allocations.

3. Promote public awareness of community health needs, emphasizing health promotion and cost-effective health service selection.

4. Collect data and conduct analyses and studies related to health care needs of the district, including the needs of medically indigent persons, and assist the *agency* ~~department~~ and other state agencies in carrying out data collection activities that relate to the functions in this subsection.

5. Monitor the onsite construction progress, if any, of certificate-of-need approved projects and report council findings to the *agency* ~~department~~ on forms provided by the *agency* ~~department~~.

6. Advise and assist regional planning councils within each district with the development of the health element of the comprehensive regional policy plan to address the health goals and policies in the State Comprehensive Plan.

7. Advise and assist local governments within each district on the development of an optional health plan element of the comprehensive plan provided in chapter 163, to assure compatibility with the health goals and policies in the State Comprehensive Plan and district health plan. To facilitate the implementation of this section, the local health council shall annually provide the local governments in its service area, upon request, with:

a. A copy and appropriate updates of the district health plan;

b. A report of hospital and nursing home utilization statistics for facilities within the local government jurisdiction; and

c. Applicable *agency* ~~department~~ rules and calculated need methodologies for health facilities and services regulated under *s. 408.034* ~~s. 381.704~~ for the district served by the local health council.

8. Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of local, state, federal, and private funds distributed to meet the needs of the medically indigent and other underserved population groups.

9. In conjunction with the Department of Health and Rehabilitative Services and Statewide Health Council, plan for services at the local level for persons infected with the human immunodeficiency virus.

10. Provide technical assistance to encourage and support activities by providers, purchasers, consumers, and local, regional, and state agencies in meeting the health care goals, objectives, and policies adopted by the local health council.

11. Provide the *agency* ~~department~~ with data required by rule for the review of certificate-of-need applications and the projection of need for health services and facilities in the district.

(c) Local health councils may conduct public hearings pursuant to *s. 408.039(3)(b)* ~~s. 381.709(3)(b)~~.

(d) Each local health council shall enter into a memorandum of agreement with each regional planning council in its district. In addition, each local health council shall enter into a memorandum of agreement with each local government that includes an optional health element in its comprehensive plan. Each memorandum of agreement must specify the manner in which each local government, regional planning council, and local health council will coordinate its activities to ensure a unified approach to health planning and implementation efforts.

(e) Local health councils may employ personnel to carry out the councils' purposes. Such personnel shall possess qualifications and be compensated in a manner commensurate with comparable positions in the Career Service System. However, such personnel shall not be deemed to be state employees.

(f) Personnel of the local health councils shall provide an annual orientation to council members about council member responsibilities. The orientation shall include presentations and participation by *agency* ~~department~~ staff.

(g) Each local health council is authorized to accept and receive, in furtherance of its health planning functions, funds, grants, and services from governmental agencies and from private or civic sources and to perform studies related to local health planning in exchange for such funds, grants, or services. Each local health council shall, no later than January 30 of each year, render an accounting of the receipt and disbursement of such funds received by it to the *agency* ~~department~~. The *agency* ~~department~~ shall consolidate all such reports and submit such consolidated report to the Legislature no later than March 1 of each year. Funds received by a local health council pursuant to this paragraph shall not be deemed to be a substitute for, or an offset against, any funding provided pursuant to subsection (3).

(2) STATEWIDE HEALTH COUNCIL.—The Statewide Health Council is hereby established as a state-level comprehensive health planning and policy advisory board. For administrative purposes, the council shall be located within the *agency* ~~department~~. The Statewide Health Council shall be composed of: the State Health Officer and the Assistant Secretary for Medicaid of the Department of Health and Rehabilitative Services; the Deputy Director for Health Policy and *Cost Control* ~~Planning~~ and the Deputy Director for Health Quality Assurance of the *agency* ~~department~~; *a member* ~~the director~~ of the Health Care Board; the Insurance Commissioner or his designee; the Vice Chancellor for Health Affairs of the Board of Regents; three chairmen of regional planning councils, selected by the regional planning councils; five chairmen of local health councils, selected by the local health councils; four members appointed by the Governor, one of whom is a consumer over 60 years of age, one of whom is a representative of organized labor, one of whom is a physician, and one of whom represents the nursing home industry; five members appointed by the President of the Senate, one of whom is a representative of the insurance industry in this state, one of whom is the chief executive officer of a business with more than 300 employees in this state, one of whom represents the hospital industry, one of whom is a primary care physician, and one of whom is a nurse, and five members appointed by the Speaker of the House of Representatives, one of whom is a consumer who represents a minority group in this state, one of whom represents the home health care industry in this state, one of whom is an allied health care professional, one of whom is the chief executive officer of a business with fewer than 25 employees in this state, and one of whom represents a county social services program that provides health care services to the indigent. Appointed members of the council shall serve for 2-year terms commencing October 1 of each even-numbered year. The council shall elect a president from among the members who are not state employees. The Statewide Health Council shall:

(a) Advise the Governor, the Legislature, and the *agency* ~~department~~ on state health policy issues, state and local health planning activities, and state health regulation programs;

(b) Prepare a state health plan that specifies subgoals, quantifiable objectives, strategies, and resource requirements to implement the goals and policies of the health element of the State Comprehensive Plan. The plan must assess the health status of residents of this state; evaluate the adequacy, accessibility, and affordability of health services and facilities; assess government-financed programs and private health care insurance coverages; and address other topical local and state health care issues. Within 2 years after the health element of the State Comprehensive Plan is amended, and by July 1 of every 3rd year, if it is not amended, the Statewide Health Council shall submit the state health plan to the Executive Office of the Governor, the *director* ~~secretary~~ of the *agency* ~~department~~, the President of the Senate, and the Speaker of the House of Representatives;

(c) Promote public awareness of state health care issues and, in conjunction with the local health councils, conduct public forums throughout the state to solicit the comments and advice of the public on the adequacy, accessibility, and affordability of health care services in this state and other health care issues;

(d) Consult with local health councils, *the agency,* the Health Care ~~Cost Containment~~ Board, the Department of Insurance, the Department of Health and Rehabilitative Services, and other appropriate public and private entities, including health care industry representatives regarding the development of health policies;

(e) Serve as a forum for the discussion of local health planning issues of concern to the local health councils and regional planning councils;

(f) Review district health plans for consistency with the State Comprehensive Plan and the state health plan;

(g) Review the health components of agency functional plans for consistency with the health element of the State Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to agency functional plans to make them consistent with the State Comprehensive Plan;

(h) Review the comprehensive regional plans for consistency with the health element of the State Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to comprehensive regional policy plans to make them consistent with the State Comprehensive Plan;

(i) Assist the Department of Community Affairs in the review of local government comprehensive plans to ensure consistency with policy developed in the district health plans;

(j) With the assistance of the local health councils, conduct public forums and use other means to determine the opinions of health care consumers, providers, payers, and insurers regarding the state's health care goals and policies and develop suggested revisions to the health element of the State Comprehensive Plan. The council shall submit the proposed revisions to the health element of the State Comprehensive Plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1993, and shall widely circulate the proposed revisions to affected parties. The council shall periodically assess the progress made in achieving the goals and policies contained in the health element of the State Comprehensive Plan and report to the *agency* ~~department~~, the Governor, the President of the Senate, and the Speaker of the House of Representatives; and

(k) Conduct any other functions or studies and analyses falling under the duties listed above.

(3) FUNDING.—

(a) The Legislature intends that the cost of local health councils and the Statewide Health Council be borne by application fees for certificates of need and by assessments on selected health care facilities subject to facility licensure by the *agency* ~~department~~, including abortion clinics, adult congregate living facilities, ambulatory surgical centers, birthing centers, clinical laboratories except community nonprofit blood banks, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, and multiphasic testing centers and by assessments on organizations subject to certification by the *agency* ~~department~~ pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics.

(b)1. A hospital licensed under chapter 395, a nursing home licensed under chapter 400, and an adult congregate living facility licensed under chapter 400 shall be assessed an annual fee based on number of beds.

2. All other facilities and organizations listed in paragraph (a) shall each be assessed an annual fee of $150.

3. Facilities operated by the Department of Health and Rehabilitative Services or the Department of Corrections and any hospital which meets the definition of rural hospital pursuant to s. 395.602 are exempt from the assessment required in this subsection.

(c)1. The *agency* ~~department~~ shall, by rule, establish fees for hospitals and nursing homes based on an assessment of $2 per bed. However, no such facility shall be assessed more than a total of $500 under this subsection.

2. The *agency* ~~department~~ shall, by rule, establish fees for adult congregate living facilities based on an assessment of $1 per bed. However, no such facility shall be assessed more than a total of $150 under this subsection.

3. The *agency* ~~department~~ shall, by rule, establish an annual fee of $150 for all other facilities and organizations listed in paragraph(a).

(d) The *agency* ~~department~~ shall, by rule, establish a facility billing and collection process for the billing and collection of the health facility fees authorized by this subsection.

(e) A health facility which is assessed a fee under this subsection is subject to a fine of $100 per day for each day in which the facility is late in submitting its annual fee *but no more than* ~~up to maximum of~~ the annual fee owed by the facility *or $100, whichever is greater. The agency shall not renew a license for any health facility which has not paid a fee or fine owed by the facility pursuant to this subsection.* ~~A facility which refuses to pay the fee or fine is subject to the forfeiture of its license.~~

(f) There is created in the State Treasury the Local and State Health Trust Fund. Moneys in the fund shall be appropriated only to the *agency* ~~department~~ for the purposes of subsections (1) and (2) of this section.

(g) The *agency* ~~department~~ shall deposit in the Local and State Health Trust Fund all health care facility assessments that are assessed under this subsection and proceeds from the certificate-of-need application fees which are sufficient to maintain the aggregate funding level for the local health councils and the Statewide Health Council as specified in the General Appropriations Act for the 1990-1991 fiscal year, plus any increase specifically mandated by the Legislature for the Statewide Health Council. The remaining certificate-of-need application fees shall be deposited in a trust account administered by the *agency* ~~department~~ and may be used only for the purpose of administering the Health Facility and Services Development Act.

(4) DUTIES AND RESPONSIBILITIES OF THE *AGENCY* ~~DEPARTMENT~~.—

(a) The *agency* ~~department~~, in conjunction with the Statewide Health Council and the local health councils, is responsible for the planning of all health care services in the state and for assisting the Statewide Health Council in the preparation of the state health plan.

(b) The *agency* ~~department~~ shall develop and maintain a comprehensive health care data base for the purpose of health planning and for certificate-of-need determinations. The *agency* ~~department~~ or its contractor is authorized to require the submission of information from health facilities, health service providers, and licensed health professionals which is determined by the *agency* ~~department~~, through rule, to be necessary for meeting the *agency's* ~~department's~~ responsibilities as established in this section.

(c) The *agency* ~~department~~ shall assist personnel of the local health councils in providing an annual orientation to council members about council member responsibilities.

(d) The *agency* ~~department~~ shall contract with the local health councils for the services specified in subsection (1). All contract funds shall be distributed according to an allocation plan developed by the *agency* ~~department~~ that provides for a minimum and equal funding base for each local health council. Any remaining funds shall be distributed based on adjustments for workload. The *agency* ~~department~~ may also make grants to or reimburse local health councils from federal funds provided to the state for activities related to those functions set forth in this section. The *agency* ~~department~~ may withhold funds from a local health council or cancel its contract with a local health council which does not meet performance standards agreed upon by the *agency* ~~department~~ and local health councils.

Section 64. Section 408.034, Florida Statutes, 1992 Supplement, is amended to read:

408.034 Duties and responsibilities of *agency* ~~department~~; rules.—

(1) The *agency* ~~department~~ is designated as the single state agency to issue, revoke, or deny certificates of need and to issue, revoke, or deny exemptions from certificate-of-need review in accordance with the district plans, the statewide health plan, and present and future federal and state statutes. The *agency* ~~department~~ is designated as the state health planning agency for purposes of federal law.

(2) In the exercise of its authority to issue licenses to health care facilities ~~and health service providers~~, as provided under chapters 393, 395, and 400, and to hospices, the *agency* ~~department~~ shall not issue a license to any health care facility, ~~health service provider,~~ hospice, or part of a health care facility which fails to receive a certificate of need for the licensed facility or service.

(3) The *agency* ~~department~~ shall establish, by rule, uniform need methodologies for health services and health facilities. In developing uniform need methodologies, the *agency* ~~department~~ shall, at a minimum, consider the demographic characteristics of the population, the health status of the population, service use patterns, standards and trends, geographic accessibility, and market economics.

(4) The *agency* ~~department~~ shall establish by rule a nursing home bed need methodology which reduces the community nursing home bed need for the areas of the state where the *agency* ~~department~~ establishes pilot community diversion programs through the Title XIX aging waiver program.

(5) The *agency* ~~department~~ may adopt rules necessary to implement *ss 408.031-408.045* ~~ss. 381.701-381.715~~.

Section 65. Section 408.035, Florida Statutes, 1992 Supplement, is amended to read:

408.035 Review criteria.—

(1) The *agency* ~~department~~ shall determine the reviewability of applications and shall review applications for certificate-of-need determinations for health care facilities and services, hospices, and health maintenance organizations in context with the following criteria:

(a) The need for the health care facilities, beds, and services based upon the agency's numeric need methodology for beds or services.

(b)~~(a)~~ The need for the health care facilities and services and hospices being proposed in relation to the applicable district plan and state health plan, except in emergency circumstances which pose a threat to the public health.

(c)~~(b)~~ The availability, quality of care, efficiency, appropriateness, accessibility, extent of utilization, and adequacy of like and existing *and approved health services provided or planned in* health care *facilities* ~~services~~ and hospices in the service district of the applicant.

(d)~~(c)~~ The ability of the applicant to provide quality of care and the applicant's record of providing quality of care.

(e)~~(d)~~ The availability and adequacy of other health care facilities and services and hospices in the service district of the applicant, such as outpatient care and ambulatory or home care services, which may serve as alternatives for the health care facilities and services to be provided by the applicant.

(f)~~(e)~~ Probable economies and improvements in service that may be derived from operation of joint, cooperative, or shared health care resources.

(g)~~(f)~~ The need in the service district of the applicant for special equipment and services which are not reasonably and economically accessible in adjoining areas.

(h)~~(g)~~ The need for research and educational facilities, including, but not limited to, institutional training programs and community training programs for health care practitioners and for doctors of osteopathy and medicine at the student, internship, and residency training levels.

(i)~~(h)~~ The availability of resources, including health manpower, management personnel, and funds for capital and operating expenditures, for project accomplishment and operation; the effects the project will have on clinical needs of health professional training programs in the service district; the extent to which the services will be accessible to schools for health professions in the service district for training purposes if such services are available in a limited number of facilities; the availability of alternative uses of such resources for the provision of other health services; and the extent to which the proposed services will be accessible to all residents of the service district.

(j)~~(i)~~ The immediate and long-term financial feasibility of the proposal.

~~(j) The special needs and circumstances of health maintenance organizations.~~

(k) The needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the service district in which the entities are located or in adjacent service districts. Such entities may include medical and other health professions, schools, multidisciplinary clinics, and specialty services such as open-heart surgery, radiation therapy, and renal transplantation.

(l) The probable impact of the proposed project on the costs of providing health services proposed by the applicant, upon consideration of factors including, but not limited to, the effects of competition on the supply of health services being proposed and the improvements or innovations in the financing and delivery of health services which foster competition and service to promote quality assurance and cost-effectiveness.

(m) The costs and methods of the proposed construction, including the costs and methods of energy provision and the availability of alternative, less costly, or more effective methods of construction.

(n) The applicant's past and proposed provision of health care services to Medicaid patients and the medically indigent.

(o) The applicant's past and proposed provision of services which promote a continuum of care in a multilevel health care system, which may include, but is not limited to, acute care, skilled nursing care, home health care, and adult congregate living facilities.

(2) In cases of capital expenditure proposals for the provision of new health services to inpatients, the *agency* ~~department~~ shall also reference each of the following in its findings of fact:

(a) That less costly, more efficient, or more appropriate alternatives to such inpatient services are not available and the development of such alternatives has been studied and found not practicable.

(b) That existing inpatient facilities providing inpatient services similar to those proposed are being used in an appropriate and efficient manner.

(c) In the case of new construction, that alternatives to new construction, for example, modernization or sharing arrangements, have been considered and have been implemented to the maximum extent practicable.

(d) That patients will experience serious problems in obtaining inpatient care of the type proposed, in the absence of the proposed new service.

(e) In the case of a proposal for the addition of beds for the provision of skilled nursing or intermediate care services, that the addition will be consistent with the plans of other agencies of the state responsible for the provision and financing of long-term care, including home health services.

~~(3) For any application authorized by s. 381.706(2)(j) or (k) involving an approved facility based on a certificate-of-need application filed prior to December 31, 1984, the department shall approve such application unless the proposed consolidation or division would result in a facility or facilities not meeting the criterion of financial feasibility or unless the consolidation or division would result in beds or services being moved more than 15 miles from their original certificated location.~~

Section 66. Section 408.036, Florida Statutes, 1992 Supplement, is amended to read:

408.036 *Projects subject to review.*—

(1) APPLICABILITY.—Unless exempt pursuant to subsection (3), all health-care-related projects, as described in paragraphs (a)-*(m)*~~(n)~~, are subject to review and must file an application for a certificate of need with the *agency* ~~department~~. The *agency* ~~department~~ is exclusively responsible for determining whether a health-care-related project is subject to review under *ss. 408.031-408.045* ~~ss. 381.701-381.715~~.

(a) The addition of beds by new construction or alteration.

(b) The new construction or establishment of additional health care facilities.

(c) A capital expenditure of $1 million or more by or on behalf of a health care facility or hospice for a purpose directly related to the furnishing of health services at such facility; provided that a certificate of need shall not be required for an expenditure to provide an outpatient health service, or to acquire equipment or refinance debt, for which a certificate of need is not otherwise required pursuant to this subsection. The *agency* ~~department~~ shall, by rule, adjust the capital expenditure threshold annually using an appropriate inflation index.

(d) The conversion from one type of health care facility to another, *including the conversion of an acute care hospital to a long-term care hospital, and* including the conversion from one level of care to another, in a skilled or intermediate nursing facility, if such conversion effects a change in the level of care of 10 beds or 10 percent of total bed capacity of such skilled or intermediate nursing facility within a 2-year period. If such nursing facility is certified for both skilled and intermediate nursing care, the provisions of this paragraph do not apply.

(e) Any change in licensed bed capacity.

(f) The establishment of a home health agency or hospice, or the direct provision of such services by a health care facility or health maintenance organization for those other than the subscribers of the health maintenance organization.

(g) An acquisition by or on behalf of a health care facility or health maintenance organization, by any means, which acquisition would have required review if the acquisition had been by purchase, including an acquisition at less than fair market value if the fair market value is greater than the capital expenditure threshold.

(h) The establishment of inpatient institutional health services by a health care facility, or a substantial change in such services, or the obligation of capital expenditures for the offering of, or a substantial change in, any such services which entails a capital expenditure in any amount, or an annual operating cost of $500,000 or more. ~~The department shall, by rule, adjust the annual operating cost threshold annually using an appropriate inflation index.~~

(i) The acquisition by any means of an existing health care facility by any person, unless such person provides the *agency* ~~department~~ with at least 30 days' written notice of the proposed acquisition, which notice is to include the services to be offered and the bed capacity of the facility, and unless the *agency* ~~department~~ does not determine, within 30 days of receipt of such letter of intent, that the services to be provided and the bed capacity of the facility will be changed.

(j) The acquisition, by any means, of major medical equipment by a health maintenance organization or health care facility ~~to the extent that the health maintenance organization or health care facility is not exempt pursuant to s. 381.713(1)~~.

(k) An increase in the cost of a project for which a certificate of need has been issued when such increase in cost exceeds the limits set forth in paragraph (c), paragraph (h), or *s. 408.032* ~~s. 381.702~~, or 10 percent of the originally approved cost of the project, whichever is less, except that no cost overrun review is necessary when the cost overrun is less than $10,000.

(l) A change in the number of psychiatric or rehabilitation beds.

(m) The establishment of tertiary health services.

~~(n) A transfer of a certificate of need, in which case an expedited review shall be conducted according to rule and in accordance with s. 381.712.~~

(2) PROJECTS SUBJECT TO EXPEDITED REVIEW.—Unless exempt pursuant to subsection (3), projects subject to an expedited review shall include, but not be limited to:

(a) Cost overruns, unless such cost overruns are caused by a change in service or scope which the *agency* ~~department~~ determines are otherwise reviewable.

(b) Research, education, and training programs.

(c) Donations, when market value equals or exceeds the applicable capital expenditure thresholds for operating expenditures, or major medical equipment, as defined in this act.

~~(d) Acquisition of land which is to be used for the construction of a health care facility, or office facilities for health care providers.~~

(d)~~(e)~~ Termination of a health care service.

(e)~~(f)~~ Shared services contracts or projects.

~~(g) A transfer of a certificate of need.~~

(f)~~(h)~~ Emergency projects and unforeseen major public health hazards.

(g)~~(i)~~ A 50-percent increase in nursing home beds for a facility incorporated and operating in this state for at least 60 years on or before July 1, 1988, which has a licensed nursing home facility located on a campus providing a variety of residential settings and supportive services. The increased nursing home beds shall be for the exclusive use of the campus residents.

(j) Combination within one nursing home facility of the beds or services authorized by two or more certificates of need *held by the same legal entity* issued in the same planning subdistrict.

(k) Addition in the same planning subdistrict of beds authorized by a certificate of need to an existing licensed nursing home facility where the same legal entity holds both the certificate of need and license.

~~(k) Division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. Such division shall not be approved if it would adversely affect the original certificate's approved cost.~~

The *agency* ~~department~~ shall develop rules to implement the provisions for expedited review, including time schedule, application content, and application processing.

(3) EXEMPTIONS.—Upon request, supported by such documentation as the *agency* ~~department~~ may require, the *agency* ~~department~~ shall grant an exemption from the provisions of subsection (1):

(a) For any expenditure by or on behalf of a health care facility for any part of the physical plant which is not to be directly utilized for providing health services ~~or housing health care providers~~. This exemption shall apply to expenditures for parking facilities, meeting rooms, cafeterias, administrative data processing facilities, research buildings, landscaping, and similar projects, *and* ~~but shall not apply~~ to expenditures for office facilities for health care providers.

(b) For any expenditure to eliminate or prevent safety hazards as defined by federal, state, or local codes.

(c) For any expenditure to replace any part of a facility or equipment which is destroyed as a result of fire, civil disturbance, or storm or any other act of God.

(d) For any expenditure to acquire major medical equipment which is a substantially identical replacement for existing equipment being taken out of service.

(e) For the initiation or expansion of obstetric services after July 1, 1988.

(f) For any expenditure to replace or renovate any part of a licensed nursing facility, provided that the number of licensed beds will not increase and, in the case of a replacement facility, the project site is the same as the facility being replaced.

(g) For providing respite care services. "Respite care" means short-term care in a licensed health care facility which is personal or custodial in nature and is provided by reason of chronic illness, physical infirmity, or advanced age for the purpose of temporarily relieving family members of the burden of providing care and attendance in the home. In providing respite care, the health care facility shall become the primary caregiver. An individual may be admitted to a respite care program in a hospital without regard to inpatient requirements relating to admitting order and attendance of a member of a medical staff.

(h) For hospice or home health services provided by a rural hospital, as defined in s. 395.602, or for swing beds in such rural hospital in a number that does not exceed one-half of its licensed beds.

(i) For the establishment of diagnostic cardiac catheterization services.

(j) For the acquisition of land or for the construction of office facilities for health care providers.

(k) For the construction of any intermediate care facility for the developmentally disabled which is to provide housing for clients of the Department of Health and Rehabilitative Services whose intermediate care facility for the developmentally disabled residences were destroyed or substantially damaged by Hurricane Andrew in August 1992, provided the existing number of beds are not increased, provided, prior to the grant of the exemption under this paragraph, the Department of Health and Rehabilitative Services shall submit, after calling a social services impact conference, to the chairs of the legislative appropriations committees a 3-year projection showing that such exemption will not result in increased costs to the Medicaid Intermediate Care Facility appropriation category.

(l) For the conversion of licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital as defined in s. 395.602, so long as the conversion of the beds does not involve the construction of new facilities. The total number of skilled nursing beds, including swing beds, may not exceed one-half of the total number of licensed beds in the rural hospital as of July 1, 1993. Certified skilled nursing beds designated under this paragraph, excluding swing beds, must be included in the community nursing home bed inventory. A rural hospital that subsequently decertifies any acute care beds exempted under this paragraph shall notify the agency of the decertification and the agency shall adjust the community nursing home bed inventory accordingly.

A request for exemption pursuant to this subsection may be made at any time and is not subject to the batching requirements of this section.

Section 67. Section 408.037, Florida Statutes, 1992 Supplement, is amended to read:

408.037 Application content.—An application for a certificate of need shall contain:

(1) A detailed description of the proposed project and statement of its purpose and need in relation to ~~the applicant's long-range plan,~~ the local health plan~~,~~ and the state health plan.

(2) A statement of the financial resources needed by and available to the applicant to accomplish the proposed project. This statement shall include:

(a) A complete listing of all capital projects, including new health facility development projects and health facility acquisitions applied for, pending, approved, or underway in any state at the time of application, regardless of whether or not that state has a certificate-of-need program ~~or a capital expenditure review program pursuant to section 1122 of the Social Security Act~~. The *agency* ~~department~~ may, by rule, require less-detailed information from major health care providers. This listing shall include the applicant's actual or proposed financial commitment to those projects and an assessment of their impact on the applicant's ability to provide the proposed project.

(b) A detailed listing of the needed capital expenditures, including sources of funds.

(c) A detailed financial projection, including a statement of the projected revenue and expenses ~~for the period of construction and~~ for the first 2 years of operation after completion of the proposed project. This statement shall include a detailed evaluation of the impact of the proposed project on the cost of other services provided by the applicant.

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

(4) A certified copy of a resolution by the board of directors of the applicant, or other governing authority if not a corporation, authorizing the filing of the application; authorizing the applicant to incur the

expenditures necessary to accomplish the proposed project; certifying that if issued a certificate, the applicant shall accomplish the proposed project within the time allowed by law and at or below the costs contained in the application; and certifying that the applicant shall license and operate the facility.

Section 68. Section 408.038, Florida Statutes, 1992 Supplement, is amended to read:

408.038 Fees.—The *agency* ~~department~~ shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the Statewide Health Council, the functions of the local health councils, and the activities of the *agency* ~~department~~ and shall be allocated as provided in *s. 408.033* ~~s. 381.703~~. The fee shall be determined as follows:

(1) A minimum base fee of $5,000.

(2) In addition to the base fee of $5,000, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed $22,000.

Section 69. Section 408.039, Florida Statutes, 1992 Supplement, is amended to read:

408.039 Review process.—The review process for certificates of need shall be as follows:

(1) REVIEW CYCLES.—The *agency* ~~department~~ by rule shall provide for applications to be submitted on a timetable or cycle basis; provide for review on a timely basis; and provide for all completed applications pertaining to similar types of services, facilities, or equipment affecting the same service district to be considered in relation to each other no less often than two times a year.

(2) LETTERS OF INTENT.—

(a) At least 30 days prior to filing an application, a letter of intent shall be filed by the applicant with the local health council and the *agency* ~~department~~, respecting the development of a proposal subject to review. No letter of intent is required for expedited projects as defined by rule by the *agency* ~~department~~.

(b) The *agency* ~~department~~ shall provide a mechanism by which applications may be filed to compete with proposals described in filed letters of intent.

(c) Letters of intent shall describe the proposal with specificity, including proposed capital expenditures, number of beds sought, if any, services, specific subdistrict location, identification of the applicant, including the names of those with controlling interest in the applicant, and such other information as the *agency* ~~department~~ may by rule prescribe. The letter of intent shall contain a certified copy of a resolution by the board of directors of the applicant, or other governing authority if not a corporation, authorizing the filing of the application described in the letter of intent; authorizing the applicant to incur the expenditures necessary to accomplish the proposed project; certifying that if issued a certificate, the applicant shall accomplish the proposed project within the time allowed by law and at or below the costs contained in the application; and certifying that the applicant shall license and operate the facility.

(d) Within 14 days after filing a letter of intent, the applicant shall publish a notice of filing to be published in a newspaper of general circulation in the area affected by the proposal. The notice of filing shall be published once a week for 2 consecutive weeks on forms and in the format and content specified by the *agency* ~~department~~ by rule. Within 21 days after the filing, the *agency* ~~department~~ shall publish notice of the filing of letters of intent in the Florida Administrative Weekly and notice that, if requested, a public hearing shall be held at the local level within 21 days after the application is deemed complete. Notices under this subsection shall contain due dates applicable to the cycle for filing applications and for requesting a hearing.

(3) APPLICATION PROCESSING.—

(a) An applicant shall file an application with the *agency* ~~department~~, and shall furnish a copy of the application to the local health council and the *agency* ~~department~~. Within 15 days after the applicable application filing deadline established by *agency* ~~department~~ rule, the staff of the *agency* ~~department~~ shall determine if the application is complete. If the application is incomplete, the staff shall request specific information from the applicant necessary for the application to be complete; however, the staff may make only one such request. If the requested information is not filed with the *agency* ~~department~~ within 21 days ~~of the receipt~~ of the staff's request, the application shall be deemed incomplete and deemed withdrawn from consideration. *Effective June 30, 1993, from the time an application is filed until all applications which are to be comparatively reviewed are deemed complete or any application is deemed incomplete and withdrawn from consideration, all applications are confidential and exempt from the provisions of s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.*

(b) Upon the request of any applicant or substantially affected person within 7 ~~14~~ days after notice that an application has been *deemed complete* ~~filed~~, a public hearing may be held at the *agency's* ~~department's~~ discretion if the *agency* ~~department~~ determines that a proposed project involves issues of great local public interest. The public hearing shall allow applicants and other interested parties reasonable time to present their positions and to present rebuttal information. A recorded verbatim record of the hearing shall be maintained. The public hearing shall be held at the local level within 21 days after the application is deemed complete.

(4) STAFF RECOMMENDATIONS.—

(a) The *agency's* ~~department's~~ review of and final agency action on applications shall be in accordance with the district plan, and statutory criteria, and the implementing administrative rules. In the application review process, the *agency* ~~department~~ shall give a preference, as defined by rule of the *agency* ~~department~~, to an applicant which proposes to develop a nursing home in a nursing home geographically underserved area.

(b) Within 60 days after all the applications in a review cycle are determined to be complete, the *agency* ~~department~~ shall issue its State Agency Action Report and Notice of Intent to grant a certificate of need for the project in its entirety, to grant a certificate of need for identifiable portions of the project, or to deny a certificate of need. The State Agency Action Report shall set forth in writing its findings of fact and determinations upon which its decision is based. If a finding of fact or determination by the *agency* ~~department~~ is counter to the district plan of the local health council, the *agency* ~~department~~ shall provide in writing its reason for its findings, item by item, to the local health council and the Statewide Health Council. If the *agency* ~~department~~ intends to grant a certificate of need, the State Agency Action Report or the Notice of Intent shall also include any conditions which the *agency* ~~department~~ intends to attach to the certificate of need. The *agency* ~~department~~ shall designate by rule a senior staff person, other than the person who issues the final order, to issue State Agency Action Reports and Notices of Intent.

(c) The *agency* ~~department~~ shall publish its proposed decision set forth in the Notice of Intent in the Florida Administrative Weekly within 14 days after the Notice of Intent is issued.

(d) If no administrative hearing is requested pursuant to subsection (5), the State Agency Action Report and the Notice of Intent shall become the final order of the *agency. If an administrative hearing is requested, the agency may change its initial decision as contained in the State Agency Action Report and the Notice of Intent. Once an administrative hearing has occurred, the final order shall be based upon the findings of fact in the hearing officer's recommended order or upon separate settlement signed by the agency and all remaining parties* ~~department~~. The *agency* ~~department~~ shall provide a copy of the final order to the appropriate local health council.

(5) ADMINISTRATIVE HEARINGS.—

(a) Within 21 days after publication of notice of the State Agency Action Report and Notice of Intent, any person authorized under paragraph (b) to participate in a hearing may file a request for an administrative hearing; failure to file a request for hearing within 21 days of publication of notice shall constitute a waiver of any right to a hearing and a waiver of the right to contest the final decision of the *agency* ~~department~~. A copy of the request for hearing shall be served on the applicant.

(b) Hearings shall be held in Tallahassee unless the hearing officer determines that changing the location will facilitate the proceedings. In administrative proceedings challenging the issuance or denial of a certificate of need, only applicants considered by the *agency* ~~department~~ in the same batching cycle are entitled to a comparative hearing on their applications. Existing *or approved* health care facilities may initiate or intervene in such administrative hearing upon a showing that an established

or approved program will be substantially affected by the issuance of a certificate of need to a competing proposed facility or program within the same district *or regional planning district, where applicable*, provided that existing health care providers, other than the applicant, have no standing or right to initiate or intervene in an administrative hearing involving a health care project which is subject to certificate-of-need review solely on the basis of *s. 408.036(1)(c)* ~~s. 381.706(1)(c)~~. *Associations or consumer groups which are substantially affected by the issuance, revocation, or denial of a certificate of need shall have the right to initiate or intervene in an administrative hearing concerning the agency's action.* The *agency* ~~department~~ shall assign proceedings requiring hearings to the Division of Administrative Hearings of the Department of Management Services within 10 days after the time has run to request a hearing. Except upon unanimous consent of the parties or upon the granting by the hearing officer of a motion of continuance, hearings shall commence within 60 days after the hearing officer has been assigned. All non-state-agency parties shall bear their own expense of preparing a transcript. In any application for a certificate of need which is referred to the Division of Administrative Hearings for hearing, the hearing officer shall complete and submit to the parties a recommended order as provided in s. 120.57(1)(b). The recommended order shall be issued within 30 days after the receipt of the proposed recommended orders or the deadline for submission of such proposed recommended orders, whichever is earlier. The division shall adopt procedures for administrative hearings which shall maximize the use of stipulated facts and shall provide for the admission of prepared testimony.

(c) The *agency* ~~department~~ shall issue its final order within 45 days after receipt of the recommended order.

(d) If the *agency* ~~department~~ fails to take action within the time specified in paragraph (4)(a) or paragraph (5)(c), or as otherwise agreed to by the applicant and the *agency* ~~department~~, the applicant may take appropriate legal action to compel the *agency* ~~department~~ to act. When making a determination on an application for a certificate of need, the *agency* ~~department~~ is specifically exempt from ~~the time limitations provided in~~ s. 120.60(2).

(6) JUDICIAL REVIEW.—

(a) A party to an administrative hearing for an application for a certificate of need has the right, within not more than 30 days after the date of the final order, to seek judicial review in the District Court of Appeal pursuant to s. 120.68. The *agency* ~~department~~ shall be a party in any such proceeding.

(b) In such judicial review, the court shall affirm the final order of the *agency* ~~department~~, unless the decision is arbitrary, capricious, or not in compliance with *ss. 408.031-408.045* ~~ss. 381.701-381.715~~.

(c) The court, in its discretion, may award reasonable attorney's fees and costs to the prevailing party if the court finds that there was a complete absence of a justiciable issue of law or fact raised by the losing party.

Section 70. Section 408.040, Florida Statutes, 1992 Supplement, is amended to read:

408.040 Conditions and monitoring.—

(1)(a) The *agency* ~~department~~ may issue a certificate of need predicated upon statements of intent expressed by an applicant in the application for a certificate of need. Any certificate of need issued for construction of a new hospital or for the addition of beds to an existing hospital shall include a statement of the number of beds approved by category of service, including rehabilitation or psychiatric service, for which the *agency* ~~department~~ has adopted by rule a specialty-bed-need methodology. All beds which are approved, but are not covered by any specialty-bed-need methodology, shall be designated as general. If the holder of a certificate of need demonstrates good cause why the certificate should be modified, the *agency* ~~department~~ shall reissue the certificate of need with such modifications as may be appropriate. The *agency* ~~department~~ shall by rule define the factors constituting good cause for modification. *Failure of a holder of a certificate of need to substantially comply with statements of intent made in the application and relied upon by the agency as set forth in the certificate shall be cause for the agency to initiate an action for specific performance, for fines as specified in s. 408.041(2), or for injunctive relief.*

(b) If the holder of a certificate of need fails to comply with a condition upon which the issuance of the certificate was predicated, *or to report its compliance with a condition,* the *agency* ~~department~~ may assess an administrative fine against the certificateholder in an amount not to exceed $1,000 per failure per day. In assessing the penalty, the *agency* ~~department~~ shall take into account as mitigation the relative lack of severity of a particular failure. Proceeds of such penalties shall be deposited in the Public Medical Assistance Trust Fund.

(2)(a) Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate *18 months* ~~1 year~~ after the date of issuance~~, except in the case of a multifacility project, as defined in s. 381.702(17), where the certificate of need shall terminate 2 years after the date of issuance. The department may extend the period of validity of the certificate for an additional period of up to 6 months, upon a showing of good cause, as defined by rule, by the applicant for the extension~~. The *agency* ~~department~~ shall monitor the progress of the holder of the certificate of need in meeting the timetable for project development specified in the application with the assistance of the local health council as specified in *s. 408.033(1)(b)7.* ~~s. 381.703(1)(b)7.~~, and may revoke the certificate of need, if the holder of the certificate is not meeting such timetable and is not making a good faith effort, as defined by rule, to meet it. *A certificate of need may not be transferred.*

(b) A certificate of need issued to an applicant holding a provisional certificate of authority under chapter 651 shall terminate 1 year after the applicant receives a valid certificate of authority from the Department of Insurance. The certificate-of-need validity period may be extended by the *agency* ~~department~~ for an additional period of up to 6 months upon a showing of good cause, as defined by rule, by the applicant for the extension.

(c) The certificate-of-need validity period for a project shall be extended by the *agency* ~~department~~, to the extent that the applicant demonstrates to the satisfaction of the *agency* ~~department~~ that good faith commencement of the project is being delayed by litigation or by governmental action or inaction with respect to regulations or permitting precluding commencement of the project.

(d) *The consolidation of two or more certificates of need or the division of a certificate of need into two or more facilities is prohibited, except where authorized by s. 408.036(2)(j) and (k).* ~~If an application is filed to consolidate two or more certificates as authorized by s. 381.706(2)(j) or to divide a certificate of need into two or more facilities as authorized by s. 381.706(2)(k), the validity period of the certificate or certificates of need to be consolidated or divided shall be extended for the period beginning upon submission of the application and ending when final agency action and any appeal from such action has been concluded. However, no such suspension shall be effected if the application is withdrawn by the applicant.~~

(3) The *agency* ~~department~~ shall require the submission of an executed architect's certification of final payment for each certificate-of-need project approved by the *agency* ~~department~~. Each project which involves construction shall submit such certification to the *agency* ~~department~~ within 30 days following completion of construction.

Section 71. Section 408.041, Florida Statutes, 1992 Supplement, is amended to read:

408.041 Certificate of need required; penalties; *fines.*—

(1) It is unlawful for any person to undertake a project subject to review under *ss. 408.031-408.045* ~~ss. 381.701-381.715~~ without a valid certificate of need. Any person violating the provisions of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation shall be considered a separate offense.

(2) The agency, as a part of any final order issued by it under the provisions of ss. 408.031-408.045, may impose such fine as it deems proper, except that such fine shall not exceed $1,000 for each violation of ss. 408.031-408.045. Each day of continuing violation shall constitute a separate violation and shall be subject to a separate fine. A fine may be levied pursuant to this section in lieu of and notwithstanding any other remedy available for use by the agency.

Section 72. Section 408.043, Florida Statutes, 1992 Supplement, is amended to read:

408.043 Special provisions.—

(1) OSTEOPATHIC ACUTE CARE HOSPITALS.—When an application is made for a certificate of need to construct or to expand an osteopathic acute care hospital, the need for such hospital shall be determined on the basis of the need for and availability of osteopathic services and osteopathic acute care hospitals in the district. When a prior certificate of need to establish an osteopathic acute care hospital has been issued in a district, and the facility is no longer used for that purpose, the department may continue to count such facility and beds as an existing osteopathic facility in any subsequent application for construction of an osteopathic acute care hospital.

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

(3) COOPERATIVE AGREEMENTS.—Preference shall be given in the award of a certificate-of-need, upon the demonstration of need pursuant to s. 408.035, to a hospital which seeks to provide a tertiary health service based upon a cooperative agreement with other hospitals in the district.

(4) RURAL HEALTH NETWORKS.—Preference shall be given in the award of a certificate of need to members of certified rural health networks, subject to the following conditions:

(a) Need is shown pursuant to s. 408.035.

(b) The proposed project must:

1. Strengthen health care services in rural areas through partnerships between health care providers; or

2. Increase access to inpatient health care services for Medicaid recipients or other low-income persons who live in rural areas.

(c) No preference shall be given under this subsection for the establishment of skilled nursing facility services by a hospital.

For the purposes of this subsection "rural health network" means a nonprofit legal entity, consisting of local community health care providers and others, that is organized to plan and deliver health care services on a cooperative basis.

~~(3) VALIDITY OF CERTIFICATE OF NEED.—A certificate of need issued by the department for nursing home facilities of 100 beds or more prior to February 14, 1986, is valid, provided that such facility has expended at least $50,000 in reliance upon such certificate of need, excluding legal fees, prior to the initiation of proceedings under the Administrative Procedure Act subsequent to February 14, 1986, contesting the validity of the certificate of need. If such nursing home certificate of need includes beds that have not yet been licensed as of June 17, 1987, such beds shall not be considered or utilized in the determination of need or included in the inventory of licensed or approved nursing home beds by the department, with respect to applications filed before June 17, 1987. This subsection shall only apply to nursing home beds. Nothing contained herein shall be construed to deny action pursuant to s. 120.69, or to eliminate any conditions of the certificate of need or time requirements to commence construction, including any authorized extensions.~~

Section 73. Section 408.044, Florida Statutes, 1992 Supplement, is amended to read:

408.044 Injunction.—Notwithstanding the existence or pursuit of any other remedy, the *agency* ~~department~~ may maintain an action in the name of the state for injunction or other process against any person to restrain or prevent the pursuit of a project subject to review under *ss. 408.031-408.045* ~~ss. 381.701-381.715~~, in the absence of a valid certificate of need.

Section 74. Section 408.045, Florida Statutes, 1992 Supplement, is amended to read:

408.045 Certificate of need; competitive sealed proposals.—

(1) The application, review, and issuance procedures for a certificate of need for an intermediate care facility for the developmentally disabled may be made by the *agency* ~~department~~ by competitive sealed proposals.

(2) The *agency* ~~department~~ shall make a decision regarding the issuance of the certificate of need in accordance with the provisions of s. 287.057(15), rules adopted by the *agency* ~~department~~ relating to intermediate care facilities for the developmentally disabled, and the criteria in *s. 408.035* ~~s. 381.705~~, as further defined by rule.

(3) Notification of the decision shall be issued to all applicants not later than 28 calendar days after the date responses to a request for proposal are due.

(4) The procedures provided for under this section are exempt from the batching cycle requirements and the public hearing requirement of s. 408.039.

(5) The *agency* ~~department~~ may use the competitive sealed proposal procedure for determining a certificate of need for other types of health care facilities and services if the *agency* ~~department~~ identifies an unmet health care need and when funding in whole or in part for such health care facilities or services is authorized by the Legislature.

Section 75. The Legislature recognizes that as the Agency for Health Care Administration proposes and implements positive changes in the health care delivery system, the Legislature should be advised on a systematic and comprehensive basis as to the continued need for certificate-of-need regulation. It is the intent of the Legislature that, by 1997, certificate-of-need regulation for all health care related projects may no longer be necessary and that some projects should be deregulated before 1997. Accordingly, the Legislature directs the Agency for Health Care Administration to advise the Legislature and Governor annually through written recommendations as to which particular health care related projects, in the agency's opinion, no longer need to be subject to certificate-of-need review. The recommendations of the agency shall be submitted to the Governor, the Speaker of the House of Representatives, the President of the Senate, the Minority Leaders of the House of Representatives and the Senate, and the chairpersons of the health care committees in both chambers by December 1 of each year.

Section 76. Subsection (3) of section 189.415, Florida Statutes, is amended to read:

189.415 Special district public facilities report.—

(3) A special district proposing to build, improve, or expand a public facility which requires a certificate of need pursuant to chapter *408* ~~381~~ shall elect to notify the appropriate local general-purpose government of its plans either in its 5-year plan or at the time the letter of intent is filed with the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ pursuant to *s. 408.039* ~~s. 381.709~~.

Section 77. Section 651.118, Florida Statutes, is amended to read:

651.118 *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~; certificates of need; sheltered beds; community beds.—

(1) The provisions of this section shall control in the case of conflict with the provisions of the Health Facility and Services Development Act, *ss. 408.031-408.045* ~~ss. 381.701-381.715~~; the provisions of chapter 395; or the provisions of parts I and II of chapter 400.

(2) The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall issue a certificate of need to any holder of a provisional certificate of authority pursuant to s. 651.022 to construct nursing home beds for the exclusive use of the prospective residents of the proposed continuing care facility if the holder of the provisional certificate of authority meets the *agency's* ~~Department of Health and Rehabilitative Services'~~ applicable review criteria, utilizing the bed need provisions of subsection (4).

(3) Nursing home beds located within a continuing care facility for which a certificate of need is issued pursuant to subsection (2) shall be known as sheltered nursing home beds.

(4) The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall approve one sheltered nursing home bed for every four proposed residential units in the continuing care facility unless the provider demonstrates the need for a lesser number of sheltered nursing home beds based on proposed utilization by prospective residents or demonstrates the need for additional sheltered nursing home beds based on actual utilization and demand by current residents.

(5) Construction on any sheltered nursing home beds shall not begin until the holder of the provisional certificate of authority has been issued a certificate of authority pursuant to s. 651.021 and a certificate of need from the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~.

(6) Unless the provider already has a component which is to be a part of the continuing care facility and which is licensed pursuant to chapter 395, or part I or part II of chapter 400 at the time of construction of the continuing care facility, the provider shall construct the nonnursing home portion of the facility and the nursing home portion of the facility at the same time. If a provider constructs less than the number of residential units approved in the certificate of authority, the number of licensed sheltered nursing home beds shall be reduced by a proportionate share.

(7) Notwithstanding the provisions of subsection (2), at the discretion of the continuing care provider, sheltered nursing home beds may be used for persons who are not residents of the facility, and who are not parties to a continuing care contract, for a period of up to 5 years from the date of issuance of the initial nursing home license.

(8) This section shall not preclude a continuing care provider from applying to the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ for a certificate of need for community nursing home beds or a combination of community and sheltered nursing home beds. Any nursing home bed located in a continuing care facility that is or has been issued for nonrestrictive use shall retain its legal status as a community nursing home bed unless the provider requests a change in status. Any nursing home bed located in a continuing care facility and not issued as a sheltered nursing home bed prior to 1979 shall be classified as a community bed. The *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ may require continuing care facilities to submit bed utilization reports for the purpose of determining community and sheltered nursing home bed inventories based on historical utilization by residents and nonresidents.

(9) Whenever the department has been appointed receiver of a provider pursuant to the provisions of part I of chapter 631, the receiver may petition, upon approval of the court having jurisdiction as being in the best interest of the residents, the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ for the conversion of sheltered nursing home beds of the facility to community nursing home beds. The *agency* ~~Department of Health and Rehabilitative Services~~ shall, upon petition of the receiver and through an expedited review, issue a certificate of need converting the sheltered nursing home beds to community nursing home beds. The court having jurisdiction of the delinquency proceeding shall enforce the provisions of this section.

(10) For a provider issued a provisional certificate of authority after July 1, 1986, to operate a facility not previously regulated under this chapter, the following criteria shall be met in order to obtain a certificate of need for sheltered beds pursuant to subsections (2), (3), (4), (5), (6), and (7):

(a) Seventy percent or more of the current residents hold continuing care agreements pursuant to s. 651.011(2) or, if the facility is not occupied, 70 percent or more of the prospective residents will hold continuing care agreements pursuant to s. 651.011(2) as projected in the feasibility study and demonstrated by the provider's marketing practices; and

(b) The continuing care agreements entered into or to be entered into by 70 percent or more of the current residents or prospective residents pursuant to s. 651.011(2) shall provide nursing home care for a minimum of 360 cumulative days, and the holders of the continuing care agreements shall be charged at rates which are 80 percent or less than the rates charged by the provider to persons receiving nursing home care who have not entered into continuing care agreements pursuant to s. 651.011(2).

Section 78. Section 381.712, Florida Statutes, as transferred to s. 408.042, Florida Statutes, 1992 Supplement, by chapter 92-33, Laws of Florida, is repealed.

Section 79. Effective July 1, 1993, all powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Medicaid program within the Department of Health and Rehabilitative Services, as well as the infrastructure and support services that support the program, including, but not limited to, investigative, licensing, legal, and administrative activities, are transferred by a type four transfer, as defined in section 20.06(4), Florida Statutes, to the Agency for Health Care Administration. Administrative infrastructure associated with finance and accounting, personnel, budget and general services shall also be transferred to the Agency and shall include at a minimum: 41 full time career service positions, one select exempt position and, $870,261 from general revenue funds to be used as a fifty/fifty match for the federal Medicaid financial participation. Any rules adopted by or for the Medicaid program are included in such transfer.

Section 80. Effective July 1, 1993, the powers, duties and functions, records, property and unexpended allocations of funds associated with seven career service positions, including $434,379 from the State Employee Health Trust Fund in the State Employees Health Insurance Program shall be transferred from the Department of Management Services by a type four transfer, as defined in section 20.06(4), Florida Statutes, to the Agency for Health Care Administration. The seven positions include two benefit analysts and one secretary specialist from the benefits programs section and one administrator, one secretary specialist, and two auditors from the state benefits audit section.

Section 81. There is hereby appropriated to the Agency for Health Care Administration: 60 full time positions; $13,775,773 from the General Revenue Fund; and, the agency is authorized to transfer in accordance with chapter 216, Florida Statutes, up to $165,204 in General Revenue from the Medicaid Hospital Outpatient Services Category and, $1,114,611 in General Revenue from the Medicaid Physician's Services Category as a result of the co-payment savings; $597,109 from the State Employees Health Insurance Trust Fund; $5,217,903 from the Medical Care Trust Fund; and $713,349 from the Health Care Trust Fund to be allocated as follows:

(1) Ten positions and $597,109 from the State Employees Health Insurance Trust Fund for the added responsibilities related to the State Employees Health Insurance Program.

(2) Two positions and $147,955 from the General Revenue Fund for Deputy Director's Office for State Health Purchasing.

(3) One million dollars from General Revenue Fund and $713,349 from the Health Care Trust Fund for Data Collection and Analysis.

(4) Twenty-one positions and $927,919 from the General Revenue Fund for MedAccess development and consultants.

(5) Fifty thousand dollars from the General Revenue Fund for a fraud and abuse study.

(6) Twenty-five positions and $503,670 from the General Revenue Fund and $503,670 from the Medical Care Trust Fund for Medipass expansion.

(7) Two positions and $275,000 from the General Revenue Fund for the community health purchasing alliance administration.

(8) Three million twenty-five thousand dollars from the General Revenue Fund for grants to 11 community health purchasing alliances.

(9) Five million dollars from the General Revenue Fund for rural hospital financial assistance program.

(10) Three million, eight hundred twenty-six thousand, forty-four dollars from the General Revenue Fund and $4,417,233 from the Medical Care Trust Fund for Medicaid reimbursement for skilled nursing facility beds in acute care hospitals.

(11) Three hundred thousand dollars from the General Revenue Funds for four rural health network development grants.

Section 82. There is hereby appropriated to the Department of Health Rehabilitative Services, three career service positions and $2,150,000 from the General Revenue Fund to be allocated as follows:

(1) One hundred fifty thousand dollars and three positions for the Office of Rural Health.

(2) Two million dollars for the Florida Health Services Corps Program.

Section 83. Paragraph (c) of subsection (2) of section 627.4106, Florida Statutes, 1992 Supplement, is amended to read:

627.4106 Small group health insurance; rates; restrictions.—

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

(c) "Health benefit plan" means any hospital or medical policy or certificate or any health maintenance organization subscriber contract. "Health benefit plan" does not include *specified disease,* accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation and employers' liability or similar insurance, or motor vehicle medical-payment insurance.

Section 84. Effective January 1, 1994, section 627.4106, Florida Statutes, is repealed.

Section 85. (1) Section 627.6699, Florida Statutes, 1992 Supplement, is amended to read:

627.6699 Employee Health Care Access Act.—

(1) SHORT TITLE.—This section may be cited as the "Employee Health Care Access Act."

(2) PURPOSE AND INTENT.—The purpose and intent of this section is to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status, to establish rules regarding renewability of that coverage, to establish limitations on the use of exclusions for preexisting conditions, to provide for development of a standard health benefit plan and a basic health benefit plan to be offered to all small employers, to provide for establishment of a reinsurance program for coverage of small employers, and to improve the overall fairness and efficiency of the small group health insurance market.

(3) DEFINITIONS.—As used in this section, *the term:*

(a) "Actuarial certification" means a written statement, by a member of the American Academy of Actuaries or another person acceptable to the department, that a small employer carrier is in compliance with subsection (4), based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans.

(b)~~(a)~~ "Basic health benefit plan" and "standard health benefit plan" mean low-cost health care plans developed pursuant to subsection *(12)*~~(9)~~.

(c)~~(b)~~ "Board" means the board of directors of the program.

(d)~~(c)~~ "Carrier" means a person who provides health benefit plans in this state, including an authorized insurer, a health maintenance organization, a multiple-employer welfare arrangement, or any other person providing a health benefit plan that is subject to insurance regulation in this state. However, *the term* ~~"carrier"~~ does not include a multiple-employer welfare arrangement established by an association of members of the same profession, which multiple-employer welfare arrangement operates solely for the benefit of the members or the members and the employees of such members, was in existence on January 1, 1992, and provides coverage for any member of the association with 11 or more employees or any such member and dependents of the member, upon the member's request for such coverage.

(e)~~(d)~~ "Case management program" means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the carrier.

(f)~~(e)~~ "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the health benefit plan covering that employee.

(g)~~(f)~~ "Eligible employee" means an employee who works full time, having a normal workweek of *25* ~~30~~ or more hours, and who has met any applicable waiting-period requirements *or other requirements of this act.* The term includes *a self-employed individual,* a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.

(h)~~(g)~~ "Established geographic area" means the county or counties, or any portion of a county or counties, within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(i) "Guarantee-issue basis" means an insurance policy that must be offered to an employer, employee, or dependent of the employee, regardless of health status, preexisting conditions, or claims history.

(j)~~(h)~~ "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(k)~~(i)~~ "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the initial enrollment period provided under the terms of the plan has ended. However, an eligible employee or dependent is not considered a late enrollee if the enrollee:

1. Was covered under another employer health benefit plan at the time the individual was eligible to enroll; lost coverage under that plan as a result of termination of employment, the termination of the other plan's coverage, the death of a spouse, or divorce; and requests enrollment within 30 days after coverage under that plan was terminated;

2. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

3. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(l)~~(j)~~ "Limited benefit policy or contract" means a policy or contract that provides coverage for each person insured under the policy for a specifically named disease or diseases, a specifically named accident, or a specifically named limited market that fulfills an experimental or reasonable need, such as the small group market.

(m) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(k).

(n)~~(k)~~ "Participating carrier" means any carrier that issues health benefit plans in this state except a small employer carrier that elects to be a risk-assuming carrier.

(o)~~(l)~~ "Plan of operation" means the plan of operation of the program, including articles, bylaws, and operating rules, adopted by the board *under* ~~pursuant to~~ subsection *(11)*~~(8)~~.

(p)~~(m)~~ "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to:

1. A condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition; or

2. Pregnancy existing on the effective date of coverage.

(q)~~(n)~~ "Program" means the Florida Small Employer Carrier Reinsurance Program created under subsection *(11)*~~(8)~~.

(r)~~(o)~~ "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

1. An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health plan; or

2. An individual health insurance policy, including coverage issued by a health maintenance organization, a fraternal benefit society, or a multiple-employer welfare arrangement, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least 1 year.

(s) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(t)~~(p)~~ "Reinsuring carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection *(11)*~~(8)~~.

(u)~~(q)~~ "Risk-assuming carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection *(10)*~~(7)~~.

(v) "Self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years.

(w)~~(r)~~ "Small employer" means any person, *sole proprietor, self-employed individual, independent contractor,* firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50 percent of its working days during the preceding calendar quarter, employed ~~at least 3, but~~ not more than *50* ~~25~~, eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, may be considered a single employer. *For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.*

(x)~~(s)~~ "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers.

(4) APPLICABILITY AND SCOPE.—

(a) This section applies to a health benefit plan that provides coverage to a small employer in this state, *unless the policy is marketed directly to the individual employee, and the employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy in any manner.* ~~if:~~

~~1. Any portion of the premium or benefits is paid by a small employer;~~

~~2. Any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium; or~~

~~3. The plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of s. 106, s. 125, or s. 162 of the United States Internal Revenue Code.~~

(b) With respect to a group of affiliated carriers or a group of carriers that is eligible to file a consolidated tax return, any restrictions, limitations, or requirements of this section that apply to one of the carriers applies to all of the carriers as if they were one carrier. However, with respect to affiliated companies, all of which are in existence and affiliated on January 1, 1992, the group of affiliated companies is considered one carrier only after one member of the group transfers any small employer business to another member of the group.

(c) An affiliated carrier that is a health maintenance organization having a certificate of authority under part I of chapter 641 may be considered a separate carrier for the purposes of this section.

(d) This section shall not apply to a carrier that does not issue new health benefit plans to small employers on or after January 1, 1994, except that it shall apply to any such carrier that renews a health benefit plan on or after January 1, 1995.

(5) AVAILABILITY OF COVERAGE.—

(a) Beginning January 1, 1993, every small employer carrier issuing new health benefit plans to small employers in this state must, as a condition of transacting business in this state, offer to eligible small employers a standard health benefit plan and a basic health benefit plan. Such a small employer carrier shall issue a standard health benefit plan or a basic health benefit plan to every eligible small employer that elects to be covered under such plan, agrees to make the required premium payments under such plan and to satisfy the other provisions of the plan.

(b) In the case of a small employer carrier which does not, on or after January 1, 1993, offer coverage but which does, on or after January 1, 1993, renew or continue coverage in force, such carrier shall be required to provide coverage to newly eligible employees and dependents on the same basis as small employer carriers which are offering coverage on or after January 1, 1993.

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Beginning January 1, 1994, offer and issue all small employer health benefit plans on a guarantee-issue basis to every eligible small employer, with 3 to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan.

2. Beginning April 15, 1994, offer and issue all small employer health benefit plans on a guarantee-issue basis to every eligible small employer, with 1 or 2 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan.

3. Offer to eligible small employers the standard and basic health benefit plans. This subparagraph does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.

~~(b) In the case of a small employer carrier that establishes more than one class of business, the small employer carrier shall offer, upon request, and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:~~

~~1. The criteria are not intended to discourage or prevent acceptance of small employers from applying for a basic or standard health benefit plan.~~

~~2. The criteria are not related to the health status or claims experience of the small employer.~~

~~3. The criteria are applied consistently to all small employers applying for coverage in the class of business.~~

~~4. The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.~~

(d)~~(c)~~ A small employer carrier must file with the department, in a format and manner prescribed by the committee, a standard health care plan and a basic health care plan to be used by the carrier.

(e)~~(d)~~ The department at any time may, after providing notice and an opportunity for a hearing, disapprove the continued use by the small employer carrier of the standard or basic health benefit plan on the grounds that such plan does not meet the requirements of this section.

(f)~~(e)~~ A health *benefit* ~~care~~ plan covering small employers, issued or renewed on or after October 1, 1992, must comply with the following provisions:

1. Preexisting condition provisions must not exclude coverage for a period beyond 12 months following the individual's effective date of coverage; and

2. *Preexisting condition provisions* may ~~only~~ relate *only* to:

a. Conditions that, during the 6-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(g) A health benefit plan covering small employers, issued or renewed on or after January 1, 1994, must comply with the following conditions:

1. All health benefit plans must be offered and issued on a guarantee-issue basis.

2. The provisions of paragraph (f) apply to health benefit plans issued to a small employer who has three or more eligible employees, and to health benefit plans that are issued to a small employer who has fewer than three eligible employees and that cover an employee who has had qualifying previous coverage continually to a date not more than 30 days before the effective date of the new coverage.

3. With respect to any employee or dependent excluded from coverage due to disease or medical condition or whose coverage had been restricted for certain diseases or medical conditions prior to January 1, 1993, and who has continued to be an eligible employee or dependent as of April 1, 1993, an open enrollment period shall be provided for a 90-day period beginning within 60 days following the effective date of this act, during which period any such employee or dependent shall be entitled to be included within coverage and or issued coverage without restrictions for certain diseases or medical conditions.

4. For health benefit plans that are issued to a small employer who has fewer than three employees and that cover an employee who has not been continually covered by qualifying previous coverage within 30 days before the effective date of the new coverage, preexisting condition provisions must not exclude coverage for a period beyond 24 months following the employee's effective date of coverage and may relate only to:

a. Conditions that, during the 24-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(h) All health benefit plans issued under this section must comply with the following conditions:

1.~~2.~~ In determining whether a preexisting condition provision applies to an eligible employee or dependent, credit must be given for the time the person was covered under qualifying previous coverage if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under the plan.

2.~~3.~~ Late enrollees may be excluded from coverage only for the greater of 18 months or the period of an 18-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months after the effective date of coverage. *For employers who have fewer than three employees, a late enrollee may be excluded from coverage for no longer than 24 months if he was not covered by qualifying previous coverage continually to a date not more than 30 days before the effective date of his new coverage.*

3.~~4.~~ Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

4.~~5.~~a. Except as provided in sub-subparagraph b., in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

b. With respect to a small employer with 10 or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

5.~~6.~~ A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

6.~~7.~~ If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

7.~~8.~~ A small employer carrier *may* ~~shall~~ not modify *any health benefit plan issued to a small employer* ~~a standard or basic health benefit plan~~ with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the ~~standard or basic~~ health benefit plan.

8.~~9.~~ An initial enrollment period of at least 30 days must be provided.

(i)~~(f)~~1. A small employer carrier need not offer coverage or accept applications pursuant to paragraph (a):

a. To a small employer if the small employer is not physically located in an established geographic service area of the small employer carrier, *provided such geographic service area shall not be less than a county*;

b. To an employee if the employee does not work or reside within an established geographic service area of the small employer carrier; or

c. To a small employer group within an area in which the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the department, that it cannot, within its network of providers, deliver service adequately to the members of such groups because of obligations to existing group contract holders and enrollees.

2. A small employer carrier that cannot offer coverage pursuant to sub-subparagraph 1.c. may not offer coverage in the applicable area to new cases of employer groups having more than *50* ~~25~~ eligible employees or small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the department that it has regained its ability to deliver services to small employer groups.

3.a. The department shall, by rule, require each small employer carrier to report, along with its annual statement for calendar year 1992, its gross annual premiums for health benefit plans issued to small employers during calendar year 1992, including both new and renewal business. No later than May 1, 1993, the department shall calculate each carrier's percentage of all small employer carrier premiums for calendar year 1992.

b. During calendar year 1993, a small employer carrier may elect to not offer coverage or accept applications pursuant to paragraph (a):

(I) After its gross annual premiums for all small employer group health benefit plans written or renewed for that year, excluding blocks of business assumed from other carriers, exceeds 25 percent of the total of all small employer carrier premiums for calendar year 1992; or

(II) After its gross annual premiums for small employer group health benefit plans written or renewed for that year, excluding blocks of business assumed from other carriers, exceeds three times that carrier's gross annual premiums for small employer group health benefit plans written or renewed during calendar year 1992, if its share of small employer carrier business for calendar year 1992 calculated under sub-subparagraph a. exceeds 2 percent.

c. The election under sub-subparagraph b. is effective upon filing of a notice of election with the department. The department may, within 30 days after the filing of the notice, disapprove the election if it finds that the carrier does not meet the criteria of sub-subparagraph b. If the department disapproves the election, the carrier is subject to paragraph (a), effective on the date of such disapproval.

d. An election under sub-subparagraph b. expires on December 31, 1993, or upon revocation, whichever occurs earlier.

e. A carrier may file with the department a notice revoking its election under sub-subparagraph b. after the election has been in effect for at least 3 months. Such revocation of an election takes effect on the first day of the calendar quarter following the filing of such notice with the department and subjects the carrier to all requirements of paragraph (a).

f. While a carrier's election under sub-subparagraph b. is in effect, the carrier may not write any further small employer group health benefit plans.

g. A carrier may not make an election under sub-subparagraph b. more than once.

4.a. Beginning in 1994, the department shall, by rule, require each small employer carrier to report, on or before March 1 of each year, its gross annual premiums for all health benefit plans issued to small employers during the previous calendar year, and also to report its gross annual premiums for new, but not renewal, standard and basic health benefit plans subject to this section issued during the previous calendar year. No later than May 1 of each year, the department shall calculate each carrier's percentage of all small employer group health premiums for the previous calendar year and shall calculate the aggregate gross annual premiums for new, but not renewal, standard and basic health benefit plans for the previous calendar year.

b. Beginning with calendar year 1994, a small employer carrier may elect to not offer coverage or accept applications pursuant to paragraph (a):

(I) After its gross annual premiums for new, but not renewal, ~~standard and basic~~ health benefit plans subject to this section for that year, excluding blocks of business assumed from other carriers, exceeds 25 percent of the aggregate gross annual premiums for new, but not renewal, ~~standard and basic~~ health benefit plans subject to this section for the previous calendar year as determined under sub-subparagraph a.; or

(II) After its gross annual premiums for new, but not renewal, ~~standard and basic~~ health benefit plans subject to this section, excluding blocks of business assumed from other carriers, exceeds three times the carrier's percentage of all small employer group premiums for the previous calendar year as determined under sub-subparagraph a., multiplied by the aggregate gross annual premiums for new ~~standard and basic~~ health benefit plans for the previous year as determined under sub-subparagraph a. A carrier may not exercise this option unless its percentage of all small employer group premiums for the previous calendar year as determined under sub-subparagraph a. exceeds 2 percent.

c. The election under sub-subparagraph b. is effective upon filing of a notice of election with the department. The department may, within 30 days after the filing of the notice, disapprove the election if it finds that the carrier does not meet the criteria of sub-subparagraph b. If the department disapproves the election, the carrier is subject to paragraph (a), effective on the date of such disapproval.

d. An election under sub-subparagraph b. expires on December 31 of the year in which the election was made or upon revocation, whichever occurs earlier.

e. A carrier may file with the department a notice revoking its election under sub-subparagraph b. after the election has been in effect for at least 3 months. Such revocation of an election takes effect on the first day of the calendar quarter following the filing of such notice with the department and subjects the carrier to all requirements of paragraph (a).

f. While a carrier's election under sub-subparagraph b. is in effect, the carrier may not write any further new small employer group health benefit plans during the remainder of the calendar year.

g. A carrier may not make an election under sub-subparagraph b. more than once in any calendar year.

(j)~~(g)~~ A small employer carrier may not offer coverage or accept applications pursuant to paragraph (a) if the department finds that the acceptance of an application or applications would endanger the financial condition of the small employer carrier or endanger the interests of the small employer carrier's insureds.

(k) The boundaries of geographic areas used by a small employer carrier must coincide with county lines. A carrier may not apply different geographic rating factors to the rates of small employers located within the same county.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

(a) The department may, by rule, establish regulations to administer this section and to assure that rating practices used by small employer carriers are consistent with the purpose of this section, including assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers on or after January 1, 1994, premium rates for health benefits plans subject to this section are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(k).

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to department review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed.

4. Carriers participating in the alliance program, in accordance with ss. 408.700-408.707, may apply a different community rate to business written in that program.

(c) For all small employer health benefit plans that are subject to this section, that are issued by small employer carriers before January 1, 1994, and that are renewed on or after January 1, 1995, renewal rates must be based on the same modified community rating standard applied to new business.

(d) Notwithstanding s. 627.401(2), this section and ss. 627.410 and 627.411 apply to any health benefit plan provided by a small employer carrier that provides coverage to one or more employees of a small employer regardless of where the policy, certificate, or contract is issued or delivered, if the health benefit plan covers employees or their covered dependents who are residents of this state.

(7) RENEWABILITY OF COVERAGE.—

(a) Except as provided in paragraph (b), a health benefit plan that is subject to this section is renewable for all eligible employees and dependents at the option of the small employer, except for any of the following reasons:

1. Nonpayment of required premiums;

2. Fraud or misrepresentation by the small employer or fraud or misrepresentation by the insured individual or subscriber or the individual's or subscriber's representative;

3. Noncompliance with plan provisions;

4. Noncompliance with the carrier's minimum participation requirements;

5. Noncompliance with the carrier's employer contribution requirements;

6. The small employer's termination of the business in which it was engaged on the effective date of the plan; or

7. A determination by the department that the continuation of the coverage is not in the best interest of the policyholders or certificateholders or will impair the carrier's ability to meet its contractual obligations. In such instances, the department must assist affected small employers in finding replacement coverage.

(8) MAINTENANCE OF RECORDS.—

(a) Each small employer carrier must maintain at its principal place of business a complete and detailed description of its rating practices and renewal practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier must file with the department on or before March 15 of each year an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. The certification must be in a form and manner and contain the information prescribed by the department. The carrier must retain a copy of the certification at its principal place of business.

(c) A small employer carrier must make the information and documentation described in paragraph (a) available to the department upon request. The information constitutes proprietary and trade secret information and may not be disclosed by the department to persons outside the department, except as agreed to by the carrier or as ordered by a court of competent jurisdiction. The exemption from s. 119.07 provided in this paragraph is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(d) Each small employer carrier must file with the department quarterly an enrollment report as directed by the department. Such report shall not constitute proprietary or trade secret information.

(9)~~(6)~~ SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.—

(a) A small employer carrier must elect to become either a risk-assuming carrier or a reinsuring carrier. *Each small employer carrier must make an initial election, binding through January 1, 1994.* ~~The election is binding for a 5-year period, except that~~ The carrier's initial election must be made no later than October 31, 1992~~, and is binding for 2 years~~. *By October 31, 1993, all small employer carriers must file a final election, which is binding for 2 years, from January 1, 1994, through December 31, 1995, after which an election shall be binding for a period of 5 years.* Any carrier that is not a small employer carrier on October 31, 1992, and intends to become a small employer carrier after October 31, 1992, must file its designation when it files the forms and rates it intends to use for small employer group health insurance; such designation shall be binding for 2 years after the date of approval of the forms and rates, and any subsequent designation is binding for 5 years. The department may permit a carrier to modify its election at any time for good cause shown, after a hearing.

(b) The department shall establish an application process for small employer carriers seeking to change their status under this subsection.

(c) An election to become a risk-assuming carrier is subject to approval under subsection *(10)*~~(7)~~.

(d) A small employer carrier that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan *under* ~~pursuant to~~ subsection *(11)*~~(8)~~ as soon as the carrier becomes a risk-assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans under the terms set forth in subsection *(11)*~~(8)~~ and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

(10)~~(7)~~ ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—

(a)1. A small employer carrier may become a risk-assuming carrier by filing with the department a designation of election under subsection *(9)*~~(6)~~ in a format and manner prescribed by the department. The department shall approve the election of a small employer carrier to become a risk-assuming carrier if the department finds that the carrier is capable of assuming that status pursuant to the criteria set forth in paragraph (b).

2. The department must approve or disapprove any designation as a risk-assuming carrier within 60 days after filing.

(b) In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the department shall consider:

1. The carrier's financial ability to support the assumption of the risk of small employer groups.

2. The carrier's history of rating and underwriting small employer groups.

3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable.

4. The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance program provided in subsection *(11)*~~(8)~~.

(c) A small employer carrier that becomes a risk-assuming carrier pursuant to this subsection is not subject to the assessment provisions of subsection *(11)*~~(8)~~.

(d) The department shall provide public notice of a small employer carrier's designation of election under subsection *(9)*~~(6)~~ to become a risk-assuming carrier and shall provide at least a 21-day period for public comment prior to making a decision on the election. The department shall hold a hearing on the election at the request of the carrier.

(e) The department may rescind the approval granted to a risk-assuming carrier under this subsection if the department finds that the carrier no longer meets the criteria of paragraph (b).

~~(f) A risk-assuming carrier shall make available to all small employers in this state, throughout the year and without regard to the health status or industry of the eligible employees and dependents of the small employers, health benefit plans that provide at least that coverage provided by a standard health benefit plan and a basic health benefit plan complying with subsection (9).~~

(11)~~(8)~~ SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—

(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."

(b)1. The program shall operate subject to the supervision and control of the board.

2. Until December 31, 1993, the board shall consist of the commissioner or his designee, who shall serve as chairman, and seven additional members appointed by the commissioner on or before May 1, 1992, as follows:

a. One member shall be a representative of the largest health insurer in the state, as determined by market share as of December 31, 1991.

b. One member shall be a representative of the largest health maintenance organization in the state, as determined by market share as of December 31, 1991.

c. Three members shall be selected from a list of individuals recommended by the Health Insurance Association of America.

d. Two members shall be selected from a list of individuals recommended by the Florida Insurance Council.

The terms of members appointed under this subparagraph expire on December 31, 1993. The appointment of a member under this subparagraph does not preclude the commissioner from appointing the same person to serve as a member under subparagraph 3.

3. Beginning January 1, 1994, the board shall consist of the commissioner or his designee, who shall serve as chairman, and eight additional members who are representatives of carriers and are appointed by the commissioner and serve as follows:

a. The commissioner shall include representatives of small employer carriers subject to assessment under this subsection. If two or more carriers elect to be risk-assuming carriers, the membership must include at least two representatives of risk-assuming carriers; if one carrier is risk-assuming, one member must be a representative of such carrier. At least one member must be a carrier who is subject to the assessments, but is not a small employer carrier. Subject to such restrictions, at least five members shall be selected from individuals recommended by small employer carriers pursuant to procedures provided by rule of the department.

b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the commissioner shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.

4. The commissioner may remove a member for cause.

5. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.

6. The commissioner may require an entity that recommends persons for appointment to submit additional lists of recommended appointees.

(c)1.a. No later than August 15, 1992, the board shall submit to the department a plan of operation to assure the fair, reasonable, and equitable administration of the program. The board may at any time submit to the department any amendments to the plan that the board finds to be necessary or suitable.

b. No later than September 15, 1992, the department shall, after notice and hearing, approve the plan of operation if it determines that the plan submitted by the board is suitable to assure the fair, reasonable, and equitable administration of the program and provides for the sharing of program gains and losses equitably and proportionately in accordance with paragraph (j).

c. The plan of operation, or any amendment thereto, becomes effective upon written approval of the department.

2. If the board fails to submit a suitable plan of operation by August 15, 1992, the department shall, after notice and hearing, adopt a temporary plan of operation by September 15, 1992. The department shall amend or rescind the temporary plan of operation, as appropriate, after it approves a suitable plan of operation submitted by the board.

(d) The plan of operation must, among other things:

1. Establish procedures for handling and accounting for program assets and moneys and for an annual fiscal reporting to the department.

2. Establish procedures for selecting an administering carrier and set forth the powers and duties of the administering carrier.

3. Establish procedures for reinsuring risks.

4. Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses, *other than amounts payable to the administrative carrier,* incurred or estimated to be incurred during the period for which the assessment is made.

5. Provide for any additional matters at the discretion of the board.

(e) The board shall:

1. Recommend to the department market conduct requirements and other requirements for carriers and agents, including requirements relating to:

a. Registration by each carrier with the department of its intention to be a small employer carrier under this section;

b. Publication by the department of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;

c. The availability of a broadly publicized, toll-free telephone number for access by small employers to information concerning this section;

d. Periodic reports by carriers and agents concerning health benefit plans issued; and

e. Methods concerning periodic demonstration by small employer carriers and agents that they are marketing or issuing health benefit plans to small employers.

2. *By January* ~~No later than October~~ 1, 1995, the board shall conduct a study of the effectiveness of this section and may recommend, to the department, improvements to achieve greater rate stability, accessibility, and affordability in the small employer marketplace.

(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals. In addition thereto, the program has specific authority to:

1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.

2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.

3. Take any legal action necessary to avoid the payment of improper claims against the program.

4. Issue reinsurance policies, in accordance with the requirements of this act.

5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.

6. Establish actuarial functions as appropriate for the operation of the program.

7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.

8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.

9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.

10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation.

(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:

1. With respect to a standard and basic health care plan, the program must reinsure the level of coverage provided; and, with respect to any other plan, the program must reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan.

2. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a ~~reinsured~~ small employer may be reinsured within 60 days after the commencement of his coverage.

3. A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan. The carrier may choose to reinsure newly eligible employees and dependents of the reinsured group pursuant to subparagraph 1.

4. The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.

5. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the department approves a lower adjustment factor.

6. A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.

7. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 4., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 4. which may not be ceded to the program.

8. The board may consider adjustments to the premium rates charged

for reinsurance by the program for carriers that use effective cost-containment measures, including high-cost case management, as defined by the board.

9. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed-care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.

(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the department, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan. The premium rates set by the board may vary by geographical *area, as determined under this section,* ~~territory~~ to reflect differences in cost. The multiplying factors *must* ~~shall~~ be established as follows:

a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.

b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.

2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates which shall be subject to the approval of the department.

(i) If a health benefit plan for a small employer issued in accordance with this subsection is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must be consistent with the requirements relating to premium rates set forth in s. 627.4106.

(j)1. *Before* ~~Prior to~~ March 1 of each calendar year, the board shall determine and report to the department the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. *Except as provided in paragraph (n),* risk assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers *for operating losses of the plan* based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year ~~preceding that~~ for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

c. Subject to the approval of the department, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. *Before* ~~Prior to~~ March 1 of each year, the board shall determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the department within 90 days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the department within 90 days following the end of the applicable calendar year, the department may evaluate the operations of the program and implement such amendments to the plan of operation the department deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the commissioner, a deferment, in whole or in part, from any assessment made by the board. The department may defer, in whole or in part, the assessment of a carrier if, in the opinion of the department, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.

(l) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(m) The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the

department any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The department shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the Insurance Code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the department.

(n) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.

(12)~~(9)~~ STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.—

(a)1. *By May 15, 1993* ~~No later than May 15, 1992~~, the commissioner shall appoint a health benefit plan committee composed of four representatives of carriers *which shall include at least two representatives of HMO's, at least one of which is a staff model HMO, two representatives of agents, four* ~~two~~ representatives of small employers, and one employee of a small employer. The carrier members shall be selected from a list of individuals recommended by the board. The commissioner may require the board to submit additional recommendations of individuals for appointment. *As alliances are established under s. 408.702, each alliance shall also appoint an additional member to the committee.*

2. The committee shall develop *changes to* the form and level of coverages for the standard health benefit plan and the basic health benefit plan, and shall submit the forms, and levels of coverages to the department by *September 30, 1993* ~~July 1, 1992~~. The department must approve such forms and levels of coverages by *November 30, 1993* ~~August 1, 1992~~, and may return the submissions to the committee for modification on a schedule that allows the department to grant final approval by *November 30, 1993* ~~August 1, 1992. The committee ceases to exist upon the granting of such final approval~~.

3. The plans shall comply with all of the requirements of this subsection.

4. The plans must be filed with and approved by the department prior to issuance or delivery by any small employer carrier.

5. After approval of the *revised* ~~standard health benefit plan and the basic~~ health benefit *plans* ~~plan~~, if the department determines that modifications to a plan might be appropriate, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the department for approval.

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan and a basic health benefit plan that meets the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan" and "basic health benefit plan" mean policies or contracts that a small employer carrier offers to eligible small employers that contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; and

b. A procedure for preauthorization by the small employer carrier, or its designees.

3. A small employer carrier may include the following managed-care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. *A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.*

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed-care and cost-containment provisions, subject to the approval of the department, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. *The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.*

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for handicapped children pursuant to s. 627.6615; and

h. Emergency or urgent care out of the geographic service area.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan shall include all of the benefits specified in subparagraph *4.* ~~5.~~; however, the basic health benefit plan shall place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.6616, 627.6618, and 627.668 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding said provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.

(c) If a small employer rejects, in writing, the standard health benefit plan and the basic health benefit plan, the small employer carrier may offer the small employer a limited benefit policy or contract.

(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for any small employer, the small employer carrier shall provide such employer group with a written statement that contains, at a minimum:

a. An explanation of those mandated benefits and providers that are not covered by the policy or contract;

b. An explanation of the managed-care and cost-control features of the policy or contract, along with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information or authorization; and

c. An explanation of the primary and preventive care features of the policy or contract.

Such disclosure statement must be presented in a clear and understandable form and format and must be separate from the policy or certificate or evidence of coverage provided to the employer group.

2. Before a small employer carrier issues a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, it must obtain from the prospective policyholder a signed written statement in which the prospective policyholder:

a. Certifies as to eligibility for coverage under the standard health benefit plan, basic health benefit plan, or limited benefit policy or contract;

b. Acknowledges the limited nature of the coverage and an understanding of the managed-care and cost-control features of the policy or contract;

c. Acknowledges that if misrepresentations are made regarding eligibility for coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the person making such misrepresentations forfeits coverage provided by the policy or contract; and

d. *If a limited plan is requested,* acknowledges that the prospective policyholder had been offered, at the time of application for the insurance policy or contract, the opportunity to purchase *any* ~~a standard~~ health benefit plan *offered by the carrier* ~~and a basic health benefit plan~~ and that the prospective policyholder had rejected that coverage.

A copy of such written statement shall be provided to the prospective policyholder no later than at the time of delivery of the policy or contract, and the original of such written statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.

3. Any material statement made by an applicant for coverage under a ~~standard~~ health benefit plan~~, a basic health benefit plan, or a limited benefit policy or contract~~ which falsely certifies as to the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.

4. Each marketing communication that is intended to be used in the marketing of a ~~standard~~ health benefit plan~~, a basic health benefit plan, or a limited benefit policy or contract~~ in this state must be submitted for review by the department prior to use and must contain the disclosures stated in this subsection.

(e)1. A small employer carrier may not use any policy, contract, form, or rate under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the insurer has filed it with the department and the department has approved it under ss. 627.410, 627.4106, and 627.411.

2. A small employer carrier must file with the department *by December 1, 1993,* ~~no later than September 15, 1992,~~ the standard ~~health benefit plan~~ and basic health benefit plan that it intends to initially use to comply with this subsection during calendar year *1994* ~~1993~~, together with the rates therefor, and the department must approve the submissions *by January 1, 1994* ~~no later than November 1, 1992~~.

(13)~~(10)~~ STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, *including any subsequent modifications or additions to those plans,* to eligible small employers in the state. *Before January 1, 1994,* if a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan. *Beginning January 1, 1994, small employer carriers must offer and issue all plans on a guarantee-issue basis.*

(b) No small employer carrier or agent shall, directly or indirectly, engage in the following activities:

1. Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

2. Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(c) The provisions of paragraph (a) shall not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(d) No small employer carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer except if the compensation arrangement provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(e) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for the sale of a basic or standard health benefit plan.

(f) No small employer carrier shall terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent with the small employer carrier unless the agent consistently engages in practices that violate this section or s. 626.9541.

(g) No small employer carrier or agent shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(h) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(i) The department may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(j) A violation of this section by a small employer carrier or an agent shall be an unfair trade practice under s. 626.9541 *or ss. 641.3903 and 641.3907.*

(k) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services relating to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section.

(14)~~(11)~~ APPLICABILITY OF OTHER STATE LAWS.—

(a) Except as expressly provided in this section, a law requiring coverage for a specific health care service or benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to a standard or basic health benefit plan policy or contract or a limited benefit policy or contract offered or delivered to a small employer unless that law is made expressly applicable to such policies or contracts.

(b) Except as provided in this section, a standard or basic health benefit plan policy or contract or limited benefit policy or contract offered to a small employer is not subject to any provision of this code which:

1. Inhibits a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits;

2. Imposes any restriction on a small employer carrier's ability to negotiate with providers regarding the level or method of reimbursing care or services provided under a health benefit plan; or

3. Requires a small employer carrier to either include a specific provider or class of providers when contracting for health care services or benefits or to exclude any class of providers that is generally authorized by statute to provide such care.

(c) Any second tier assessment paid by a carrier pursuant to paragraph *(11)(j)* ~~(8)(j)~~ may be credited against assessments levied against the carrier pursuant to s. 627.6494.

(d) Notwithstanding chapter 641, a health maintenance organization is authorized to issue contracts providing benefits equal to the standard health benefit plan, the basic health benefit plan, and the limited benefit policy authorized by this *section* ~~act~~.

(15)~~(12)~~ RULEMAKING AUTHORITY.—The department may adopt rules *to administer* ~~for the implementation and administration of~~ this section, including *rules governing* compliance by small employer carriers and small employers.

(2) This section shall take effect January 1, 1994, except that subsections (6) and (9) of section 627.6699, Florida Statutes, 1992 Supplement, renumbered as subsections (9) and (12), respectively, of that section and as amended by subsection (1) of this section, shall take effect upon becoming a law.

Section 86. Subsection (2) of section 627.4236, Florida Statutes, 1992 Supplement, is amended to read:

627.4236 Coverage for bone marrow transplant procedures.—

(2) An insurer *or a health maintenance organization* may not exclude coverage for bone marrow transplant procedures recommended by the referring physician and the treating physician under a policy exclusion for experimental, clinical investigative, educational, or similar procedures contained in any individual or group health insurance policy *or health maintenance organization contract* issued, amended, delivered, or renewed in this state that covers treatment for cancer, if the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to subsection (3).

Section 87. This section and section 19 of this act shall take effect upon becoming a law; and the remainder of this act, except as otherwise provided in this act, shall take effect October 1, 1993.

And the title is amended as follows:

In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to health care; amending s. 20.42, F.S.; modifying organization and responsibilities of the Agency for Health Care Administration; revising division responsibilities; delaying transfer to the agency of certain responsibilities relating to health care professionals; transferring to the agency certain responsibilities relating to state employee health insurance; amending ss. 32 and 33 of ch. 92-33, Laws of Florida; delaying transfer of the Division of Medical Quality Assurance, and the boards thereunder, from the Department of Professional Regulation to the agency; amending s. 110.123, F.S., relating to the state group insurance program; providing legislative intent; providing agency responsibilities; amending s. 112.0455, F.S.; providing agency responsibilities under the Drug-Free Workplace Act; amending s. 408.001, F.S.; revising membership of the board of directors of the Florida Health Care Purchasing Cooperative; deleting obsolete language; transferring, renumbering, and amending s. 409.701, F.S.; revising membership of the board of directors of the Florida Health Access Corporation; amending ss. 408.062, 409.7105, and 455.201, F.S.; conforming references and terminology to the provisions of the act; creating s. 408.301, F.S.; providing legislative findings and intent; providing for an inter-agency agreement between the Agency for Health Care Administration and the Department of Health and Rehabilitative Services; amending s. 408.07, F.S.; revising definition of "banked points"; amending ss. 408.072 and 408.08, F.S., relating to review of hospital budgets, inspections, audits, and enforcement; clarifying allowable rate of increase in net revenue per adjusted admission; authorizing the Health Care Board to adjust excess revenues for certain hospitals; amending s. 408.061, F.S., requiring the submission of certain data by nursing homes; requiring a study and a report to the Legislature; amending s. 624.91, F.S.; revising membership of the board of directors of the Florida Healthy Kids Corporation; transferring to the agency administration of the Florida Healthy Kids Trust Fund; amending s. 766.1115, F.S.; expanding the definition of "health care provider" under the Access to Health Care Act; delaying amendment and repeal of specified sections in ch. 455, F.S., to conform to the act; amending s. 240.4067, F.S., relating to the medical education reimbursement and loan repayment program; providing for penalties for noncompliance; deleting a 3-year limit on payment period; amending s. 240.4075, F.S.; adding birth centers to the list of eligible employing institutions for the nursing student loan forgiveness program; amending s. 381.0302, F.S.; providing additional membership in the Florida Health Services Corps; authorizing the Department of Health and Rehabilitative Services to provide certain financial assistance to primary care medical residents, physician assistants, and nurse practitioners; authorizing use of certain appropriated funds as federal matching funds; creating s. 381.0406, F.S., relating to rural health networks; providing legislative findings and intent; providing definitions; providing for organization, administration, and nonprofit corporate status; specifying services to be provided; requiring participation of certain trauma agencies; providing for public and private financing; providing for phased-in implementation; specifying responsibilities of the agency and the State Health Office relating to establishment and certification of rural health networks; providing for rules; amending s. 395.1055, F.S.; providing for separate standards for statutory rural hospitals; creating s. 395.606, F.S., relating to rural health network cooperative agreements; providing legislative intent with respect to antitrust laws; specifying conditions under which health care providers who are members of rural health networks may consolidate services or enter into cooperative agreements; requiring approval and oversight by the agency; providing for administrative and judicial review; amending s. 409.905, F.S.; providing for Medicaid nursing facility services for recipients in rural hospitals; creating s. 409.9116, F.S.; creating a disproportionate share program for rural hospitals; establishing a funding formula; providing for creation of a rural hospital financial assistance program under certain circumstances; specifying requirements for participation; providing for a workgroup to examine personnel licensing and training issues; amending s. 768.28, F.S.; correcting a cross-reference; directing the agency to establish a workgroup to examine personnel licensing and training issues relating to rural hospitals; providing membership; requiring a report; amending s. 408.02, F.S.; providing for the development of state practice parameters; providing a liability defense; creating s. 408.700, F.S.; providing legislative intent regarding the need to reform Florida's health care delivery system; proposing the creation of managed competition throughout the state; proposing the creation of community health purchasing alliances; creating s. 408.701, F.S.; providing definitions; creating s. 408.702, F.S., establishing community health purchasing alliance regions; providing for alliance standards; providing for voluntary membership; providing duties, powers, and responsibilities; providing for membership fees; providing for a choice of health plans for nonstate employees and for state employees; creating s. 408.7025, F.S.; providing agency responsibilities with respect to community health purchasing alliances; authorizing the agency to contract with alliances and provide start-up funds; requiring an annual audit; establishing a data committee and specifying membership; requiring a report to the Legislature; providing for confidentiality of medical information; requiring the submission of data by health care providers; authorizing the agency to adopt rules to implement the recommendations of the data committee; providing for a provider and consumer advisory panel; creating s. 408.703, F.S.; providing for community health purchasing alliance boards of directors; providing for membership, appointment, and terms; providing for staff; creating s. 408.704, F.S., establishing standards for accountable health partnerships; providing for designation of accountable health partnerships by the agency; specifying standards and requirements; providing for panels of providers to make recommendations to accountable health partnerships on health plans and issues; providing for notice and hearing; limiting coverage for professional liability; prohibiting the exclusion of physicians from participating solely on the basis of economic criteria; creating s. 408.705, F.S.; requiring a study relating to community health purchasing alliances; requiring a report; creating s. 408.707, F.S.; providing legislative intent with respect to certain antitrust issues; requiring a study and specifying contents; requiring a report; providing for the establishment of criteria and conditions for formation and certification of provider networks; creating s. 408.90, F.S.; providing legislative findings and intent; creating s. 408.901, F.S.; providing definitions; creating s. 408.902, F.S.; creating the MedAccess program within the Agency for Health Care Administration; providing for a report; creating s. 408.903, F.S.; providing eligibility requirements; creating s. 408.904, F.S.; providing health care benefits; creating s. 408.905, F.S.; providing limitations and exclusions; creating s. 408.906, F.S.; providing for the payment of claims; creating s. 408.907, F.S.; providing for the collection of premiums; creating s. 408.9075, F.S.; providing agency responsibilities for the administration of the MedAccess program; amending s. 409.908, F.S.; providing for a new methodology for reimbursing for Medicaid physician services; creating s. 409.9081, F.S.; providing for copayments for Medicaid services; providing for a study of the costs and benefits of collecting Medicaid copayments; amending s. 409.911, F.S.; creating new requirements for the regular disproportionate share program; creating s. 409.9121, F.S.; providing legislative findings and intent; creating s. 409.9122, F.S.; providing for an independent study of the MediPass program; providing for the expansion of the MediPass program; directing the agency to encourage the enrollment of Medicaid recipients in managed care plans; providing for a study of the feasibility

of managed care programs for Medicaid recipients with special needs; providing for funds for technical assistance in developing Medicaid prepaid health plans; amending s. 409.914, F.S.; directing the agency to seek federal authority to establish a Medicaid buy-in program; providing for the consolidation of the state health insurance and Medicaid buy-in programs once federal waivers are obtained; repealing s. 409.9114, F.S., relating to the extraordinary disporportionate share program; repealing s. 407.60, F.S., relating to charges for radiation therapy procedures; amending s. 15 of ch. 92-178, Laws of Florida; revising the divestiture date for designated health services; clarifying the application of that provision; repealing s. 455.238, F.S., relating to mark-ups by health care providers; providing legislative intent relating to health care fraud and abuse; establishing a workgroup on care fraud and abuse; requiring a report; amending s. 408.031, F.S.; correcting a cross-reference; amending s. 408.032, F.S.; revising definitions; amending s. 408.033, F.S., relating to local and state health planning; revising a fine; providing for denial of relicensure for failure to pay facility fees; amending s. 408.034, F.S., relating to duties and responsibilities of the Agency for Health Care Administration; amending s. 408.035, F.S.; revising review criteria; amending s. 408.036, F.S.; providing projects subject to review; revising projects subject to expedited review; providing additional exemptions; amending s. 408.037, F.S.; modifying application content; amending s. 408.038, F.S., relating to fees; amending s. 408.039, F.S., relating to review process; providing for confidentiality of applications until deemed complete; providing for review and repeal; reducing timeframe for a public hearing request; providing basis for final orders; providing for the right to initiate or intervene in administrative hearings; amending s. 408.040, F.S., relating to conditions and monitoring; providing for agency actions, fines, and injunctive relief; extending the validity period for certificates of need; prohibiting transfers, consolidations, and divisions of certificates of need; amending s. 408.041, F.S., relating to penalties; providing for fines; amending s. 408.043, F.S.; eliminating special provisions for specified nursing homes; providing for preferences for rural health networks and cooperative agreements for tertiary service providers; amending s. 408.044, F.S., relating to injunctions; amending s. 408.045, F.S., relating to competitive sealed proposals; creating a requirement for recommendations by the agency regarding continued need for certificate-of-need regulation; amending ss. 189.415 and 651.118, F.S., to conform to the act; repealing s. 408.042, F.S., relating to limitation on transfers; transferring the Medicaid program from the Department of Health and Rehabilitative Services to the agency; transferring of certain positions from the Department of Management Services to the agency; providing appropriations; amending s. 627.4106, F.S.; revising a definition; repealing s. 627.4106, F.S., relating to small group health insurance; amending s. 627.6699, F.S.; providing definitions; requiring guarantee issue of all health plans to small employers; requiring modified community rating of health plans issued to small employers; revising definition of small employer; revising preexisting conditions requirements for certain groups; requiring that geographic regions for rating purposes be by county line; providing for guaranteed renewability of small group health plans; requiring carriers to maintain records; providing confidentiality; providing for review and repeal; providing for revisions in the standard and basic health benefit plans; requiring the reinsurance board to report complaints of abuse and misrepresentation to the Department of Insurance; providing for alliance membership on the health benefit plan committee; amending s. 627.4236, F.S.; prohibiting health maintenance organizations from excluding coverage for bone marrow transplant procedures under certain circumstances; providing effective dates.

The vote was:

Yeas—23 Nays—17

Senator Gutman moved the following amendment:

Amendment 3 (with Title Amendment)—On page 1, line 12 through page 9, line 5, strike all of said lines and insert:

Section 1. Section 33 of chapter 92-33, Laws of Florida, is repealed.

Section 2. Section 20.30, Florida Statutes, 1992 Supplement, as amended by section 32 of chapter 92-33, Laws of Florida, section 35 of chapter 92-58, Laws of Florida, sections 1, 72, and 159 of chapter 92-149, Laws of Florida, and sections 1 and 2 of chapter 92-292, Laws of Florida is amended to read:

20.30 Department of Professional Regulation.—There is created a Department of Professional Regulation.

(1) The head of the Department of Professional Regulation is the Secretary of Professional Regulation. The secretary shall be appointed by the Governor subject to confirmation by the Senate. The secretary shall serve at the pleasure of the Governor.

(2) The following divisions of the Department of Professional Regulation are established:

(a) Division of Technology, Testing and Training.

(b) Division of Professions.

(c) Division of Medical Quality Assurance.

1. The director of the division shall be appointed by the Secretary of Professional Regulation.

2. The division shall concentrate sufficient resources and efforts on the investigation and discipline of health care practitioners regulated by the department who are in violation of the unprofessional conduct provisions of the applicable practice acts and other provisions of law, as are necessary to meet the challenge of identifying those health care practitioners who are not providing adequate medical care in order to take forceful corrective measures to assure quality medical care throughout the state.

3. The division shall coordinate closely with the Agency for Health Care Administration to ensure that the state's regulation of health care facilities and the health care practitioners who practice therein is consistent and offers adequate protection to the public.

4. The division shall establish and maintain a disciplinary training program for division staff and board members designed to ensure the proper and appropriate administration of medical quality assurance. The program shall provide for initial and periodic training in the grounds for disciplinary action, the actions which may be taken, changes in any relevant law, sanctions which are most appropriate for specified types of unprofessional conduct, guidelines for the conduct of hearings, and any other matters which the division shall determine may be necessary or useful.

(d)~~(c)~~ Division of Real Estate.

1. The director of the division shall be appointed by the Secretary of Professional Regulation, subject to approval by a majority of the Florida Real Estate Commission.

2. The offices of the Division of Real Estate shall be located in Orlando.

(e)~~(d)~~ Division of Regulation.

(f)~~(e)~~ Division of Administration.

(g)~~(f)~~ Division of Certified Public Accounting.

1. The director of the division shall be appointed by the Secretary of Professional Regulation, subject to approval by a majority of the Board of Accountancy.

2. The offices of the division shall be located in Gainesville.

(3) There shall be a director for each division established within this section. Each division director shall directly administer the division and shall be responsible to the secretary of the department. The secretary of the department may appoint assistant secretaries as necessary to fulfill the secretary's statutory obligations.

(4) The following boards are established within the Department of Professional Regulation, Division of Professions:

(a) Board of Architecture and Interior Design, created under part I of chapter 481.

(b) Board of Auctioneers, created under part VI of chapter 468.

(c) Barbers' Board, created under chapter 476.

(d) Construction Industry Licensing Board, created under part I of chapter 489.

(e) Board of Cosmetology, created under chapter 477.

(f) Electrical Contractors' Licensing Board, created under part II of chapter 489.

(g) Board of Professional Engineers, created under chapter 471.

(h) Board of Funeral Directors and Embalmers, created under chapter 470.

(i) Board of Professional Geologists, created under chapter 492.

(j) Board of Hearing Aid Specialists, created under part II of chapter 484.

(k) Board of Professional Land Surveyors, created under chapter 472.

(l) Board of Landscape Architecture, created under part II of chapter 481.

(m) Board of Massage, created under chapter 480.

(n) Board of Nursing Home Administrators, created under part II of chapter 468.

(o) Board of Opticianry, created under part I of chapter 484.

(p)~~(n)~~ Board of Pilot Commissioners, created under chapter 310.

(q)~~(o)~~ Board of Employee Leasing Companies, created under part XI of chapter 468.

~~(p) Board of Veterinary Medicine, created under chapter 474.~~

(5) The following boards are established within the Department of Professional Regulation, Division of Medical Quality Assurance:

(a) Board of Medicine, created under chapter 458.

(b) Board of Osteopathic Medicine, created under chapter 459.

(c) Board of Acupuncture, created under chapter 457.

(d) Board of Chiropractic, created under chapter 460.

(e) Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

(f) Board of Dentistry, created under chapter 466.

(g) Board of Nursing, created under chapter 464.

(h) Board of Optometry, created under chapter 463.

(i) Board of Pharmacy, created under chapter 465.

(j) Board of Physical Therapy Practice, created under chapter 486.

(k) Board of Podiatric Medicine, created under chapter 461.

(l) Board of Psychological Examiners, created under chapter 490.

(m) Board of Veterinary Medicine, created under chapter 474.

(n) Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

(o) Board of Clinical Laboratory Personnel, created by s. 483.805.

(6)~~(5)~~ The following board and commission are established within the Department of Professional Regulation, Division of Real Estate:

(a) Florida Real Estate Commission, created under part I of chapter 475.

(b) Florida Real Estate Appraisal Board, created under part II of chapter 475.

(7)~~(6)~~ The following board is established within the Department of Professional Regulation, Division of Certified Public Accounting.

(a) Board of Accountancy, created under chapter 473.

(8)~~(7)~~ The members of each board established pursuant to subsections (4), (5), ~~and~~ (6), *and (7)* shall be appointed by the Governor, subject to confirmation by the Senate. Consumer members on the board shall be appointed pursuant to subsection *(9)* ~~(8)~~. Members shall be appointed for 4-year terms, and such terms shall expire on October 31. However, a term of less than 4 years may be utilized to ensure the following:

(a) No more than two members' terms shall expire during the same calendar year for boards consisting of seven or eight members.

(b) No more than three members' terms shall expire during the same calendar year for boards consisting of nine to twelve members.

(c) No more than five members' terms shall expire during the same calendar year for boards consisting of thirteen or more members.

(d) A member whose term has expired shall continue to serve on the board until such time as a replacement is appointed.

A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment. No member shall serve for more than the remaining portion of a previous member's unexpired term, plus two consecutive 4-year terms of the member's own appointment thereafter.

(9)~~(8)~~ Each board with five or more members shall have at least two consumer members who are not, and have never been, members or practitioners of the profession regulated by *the* ~~such~~ board or of any closely related profession. Each board with fewer than five members shall have at least one consumer member who is not, and has never been, a member or practitioner of the profession regulated by *the* ~~such~~ board or of any closely related profession.

(10)~~(9)~~ No board, with the exception of joint coordinatorships, shall be transferred from its present location unless authorized by the Legislature in the General Appropriations Act.

(11)~~(10)~~ It is legislative intent that all newly regulated professions, and all professions newly regulated under the department, shall be regulated directly under the department unless a compelling need for the existence of a board is documented. In an instance where a board is statutorily established, the department shall not create the board for a minimum of 1 full year after statutory authority regulating a profession becomes effective, and the profession shall initially be directly regulated by the department. Prior to implementing a new board or council, the department shall seek and receive specific legislative authorization. Such recommendation to establish a new board or council shall be included in the department's annual report to the Legislature required by s. 455.2285.

Section 3. Section 20.42, Florida Statutes, 1992 Supplement, is amended to read:

20.42 Agency for Health Care Administration.—There is created the Agency for Health Care Administration within the Department of Professional Regulation. The agency shall be a separate budget entity, and the director of the agency shall be the agency head for all purposes. The agency shall not be subject to control, supervision, or direction by the Department of Professional Regulation in any manner, including, but not limited to, personnel, purchasing, transactions involving real or personal property, and budgetary matters.

(1) DIRECTOR OF HEALTH CARE ADMINISTRATION.—The head of the agency is the Director of Health Care Administration, who shall be appointed by the Governor. The director shall serve at the pleasure of and report to the Governor.

(2) ORGANIZATION OF THE AGENCY.—The agency shall be organized as follows:

(a) ~~Effective July 1, 1993,~~ The Division of Health Quality Assurance, which shall be responsible for *health care:* facility licensure and inspection.;

(b) The Health Care Advisory Commission, composed of the chairpersons of: ~~certificate of need;~~ the Board of Medicine, created under chapter 458; the Board of Osteopathic Medicine, created under chapter 459; the Board of Acupuncture, created under chapter 457; the Board of Chiropractic, created under chapter 460; the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491; the Board of Dentistry, created under chapter 466; the Board of Optometry, created under chapter 463; the Board of Pharmacy, created under chapter 465; the Board of Podiatric Medicine, created under chapter 461; the Board of Nursing, created under chapter 464; the Board of Psychological Examiners, created under chapter 490; the Board of Speech-Language Pathology and Audiology, created under chapter 468; the Board of Nursing Home Administrators, created under part II of chapter 468; *the Board of* ~~occupational therapy, as regulated under part III of chapter 468; respiratory therapy, as regulated under part V of chapter 468;~~ Physical Therapy, *created* ~~as regulated~~ under chapter 486; *the Board of Clinical Laboratory Personnel, created under part IV of chapter 483;* and the Board of Opticianry, created under part I of chapter 484. *The director is chairman of the commission.*

1. The commission shall review and evaluate any legislation or rules proposed by any board represented on the commission which may directly affect more than one board, and make recommendations to the Secretary of Professional Regulation, the Governor, and the Legislature regarding such proposed legislation or rules. The commission shall also make recommendations to the Health Care Board, as requested by the director or the Health Care Board, regarding hospital budget review, nursing home financial review, and special studies conducted by the Health Care Board or the agency.

2. The commission shall annually prepare and submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report stating its findings and making specific programmatic recommendations it deems appropriate. The reports shall be submitted no later than December 31 of each year, beginning December 31, 1994.

3. The commission shall meet at least once each quarter. The members of the commission are entitled to reimbursement for all necessary expenses in the performance of their duties, including travel expenses, in accordance with s. 112.061.

4. The agency, the Department of Professional Regulation, and all boards represented on the commission shall supply information, assistance, and facilities as the commission deems necessary for it to carry out its duties under this section, and shall provide staff assistance necessary for the performance of required clerical and administrative functions of the commission.

(c)~~(b)~~ The Division of Health Policy and *Cost Control* ~~Planning~~, which shall be responsible for *health policy,* the State Center for Health Statistics, the development of The Florida Health Plan, *state and local health planning under s. 408.033, certificate-of-need review, hospital budget review,* and research and analysis.

(d)~~(c) Effective July 1, 1993,~~ The Division of State Health Purchasing, which shall be responsible for *the Medicaid program* ~~supervising the purchase of health care by: Medicaid; the Florida Health Access Program; the Pooled Purchasing Cooperative;~~ and *the* state employee health insurance *program, including functions related to: the selection of the entity that administers the state employee health insurance plan; the development of the plan's benefit design; the establishment of the plan's cost sharing and cost containment requirements; the creation and maintenance of administrative cost controls; the collection and analysis of data; and the monitoring and evaluation of the administrator and provider network performance. The division shall also administer the contracts with the Florida Health Access Corporation, the Florida Health Care Purchasing Cooperative, and the Florida Healthy Kids Corporation.*

(e)~~(d)~~ The Health Care Board, which shall be responsible for hospital budget review, nursing home financial analysis, and special studies as assigned by the *director* ~~secretary~~ or the Legislature.

(f)~~(e)~~ The Division of Administrative Services, which shall be responsible for revenue management, budget, personnel, *management information services,* and general services.

(3) *DIVISION* ~~DEPUTY~~ DIRECTOR FOR HEALTH QUALITY ASSURANCE.—The director shall appoint a *Division* ~~Deputy~~ Director for Health Quality Assurance who shall serve at the pleasure of, and be directly responsible to, the director. The *Division* ~~Deputy~~ Director for Health Quality Assurance shall be responsible for the Division of Health Quality Assurance.

(4) *DIVISION* ~~DEPUTY~~ DIRECTOR FOR HEALTH POLICY AND *COST CONTROL* ~~PLANNING~~.—The director shall appoint a *Division* ~~Deputy~~ Director for Health Policy and *Cost Control* ~~Planning~~ who shall serve at the pleasure of, and be directly responsible to, the director. The *Division* ~~Deputy~~ Director for Health Policy and *Cost Control* ~~Planning~~ shall be responsible for the Division of Health Policy and *Cost Control* ~~Planning and the Division of State Health Purchasing~~.

(5) DIVISION DIRECTOR FOR STATE HEALTH PURCHASING.—The director shall appoint a Division Director for State Health Purchasing who shall serve at the pleasure of, and be directly responsible to, the director. The Division Director for State Health Purchasing shall be responsible for the Division of State Health Purchasing.

(6)~~(5)~~ HEALTH CARE BOARD.—The Health Care Board shall be composed of 11 members appointed by the Governor, subject to confirmation by the Senate. The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall be responsible for hospital budget review, nursing home financial review and analysis, and special studies requested by ~~the Governor,~~ the Legislature~~,~~ or the director.

(7)~~(6)~~ *DIVISION* ~~DEPUTY~~ DIRECTOR *FOR* ~~OF~~ ADMINISTRATIVE SERVICES.—The director shall appoint a *Division* ~~Deputy~~ Director of Administrative Services who shall serve at the pleasure of, and be directly responsible to, the director. The *Division* ~~deputy~~ Director *for Administrative Services is* ~~shall be~~ responsible for the Division of Administrative Services.

And the title is amended as follows:

In title, on page 218, line 21 through page 219, line 4, strike all of said lines and insert: A bill to be entitled An act relating to health care; repealing s. 33, ch. 92-33, Laws of Florida; abrogating the transfer of powers, duties, and funds of the Division of Medical Quality Assurance of the Department of Professional Regulation to the Agency for Health Care Administration; amending s. 20.30, F.S.; reinstating the Division of Medical Quality Assurance within the Department of Professional Regulation; reestablishing the Board of Nursing Home Administrators and the Board of Opticianry within the Division of Professions of the Department of Professional Regulation; reestablishing the Board of Medicine, the Board of Osteopathic Medicine, the Board of Acupuncture, the Board of Chiropractic, the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, the Board of Dentistry, the Board of Nursing, the Board of Optometry, the Board of Pharmacy, the Board of Physical Therapy Practice, the Board of Podiatric Medicine, the Board of Psychological Examiners, the Board of Veterinary Medicine, the Board of Speech-Language Pathology and Audiology, and the Board of Clinical Laboratory Personnel within the Division of Medical Quality Assurance; amending s. 20.42, F.S., relating to organization of the Agency for Health Care Administration; creating the Health Care Advisory Commission within the agency; providing for membership of the commission; providing duties of the commission; renaming the Division of Health Policy and Planning as the Division of Health Policy and Cost Control; providing additional responsibilities relating to state and local health planning, certificate-of-need review, hospital budget review, and the administration of specified contracts; providing duties of the Division Director for State Health Purchasing; amending s. 110.123, F.S.;

On motion by Senator Gutman, further consideration of **CS for SB's 1914, 2006, 1784 and 406** with pending **Amendment 3** was deferred.

REPORTS OF COMMITTEES

The Committee on Rules and Calendar submits the following bills to be placed on the Special Order Calendar for Wednesday, March 31, 1993: CS for SB's 1914, 2006, 1784 and 406 (to be taken up at 2:00 p.m.), CS for SB 152, CS for SB 194, CS for SB 202, CS for SB 306, CS for SB 2000, CS for CS for SB 146, CS for CS for SB 164, CS for SB 298, SB 258, SB 304, CS for SB 144, CS for CS for SB 156, CS for CS for SB 402, HB 2007, CS for SB 1080, CS for SB 522, SB 724, CS for SB 1208, SB 280, SB 12, CS for SB 2260, SB 1086, CS for HB 1085, CS for SB 368, CS for SB 536, CS for SB's 1774 and 1480, CS for SB 436, CS for SB 652, CS for SB 884, SB 1644, CS for SB 2224, SB 612, SB 676, CS for SB 752, CS for SB 640, SB 1356, SB 2184, CS for CS for SB 1694, CS for CS for CS for SB 1858, CS for SB 2130, SB 474, CS for SB 520, SB 1252, SB 212, CS for CS for SB 288, HB 127, CS for HB 1295, CS for HB 1221, CS for HB 21, CS for HB 55, CS for HB 113, CS for HB 163, HB 275, CS for SB 1954, CS for SB 50, SB 74, SB 614, SB 670, CS for SB 790, SB 794, SB 816, SB 820, SB 1204, SB 1214, SB 1238, CS for SB 1442, SB 1424, CS for SB 1554, CS for SB 1658, CS for SB 1764, SB 1760, CS for SB 1710, SB 1872, CS for SB 1982, SB 2084, CS for SB 2082, CS for SB 1988, SB 698, CS for SB 952, SB 978, SB 974, SB 1856, SB 716, HB 1307, HB 1309, HB 1311, HB 1313, HB 1315, HB 1317, HB 1319, HB 1321, HB 1323, HB 1325, HB 1327, HB 1329, HB 1331, HB 1333, HB 1335, CS for SB 1666, CS for SB 1668, CS for SB 1018, CS for SB 1844

Respectfully submitted,
Toni Jennings, Chairman

The Committee on Rules and Calendar submits the following bills to be placed on the Local Bill Calendar for Wednesday, March 31, 1993: SB 2378, SB 2386, SB 2390, SB 2396, SB 2398, SB 2400, SB 2412, SB 2416

Respectfully submitted,
Toni Jennings, Chairman

The Committee on Education recommends a committee substitute for the following: Senate Bills 2078 and 1608

The bills with committee substitute attached were referred to the Committee on Appropriations under the original reference.

The Committee on Appropriations recommends a committee substitute for the following: CS for SB 1932

The bill with committee substitute attached was placed on the calendar.

COMMITTEE SUBSTITUTES

FIRST READING

By the Committees on Appropriations; Finance, Taxation and Claims; and Senator Kiser—

CS for CS for SB 1932—A bill to be entitled An act relating to tax administration; amending s. 125.0108, F.S.; revising obsolete language; amending s. 201.17, F.S.; revising the date from which interest accrues for nonpayment of certain taxes; amending s. 212.08, F.S.; exempting from sales tax the charges by a utility for attaching wires to a transmission pole; amending s. 212.031, F.S.; exempting certain property from taxation pursuant to a previously issued technical assistance advisement; amending s. 212.054, F.S., relating to provisions that specify requirements for the administration and collection of discretionary sales surtaxes; providing for application of such surtaxes to the sale of services; providing that the exemption for sales amounts above $5,000 does not apply to the sale of services; revising the conditions under which a transaction is deemed to occur in a county imposing the surtax; deleting provisions requiring administrative costs of the discretionary sales surtaxes to be prorated among the counties that levy the taxes; requiring a study committee to recommend a method of allocation; specifying when a surtax applies to dealers outside the county; providing for distribution of the proceeds of such surtaxes collected by a dealer located in a county that does not impose a surtax; specifying consequences if a county does not provide timely information to the Department of Revenue; amending s. 212.055, F.S.; removing the limitations on the length of time the local government infrastructure surtax may be levied and the period during which a referendum levying the surtax may be held; authorizing additional uses for surtax revenues; amending s. 212.06, F.S.; revising the calculation of the indexed tax on asphalt manufactured for one's own use; amending s. 212.14, F.S.; providing procedures under which the department may issue subpoenas and subpoenas duces tecum; amending s. 212.15, F.S.; revising the penalties imposed for failing to remit taxes; amending s. 212.183, F.S.; authorizing self-accrual of sales tax for certain commercial rentals; amending s. 213.053, F.S.; providing that certain information with respect to railroads and private car and freight lines may be made available to certain federal agencies by the department; amending s. 213.10, F.S.; authorizing the department to account for the collection and distribution of tax moneys in separate clearing trust funds; amending s. 213.27, F.S.; authorizing the department to enter into contracts for the purpose of determining liability for intangible personal property tax; revising the requirements for notice before the department commences litigation to recover taxes due or before the department assigns a tax debt for collection; amending s. 213.28, F.S.; deleting certain limitations on contracts by the department with private auditors; prohibiting audit fees based on the amount of tax assessed or collected as a result of an audit; amending s. 218.21, F.S.; prescribing distributions from the Revenue Sharing Trust Fund for Municipalities to certain governments exercising municipal powers; amending s. 220.13, F.S.; correcting a cross-reference to a provision in the Internal Revenue Code; amending ss. 403.718, 403.7185, 403.7195, F.S.; revising the criteria under which administration costs may be deducted by the department from the proceeds of waste tire fees, lead-acid battery fees, and waste newsprint disposal fees; amending s. 624.5092, F.S.; revising requirements for calculating estimated tax payments; amending s. 731.111, F.S.; authorizing the department to file a claim, or amend a previously filed claim, against a taxpayer following receipt of the taxpayer's federal estate tax return or an amended or supplemented federal estate tax return; amending s. 212.05, F.S.; excluding franchise fees passed on to the television system program service provider's customer from the definition of the term "charges" for tax purposes of the sales, storage, or use tax; revising the sales tax on certain transactions involving coins; amending s. 212.0515, F.S.; revising the method for calculating the amount of sales tax to be paid on certain beverages sold in vending machines; amending s. 212.08, F.S.; exempting taxicabs from charging sales tax on taxicab leases and equipment; amending s. 212.02, F.S.; providing an additional exemption from the definition of the term "admission"; providing an effective date.

By the Committee on Education and Senator Kirkpatrick—

CS for SB's 2078 and 1608—A bill to be entitled An act relating to postsecondary education; amending s. 240.2601, F.S., relating to the State University System Facility Enhancement Challenge Grant Program; providing that a university may expend funds from private sources for certain fundraising activities; providing that the funds used for fundraising are eligible for matching funds if the facility project is initiated; amending s. 240.2605, F.S., relating to the Trust Fund for Major Gifts; providing for the trust fund to be administered by the Board of Regents as a part of the major gifts program; providing that moneys appropriated for the new donors program and the eminent scholars program shall be transferred into the Trust Fund for Major Gifts; providing that all real estate that is donated for the purposes of the major gifts program shall be administered under rules of the Board of Regents; providing for administration and for matching grants; requiring that foundations submit a report to the Board of Regents specifying the use of the proceeds of endowments established; deleting certain provisions relating to the trust fund; amending s. 240.207, F.S.; providing for a 2-year term of office for the student member of the Board of Regents; amending s. 240.253, F.S.; providing for confidentiality of certain personnel records of university direct-support organizations; amending s. 240.299, F.S.; providing for confidentiality of certain financial information of university direct-support organizations; amending s. 240.522, F.S.; providing for transfer of assets to the direct-support organization for the new state university in southwest Florida; amending s. 240.5285, F.S.; providing for a direct-support organization at the Broward County campus of Florida Atlantic University; prohibiting universities from assessing student fees not authorized by law; providing requirements for organizations that solicit financial support on university campuses; amending s. 215.16, F.S., relating to reductions in vacant positions; amending s. 240.209, F.S.; modifying provisions relating to the setting of fees by the Board of Regents; authorizing varying fee schedules and expenditures; requiring rules relating to financial aid fees; prescribing responsibilities of specified state universities for providing certain programs and services statewide; authorizing instruction in certain disciplines to be provided throughout the state; amending s. 240.2094, F.S.; authorizing an increase in salary rate under certain circumstances; amending s. 240.214, F.S.; revising data in the accountability process plan; requiring additional information in the accountability reports; amending s. 240.271, F.S.; revising provisions relating to funding based on enrollment; providing for the retention and expenditure of certain fee revenues; amending s. 240.272, F.S.; revising provisions relating to the carryforward and expenditure of certain funds; amending s. 240.278, F.S.; revising provisions relating to the required course program and the Quality Assurance Fund; amending ss. 240.531, 282.308, 447.203, F.S.; correcting cross-references; amending s. 240.311, F.S.; revising duties of the State Board of Community Colleges; providing procedures for selection of presidents of community colleges; amending s. 240.319, F.S.; prescribing requirements for rules, procedures, and policies; amending s. 240.324, F.S.; revising community college planning relating to the accountability process; requiring automated student records systems; amending s. 240.325, F.S.; revising provisions relating to guidelines for community colleges; amending s. 240.331, F.S.; conforming provisions; amending s. 240.347, F.S.; revising provisions relating to the State Community College Program Fund; providing community college program requirements; amending s. 240.359, F.S.; providing for community college budgets and budget categories; amending s. 240.363, F.S.; providing requirements for purchases generated from external funding; repealing s. 240.257, F.S., relating to the Florida Endowment Trust Fund

for Eminent Scholars Act; repealing s. 240.259, F.S., relating to the Trust Fund for New Donors; repealing ss. 240.349 and 240.361, F.S., relating to requirements for participation in the Community College Program Fund and budgets for community colleges; providing an effective date.

MESSAGES FROM THE GOVERNOR AND OTHER EXECUTIVE COMMUNICATIONS

The Governor advised that he had filed with the Secretary of State SB 1122, which became law without his signature on March 31, 1993.

MESSAGES FROM THE HOUSE OF REPRESENTATIVES

FIRST READING

The Honorable Ander Crenshaw, President

I am directed to inform the Senate that the House of Representatives has passed CS for HB 321, HB 1483; has passed as amended CS for HB 1045, CS for HB 2069, CS for HB 2197 and requests the concurrence of the Senate.

John B. Phelps, Clerk

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By the Committee on Judiciary and Representative Glickman—

CS for HB 321—A bill to be entitled An act relating to testimony by child victims or witnesses; amending ss. 92.53, 92.54, and 92.55, F.S., relating to videotaping, closed circuit television, and other special protections for child victims and witnesses; requiring a finding that the harm caused if the child were required to testify would be due to the presence of the defendant; deleting the sexual abuse or child abuse limitation on the videotaping of a child's testimony and the sexual offense limitation on the use of closed circuit television; preserving the defendant's right to immediate consultation with counsel when closed circuit television is used for the child's testimony; requiring the Supreme Court to adopt rules; providing an effective date.

(Substituted for **SB 670** on the Special Order Calendar this day.)

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By Representative Kelly—

HB 1483—A bill to be entitled An act relating to education; providing legislative intent; authorizing the establishment of regional consortium service organizations; providing requirements for such organizations; providing eligibility and application procedures for incentive grants; providing an effective date.

On motions by Senator Kirkpatrick, by unanimous consent **HB 1483** was taken up out of order and by two-thirds vote was read the second time by title, and by two-thirds vote read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

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By the Committee on Business and Professional Regulation; and Representative Davis and others—

CS for HB 1045—A bill to be entitled An act relating to energy efficiency; amending s. 377.703, F.S.; providing duties and responsibilities of the Department of Community Affairs with respect to solar energy resource promotion and development; requiring a report; creating s. 288.041, F.S.; providing legislative intent; providing duties and responsibilities of the Department of Commerce with respect to solar energy resource promotion and development; amending s. 553.71, F.S.; defining "load management control device"; amending s. 553.79, F.S.; exempting load management control devices from permit and fee requirements under the State Minimum Building Codes; amending s. 553.901, F.S.; providing for triennial determinations and updates of the Florida Thermal Efficiency Code; amending ss. 553.903, 553.904, and 553.905, F.S.; providing applicability of thermal efficiency standards to products covered by the Florida Energy Efficiency Code for Building Construction; amending s. 553.9085, F.S.; requiring energy performance levels for new residential buildings to be disclosed upon request by prospective purchasers; requiring the energy performance level display card to be signed, completed, and certified by the builder as accurate and correct and included as an addendum to each sales contract; amending ss. 553.909 and 553.963, F.S.; modifying certain energy conservation standards; authorizing inclusion of standards for certain additional appliances in the energy efficiency construction code; amending s. 553.955, F.S.; redefining the term "energy conservation standard"; creating part XI of chapter 553, F.S., the Florida Building Energy-Efficiency Rating Act; requiring the Department of Community Affairs to develop and maintain a statewide uniform energy-efficiency rating system for new and existing buildings to encourage the consideration of the energy-efficiency rating in the market and provide market rewards for energy-efficient buildings; providing definitions and applicability; providing rating system schedules for the different classes of buildings; providing minimum requirements of the system; providing for an interest group of volunteers to advise and assist the department; providing for training and certification of raters, including a fee therefor; providing for rating disclosure and supplemental information; providing for compliance; amending s. 163.04, F.S. (1992 Supp.), providing clarification regarding the installation of solar collectors in a certain manner; providing an effective date.

—was referred to the Committee on Rules and Calendar.

By the Committees on Appropriations; and Aging and Human Services; and Representative Gordon—

CS for HB 2069—A bill to be entitled An act relating to adult day care centers; amending s. 400.55, F.S.; modifying purpose of pt. IV of ch. 400, F.S.; amending ss. 400.551, 400.552, 400.556, 400.557, 400.5575, 400.558, 400.559, 400.56, and 400.562, F.S.; conforming definitions and language to transfer of responsibilities from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; expanding definition of "basic services"; amending s. 400.553, F.S.; revising exemptions from regulation under pt. IV of ch. 400, F.S.; authorizing provision of certain services by an adult congregate living facility, nursing home facility, or hospital; requiring monitoring by the agency; amending s. 400.554, F.S.; providing for biennial rather than annual license fee; providing an additional fee; deleting license fee exemption for centers operated by local governments; amending s. 400.555, F.S.; providing additional license application requirements; amending s. 400.5565, F.S.; clarifying authority to impose fines; conditioning license renewal on payment of outstanding fines; saving pt. IV of ch. 400, F.S., from Sunset repeal; providing for future review and repeal; providing an effective date.

(Substituted for **CS for SB 306** on the Special Order Calendar this day.)

By the Committees on Appropriations; and Aging and Human Services; and Representative Gordon—

CS for HB 2197—A bill to be entitled An act relating to adult congregate living facilities; amending s. 400.401, F.S.; providing legislative findings; amending s. 400.402, F.S.; revising definitions; amending s. 400.404, F.S.; revising exemptions; amending s. 400.407, F.S.; providing penalties for neglect; providing for care of residents designated as being mentally ill; revising requirements for existing facilities requesting to provide extended congregate care services; requiring annual monitoring of facilities with substantiated complaints; revising a restriction on facilities providing limited mental health services; providing for biennial license fees; providing a duplicate license fee; amending s. 400.408, F.S.; providing penalties for referral to an unlicensed facility, a facility whose license is under denial or has been suspended or revoked, or a facility that has a moratorium on admissions; amending s. 400.411, F.S.; providing an additional license application requirement; amending s. 400.412, F.S.; requiring a corrective action plan prior to transfer of ownership; amending s. 400.414, F.S.; providing additional grounds for license suspension, denial, or revocation, or administrative fine; providing for hearing; requiring provision of specified information to the Division of Hotels and Restaurants of the Department of Business Regulation; amending s. 400.415, F.S.; providing for moratorium on admissions after license denial, suspension, or revocation; amending s. 400.4174, F.S.; requiring certain notice of confirmed reports of child abuse or neglect by a facility owner or employee; amending s. 400.4176, F.S.; increasing time period for notice of change of facility administrator; amending s. 400.418, F.S.; providing use of fees and fines; amending s. 400.419, F.S.; providing penalties

for certain action by an administrator; providing an additional classification of violations; providing a penalty; providing for dissemination of information on facilities with violations; providing a fee; amending s. 400.42, F.S.; authorizing acceptance of third-party supplementation under specified circumstances; amending s. 400.422, F.S.; providing certain notice of receivership proceedings; revising provisions relating to expenditures to correct or eliminate deficiencies; amending s. 400.424, F.S.; requiring contract notice of a facility's policy on advance deposits; providing for disposition of personal belongings after termination date; specifying time period for refunds; providing a penalty; providing for disposition of fines; revising requirement for physical examination; amending s. 400.4255, F.S.; expanding authorized use of licensed personnel; providing for use of certified nursing assistants; amending s. 400.426, F.S.; revising provisions relating to assessment of appropriateness of placement and requirements for continued residency; requiring certain agreement or notice prior to moving a resident to another facility; amending s. 400.427, F.S.; modifying provisions relating to personal affairs of residents; prohibiting payment of benefits to an owner, administrator, or staff member without resident's consent; providing a penalty for certain misuse of a resident's personal needs allowance; amending s. 400.428, F.S.; revising the resident bill of rights; providing for extended visiting hours; requiring a grievance procedure; requiring telephone access to advocacy or special interest groups; requiring monitoring visits to facilities with certain violations; amending s. 400.431, F.S.; providing for relocation of residents receiving services from the Department of Health and Rehabilitative Services when a facility discontinues operation; extending period for return of payments by such a facility; amending s. 400.434, F.S.; authorizing inspection of facilities after license suspension or revocation; providing restrictions; amending s. 400.435, F.S.; providing copies of inspection reports to certain persons; amending s. 400.441, F.S.; revising rules relating to minimum standards for fire safety, food service inspection, and use of restraints; providing for distinct standards for facilities of different sizes; providing a restriction; amending s. 400.442, F.S.; requiring a corrective action plan for deficiencies in provision of medication; amending s. 400.444, F.S.; conforming terminology; amending s. 400.447, F.S.; deleting restrictions on advertising while under construction; providing a penalty for certain advertising violations; amending s. 400.452, F.S.; revising core educational requirements for staff; amending ss. 400.417, 400.4195, 400.421, 400.429, 400.4445, and 400.453, F.S.; conforming language to transfer of responsibilities to the Agency for Health Care Administration from the Department of Health and Rehabilitative Services; amending s. 509.032, F.S.; providing duties of the Division of Hotels and Restaurants of the Department of Business Regulation relating to inspection of public lodging establishments; amending s. 651.011, F.S.; correcting a cross reference; providing an appropriation; saving pt. II of ch. 400, F.S., from Sunset repeal; providing for future review and repeal; providing an effective date.

—was referred to the Committee on Health and Rehabilitative Services.

RETURNING MESSAGES—FINAL ACTION

The Honorable Ander Crenshaw, President

I am directed to inform the Senate that the House of Representatives has passed SB 154, SB 230, SB 376, CS for SB 382, CS for SB 430, CS for SB 540, SB 664, CS for SB 910, CS for SB 912, CS for SB 1022, CS for SB 1070, CS for SB 1092, SB 2340 and SB 2356.

John B. Phelps, Clerk

The bills contained in the foregoing message were ordered enrolled.

ROLL CALLS ON SENATE BILLS

SB 74

Yeas—30

Bankhead	Dudley	Kirkpatrick	Sullivan
Beard	Dyer	Kiser	Thomas
Boczar	Foley	Kurth	Turner
Burt	Harden	McKay	Weinstein
Casas	Holzendorf	Meadows	Wexler
Childers	Jenne	Myers	Williams
Dantzler	Jennings	Siegel	
Diaz-Balart	Jones	Silver	

Nays—None

CS for SB 194

Yeas—34

Mr. President	Dantzler	Jenne	Siegel
Bankhead	Diaz-Balart	Jennings	Silver
Beard	Dudley	Johnson	Sullivan
Boczar	Dyer	Jones	Thomas
Brown-Waite	Foley	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Harden	Kurth	Williams
Childers	Hargrett	McKay	
Crist	Holzendorf	Meadows	

Nays—None

CS for SB 202

Yeas—36

Mr. President	Dantzler	Hargrett	McKay
Bankhead	Diaz-Balart	Holzendorf	Meadows
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Jones	Thomas
Casas	Grant	Kirkpatrick	Turner
Childers	Gutman	Kiser	Weinstein
Crist	Harden	Kurth	Williams

Nays—None

SB 212

Yeas—36

Bankhead	Diaz-Balart	Holzendorf	Meadows
Beard	Dyer	Jenne	Myers
Boczar	Foley	Jennings	Siegel
Brown-Waite	Forman	Johnson	Silver
Burt	Grant	Jones	Thomas
Casas	Grogan	Kirkpatrick	Turner
Childers	Gutman	Kiser	Weinstein
Crist	Harden	Kurth	Wexler
Dantzler	Hargrett	McKay	Williams

Nays—None

SB 258

Yeas—39

Mr. President	Diaz-Balart	Jenne	Scott
Bankhead	Dudley	Jennings	Siegel
Beard	Dyer	Johnson	Silver
Boczar	Foley	Jones	Sullivan
Brown-Waite	Forman	Kirkpatrick	Thomas
Burt	Grant	Kiser	Turner
Casas	Gutman	Kurth	Weinstein
Childers	Harden	McKay	Wexler
Crist	Hargrett	Meadows	Williams
Dantzler	Holzendorf	Myers	

Nays—None

SB 280

Yeas—36

Mr. President	Dantzler	Holzendorf	Myers
Bankhead	Diaz-Balart	Jenne	Siegel
Beard	Dudley	Jennings	Silver
Boczar	Dyer	Johnson	Sullivan
Brown-Waite	Foley	Kirkpatrick	Thomas
Burt	Forman	Kiser	Turner
Casas	Grant	Kurth	Weinstein
Childers	Gutman	McKay	Wexler
Crist	Hargrett	Meadows	Williams

Nays—None

CS for CS for SB 288

Yeas—24

Bankhead	Grant	Jennings	Silver
Dantzler	Gutman	Johnson	Thomas
Diaz-Balart	Harden	Kirkpatrick	Turner
Dyer	Hargrett	Meadows	Weinstein
Foley	Holzendorf	Myers	Wexler
Forman	Jenne	Siegel	Williams

Nays—9

Beard	Grogan	Kurth
Boczar	Jones	McKay
Childers	Kiser	Sullivan

CS for SB 368

Yeas—33

Mr. President	Diaz-Balart	Holzendorf	Silver
Bankhead	Dudley	Jennings	Sullivan
Beard	Dyer	Johnson	Thomas
Boczar	Foley	Jones	Turner
Burt	Forman	Kirkpatrick	Weinstein
Casas	Grant	Kurth	Williams
Childers	Gutman	McKay	
Crist	Harden	Myers	
Dantzler	Hargrett	Siegel	

Nays—None

CS for SB 436

Yeas—38

Mr. President	Dudley	Jenne	Siegel
Bankhead	Dyer	Jennings	Silver
Beard	Foley	Johnson	Sullivan
Boczar	Forman	Jones	Thomas
Burt	Grant	Kirkpatrick	Turner
Casas	Grogan	Kiser	Weinstein
Childers	Gutman	Kurth	Wexler
Crist	Harden	McKay	Williams
Dantzler	Hargrett	Meadows	
Diaz-Balart	Holzendorf	Myers	

Nays—None

CS for SB 520

Yeas—38

Mr. President	Boczar	Casas	Diaz-Balart
Bankhead	Brown-Waite	Childers	Dudley
Beard	Burt	Dantzler	Dyer
Foley	Holzendorf	McKay	Thomas
Forman	Jenne	Meadows	Turner
Grant	Jennings	Myers	Weinstein
Grogan	Johnson	Scott	Wexler
Gutman	Jones	Siegel	Williams
Harden	Kirkpatrick	Silver	
Hargrett	Kurth	Sullivan	

Nays—None

CS for SB 536

Yeas—37

Mr. President	Diaz-Balart	Jenne	Silver
Bankhead	Dudley	Jennings	Sullivan
Beard	Dyer	Johnson	Thomas
Boczar	Foley	Jones	Turner
Brown-Waite	Forman	Kirkpatrick	Weinstein
Burt	Grant	Kiser	Wexler
Casas	Gutman	Kurth	Williams
Childers	Harden	McKay	
Crist	Hargrett	Myers	
Dantzler	Holzendorf	Siegel	

Nays—None

CS for SB 536—After Reconsideration

Yeas—38

Bankhead	Dudley	Jenne	Siegel
Beard	Dyer	Jennings	Silver
Boczar	Foley	Johnson	Sullivan
Brown-Waite	Forman	Jones	Thomas
Burt	Grant	Kirkpatrick	Turner
Casas	Grogan	Kiser	Weinstein
Childers	Gutman	Kurth	Wexler
Crist	Harden	McKay	Williams
Dantzler	Hargrett	Meadows	
Diaz-Balart	Holzendorf	Myers	

Nays—None

SB 614

Yeas—28

Bankhead	Crist	Jennings	Scott
Beard	Dantzler	Jones	Siegel
Boczar	Diaz-Balart	Kirkpatrick	Sullivan
Brown-Waite	Dudley	Kurth	Turner
Burt	Dyer	McKay	Weinstein
Casas	Foley	Meadows	Wexler
Childers	Harden	Myers	Williams

Nays—None

SB 676

Yeas—33

Bankhead	Forman	Kirkpatrick	Sullivan
Beard	Gutman	Kiser	Thomas
Boczar	Harden	Kurth	Turner
Brown-Waite	Hargrett	McKay	Weinstein
Casas	Holzendorf	Meadows	Wexler
Childers	Jenne	Myers	Williams
Diaz-Balart	Jennings	Scott	
Dyer	Johnson	Siegel	
Foley	Jones	Silver	

Nays—3

Dantzler	Grant	Grogan

SB 716

Yeas—32

Beard	Dudley	Johnson	Siegel
Boczar	Dyer	Jones	Silver
Burt	Foley	Kirkpatrick	Sullivan
Casas	Forman	Kiser	Thomas
Childers	Grant	Kurth	Turner
Crist	Gutman	McKay	Weinstein
Dantzler	Harden	Meadows	Wexler
Diaz-Balart	Jenne	Myers	Williams

Nays—None

Vote after roll call:

Yea—Holzendorf

CS for SB 752

Yeas—34

Bankhead	Diaz-Balart	Jenne	Siegel
Beard	Dudley	Jennings	Silver
Boczar	Dyer	Johnson	Sullivan
Brown-Waite	Foley	Jones	Thomas
Burt	Forman	Kiser	Weinstein
Casas	Grant	Kurth	Wexler
Childers	Grogan	McKay	Williams
Crist	Gutman	Meadows	
Dantzler	Holzendorf	Myers	

Nays—None

SB 794

Yeas—35

Bankhead	Diaz-Balart	Jenne	Siegel
Beard	Dudley	Jennings	Silver
Boczar	Dyer	Johnson	Sullivan
Brown-Waite	Foley	Jones	Thomas
Burt	Forman	Kiser	Turner
Casas	Grant	Kurth	Weinstein
Childers	Gutman	McKay	Wexler
Crist	Hargrett	Meadows	Williams
Dantzler	Holzendorf	Myers	

Nays—None

Vote after roll call:

Yea—Harden

SB 820

Yeas—34

Bankhead	Diaz-Balart	Jenne	Siegel
Beard	Dyer	Johnson	Silver
Boczar	Foley	Jones	Sullivan
Brown-Waite	Forman	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Grogan	Kurth	Wexler
Childers	Gutman	McKay	Williams
Crist	Harden	Meadows	
Dantzler	Hargrett	Myers	

Nays—None

CS for SB 884

Yeas—36

Mr. President	Diaz-Balart	Holzendorf	Myers
Bankhead	Dudley	Jenne	Siegel
Beard	Dyer	Jennings	Silver
Boczar	Foley	Johnson	Sullivan
Brown-Waite	Forman	Jones	Thomas
Burt	Grant	Kirkpatrick	Turner
Casas	Gutman	Kurth	Weinstein
Childers	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—1

Crist

CS for SB 952

Yeas—38

Bankhead	Dudley	Jenne	Siegel
Beard	Dyer	Jennings	Silver
Boczar	Foley	Johnson	Sullivan
Brown-Waite	Forman	Jones	Thomas
Burt	Grant	Kirkpatrick	Turner
Casas	Grogan	Kiser	Weinstein
Childers	Gutman	Kurth	Wexler
Crist	Harden	McKay	Williams
Dantzler	Hargrett	Meadows	
Diaz-Balart	Holzendorf	Myers	

Nays—None

CS for SB 1080

Yeas—36

Mr. President	Dantzler	Jenne	Myers
Bankhead	Diaz-Balart	Jennings	Siegel
Beard	Dyer	Johnson	Silver
Boczar	Forman	Jones	Sullivan
Brown-Waite	Grant	Kirkpatrick	Thomas
Burt	Gutman	Kiser	Turner
Casas	Harden	Kurth	Weinstein
Childers	Hargrett	McKay	Wexler
Crist	Holzendorf	Meadows	Williams

Nays—2

Dudley Foley

SB 1086

Yeas—35

Bankhead	Foley	Johnson	Siegel
Beard	Forman	Jones	Silver
Boczar	Grant	Kirkpatrick	Sullivan
Brown-Waite	Grogan	Kiser	Thomas
Casas	Gutman	Kurth	Turner
Childers	Harden	McKay	Weinstein
Dantzler	Hargrett	Meadows	Wexler
Diaz-Balart	Holzendorf	Myers	Williams
Dyer	Jenne	Scott	

Nays—None

SB 1086—After Reconsideration

Yeas—34

Bankhead	Dyer	Jennings	Silver
Beard	Forman	Johnson	Sullivan
Boczar	Grant	Jones	Thomas
Brown-Waite	Grogan	Kirkpatrick	Turner
Burt	Gutman	Kurth	Weinstein
Casas	Harden	McKay	Wexler
Childers	Hargrett	Meadows	Williams
Dantzler	Holzendorf	Myers	
Diaz-Balart	Jenne	Siegel	

Nays—None

SB 1086—After Reconsideration

Yeas—36

Bankhead	Dyer	Jenne	Myers
Beard	Foley	Jennings	Siegel
Boczar	Forman	Johnson	Silver
Brown-Waite	Grant	Jones	Sullivan
Burt	Grogan	Kirkpatrick	Thomas
Casas	Gutman	Kiser	Turner
Childers	Harden	Kurth	Weinstein
Diaz-Balart	Hargrett	McKay	Wexler
Dudley	Holzendorf	Meadows	Williams

Nays—None

SB 1204

Yeas—37

Bankhead	Dudley	Jenne	Silver
Beard	Dyer	Jennings	Sullivan
Boczar	Foley	Johnson	Thomas
Brown-Waite	Forman	Jones	Turner
Burt	Grant	Kirkpatrick	Weinstein
Casas	Grogan	Kurth	Wexler
Childers	Gutman	McKay	Williams
Crist	Harden	Meadows	
Dantzler	Hargrett	Myers	
Diaz-Balart	Holzendorf	Siegel	

Nays—None

CS for SB 1208

Yeas—37

Mr. President	Dudley	Jennings	Silver
Bankhead	Dyer	Johnson	Sullivan
Boczar	Foley	Jones	Thomas
Brown-Waite	Forman	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Gutman	Kurth	Wexler
Childers	Harden	McKay	Williams
Crist	Hargrett	Meadows	
Dantzler	Holzendorf	Myers	
Diaz-Balart	Jenne	Siegel	

Nays—None

SB 1214

Yeas—37

Bankhead	Childers	Foley	Hargrett
Beard	Crist	Forman	Holzendorf
Boczar	Dantzler	Grant	Jenne
Brown-Waite	Diaz-Balart	Grogan	Jennings
Burt	Dudley	Gutman	Johnson
Casas	Dyer	Harden	Jones
Kirkpatrick	Myers	Thomas	Williams
Kurth	Siegel	Turner	
McKay	Silver	Weinstein	
Meadows	Sullivan	Wexler	

Nays—None

SB 1238

Yeas—37

Bankhead	Dudley	Jenne	Silver
Beard	Dyer	Jennings	Sullivan
Boczar	Foley	Johnson	Thomas
Brown-Waite	Forman	Jones	Turner
Burt	Grant	Kirkpatrick	Weinstein
Casas	Grogan	Kurth	Wexler
Childers	Gutman	McKay	Williams
Crist	Harden	Meadows	
Dantzler	Hargrett	Myers	
Diaz-Balart	Holzendorf	Siegel	

Nays—None

SB 1252

Yeas—33

Mr. President	Dyer	Johnson	Silver
Bankhead	Foley	Jones	Sullivan
Beard	Grant	Kirkpatrick	Thomas
Boczar	Grogan	Kurth	Weinstein
Brown-Waite	Harden	McKay	Wexler
Casas	Hargrett	Meadows	Williams
Childers	Holzendorf	Myers	
Dantzler	Jenne	Scott	
Diaz-Balart	Jennings	Siegel	

Nays—None

SB 1252—After Reconsideration

Yeas—36

Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dyer	Jenne	Siegel
Boczar	Foley	Jennings	Silver
Brown-Waite	Forman	Johnson	Sullivan
Burt	Grant	Jones	Thomas
Casas	Grogan	Kirkpatrick	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

SB 1356

Yeas—35

Bankhead	Dyer	Jennings	Siegel
Beard	Foley	Johnson	Silver
Boczar	Forman	Jones	Sullivan
Brown-Waite	Grant	Kirkpatrick	Thomas
Burt	Grogan	Kiser	Turner
Casas	Gutman	Kurth	Weinstein
Childers	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams
Diaz-Balart	Jenne	Myers	

Nays—None

CS for SB 1442

Yeas—36

Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Jones	Thomas
Casas	Grant	Kirkpatrick	Turner
Childers	Grogan	Kurth	Weinstein
Crist	Gutman	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

Vote after roll call:

Yea—Harden

SB 1644

Yeas—38

Mr. President	Diaz-Balart	Jenne	Siegel
Bankhead	Dudley	Jennings	Silver
Beard	Dyer	Johnson	Sullivan
Boczar	Foley	Jones	Thomas
Brown-Waite	Forman	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Gutman	Kurth	Wexler
Childers	Harden	McKay	Williams
Crist	Hargrett	Meadows	
Dantzler	Holzendorf	Myers	

Nays—None

CS for SB 1658

Yeas—37

Bankhead	Dudley	Jenne	Silver
Beard	Dyer	Jennings	Sullivan
Boczar	Foley	Johnson	Thomas
Brown-Waite	Forman	Jones	Turner
Burt	Grant	Kirkpatrick	Weinstein
Casas	Grogan	Kurth	Wexler
Childers	Gutman	McKay	Williams
Crist	Harden	Meadows	
Dantzler	Hargrett	Myers	
Diaz-Balart	Holzendorf	Siegel	

Nays—None

SB 1760

Yeas—38

Bankhead	Dudley	Jenne	Siegel
Beard	Dyer	Jennings	Silver
Boczar	Foley	Johnson	Sullivan
Brown-Waite	Forman	Jones	Thomas
Burt	Grant	Kirkpatrick	Turner
Casas	Grogan	Kiser	Weinstein
Childers	Gutman	Kurth	Wexler
Crist	Harden	McKay	Williams
Dantzler	Hargrett	Meadows	
Diaz-Balart	Holzendorf	Myers	

Nays—None

CS for SB's 1914, 2006, 1784 and 406
Amendment 1

Yeas—20

Mr. President	Casas	Grant	McKay
Bankhead	Crist	Gutman	Myers
Beard	Diaz-Balart	Harden	Scott
Brown-Waite	Dudley	Jennings	Siegel
Burt	Foley	Kiser	Sullivan

Nays—20

Boczar	Grogan	Jones	Thomas
Childers	Hargrett	Kirkpatrick	Turner
Dantzler	Holzendorf	Kurth	Weinstein
Dyer	Jenne	Meadows	Wexler
Forman	Johnson	Silver	Williams

CS for SB's 1914, 2006, 1784 and 406
Amendment 2

Yeas—23

Mr. President	Childers	Gutman	Myers
Bankhead	Crist	Harden	Scott
Beard	Diaz-Balart	Jennings	Siegel
Brown-Waite	Dudley	Kirkpatrick	Sullivan
Burt	Foley	Kiser	Williams
Casas	Grant	McKay	

Nays—17

Boczar	Hargrett	Kurth	Weinstein
Dantzler	Holzendorf	Meadows	Wexler
Dyer	Jenne	Silver	
Forman	Johnson	Thomas	
Grogan	Jones	Turner	

CS for SB 1954

Yeas—34

Bankhead	Dudley	Jennings	Silver
Beard	Dyer	Johnson	Sullivan
Boczar	Foley	Jones	Thomas
Brown-Waite	Forman	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Gutman	McKay	Wexler
Childers	Harden	Meadows	Williams
Dantzler	Hargrett	Myers	
Diaz-Balart	Jenne	Siegel	

Nays—None

CS for SB 1982

Yeas—36

Bankhead	Diaz-Balart	Jenne	Myers
Beard	Dudley	Jennings	Siegel
Boczar	Dyer	Johnson	Silver
Brown-Waite	Foley	Jones	Sullivan
Burt	Grant	Kirkpatrick	Thomas
Casas	Grogan	Kiser	Turner
Childers	Harden	Kurth	Weinstein
Crist	Hargrett	McKay	Wexler
Dantzler	Holzendorf	Meadows	Williams

Nays—None

CS for SB 1988

Yeas—37

Bankhead	Dudley	Jenne	Siegel
Beard	Dyer	Jennings	Silver
Boczar	Foley	Johnson	Sullivan
Brown-Waite	Forman	Jones	Turner
Burt	Grant	Kirkpatrick	Weinstein
Casas	Grogan	Kiser	Wexler
Childers	Gutman	Kurth	Williams
Crist	Harden	McKay	
Dantzler	Hargrett	Meadows	
Diaz-Balart	Holzendorf	Myers	

Nays—None

SB 2084

Yeas—35

Bankhead	Dudley	Jenne	Myers
Beard	Dyer	Jennings	Siegel
Boczar	Foley	Johnson	Silver
Brown-Waite	Forman	Jones	Sullivan
Burt	Grant	Kirkpatrick	Thomas
Casas	Grogan	Kiser	Turner
Childers	Gutman	Kurth	Wexler
Crist	Hargrett	McKay	Williams
Diaz-Balart	Holzendorf	Meadows	

Nays—None

CS for SB 2260

Yeas—32

Bankhead	Diaz-Balart	Hargrett	Meadows
Beard	Dyer	Holzendorf	Myers
Brown-Waite	Foley	Jenne	Silver
Burt	Forman	Jennings	Thomas
Casas	Grant	Jones	Turner
Childers	Grogan	Kirkpatrick	Weinstein
Crist	Gutman	Kiser	Wexler
Dantzler	Harden	McKay	Williams

Nays—None

Vote after roll call:

Yea—Siegel

ROLL CALLS ON HOUSE BILLS

CS for HB 21

Yeas—37

Bankhead	Dyer	Jennings	Silver
Beard	Foley	Johnson	Sullivan
Boczar	Forman	Jones	Thomas
Brown-Waite	Grant	Kirkpatrick	Turner
Burt	Grogan	Kiser	Weinstein
Casas	Gutman	McKay	Wexler
Childers	Harden	Meadows	Williams
Crist	Hargrett	Myers	
Dantzler	Holzendorf	Scott	
Diaz-Balart	Jenne	Siegel	

Nays—None

Vote after roll call:

Yea—Kurth

CS for HB 55

Yeas—36

Bankhead	Dudley	Jenne	Myers
Beard	Dyer	Jennings	Siegel
Boczar	Foley	Johnson	Silver
Brown-Waite	Forman	Jones	Sullivan
Burt	Grogan	Kirkpatrick	Thomas
Casas	Gutman	Kiser	Turner
Childers	Harden	Kurth	Weinstein
Dantzler	Hargrett	McKay	Wexler
Diaz-Balart	Holzendorf	Meadows	Williams

Nays—None

CS for HB 83

Yeas—38

Mr. President	Diaz-Balart	Jenne	Siegel
Bankhead	Dudley	Jennings	Silver
Beard	Dyer	Johnson	Sullivan
Boczar	Foley	Jones	Thomas
Brown-Waite	Forman	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Gutman	Kurth	Wexler
Childers	Harden	McKay	Williams
Crist	Hargrett	Meadows	
Dantzler	Holzendorf	Myers	

Nays—None

CS for HB 113

Yeas—33

Bankhead	Dyer	Johnson	Sullivan
Beard	Foley	Jones	Thomas
Boczar	Forman	Kirkpatrick	Turner
Burt	Grogan	Kurth	Weinstein
Casas	Harden	McKay	Wexler
Childers	Hargrett	Meadows	Williams
Dantzler	Holzendorf	Myers	
Diaz-Balart	Jenne	Siegel	
Dudley	Jennings	Silver	

Nays—1

Gutman

HB 127

Yeas—36

Bankhead	Foley	Jennings	Scott
Beard	Forman	Johnson	Siegel
Boczar	Grant	Jones	Silver
Brown-Waite	Grogan	Kirkpatrick	Sullivan
Casas	Gutman	Kiser	Thomas
Childers	Harden	Kurth	Turner
Dantzler	Hargrett	McKay	Weinstein
Diaz-Balart	Holzendorf	Meadows	Wexler
Dyer	Jenne	Myers	Williams

Nays—None

CS for HB 139

Yeas—36

Mr. President	Boczar	Casas	Dantzler
Bankhead	Brown-Waite	Childers	Diaz-Balart
Beard	Burt	Crist	Dudley

Dyer	Hargrett	Kurth	Sullivan
Foley	Holzendorf	McKay	Thomas
Forman	Jennings	Meadows	Turner
Grant	Johnson	Myers	Weinstein
Gutman	Kirkpatrick	Siegel	Wexler
Harden	Kiser	Silver	Williams

Nays—None

CS for HB 163

Yeas—36

Bankhead	Dyer	Jenne	Myers
Beard	Foley	Jennings	Siegel
Boczar	Forman	Johnson	Silver
Brown-Waite	Grant	Jones	Sullivan
Burt	Grogan	Kirkpatrick	Thomas
Casas	Gutman	Kiser	Turner
Childers	Harden	Kurth	Weinstein
Crist	Hargrett	McKay	Wexler
Diaz-Balart	Holzendorf	Meadows	Williams

Nays—None

HB 275

Yeas—34

Bankhead	Dyer	Jennings	Siegel
Beard	Forman	Johnson	Silver
Boczar	Grant	Jones	Sullivan
Brown-Waite	Grogan	Kirkpatrick	Thomas
Burt	Gutman	Kiser	Weinstein
Casas	Harden	Kurth	Wexler
Childers	Hargrett	McKay	Williams
Crist	Holzendorf	Meadows	
Dantzler	Jenne	Myers	

Nays—None

CS for HB 277

Yeas—35

Mr. President	Diaz-Balart	Jenne	Scott
Bankhead	Dyer	Jennings	Siegel
Beard	Forman	Johnson	Silver
Boczar	Grant	Jones	Sullivan
Brown-Waite	Grogan	Kirkpatrick	Thomas
Burt	Gutman	Kurth	Turner
Casas	Harden	McKay	Wexler
Childers	Hargrett	Meadows	Williams
Dantzler	Holzendorf	Myers	

Nays—None

CS for HB 321

Yeas—32

Bankhead	Dantzler	Holzendorf	Siegel
Beard	Diaz-Balart	Jenne	Silver
Boczar	Dudley	Jennings	Sullivan
Brown-Waite	Dyer	Jones	Thomas
Burt	Foley	Kurth	Turner
Casas	Forman	McKay	Weinstein
Childers	Gutman	Meadows	Wexler
Crist	Hargrett	Myers	Williams

Nays—None

Vote after roll call:

Yea—Harden

HB 541

Yeas—36

Bankhead	Dyer	Jenne	Myers
Beard	Foley	Jennings	Siegel
Boczar	Forman	Johnson	Silver
Brown-Waite	Grant	Jones	Sullivan
Burt	Grogan	Kirkpatrick	Thomas
Casas	Gutman	Kiser	Turner
Childers	Harden	Kurth	Weinstein
Diaz-Balart	Hargrett	McKay	Wexler
Dudley	Holzendorf	Meadows	Williams

Nays—None

CS for HB 659

Yeas—36

Mr. President	Diaz-Balart	Holzendorf	Myers
Bankhead	Dudley	Jenne	Siegel
Beard	Dyer	Jennings	Silver
Boczar	Foley	Johnson	Sullivan
Burt	Forman	Jones	Thomas
Casas	Grant	Kiser	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

HB 683

Yeas—36

Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dyer	Jenne	Siegel
Boczar	Foley	Jennings	Silver
Brown-Waite	Forman	Johnson	Sullivan
Burt	Grant	Jones	Thomas
Casas	Grogan	Kirkpatrick	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

CS for HB 835

Yeas—36

Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Forman	Johnson	Sullivan
Burt	Grant	Jones	Thomas
Casas	Grogan	Kirkpatrick	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

HB 1001

Yeas—34

Mr. President	Burt	Dyer	Gutman
Bankhead	Crist	Foley	Holzendorf
Beard	Dantzler	Forman	Jenne
Boczar	Diaz-Balart	Grant	Johnson
Brown-Waite	Dudley	Grogan	Jones

Kiser	Myers	Sullivan	Wexler
Kurth	Scott	Thomas	Williams
McKay	Siegel	Turner	
Meadows	Silver	Weinstein	

Nays—None

Vote after roll call:

Yea—Childers

CS for HB 1017

Yeas—36

Mr. President	Diaz-Balart	Holzendorf	Myers
Bankhead	Dudley	Jenne	Siegel
Beard	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Jones	Thomas
Casas	Grant	Kirkpatrick	Turner
Childers	Gutman	Kiser	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

CS for HB 1029

Yeas—37

Bankhead	Dudley	Jenne	Silver
Beard	Dyer	Jennings	Sullivan
Boczar	Foley	Johnson	Thomas
Brown-Waite	Forman	Jones	Turner
Burt	Grant	Kirkpatrick	Weinstein
Casas	Grogan	Kurth	Wexler
Childers	Gutman	McKay	Williams
Crist	Harden	Meadows	
Dantzler	Hargrett	Myers	
Diaz-Balart	Holzendorf	Siegel	

Nays—None

CS for HB 1045

Yeas—37

Bankhead	Dudley	Jenne	Siegel
Beard	Dyer	Jennings	Silver
Boczar	Foley	Johnson	Sullivan
Brown-Waite	Forman	Jones	Thomas
Burt	Grant	Kirkpatrick	Turner
Casas	Grogan	Kiser	Weinstein
Childers	Gutman	Kurth	Wexler
Crist	Harden	McKay	
Dantzler	Hargrett	Meadows	
Diaz-Balart	Holzendorf	Myers	

Nays—None

CS for HB 1221

Yeas—36

Bankhead	Dyer	Jenne	Scott
Beard	Foley	Jennings	Siegel
Boczar	Forman	Johnson	Silver
Brown-Waite	Grant	Jones	Sullivan
Burt	Grogan	Kirkpatrick	Thomas
Casas	Gutman	Kurth	Turner
Childers	Harden	McKay	Weinstein
Crist	Hargrett	Meadows	Wexler
Diaz-Balart	Holzendorf	Myers	Williams

Nays—1

Dantzler

CS for HB 1295

Yeas—35

Bankhead	Dyer	Jenne	Myers
Beard	Foley	Jennings	Siegel
Boczar	Forman	Johnson	Silver
Brown-Waite	Grant	Jones	Thomas
Burt	Grogan	Kirkpatrick	Turner
Casas	Gutman	Kiser	Weinstein
Childers	Harden	Kurth	Wexler
Diaz-Balart	Hargrett	McKay	Williams
Dudley	Holzendorf	Meadows	

Nays—None

HB 1307

Yeas—36

Bankhead	Dudley	Jenne	Myers
Boczar	Dyer	Jennings	Siegel
Brown-Waite	Foley	Johnson	Silver
Burt	Grant	Jones	Sullivan
Casas	Grogan	Kirkpatrick	Thomas
Childers	Gutman	Kiser	Turner
Crist	Harden	Kurth	Weinstein
Dantzler	Hargrett	McKay	Wexler
Diaz-Balart	Holzendorf	Meadows	Williams

Nays—None

HB 1309

Yeas—36

Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Grant	Jones	Thomas
Casas	Grogan	Kirkpatrick	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

HB 1311

Yeas—35

Bankhead	Diaz-Balart	Hargrett	Meadows
Beard	Dudley	Jenne	Myers
Boczar	Dyer	Jennings	Siegel
Brown-Waite	Foley	Johnson	Silver
Burt	Forman	Jones	Sullivan
Casas	Grant	Kirkpatrick	Turner
Childers	Grogan	Kiser	Weinstein
Crist	Gutman	Kurth	Wexler
Dantzler	Harden	McKay	

Nays—None

HB 1313

Yeas—36

Bankhead	Casas	Dyer	Harden
Beard	Childers	Forman	Hargrett
Boczar	Crist	Grant	Holzendorf
Brown-Waite	Dantzler	Grogan	Jenne
Burt	Dudley	Gutman	Jennings

Johnson	Kurth	Siegel	Turner
Jones	McKay	Silver	Weinstein
Kirkpatrick	Meadows	Sullivan	Wexler
Kiser	Myers	Thomas	Williams

Nays—None

HB 1315

Yeas—34

Bankhead	Diaz-Balart	Holzendorf	Silver
Beard	Dudley	Jennings	Sullivan
Boczar	Dyer	Johnson	Thomas
Brown-Waite	Forman	Jones	Turner
Burt	Grant	Kirkpatrick	Weinstein
Casas	Grogan	McKay	Wexler
Childers	Gutman	Meadows	Williams
Crist	Harden	Myers	
Dantzler	Hargrett	Siegel	

Nays—None

HB 1317

Yeas—33

Bankhead	Diaz-Balart	Jenne	Sullivan
Beard	Dudley	Jennings	Thomas
Boczar	Dyer	Johnson	Turner
Brown-Waite	Forman	Kirkpatrick	Weinstein
Burt	Grant	McKay	Wexler
Casas	Gutman	Meadows	Williams
Childers	Harden	Myers	
Crist	Hargrett	Siegel	
Dantzler	Holzendorf	Silver	

Nays—None

HB 1319

Yeas—34

Bankhead	Diaz-Balart	Holzendorf	Silver
Beard	Dudley	Jennings	Sullivan
Boczar	Dyer	Johnson	Thomas
Brown-Waite	Forman	Jones	Turner
Burt	Grant	Kirkpatrick	Weinstein
Casas	Grogan	McKay	Wexler
Childers	Gutman	Meadows	Williams
Crist	Harden	Myers	
Dantzler	Hargrett	Siegel	

Nays—None

HB 1321

Yeas—34

Bankhead	Dyer	Jennings	Silver
Beard	Forman	Johnson	Sullivan
Boczar	Grant	Jones	Thomas
Burt	Grogan	Kirkpatrick	Turner
Casas	Gutman	Kiser	Weinstein
Childers	Harden	Kurth	Wexler
Crist	Hargrett	McKay	Williams
Dantzler	Holzendorf	Meadows	
Diaz-Balart	Jenne	Siegel	

Nays—None

Vote after roll call:

Yea—Dudley

HB 1323

Yeas—36

Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Forman	Johnson	Sullivan
Burt	Grant	Jones	Thomas
Casas	Grogan	Kirkpatrick	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

HB 1325

Yeas—33

Bankhead	Dudley	Jennings	Silver
Boczar	Dyer	Johnson	Sullivan
Brown-Waite	Forman	Jones	Turner
Burt	Grant	Kirkpatrick	Weinstein
Casas	Grogan	Kurth	Wexler
Childers	Gutman	McKay	Williams
Crist	Harden	Meadows	
Dantzler	Hargrett	Myers	
Diaz-Balart	Jenne	Siegel	

Nays—None

HB 1327

Yeas—34

Bankhead	Dudley	Jenne	Silver
Beard	Dyer	Jennings	Sullivan
Boczar	Foley	Johnson	Thomas
Burt	Forman	Jones	Turner
Casas	Grant	Kirkpatrick	Weinstein
Childers	Grogan	Kurth	Wexler
Crist	Gutman	Meadows	Williams
Dantzler	Harden	Myers	
Diaz-Balart	Hargrett	Siegel	

Nays—None

HB 1329

Yeas—37

Bankhead	Dudley	Jenne	Silver
Beard	Dyer	Jennings	Sullivan
Boczar	Foley	Johnson	Thomas
Brown-Waite	Forman	Jones	Turner
Burt	Grant	Kirkpatrick	Weinstein
Casas	Grogan	Kurth	Wexler
Childers	Gutman	McKay	Williams
Crist	Harden	Meadows	
Dantzler	Hargrett	Myers	
Diaz-Balart	Holzendorf	Siegel	

Nays—None

HB 1331

Yeas—36

Bankhead	Burt	Dantzler	Foley
Beard	Casas	Diaz-Balart	Forman
Boczar	Childers	Dudley	Grant
Brown-Waite	Crist	Dyer	Grogan

Gutman	Johnson	Meadows	Thomas
Harden	Jones	Myers	Turner
Holzendorf	Kirkpatrick	Siegel	Weinstein
Jenne	Kurth	Silver	Wexler
Jennings	McKay	Sullivan	Williams

Nays—None

HB 1333

Yeas—35

Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Grant	Jones	Thomas
Casas	Grogan	Kirkpatrick	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	

Nays—None

HB 1335

Yeas—37

Bankhead	Dudley	Jennings	Silver
Beard	Dyer	Johnson	Sullivan
Boczar	Foley	Jones	Thomas
Brown-Waite	Forman	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Grogan	Kurth	Wexler
Childers	Harden	McKay	Williams
Crist	Hargrett	Meadows	
Dantzler	Holzendorf	Myers	
Diaz-Balart	Jenne	Siegel	

Nays—None

CS for HB 1343

Yeas—38

Mr. President	Diaz-Balart	Holzendorf	Myers
Bankhead	Dudley	Jenne	Siegel
Beard	Dyer	Jennings	Silver
Boczar	Foley	Johnson	Sullivan
Brown-Waite	Forman	Jones	Thomas
Burt	Grant	Kirkpatrick	Turner
Casas	Grogan	Kiser	Wexler
Childers	Gutman	Kurth	Williams
Crist	Harden	McKay	
Dantzler	Hargrett	Meadows	

Nays—None

HB 1483

Yeas—36

Bankhead	Diaz-Balart	Hargrett	Myers
Beard	Dudley	Holzendorf	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Jones	Thomas
Casas	Grant	Kirkpatrick	Turner
Childers	Grogan	Kurth	Weinstein
Crist	Gutman	McKay	Wexler
Dantzler	Harden	Meadows	Williams

Nays—None

CS for HB 1485

Yeas—37

Mr. President	Diaz-Balart	Jennings	Silver
Bankhead	Dudley	Johnson	Sullivan
Beard	Dyer	Jones	Thomas
Boczar	Foley	Kirkpatrick	Turner
Brown-Waite	Forman	Kiser	Weinstein
Burt	Grant	Kurth	Wexler
Casas	Gutman	McKay	Williams
Childers	Harden	Meadows	
Crist	Hargrett	Myers	
Dantzler	Jenne	Siegel	

Nays—None

HB 1545

Yeas—35

Beard	Dudley	Jennings	Siegel
Boczar	Dyer	Johnson	Silver
Brown-Waite	Foley	Jones	Sullivan
Burt	Forman	Kirkpatrick	Thomas
Casas	Grant	Kiser	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams
Diaz-Balart	Holzendorf	Myers	

Nays—None

HB 1773

Yeas—33

Mr. President	Dantzler	Holzendorf	Siegel
Bankhead	Diaz-Balart	Jenne	Silver
Beard	Dudley	Johnson	Sullivan
Boczar	Dyer	Jones	Turner
Brown-Waite	Forman	Kirkpatrick	Weinstein
Burt	Grant	Kiser	Williams
Casas	Gutman	Kurth	
Childers	Harden	McKay	
Crist	Hargrett	Meadows	

Nays—None

Vote after roll call:

Yea—Thomas

CS for HB 1965

Yeas—36

Mr. President	Dantzler	Hargrett	McKay
Bankhead	Diaz-Balart	Holzendorf	Meadows
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Jones	Thomas
Casas	Grant	Kirkpatrick	Turner
Childers	Gutman	Kiser	Weinstein
Crist	Harden	Kurth	Williams

Nays—None

HB 1987

Yeas—36

Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dudley	Jennings	Siegel
Boczar	Dyer	Johnson	Silver
Brown-Waite	Foley	Jones	Sullivan
Burt	Forman	Kirkpatrick	Thomas
Casas	Grant	Kiser	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

HB 2007

Yeas—38

Mr. President	Diaz-Balart	Jenne	Siegel
Bankhead	Dudley	Jennings	Silver
Beard	Dyer	Johnson	Sullivan
Boczar	Foley	Jones	Thomas
Brown-Waite	Forman	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Gutman	Kurth	Wexler
Childers	Harden	McKay	Williams
Crist	Hargrett	Meadows	
Dantzler	Holzendorf	Myers	

Nays—None

CS for HB 2069

Yeas—37

Bankhead	Dudley	Jennings	Silver
Beard	Dyer	Johnson	Sullivan
Boczar	Foley	Jones	Thomas
Brown-Waite	Forman	Kirkpatrick	Turner
Burt	Grant	Kiser	Weinstein
Casas	Gutman	Kurth	Wexler
Childers	Harden	McKay	Williams
Crist	Hargrett	Meadows	
Dantzler	Holzendorf	Myers	
Diaz-Balart	Jenne	Siegel	

Nays—None

HB 2071

Yeas—36

Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dudley	Jennings	Siegel
Boczar	Dyer	Johnson	Silver
Brown-Waite	Foley	Jones	Sullivan
Burt	Forman	Kirkpatrick	Thomas
Casas	Grant	Kiser	Turner
Childers	Gutman	Kurth	Weinstein
Crist	Harden	McKay	Wexler
Dantzler	Hargrett	Meadows	Williams

Nays—None

CS for HB 2197

Yeas—33

Bankhead	Brown-Waite	Childers	Diaz-Balart
Beard	Burt	Crist	Dyer
Boczar	Casas	Dantzler	Foley
Grant	Johnson	Meadows	Weinstein
Gutman	Jones	Siegel	Wexler
Harden	Kirkpatrick	Silver	Williams
Hargrett	Kiser	Sullivan	
Holzendorf	Kurth	Thomas	
Jennings	McKay	Turner	

Nays—None

ROLL CALL ON LOCAL BILLS

The following roll call was taken on **Senate Bills 2378, 2386, 2390, 2396, 2398, 2400, 2412** and **2416** which passed this day:

Yeas—38

Bankhead	Dudley	Jennings	Siegel
Beard	Dyer	Johnson	Silver
Boczar	Foley	Jones	Sullivan
Brown-Waite	Forman	Kirkpatrick	Thomas
Burt	Grant	Kiser	Turner
Casas	Gutman	Kurth	Weinstein
Childers	Harden	McKay	Wexler
Crist	Hargrett	Meadows	Williams
Dantzler	Holzendorf	Myers	
Diaz-Balart	Jenne	Scott	

Nays—None

VOTES RECORDED AFTER ROLL CALL

On motion by Senator Thomas, by unanimous consent of the Senate, he was recorded as voting "yea" on **HB 1773**.

On motion by Senator Kurth, by unanimous consent of the Senate, she was recorded as voting "yea" on **CS for HB 21**.

On motion by Senator Dudley, by unanimous consent of the Senate, he was recorded as voting "yea" on **HB 1321**.

On motion by Senator Holzendorf, by unanimous consent of the Senate, she was recorded as voting "yea" on **SB 716**.

On motion by Senator Jennings, by unanimous consent of the Senate, Senator Childers was recorded as voting "yea" on **HB 1001**.

On motion by Senator Siegel, by unanimous consent of the Senate, he was recorded as voting "yea" on **CS for SB 2260**.

On motion by Senator Harden, by unanimous consent of the Senate, he was recorded as voting "yea" on **CS for SB 1442, SB 794** and **CS for HB 321**.

MOTIONS

On motions by Senator Jennings, by two-thirds vote the following bills were placed on the Special Order Calendar for Thursday, April 1: CS for SB 1914, CS for SB 1666, CS for SB 1668, CS for SB 640, CS for SB 1582, CS for SB 1814, CS for SB 2078, CS for SB 772, CS for SB 1450, CS for SB 1710, CS for SB 152, CS for CS for SB 164, CS for SB 510, HB 1993, CS for SB 904, SB 270, CS for SB 1500, SB 1830, CS for SB 1000, CS for SB 1600, SB 1906, CS for SB 2022, SB 1306, CS for SB 1312, CS for SB 1420, CS for HB 105, CS for HB 647, CS for HB 749, HB 785, CS for HB 1259, CS for HB 1269, HB 2041, CS for CS for SB 146, CS for SB 2000, CS for SB 2224, CS for HB 215, CS for SB 790, CS for SB 2130, CS for CS for SB 1694, CS for CS for SB 402, SB 698, CS for SB 1018, SB 974, SB 978, CS for SB 1844, SB 1856, CS for CS for CS for SB 1858, SB 1872, CS for SB 2082 and CS for HB 1085.

On motions by Senator Jennings, by two-thirds vote the following bills were placed on the Local Bill Calendar for Thursday, April 1: SB 2376, SB 2392, SB 2394, HB 861, HB 867, CS for HB 1007, HB 1067, HB 1791, HB 747, HB 869, HB 991, HB 993, HB 1061, HB 1339, HB 1465 and HB 1929.

On motions by Senator Jennings, by two-thirds vote the following bills were placed on the Claims Bill Calendar for Thursday, April 1: SB 96, CS for HB 279, CS for HB 401 and HB 403.

CORRECTION AND APPROVAL OF JOURNAL

The Journal of March 30 was corrected and approved.

CO-SPONSORS

Senator Bankhead—SB 496; Senator McKay—CS for SB 554; Senator Siegel—CS for SB 1258

RECESS

On motion by Senator Jennings, the Senate recessed at 8:10 p.m. to reconvene at 10:00 a.m., Thursday, April 1.