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CHAMBER ACTION

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4/23/2008 12:19 PM	.	5/1/2008 9:33 PM

Senator Jones moved the following **amendment:**

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 400.462, Florida Statutes, is amended to read:

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

(1) "Administrator" means a direct employee, as defined in subsection (9), who is~~. The administrator must be~~ a licensed physician, physician assistant, or registered nurse licensed to practice in this state or an individual having at least 1 year of supervisory or administrative experience in home health care or in a facility licensed under chapter 395, under part II of this chapter, or under part I of chapter 429. ~~An administrator may manage a maximum of five licensed home health agencies located within one agency service district or within an immediately~~

~~contiguous county. If the home health agency is licensed under this chapter and is part of a retirement community that provides multiple levels of care, an employee of the retirement community may administer the home health agency and up to a maximum of four entities licensed under this chapter or chapter 429 that are owned, operated, or managed by the same corporate entity. An administrator shall designate, in writing, for each licensed entity, a qualified alternate administrator to serve during absences.~~

(2) "Admission" means a decision by the home health agency, during or after an evaluation visit to the patient's home, that there is reasonable expectation that the patient's medical, nursing, and social needs for skilled care can be adequately met by the agency in the patient's place of residence. Admission includes completion of an agreement with the patient or the patient's legal representative to provide home health services as required in s. 400.487(1).

(3) "Advanced registered nurse practitioner" means a person licensed in this state to practice professional nursing and certified in advanced or specialized nursing practice, as defined in s. 464.003.

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

(5) "Certified nursing assistant" means any person who has been issued a certificate under part II of chapter 464. ~~The licensed home health agency or licensed nurse registry shall ensure that the certified nursing assistant employed by or under contract with the home health agency or licensed nurse registry is adequately trained to perform the tasks of a home health aide in the home setting.~~

(6) "Client" means an elderly, handicapped, or convalescent individual who receives companion services or homemaker services in the individual's home or place of residence.

(7) "Companion" or "sitter" means a person who spends time with or 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. A companion may not provide hands-on personal care to a client.

(8) "Department" means the Department of Children and Family Services.

(9) "Direct employee" means an employee for whom one of the following entities pays withholding taxes: a home health agency; a management company that has a contract to manage the home health agency on a day-to-day basis; or an employee leasing company that has a contract with the home health agency to handle the payroll and payroll taxes for the home health agency.

(10) "Director of nursing" means a registered nurse who is a direct employee, as defined in subsection (9), of the agency and who is a graduate of an approved school of nursing and is licensed in this state; who has at least 1 year of supervisory experience as a registered nurse; and who is responsible for overseeing the professional nursing and home health aid delivery of services of the agency. ~~A director of nursing may be the director of a maximum of five licensed home health agencies operated by a related business entity and located within one agency service district or within an immediately contiguous county. If the home health agency is licensed under this chapter and is part of a retirement community that provides multiple levels of care, an employee of the retirement community may serve as the director of nursing of the home health agency and of up to~~

~~four entities licensed under this chapter or chapter 429 which are owned, operated, or managed by the same corporate entity.~~

(11) "Fair market value" means the value in arms length transactions, consistent with the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement.

(12)~~(11)~~ "Home health agency" means an organization that provides home health services and staffing services.

(13)~~(12)~~ "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.

(14)~~(13)~~ "Home health services" means health and medical services and medical supplies furnished by an organization to an individual in the individual's home or place of residence. The term includes organizations that provide one or more of the following:

(a) Nursing care.

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

(c) Home health aide services.

(d) Dietetics and nutrition practice and nutrition counseling.

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

(15)~~(14)~~ "Home health aide" means a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, or assists in administering medications as permitted in rule and for which the person has received training established by the agency under s. 400.497(1). ~~The licensed home health agency or licensed nurse registry shall ensure that the home health aide employed by or under contract with the home health agency or licensed nurse registry is adequately trained to perform the tasks of a home health aide in the home setting.~~

(16)~~(15)~~ "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. A homemaker may not provide hands-on personal care to a client.

(17)~~(16)~~ "Home infusion therapy provider" means an organization that employs, contracts with, or refers a licensed professional who has received advanced training and experience in intravenous infusion therapy and who administers infusion therapy to a patient in the patient's home or place of residence.

(18)~~(17)~~ "Home infusion therapy" means the administration of intravenous pharmacological or nutritional products to a patient in his or her home.

(19) "Immediate family member" means a husband or wife; a birth or adoptive parent, child, or sibling; a stepparent, stepchild, stepbrother, or stepsister; a father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; a grandparent or grandchild; or a spouse of a grandparent or grandchild.

(20) "Medical director" means a physician who is a volunteer with, or who receives remuneration from, a home health agency.

(21)~~(18)~~ "Nurse registry" means any person that procures, offers, promises, or attempts to secure health-care-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to health care facilities licensed under chapter 395, this chapter, or chapter 429 or other business entities.

(22)~~(19)~~ "Organization" means a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline; a health care professional and a home health aide or certified nursing assistant; more than one home health aide; more than one certified nursing assistant; or a home health aide and a certified nursing assistant. The term does not include an entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.

(23)~~(20)~~ "Patient" means any person who receives home health services in his or her home or place of residence.

(24)~~(21)~~ "Personal care" means assistance to a patient in the activities of daily living, such as dressing, bathing, eating, or personal hygiene, and assistance in physical transfer, ambulation, and in administering medications as permitted by rule.

(25)~~(22)~~ "Physician" means a person licensed under chapter 458, chapter 459, chapter 460, or chapter 461.

(26)~~(23)~~ "Physician assistant" means a person who is a graduate of an approved program or its equivalent, or meets standards approved by the boards, and is licensed to perform medical services delegated by the supervising physician, as defined in s. 458.347 or s. 459.022.

(27) "Remuneration" means any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind.

(28)~~(24)~~ "Skilled care" means nursing services or therapeutic services required by law to be delivered by a health care professional who is licensed under part I of chapter 464; part I, part III, or part V of chapter 468; or chapter 486 and who is employed by or under contract with a licensed home health agency or is referred by a licensed nurse registry.

(29)~~(25)~~ "Staffing services" means services provided to a health care facility, school, or other business entity on a temporary or school-year basis pursuant to a written contract by licensed health care personnel and by certified nursing assistants and home health aides who are employed by, or work under the auspices of, a licensed home health agency or who are registered with a licensed nurse registry. ~~Staffing services may be provided anywhere within the state.~~

Section 2. Subsection (3) of section 400.464, Florida Statutes, is amended to read:

400.464 Home Health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.--

(3) A ~~Any~~ home infusion therapy provider must ~~shall~~ be licensed as a home health agency or nurse registry. ~~Any infusion therapy provider currently authorized to receive Medicare~~

~~reimbursement under a DME - Part B Provider number for the provision of infusion therapy shall be licensed as a non certified 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.~~

Section 3. Paragraphs (d), (e), (f), (g), and (h) are added to subsection (2) of section 400.471, Florida Statutes, and subsections (7), (8), and (9), are added to that section, to read:

400.471 Application for license; fee.--

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

(d) A business plan, signed by the applicant, which details the home health agency's methods to obtain patients and its plan to recruit and maintain staff.

(e) Evidence of contingency funding equal to 1 month's average operating expenses during the first year of operation.

(f) A balance sheet, income and expense statement, and statement of cash flows 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 has demonstrated financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses. An applicant may not project an operating margin of 15 percent or greater for any month in the

first year of operation. All documents required under this paragraph must be prepared in accordance with generally accepted accounting principles and compiled and signed by a certified public accountant.

(g) All other ownership interests in health care entities for each controlling interest, as defined in part II of chapter 408.

(h) In the case of an application for initial licensure, documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408. Notwithstanding s. 408.806, an applicant that has applied for accreditation must provide proof of accreditation that is not conditional or provisional within 120 days after the date of the agency's receipt of the application for licensure or the application shall be withdrawn from further consideration. Such accreditation must be maintained by the home health agency to maintain licensure. The agency shall accept, in lieu of its own periodic licensure survey, the submission of the survey of an accrediting organization that is recognized by the agency if the accreditation of the licensed home health agency is not provisional and if the licensed home health agency authorizes releases of, and the agency receives the report of, the accrediting organization.

(7) The agency may not issue an initial license to an applicant for a home health agency license if the applicant shares common controlling interests with another licensed home health agency that is located within 10 miles of the applicant

and is in the same county. The agency must return the application and fees to the applicant.

(8) An application for a home health agency license may not be transferred to another home health agency or controlling interest before issuance of the license.

(9) A licensed home health agency that seeks to relocate to a different geographic service area not listed on its license must submit an initial application for a home health agency license for the new location.

Section 4. Section 400.474, Florida Statutes, is amended to read:

400.474 Administrative penalties.--

(1) The agency may deny, revoke, and suspend a license and impose an administrative fine in the manner provided in chapter 120.

(2) Any of the following actions by a home health agency or its employee is grounds for disciplinary action by the agency:

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

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

(c) Knowingly providing home health services in an unlicensed assisted living facility or unlicensed adult family-care home, unless the home health agency or employee reports the unlicensed facility or home to the agency within 72 hours after providing the services.

(d) Preparing or maintaining fraudulent patient records, such as, but not limited to, charting ahead, recording vital signs or symptoms that were not personally obtained or observed by the home health agency's staff at the time indicated,

borrowing patients or patient records from other home health agencies to pass a survey or inspection, or falsifying signatures.

(e) Failing to provide at least one service directly to a patient for a period of 60 days.

(3) The agency shall impose a fine of $1,000 against a home health agency that demonstrates a pattern of falsifying:

(a) Documents of training for home health aides or certified nursing assistants; or

(b) Health statements for staff providing direct care to patients.

A pattern may be demonstrated by a showing of at least three fraudulent entries or documents. The fine shall be imposed for each fraudulent document or, if multiple staff members are included on one document, for each fraudulent entry on the document.

(4) The agency shall impose a fine of $5,000 against a home health agency that demonstrates a pattern of billing any payor for services not provided. A pattern may be demonstrated by a showing of at least three billings for services not provided within a 12-month period. The fine must be imposed for each incident that is falsely billed. The agency may also:

(a) Require payback of all funds;

(b) Revoke the license; or

(c) Issue a moratorium in accordance with s. 408.814.

(5) The agency shall impose a fine of $5,000 against a home health agency that demonstrates a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan

of care for that patient, unless a reduction in service is mandated by Medicare, Medicaid, or a state program or as provided in s. 400.492(3). A pattern may be demonstrated by a showing of at least three incidences, regardless of the patient or service, where the home health agency did not provide a service specified in a written agreement or plan of care during a 3-month period. The agency shall impose the fine for each occurrence. The agency may also impose additional administrative fines under s. 400.484 for the direct or indirect harm to a patient, or deny, revoke, or suspend the license of the home health agency for a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the plan of care for that patient.

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

(a) Gives remuneration for staffing services to:

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

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

unless the home health agency has activated its comprehensive emergency management plan in accordance with s. 400.492. This paragraph does not apply to a Medicare-certified home health agency that provides fair market value remuneration for staffing services to a non-Medicare-certified home health agency that is part of a continuing care facility licensed under chapter 651 for providing services to its own residents if each resident receiving home health services pursuant to this arrangement

attests in writing that he or she made a decision without influence from staff of the facility to select, from a list of Medicare-certified home health agencies provided by the facility, that Medicare-certified home health agency to provide the services.

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

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

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

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

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

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

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

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

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

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

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

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

1. Be in writing and signed by both parties;

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

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

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

(j) Gives remuneration to:

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

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

3. An immediate family member of the physician,

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

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

(7) ~~(3)~~ (a) In addition to the requirements of s. 408.813, any person, partnership, or corporation that violates s. 408.812 or s. 408.813 and that previously operated a licensed home health agency or concurrently operates both a licensed home health agency and an unlicensed home health agency commits a felony of the third degree punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If any home health agency is found to be operating without a license and that home health agency has received any government reimbursement for services, the agency shall make a fraud referral to the appropriate government reimbursement program.

Section 5. Section 400.476, Florida Statutes, is created to read:

400.476 Staffing requirements; notifications; limitations on staffing services.--

(1) ADMINISTRATOR.--

(a) An administrator may manage only one home health agency, except that an administrator may manage up to five home health agencies if all five home health agencies have identical controlling interests as defined in s. 408.803 and are located within one agency geographic service area or within an

immediately contiguous county. If the home health agency is licensed under this chapter and is part of a retirement community that provides multiple levels of care, an employee of the retirement community may administer the home health agency and up to a maximum of four entities licensed under this chapter or chapter 429 which all have identical controlling interests as defined in s. 408.803. An administrator shall designate, in writing, for each licensed entity, a qualified alternate administrator to serve during the administrator's absence.

(b) An administrator of a home health agency who is a licensed physician, physician assistant, or registered nurse licensed to practice in this state may also be the director of nursing for a home health agency. An administrator may serve as a director of nursing for up to the number of entities authorized in subsection (2) only if there are 10 or fewer full-time equivalent employees and contracted personnel in each home health agency.

(2) DIRECTOR OF NURSING.--

(a) A director of nursing may be the director of nursing for:

1. Up to two licensed home health agencies if the agencies have identical controlling interests as defined in s. 408.803 and are located within one agency geographic service area or within an immediately contiguous county; or

2. Up to five licensed home health agencies if:

a. All of the home health agencies have identical controlling interests as defined in s. 408.803;

b. All of the home health agencies are located within one agency geographic service area or within an immediately contiguous county; and

c. Each home health agency has a registered nurse who meets the qualifications of a director of nursing and who has a written delegation from the director of nursing to serve as the director of nursing for that home health agency when the director of nursing is not present.

If a home health agency licensed under this chapter is part of a retirement community that provides multiple levels of care, an employee of the retirement community may serve as the director of nursing of the home health agency and up to a maximum of four entities, other than home health agencies, licensed under this chapter or chapter 429 which all have identical controlling interests as defined in s. 408.803.

(b) A home health agency that provides skilled nursing care may not operate for more than 30 calendar days without a director of nursing. A home health agency that provides skilled nursing care and the director of nursing of a home health agency must notify the agency within 10 business days after termination of the services of the director of nursing for the home health agency. A home health agency that provides skilled nursing care must notify the agency of the identity and qualifications of the new director of nursing within 10 days after the new director is hired. If a home health agency that provides skilled nursing care operates for more than 30 calendar days without a director of nursing, the home health agency commits a class II deficiency. In addition to the fine for a class II deficiency, the agency may issue a moratorium in accordance with s. 408.814 or revoke the license. The agency shall fine a home health agency that fails to notify the agency as required in this paragraph $1,000 for the first violation and $2,000 for a repeat violation. The agency may

not take administrative action against a home health agency if the director of nursing fails to notify the department upon termination of services as the director of nursing for the home health agency.

(c) A home health agency that is not Medicare or Medicaid certified and does not provide skilled care or provides only physical, occupational, or speech therapy is not required to have a director of nursing and is exempt from paragraph (b).

(3) TRAINING.--A home health agency shall ensure that each certified nursing assistant employed by or under contract with the home health agency and each home health aide employed by or under contract with the home health agency is adequately trained to perform the tasks of a home health aide in the home setting.

(4) STAFFING.--Staffing services may be provided anywhere within the state.

Section 6. Section 400.484, Florida Statutes, is amended to read:

400.484 Right of inspection; deficiencies; fines.--

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

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

(a) A class I deficiency is any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at imminent risk of death, disablement, or permanent injury. Upon finding a class I deficiency, the agency shall ~~may~~ impose an administrative fine in

the amount of $15,000 ~~$5,000~~ for each occurrence and each day that the deficiency exists.

(b) A class II deficiency is any act, omission, or practice that has a direct adverse effect on the health, safety, or security of a patient. Upon finding a class II deficiency, the agency shall ~~may~~ impose an administrative fine in the amount of $5,000 ~~$1,000~~ for each occurrence and each day that the deficiency exists.

(c) A class III deficiency is any act, omission, or practice that has an indirect, adverse effect on the health, safety, or security of a patient. Upon finding an uncorrected or repeated class III deficiency, the agency shall ~~may~~ impose an administrative fine not to exceed $1,000 ~~$500~~ for each occurrence and each day that the uncorrected or repeated deficiency exists.

(d) A class IV deficiency is any act, omission, or practice related to required reports, forms, or documents which does not have the potential of negatively affecting patients. These violations are of a type that the agency determines do not threaten the health, safety, or security of patients. Upon finding an uncorrected or repeated class IV deficiency, the agency shall ~~may~~ impose an administrative fine not to exceed $500 ~~$200~~ for each occurrence and each day that the uncorrected or repeated deficiency exists.

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

Section 7. Subsection (2) of section 400.491, Florida Statutes, is amended to read:

400.491 Clinical records.--

(2) The home health agency must maintain for each client who receives nonskilled care a service provision plan. Such records must be maintained by the home health agency for 3 years ~~1 year~~ following termination of services.

Section 8. Present subsections (5), (6), (7), and (8) of section 400.497, Florida Statutes, are renumbered as subsections (7), (8), (9), and (10), respectively, and a new subsections (5) and (6) are added to that section, to read:

400.497 Rules establishing minimum standards.--The agency shall adopt, publish, and enforce rules to implement part II of chapter 408 and this part, including, as applicable, ss. 400.506 and 400.509, which must provide reasonable and fair minimum standards relating to:

(5) Oversight by the director of nursing. The agency shall develop rules related to:

(a) Standards that address oversight responsibilities by the director of nursing of skilled nursing and personal care services provided by the home health agency's staff;

(b) Requirements for a director of nursing to provide to the agency, upon request, a certified daily report of the home health services provided by a specified direct employee or contracted staff member on behalf of the home health agency. The agency may request a certified daily report only for a period not to exceed 2 years prior to the date of the request; and

(c) A quality assurance program for home health services provided by the home health agency.

(6) Conditions for using a recent unannounced licensure inspection for the inspection required in s. 408.806 related to a licensure application associated with a change in ownership of a licensed home health agency.

Section 9. Paragraph (a) of subsection (6) of section 400.506, Florida Statutes, is amended, present subsections (15) and (16) of that section are renumbered as subsections (16) and (17), respectively, and a new subsection (15) is added to that section, to read:

400.506 Licensure of nurse registries; requirements; penalties.--

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

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

1. Provides services to residents in an assisted living facility for which the nurse registry does not receive fair market value remuneration.

2. Provides staffing to an assisted living facility for which the nurse registry does not receive fair market value remuneration.

3. Fails to provide the agency, upon request, with copies of all contracts with assisted living facilities which were executed within the last 5 years.

4. Gives remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge-planning process of a facility licensed under chapter 395 or this chapter and from whom the nurse registry receives referrals.

5. Gives remuneration to a physician, a member of the physician's office staff, or an immediate family member of the physician, and the nurse registry received a patient referral in the last 12 months from that physician or the physician's office staff.

(b) The agency shall also impose an administrative fine of $15,000 if the nurse registry refers nurses, certified nursing assistants, home health aides, or other staff without charge to a facility licensed under chapter 429 in return for patient referrals from the facility.

(c) The proceeds of all fines collected under this subsection shall be deposited into the Health Care Trust Fund.

Section 10. Subsection (4) is added to section 400.518, Florida Statutes, to read:

400.518 Prohibited referrals to home health agencies.--

(4) The agency shall impose an administrative fine of $15,000 if a home health agency provides nurses, certified nursing assistants, home health aides, or other staff without charge to a facility licensed under chapter 429 in return for

patient referrals from the facility. The proceeds of such fines shall be deposited into the Health Care Trust Fund.

Section 11. Subsections (5) through (27) of section 409.901, Florida Statutes, are redesignated as subsections (6) through (28), respectively, and a new subsection (5) is added to that section to read:

409.901 Definitions; ss. 409.901-409.920.--As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(5) "Change of ownership" means an event in which the provider changes to a different legal entity or in which 45 percent or more of the ownership, voting shares, or controlling interest in a corporation whose shares are not publicly traded on a recognized stock exchange is transferred or assigned, including the final transfer or assignment of multiple transfers or assignments over a 2-year period that cumulatively total 45 percent or more. A change solely in the management company or board of directors is not a change of ownership.

Section 12. Subsections (6) and (9) of section 409.907, Florida Statutes, are amended to read:

409.907 Medicaid provider agreements.--The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, 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.

(6) A Medicaid provider agreement may be revoked, at the option of the agency, 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 60 days' notice before making any change in ownership of the entity named in the provider agreement as the provider.~~

(a) In the event of a change of ownership, the transferor remains liable for all outstanding overpayments, administrative fines, and any other moneys owed to the agency before the effective date of the change of ownership. In addition to the continuing liability of the transferor, the transferee is liable to the agency for all outstanding overpayments identified by the agency on or before the effective date of the change of ownership. For purposes of this subsection, the term "outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of the change of ownership. In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179.

(b) At least 60 days before the anticipated date of the change of ownership, the transferor shall notify the agency of the intended change of ownership and the transferee shall submit to the agency a Medicaid provider enrollment application. If a

change of ownership occurs without compliance with the notice requirements of this subsection, the transferor and transferee shall be jointly and severally liable for all overpayments, administrative fines, and other moneys due to the agency, regardless of whether the agency identified the overpayments, administrative fines, or other moneys before or after the effective date of the change of ownership. The agency may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to the agency. This subsection does not preclude the agency from seeking any other legal or equitable remedies available to the agency for the recovery of moneys owed to the Medicaid program. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with the s. 400.179 if the Medicaid provider enrollment application for change of ownership is submitted before the change of ownership.

(9) Upon receipt of a completed, signed, and dated application, and completion of any necessary background investigation and criminal history record check, the agency must either:

(a) Enroll the applicant as a Medicaid provider upon approval of the provider application. The enrollment effective date shall be the date the agency receives the provider application. With respect to a provider that requires a Medicare certification survey, the enrollment effective date is the date

the certification is awarded. With respect to a provider that completes a change of ownership, the effective date is the date the agency received the application, the date the change of ownership was complete, or the date the applicant became eligible to provide services under Medicaid, whichever date is later. With respect to a provider of emergency medical services transportation or emergency services and care, the effective date is the date the services were rendered. Payment for any claims for services provided to Medicaid recipients between the date of receipt of the application and the date of approval is contingent on applying any and all applicable audits and edits contained in the agency's claims adjudication and payment processing systems; or

(b) Deny the application if the agency finds that it is in the best interest of the Medicaid program to do so. The agency may consider the factors listed in subsection (10), as well as any other factor that could affect the effective and efficient administration of the program, including, but not limited to, the applicant's demonstrated ability to provide services, conduct business, and operate a financially viable concern; the current availability of medical care, services, or supplies to recipients, taking into account geographic location and reasonable travel time; the number of providers of the same type already enrolled in the same geographic area; and the credentials, experience, success, and patient outcomes of the provider for the services that it is making application to provide in the Medicaid program. The agency shall deny the application if the agency finds that a provider; any officer, director, agent, managing employee, or affiliated person; or any partner or shareholder having an ownership interest equal to 5

percent or greater in the provider if the provider is a corporation, partnership, or other business entity, has failed to pay all outstanding fines or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless the provider agrees to a repayment plan that includes withholding Medicaid reimbursement until the amount due is paid in full.

Section 13. Subsection (20) of section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.--

(20) Entities providing health insurance as defined in s. 624.603, health maintenance organizations and prepaid health clinics as defined in chapter 641, and, on behalf of their clients, third-party administrators and pharmacy benefits managers as defined in s. 409.901 (27) ~~s. 409.901(26)~~ 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 of the agency and the Director of the Office of Insurance Regulation of the Financial Services Commission shall enter into a cooperative agreement for requesting and obtaining information necessary to effect the purpose and objective of this section.

1. The agency 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).

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 and the Financial Services Commission 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.

Section 14. Subsection (48) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion

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

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

(48)(a) A provider is not entitled to enrollment in the Medicaid provider network. The agency may implement a Medicaid fee-for-service provider network controls, including, but not limited to, competitive procurement and provider credentialing. If a credentialing process is used, the agency may limit its provider network based upon the following considerations: beneficiary access to care, provider availability, provider quality standards and quality assurance processes, cultural

competency, demographic characteristics of beneficiaries, practice standards, service wait times, provider turnover, provider licensure and accreditation history, program integrity history, peer review, Medicaid policy and billing compliance records, clinical and medical record audit findings, and such other areas that are considered necessary by the agency to ensure the integrity of the program.

(b) The agency shall limit its network of durable medical equipment and medical supply providers. For dates of service after January 1, 2009, the agency shall limit payment for durable medical equipment and supplies to providers that meet all the requirements of this paragraph.

1. Providers must be accredited by a Centers for Medicare and Medicaid Services deemed accreditation organization for suppliers of durable medical equipment, prosthetics, orthotics, and supplies. The provider must maintain accreditation and is subject to unannounced reviews by the accrediting organization.

2. Providers must provide the services or supplies directly to the Medicaid recipient or caregiver at the provider location or recipient's residence or send the supplies directly to the recipient's residence with receipt of mailed delivery. Subcontracting or consignment of the service or supply to a third party is prohibited.

3. Notwithstanding subparagraph 2., a durable medical equipment provider may store nebulizers at a physician's office for the purpose of having the physician's staff issue the equipment if it meets all of the following conditions:

a. The physician must document the medical necessity and need to prevent further deterioration of the patient's

respiratory status by the timely delivery of the nebulizer in the physician's office.

b. The durable medical equipment provider must have written documentation of the competency and training by a Florida-licensed registered respiratory therapist of any durable medical equipment staff who participate in the training of physician office staff for the use of nebulizers, including cleaning, warranty, and special needs of patients.

c. The physician's office must have documented the training and competency of any staff member who initiates the delivery of nebulizers to patients. The durable medical equipment provider must maintain copies of all physician office training.

d. The physician's office must maintain inventory records of stored nebulizers, including documentation of the durable medical equipment provider source.

e. A physician contracted with a Medicaid durable medical equipment provider may not have a financial relationship with that provider or receive any financial gain from the delivery of nebulizers to patients.

4. Providers must have a physical business location and a functional landline business phone. The location must be within the state or not more than 50 miles from the Florida state line. The agency may make exceptions for providers of durable medical equipment or supplies not otherwise available from other enrolled providers located within the state.

5. Physical business locations must be clearly identified as a business that furnishes durable medical equipment or medical supplies by signage that can be read from 20 feet away. The location must be readily accessible to the public during normal, posted business hours and must operate no less than 5 hours per

day and no less than 5 days per week, with the exception of scheduled and posted holidays. The location may not be located within or at the same numbered street address as another enrolled Medicaid durable medical equipment or medical supply provider or as an enrolled Medicaid pharmacy that is also enrolled as a durable medical equipment provider. A licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider is exempt from the provisions in this paragraph.

6. Providers must maintain a stock of durable medical equipment and medical supplies on site that is readily available to meet the needs of the durable medical equipment business location's customers.

7. Providers must provide a surety bond of $50,000 for each provider location, up to a maximum of 5 bonds statewide or an aggregate bond of $250,000 statewide, as identified by Federal Employer Identification Number. Providers who post a statewide or an aggregate bond must identify all of their locations in any Medicaid durable medical equipment and medical supply provider enrollment application or bond renewal. Each provider location's surety bond must be renewed annually and the provider must submit proof of renewal even if the original bond is a continuous bond. A licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider is exempt from the provisions in this paragraph.

8. Providers must obtain a level 2 background screening, as provided under s. 435.04, for each provider employee in direct contact with or providing direct services to recipients of durable medical equipment and medical supplies in their homes. This requirement includes, but is not limited to, repair and

service technicians, fitters, and delivery staff. The provider shall pay for the cost of the background screening.

9. The following providers are exempt from the requirements of subparagraphs 1. and 7.:

a. Durable medical equipment providers owned and operated by a government entity.

b. Durable medical equipment providers that are operating within a pharmacy that is currently enrolled as a Medicaid pharmacy provider.

c. Active, Medicaid-enrolled orthopedic physician groups, primarily owned by physicians, which provide only orthotic and prosthetic devices.

Section 15. The Agency for Health Care Administration shall review the process, procedures, and contractor's performance for the prior authorization of home health agency visits that are in excess of 60 visits over the lifetime of a Medicaid recipient. The agency shall determine whether modifications are necessary in order to reduce Medicaid fraud and abuse related to home health services for a Medicaid recipient which are not medically necessary. If modifications to the prior authorization function are necessary, the agency shall amend the contract to require contractor performance that reduces potential Medicaid fraud and abuse with respect to home health agency visits.

Section 16. The Agency for Health Care Administration shall report to the Legislature by January 1, 2009, on the feasibility and costs of accessing the Medicare system to disallow Medicaid payment for home health services that are paid for under the Medicare prospective payment system for recipients who are dually eligible for Medicaid and Medicare.

Section 17. This act shall take effect July 1, 2008.

1001
1002 ========== T I T L E A M E N D M E N T ==========
1003 And the title is amended as follows:
1004 Delete everything before the enacting clause
1005 and insert:
1006 A bill to be entitled
1007 An act relating to health care fraud and abuse; amending
1008 s. 400.462, F.S.; revising and adding definitions;
1009 amending s. 400.464, F.S.; authorizing a home infusion
1010 therapy provider to be licensed as a nurse registry;
1011 deleting provisions related to Medicare reimbursement;
1012 amending s. 400.471, F.S.; requiring an applicant for a
1013 home health agency license to submit to the Agency for
1014 Health Care Administration a business plan and evidence of
1015 contingency funding, and disclose other controlling
1016 ownership interests in health care entities; requiring
1017 certain standards in documentation demonstrating financial
1018 ability to operate; requiring home health agencies to
1019 maintain certain accreditation to maintain licensure;
1020 permitting certain accrediting organizations to submit
1021 surveys regarding licensure of home health agencies;
1022 prohibiting the agency from issuing an initial license to
1023 an applicant for a home health agency license which is
1024 located within a certain distance of a licensed home
1025 health agency that has common controlling interests;
1026 prohibiting the transfer of an application to another home
1027 health agency before issuance of the license; requiring
1028 submission of an initial application to relocate a
1029 licensed home health agency to another geographic service
1030 area; amending s. 400.474, F.S.; providing additional

grounds under which the Agency for Health Care Administration may take disciplinary action against a home health agency; creating s. 400.476, F.S.; establishing staffing requirements for home health agencies; reducing the number of home health agencies that an administrator or director of nursing may serve; requiring that an alternate administrator be designated in writing; limiting the period that a home health agency that provides skilled nursing care may operate without a director of nursing; requiring notification upon the termination and replacement of a director of nursing; requiring the Agency for Health Care Administration to take administrative enforcement action against a home health agency for noncompliance with the notification and staffing requirements for a director of nursing; providing for fines; exempting a home health agency that is not Medicare or Medicaid certified and does not provide skilled care or provides only physical, occupational, or speech therapy from requirements related to a director of nursing; providing training requirements for certified nursing assistants and home health aides; amending s. 400.484, F.S.; requiring the agency to impose administrative fines for certain deficiencies; increasing the administrative fines imposed for certain deficiencies; amending s. 400.491, F.S.; extending the period that a home health agency must retain records of the nonskilled care it provides; amending s. 400.497, F.S.; requiring that the Agency for Health Care Administration adopt rules related to standards for the director of nursing of a home health agency, requirements for a director of nursing to

submit certified staff activity logs pursuant to an agency request, quality assurance programs, and inspections related to an application for a change in ownership; amending s. 400.506, F.S.; providing training requirements for certified nursing assistants and home health aides referred for contract by a nurse registry; providing for the denial, suspension, or revocation of nurse registry license and fines for paying remuneration to certain entities in exchange for patient referrals or refusing fair remuneration in exchange for patient referrals; amending s. 400.518, F.S.; providing for a fine to be imposed against a home health agency that provides complimentary staffing to an assisted care community in exchange for patient referrals; amending s, 409.901, F.S.; defining the term "change of ownership"; amending s. 409.907, F.S.; revising provisions relating to change of ownership of Medicaid provider agreements; providing for continuing financial liability of a transferor under certain circumstances; defining the term "outstanding overpayment"; requiring the transferor to provide notice of change of ownership to the agency within a specified time period; requiring the transferee to submit a Medicaid provider enrollment application to the agency; providing for joint and several liability under certain circumstances; requiring a written payment plan for certain outstanding financial obligations; providing conditions under which additional enrollment effective dates apply; amending s. 409.910, F.S.; conforming a cross-reference; amending s. 409.912, F.S.; requiring the agency to limit its network of Medicaid durable medical

equipment and medical supply providers; prohibiting reimbursement for dates of service after a certain date; requiring accreditation; requiring direct provision of services or supplies; authorizing a provider to store nebulizers at a physician's office under certain circumstances; imposing certain physical location requirements; requiring a provider to maintain a certain stock of equipment and supplies; requiring a surety bond; requiring background screenings of employees; providing for certain exemptions; requiring the Agency for Health Care Administration to review the process for prior authorization of home health agency visits and determine whether modifications to the process are necessary; requiring the agency to report to the Legislature on the feasibility of accessing the Medicare system to determine recipient eligibility for home health services; providing an effective date.