By Senator Bean

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1 A bill to be entitled
2 An act relating to the Agency for Health Care
3 Administration; amending s. 383.327, F.S.; requiring
4 birth centers to report certain deaths and stillbirths
5 to the agency; removing a requirement that a certain
6 report be submitted annually to the agency;
7 authorizing the agency to prescribe by rule the
8 frequency at which such report is submitted; amending
9 s. 395.003, F.S.; removing a requirement that
10 specified information be listed on licenses for
11 certain facilities; repealing s. 395.7015, F.S.,
12 relating to an annual assessment on health care
13 entities; amending s. 395.7016, F.S.; conforming a
14 provision to changes made by the act; amending s.
15 400.19, F.S.; revising provisions requiring the agency
16 to conduct licensure inspections of nursing homes;
17 requiring the agency to conduct additional licensure
18 surveys under certain circumstances; requiring the
19 agency to assess a specified fine for such surveys;
20 amending s. 400.462, F.S.; revising definitions;
21 amending s. 400.464, F.S.; revising licensure
22 requirements for home health agencies; amending s.
23 400.471, F.S.; revising provisions related to certain
24 application requirements for home health agencies;
25 amending s. 400.492, F.S.; revising provisions related
26 to services provided by home health agencies during an
27 emergency; amending s. 400.506, F.S.; revising
28 provisions related to licensure requirements for nurse
29 registries; amending s. 400.509, F.S.; revising

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30 provisions related to the registration of certain
31 service providers; amending s. 400.605, F.S.; removing
32 a requirement that the agency conduct specified
33 inspections of certain licensees; amending s.
34 400.60501, F.S.; deleting an obsolete date; removing a
35 requirement that the agency develop a specified annual
36 report; amending s. 400.9905, F.S.; revising the
37 definition of the term “clinic”; amending s. 400.991,
38 F.S.; removing the option for health care clinics to
39 file a surety bond under certain circumstances;
40 amending s. 400.9935, F.S.; removing a requirement
41 that certain directors conduct specified reviews;
42 requiring certain clinics to publish and post a
43 schedule of charges; amending s. 408.033, F.S.;
44 conforming a provision to changes made by the act;
45 amending s. 408.061, F.S.; revising provisions
46 requiring health care facilities to submit specified
47 data to the agency; amending s. 408.0611, F.S.;
48 removing the requirement that the agency annually
49 report to the Governor and the Legislature by a
50 specified date on the progress of implementation of
51 electronic prescribing; amending s. 408.062, F.S.;
52 removing requirements that the agency annually report
53 specified information to the Governor and Legislature
54 by a specified date and, instead, requiring the agency
55 to annually publish such information on its website;
56 amending s. 408.063, F.S.; removing a requirement that
57 the agency publish certain annual reports; amending s.
58 408.803, F.S.; conforming a definition to changes made

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59 by the act; defining the term "low-risk provider";
60 amending ss. 408.802, 408.820, 408.831, and 408.832,
61 F.S.; conforming provisions to changes made by the
62 act; amending s. 408.806, F.S.; exempting certain
63 providers from a specified inspection; amending s.
64 408.808, F.S.; authorizing the issuance of a
65 provisional license to certain applicants; amending
66 ss. 408.809 and 409.907, F.S.; revising background
67 screening requirements for certain licensees and
68 providers; amending s. 408.811, F.S.; authorizing the
69 agency to grant certain providers an exemption from a
70 specified inspection under certain circumstances;
71 authorizing the agency to adopt rules to grant waivers
72 of certain inspections and extended inspection periods
73 under certain circumstances; amending s. 408.821,
74 F.S.; revising provisions requiring licensees to have
75 a specified plan; providing requirements for the
76 submission of such plan; amending s. 408.909, F.S.;
77 removing a requirement that the agency and Office of
78 Insurance Regulation evaluate a specified program;
79 amending s. 408.9091, F.S.; requiring the agency and
80 office to each, instead of jointly, submit a specified
81 annual report to the Governor and Legislature;
82 amending s. 409.905, F.S.; deleting the requirement
83 that the agency discontinue its hospital retrospective
84 review program under certain circumstances; amending
85 s. 409.913, F.S.; revising the due date for a certain
86 annual report; deleting the requirement that certain
87 agencies submit their annual reports jointly; amending

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88 s. 429.11, F.S.; removing an authorization for the
89 issuance of a provisional license to certain
90 facilities; amending s. 429.19, F.S.; removing
91 requirements that the agency develop and disseminate a
92 specified list and the Department of Children and
93 Families disseminate such list to certain providers;
94 amending ss. 429.35, 429.905, and 429.929, F.S.;
95 revising provisions requiring a biennial inspection
96 cycle for specified facilities and centers,
97 respectively; repealing part I of ch. 483, F.S.,
98 relating to the Florida Multiphasic Health Testing
99 Center Law; redesignating parts II and III of ch. 483,
100 F.S., as parts I and II, respectively; amending ss.
101 20.43, 381.0034, 456.001, 456.057, 456.076, and
102 456.47, F.S.; conforming cross-references; providing
103 an effective date.
104
105 Be It Enacted by the Legislature of the State of Florida:
106
107 Section 1. Subsections (2) and (4) of section 383.327,
108 Florida Statutes, are amended to read:
109 383.327 Birth and death records; reports.—
110 (2) Each maternal death, newborn death, and stillbirth
111 shall be reported immediately to the medical examiner and the
112 agency.
113 (4) A report shall be submitted ~~annually~~ to the agency. The
114 contents of the report and the frequency with which it is
115 submitted shall be prescribed by rule of the agency.
116 Section 2. Subsection (4) of section 395.003, Florida

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117 Statutes, is amended to read:
118 395.003 Licensure; denial, suspension, and revocation.—
119 (4) The agency shall issue a license that ~~which~~ specifies
120 the service categories and the number of hospital beds in each
121 bed category for which a license is received. Such information
122 shall be listed on the face of the license. ~~All beds which are~~
123 ~~not covered by any specialty-bed-need methodology shall be~~
124 ~~specified as general beds.~~ A licensed facility shall not operate
125 a number of hospital beds greater than the number indicated by
126 the agency on the face of the license without approval from the
127 agency under conditions established by rule.
128 Section 3. Section 395.7015, Florida Statutes, is repealed.
129 Section 4. Section 395.7016, Florida Statutes, is amended
130 to read:
131 395.7016 Annual appropriation.—The Legislature shall
132 appropriate each fiscal year from either the General Revenue
133 Fund or the Agency for Health Care Administration Tobacco
134 Settlement Trust Fund an amount sufficient to replace the funds
135 lost due to ~~reduction by chapter 2000-256, Laws of Florida, of~~
136 ~~the assessment on other health care entities under s. 395.7015,~~
137 ~~and~~ the reduction by chapter 2000-256, Laws of Florida, in the
138 assessment on hospitals under s. 395.701~~,~~ and to maintain
139 federal approval of the reduced amount of funds deposited into
140 the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as
141 state match for the state's Medicaid program.
142 Section 5. Subsection (3) of section 400.19, Florida
143 Statutes, is amended to read:
144 400.19 Right of entry and inspection.—
145 (3) The agency shall conduct periodic, ~~every 15 months~~

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146 ~~conduct at least one~~ unannounced licensure inspections
147 ~~inspection~~ to determine compliance by the licensee with
148 statutes, and with rules adopted ~~promulgated~~ under ~~the~~
149 ~~provisions of~~ those statutes, governing minimum standards of
150 construction, quality and adequacy of care, and rights of
151 residents. ~~The survey shall be conducted every 6 months for the~~
152 ~~next 2-year period~~ If the facility has been cited for a class I
153 deficiency or~~,~~ has been cited for two or more class II
154 deficiencies ~~arising from separate surveys or investigations~~
155 within a 60-day period, the agency shall conduct an additional
156 licensure survey ~~or has had three or more substantiated~~
157 ~~complaints within a 6-month period, each resulting in at least~~
158 ~~one class I or class II deficiency~~. In addition to any other
159 fees or fines in this part, the agency shall assess a fine for
160 each facility that is subject to the additional licensure survey
161 ~~6-month survey cycle~~. The fine for the additional licensure
162 survey is $3,000 ~~2-year period shall be $6,000, one-half to be~~
163 ~~paid at the completion of each survey~~. The agency may adjust
164 such ~~this~~ fine by the change in the Consumer Price Index, based
165 on the 12 months immediately preceding the increase, to cover
166 the cost of the additional surveys. The agency shall verify
167 through subsequent inspection that any deficiency identified
168 during inspection is corrected. However, the agency may verify
169 the correction of a class III or class IV deficiency unrelated
170 to resident rights or resident care without reinspecting the
171 facility if adequate written documentation has been received
172 from the facility, which provides assurance that the deficiency
173 has been corrected. The giving or causing to be given of advance
174 notice of such unannounced inspections by an employee of the

175 agency to any unauthorized person shall constitute cause for
176 suspension of not fewer than 5 working days according to ~~the~~
177 ~~provisions of~~ chapter 110.
178 Section 6. Subsections (12), (14), (17), (21), and (22) of
179 section 400.462, Florida Statutes, are amended to read:
180 400.462 Definitions.—As used in this part, the term:
181 (12) "Home health agency" means a person or an entity ~~an~~
182 ~~organization~~ that provides one or more home health services ~~and~~
183 ~~staffing services~~.
184 (14) "Home health services" means health and medical
185 services and medical supplies furnished ~~by an organization~~ to an
186 individual in the individual's home or place of residence. The
187 term includes ~~organizations that provide one or more of~~ the
188 following:
189 (a) Nursing care.
190 (b) Physical, occupational, respiratory, or speech therapy.
191 (c) Home health aide services.
192 (d) Dietetics and nutrition practice and nutrition
193 counseling.
194 (e) Medical supplies, restricted to drugs and biologicals
195 prescribed by a physician.
196 (17) "Home infusion therapy provider" means a person or an
197 entity ~~an organization~~ that employs, contracts with, or refers a
198 licensed professional who has received advanced training and
199 experience in intravenous infusion therapy and who administers
200 infusion therapy to a patient in the patient's home or place of
201 residence.
202 (21) "Nurse registry" means any person or entity that
203 procures, offers, promises, or attempts to secure health-care-

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204 related contracts for registered nurses, licensed practical
205 nurses, certified nursing assistants, home health aides,
206 companions, or homemakers, who are compensated by fees as
207 independent contractors, including, but not limited to,
208 contracts for the provision of services to patients and
209 contracts to provide private duty or staffing services to health
210 care facilities licensed under chapter 395, this chapter, or
211 chapter 429 or other business entities.
212 ~~(22) "Organization" means a corporation, government or~~
213 ~~governmental subdivision or agency, partnership or association,~~
214 ~~or any other legal or commercial entity, any of which involve~~
215 ~~more than one health care professional discipline; a health care~~
216 ~~professional and a home health aide or certified nursing~~
217 ~~assistant; more than one home health aide; more than one~~
218 ~~certified nursing assistant; or a home health aide and a~~
219 ~~certified nursing assistant. The term does not include an entity~~
220 ~~that provides services using only volunteers or only individuals~~
221 ~~related by blood or marriage to the patient or client.~~
222 Section 7. Subsections (1), (4), and (5) of section
223 400.464, Florida Statutes, are amended to read:
224 400.464 Home health agencies to be licensed; expiration of
225 license; exemptions; unlawful acts; penalties.—
226 (1) The requirements of part II of chapter 408 apply to the
227 provision of services that require licensure pursuant to this
228 part and part II of chapter 408 and entities licensed or
229 registered by or applying for such licensure or registration
230 from the Agency for Health Care Administration pursuant to this
231 part. A license issued by the agency is required in order to
232 operate a home health agency in this state. A license issued on

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233 or after July 1, 2018, must specify the home health services the
234 licensee ~~organization~~ is authorized to perform and indicate
235 whether such specified services are considered skilled care. The
236 provision or advertising of services that require licensure
237 pursuant to this part without such services being specified on
238 the face of the license issued on or after July 1, 2018,
239 constitutes unlicensed activity as prohibited under s. 408.812.
240 (4)(a) A licensee ~~An organization~~ that offers or advertises
241 to the public any service for which licensure or registration is
242 required under this part must include in the advertisement the
243 license number or registration number issued to the licensee
244 ~~organization~~ by the agency. The agency shall assess a fine of
245 not less than $100 to any licensee or registrant who fails to
246 include the license or registration number when submitting the
247 advertisement for publication, broadcast, or printing. The fine
248 for a second or subsequent offense is $500. The holder of a
249 license issued under this part may not advertise or indicate to
250 the public that it holds a home health agency or nurse registry
251 license other than the one it has been issued.
252 (b) The operation or maintenance of an unlicensed home
253 health agency or the performance of any home health services in
254 violation of this part is declared a nuisance, inimical to the
255 public health, welfare, and safety. The agency or any state
256 attorney may, in addition to other remedies provided in this
257 part, bring an action for an injunction to restrain such
258 violation, or to enjoin the future operation or maintenance of
259 the home health agency or the provision of home health services
260 in violation of this part or part II of chapter 408, until
261 compliance with this part or the rules adopted under this part

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262 has been demonstrated to the satisfaction of the agency.
263 (c) A person or entity that ~~who~~ violates paragraph (a) is
264 subject to an injunctive proceeding under s. 408.816. A
265 violation of paragraph (a) or s. 408.812 is a deceptive and
266 unfair trade practice and constitutes a violation of the Florida
267 Deceptive and Unfair Trade Practices Act under part II of
268 chapter 501.
269 (d) A person or entity that ~~who~~ violates ~~the provisions of~~
270 paragraph (a) commits a misdemeanor of the second degree,
271 punishable as provided in s. 775.082 or s. 775.083. Any person
272 or entity that ~~who~~ commits a second or subsequent violation
273 commits a misdemeanor of the first degree, punishable as
274 provided in s. 775.082 or s. 775.083. Each day of continuing
275 violation constitutes a separate offense.
276 (e) Any person or entity that ~~who~~ owns, operates, or
277 maintains an unlicensed home health agency and who, after
278 receiving notification from the agency, fails to cease operation
279 and apply for a license under this part commits a misdemeanor of
280 the second degree, punishable as provided in s. 775.082 or s.
281 775.083. Each day of continued operation is a separate offense.
282 (f) Any home health agency that fails to cease operation
283 after agency notification may be fined in accordance with s.
284 408.812.
285 (5) The following are exempt from ~~the~~ licensure as a home
286 health agency under ~~requirements of~~ this part:
287 (a) A home health agency operated by the Federal
288 Government.
289 (b) Home health services provided by a state agency, either
290 directly or through a contractor with:

291 1. The Department of Elderly Affairs.
292 2. The Department of Health, a community health center, or
293 a rural health network that furnishes home visits for the
294 purpose of providing environmental assessments, case management,
295 health education, personal care services, family planning, or
296 followup treatment, or for the purpose of monitoring and
297 tracking disease.
298 3. Services provided to persons with developmental
299 disabilities, as defined in s. 393.063.
300 4. Companion and sitter organizations that were registered
301 under s. 400.509(1) on January 1, 1999, and were authorized to
302 provide personal services under a developmental services
303 provider certificate on January 1, 1999, may continue to provide
304 such services to past, present, and future clients of the
305 organization who need such services, notwithstanding the
306 provisions of this act.
307 5. The Department of Children and Families.
308 (c) A health care professional, whether or not
309 incorporated, who is licensed under chapter 457; chapter 458;
310 chapter 459; part I of chapter 464; chapter 467; part I, part
311 III, part V, or part X of chapter 468; chapter 480; chapter 486;
312 chapter 490; or chapter 491; and who is acting alone within the
313 scope of his or her professional license to provide care to
314 patients in their homes.
315 (d) A home health aide or certified nursing assistant who
316 is acting in his or her individual capacity, within the
317 definitions and standards of his or her occupation, and who
318 provides hands-on care to patients in their homes.
319 (e) An individual who acts alone, in his or her individual

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320 capacity, and who is not employed by or affiliated with a
321 licensed home health agency or registered with a licensed nurse
322 registry. This exemption does not entitle an individual to
323 perform home health services without the required professional
324 license.
325 (f) The delivery of instructional services in home dialysis
326 and home dialysis supplies and equipment.
327 (g) The delivery of nursing home services for which the
328 nursing home is licensed under part II of this chapter, to serve
329 its residents in its facility.
330 (h) The delivery of assisted living facility services for
331 which the assisted living facility is licensed under part I of
332 chapter 429, to serve its residents in its facility.
333 (i) The delivery of hospice services for which the hospice
334 is licensed under part IV of this chapter, to serve hospice
335 patients admitted to its service.
336 (j) A hospital that provides services for which it is
337 licensed under chapter 395.
338 (k) The delivery of community residential services for
339 which the community residential home is licensed under chapter
340 419, to serve the residents in its facility.
341 (l) A not-for-profit, community-based agency that provides
342 early intervention services to infants and toddlers.
343 (m) Certified rehabilitation agencies and comprehensive
344 outpatient rehabilitation facilities that are certified under
345 Title 18 of the Social Security Act.
346 (n) The delivery of adult family-care home services for
347 which the adult family-care home is licensed under part II of
348 chapter 429, to serve the residents in its facility.

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349 (o) A person or entity that provides skilled care by health
350 care professionals licensed solely under part I of chapter 464;
351 part I, part III, or part V of chapter 468; or chapter 486.
352 (p) A person or entity that provides services using only
353 volunteers or only individuals related by blood or marriage to
354 the patient or client.
355 Section 8. Paragraph (g) of subsection (2) of section
356 400.471, Florida Statutes, is amended to read:
357 400.471 Application for license; fee.—
358 (2) In addition to the requirements of part II of chapter
359 408, the initial applicant, the applicant for a change of
360 ownership, and the applicant for the addition of skilled care
361 services must file with the application satisfactory proof that
362 the home health agency is in compliance with this part and
363 applicable rules, including:
364 (g) In the case of an application for initial licensure, an
365 application for a change of ownership, or an application for the
366 addition of skilled care services, documentation of
367 accreditation, or an application for accreditation, from an
368 accrediting organization that is recognized by the agency as
369 having standards comparable to those required by this part and
370 part II of chapter 408. A home health agency that does not
371 provide skilled care is exempt from this paragraph.
372 Notwithstanding s. 408.806, the ~~an initial~~ applicant must
373 provide proof of accreditation that is not conditional or
374 provisional and a survey demonstrating compliance with the
375 requirements of this part, part II of chapter 408, and
376 applicable rules from an accrediting organization that is
377 recognized by the agency as having standards comparable to those

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378 required by this part and part II of chapter 408 within 120 days
379 after the date of the agency's receipt of the application for
380 licensure. Such accreditation must be continuously maintained by
381 the home health agency to maintain licensure. The agency shall
382 accept, in lieu of its own periodic licensure survey, the
383 submission of the survey of an accrediting organization that is
384 recognized by the agency if the accreditation of the licensed
385 home health agency is not provisional and if the licensed home
386 health agency authorizes release of, and the agency receives the
387 report of, the accrediting organization.
388 Section 9. Section 400.492, Florida Statutes, is amended to
389 read:
390 400.492 Provision of services during an emergency.—Each
391 home health agency shall prepare and maintain a comprehensive
392 emergency management plan that is consistent with the standards
393 adopted by national or state accreditation organizations and
394 consistent with the local special needs plan. The plan shall be
395 updated annually and shall provide for continuing home health
396 services during an emergency that interrupts patient care or
397 services in the patient's home. The plan shall include the means
398 by which the home health agency will continue to provide staff
399 to perform the same type and quantity of services to their
400 patients who evacuate to special needs shelters that were being
401 provided to those patients prior to evacuation. The plan shall
402 describe how the home health agency establishes and maintains an
403 effective response to emergencies and disasters, including:
404 notifying staff when emergency response measures are initiated;
405 providing for communication between staff members, county health
406 departments, and local emergency management agencies, including

407 a backup system; identifying resources necessary to continue
408 essential care or services or referrals to other health care
409 providers ~~organizations~~ subject to written agreement; and
410 prioritizing and contacting patients who need continued care or
411 services.
412 (1) Each patient record for patients who are listed in the
413 registry established pursuant to s. 252.355 shall include a
414 description of how care or services will be continued in the
415 event of an emergency or disaster. The home health agency shall
416 discuss the emergency provisions with the patient and the
417 patient's caregivers, including where and how the patient is to
418 evacuate, procedures for notifying the home health agency in the
419 event that the patient evacuates to a location other than the
420 shelter identified in the patient record, and a list of
421 medications and equipment which must either accompany the
422 patient or will be needed by the patient in the event of an
423 evacuation.
424 (2) Each home health agency shall maintain a current
425 prioritized list of patients who need continued services during
426 an emergency. The list shall indicate how services shall be
427 continued in the event of an emergency or disaster for each
428 patient and if the patient is to be transported to a special
429 needs shelter, and shall indicate if the patient is receiving
430 skilled nursing services and the patient's medication and
431 equipment needs. The list shall be furnished to county health
432 departments and to local emergency management agencies, upon
433 request.
434 (3) Home health agencies shall not be required to continue
435 to provide care to patients in emergency situations that are

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436 beyond their control and that make it impossible to provide
437 services, such as when roads are impassable or when patients do
438 not go to the location specified in their patient records. Home
439 health agencies may establish links to local emergency
440 operations centers to determine a mechanism by which to approach
441 specific areas within a disaster area in order for the agency to
442 reach its clients. Home health agencies shall demonstrate a good
443 faith effort to comply with the requirements of this subsection
444 by documenting attempts of staff to follow procedures outlined
445 in the home health agency's comprehensive emergency management
446 plan, and by the patient's record, which support a finding that
447 the provision of continuing care has been attempted for those
448 patients who have been identified as needing care by the home
449 health agency and registered under s. 252.355, in the event of
450 an emergency or disaster under subsection (1).
451 (4) Notwithstanding the provisions of s. 400.464(2) or any
452 other provision of law to the contrary, a home health agency may
453 provide services in a special needs shelter located in any
454 county.
455 Section 10. Subsection (4) and paragraph (a) of subsection
456 (5) of section 400.506, Florida Statutes, are amended to read:
457 400.506 Licensure of nurse registries; requirements;
458 penalties.—
459 (4) A licensee who ~~person that~~ provides, offers, or
460 advertises to the public any service for which licensure is
461 required under this section must include in such advertisement
462 the license number issued to the licensee ~~it~~ by the Agency for
463 Health Care Administration. The agency shall assess a fine of
464 not less than $100 against any licensee who fails to include the

465 license number when submitting the advertisement for
466 publication, broadcast, or printing. The fine for a second or
467 subsequent offense is $500.
468 (5)(a) In addition to the requirements of s. 408.812, any
469 person or entity that ~~who~~ owns, operates, or maintains an
470 unlicensed nurse registry and who, after receiving notification
471 from the agency, fails to cease operation and apply for a
472 license under this part commits a misdemeanor of the second
473 degree, punishable as provided in s. 775.082 or s. 775.083. Each
474 day of continued operation is a separate offense.
475 Section 11. Subsections (1), (2), (4), and (5) of section
476 400.509, Florida Statutes, are amended to read:
477 400.509 Registration of particular service providers exempt
478 from licensure; certificate of registration; regulation of
479 registrants.—
480 (1) Any person or entity ~~organization~~ that provides
481 companion services or homemaker services and does not provide a
482 home health service to a person is exempt from licensure under
483 this part. However, any person or entity ~~organization~~ that
484 provides companion services or homemaker services must register
485 with the agency. A person or an entity ~~An organization~~ under
486 contract with the Agency for Persons with Disabilities which
487 provides companion services only for persons with a
488 developmental disability, as defined in s. 393.063, is exempt
489 from registration.
490 (2) The requirements of part II of chapter 408 apply to the
491 provision of services that require registration or licensure
492 pursuant to this section and part II of chapter 408 and entities
493 registered by or applying for such registration from the Agency

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494 for Health Care Administration pursuant to this section. Each
495 applicant for registration and each registrant must comply with
496 all provisions of part II of chapter 408. Registration or a
497 license issued by the agency is required for <u>a person or an</u>
498 <u>entity to provide</u> ~~the operation of an organization that provides~~
499 companion services or homemaker services.
500 (4) Each registrant must obtain the employment or contract
501 history of persons who are employed by or under contract with
502 the <u>person or entity</u> ~~organization~~ and who will have contact at
503 any time with patients or clients in their homes by:
504 (a) Requiring such persons to submit an employment or
505 contractual history to the registrant; and
506 (b) Verifying the employment or contractual history, unless
507 through diligent efforts such verification is not possible. The
508 agency shall prescribe by rule the minimum requirements for
509 establishing that diligent efforts have been made.
510
511 There is no monetary liability on the part of, and no cause of
512 action for damages arises against, a former employer of a
513 prospective employee of or prospective independent contractor
514 with a registrant who reasonably and in good faith communicates
515 his or her honest opinions about the former employee's or
516 contractor's job performance. This subsection does not affect
517 the official immunity of an officer or employee of a public
518 corporation.
519 (5) A person <u>or an entity</u> that offers or advertises to the
520 public a service for which registration is required must include
521 in its advertisement the registration number issued by the
522 Agency for Health Care Administration.

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523 Section 12. Subsection (3) of section 400.605, Florida
524 Statutes, is amended to read:
525 400.605 Administration; forms; fees; rules; inspections;
526 fines.—
527 (3) In accordance with s. 408.811, the agency shall conduct
528 ~~annual inspections of all licensees, except that licensure~~
529 ~~inspections may be conducted biennially for hospices having a 3-~~
530 ~~year record of substantial compliance. The agency shall conduct~~
531 such inspections and investigations as are necessary in order to
532 determine the state of compliance with ~~the provisions of~~ this
533 part, part II of chapter 408, and applicable rules.
534 Section 13. Section 400.60501, Florida Statutes, is amended
535 to read:
536 400.60501 Outcome measures; adoption of federal quality
537 measures; public reporting~~; annual report~~.—
538 (1) ~~No later than December 31, 2019,~~ The agency shall adopt
539 the national hospice outcome measures and survey data in 42
540 C.F.R. part 418 to determine the quality and effectiveness of
541 hospice care for hospices licensed in the state.
542 (2) The agency shall~~:~~
543 ~~(a)~~ make available to the public the national hospice
544 outcome measures and survey data in a format that is
545 comprehensible by a layperson and that allows a consumer to
546 compare such measures of one or more hospices.
547 ~~(b) Develop an annual report that analyzes and evaluates~~
548 ~~the information collected under this act and any other data~~
549 ~~collection or reporting provisions of law.~~
550 Section 14. Subsection (4) of section 400.9905, Florida
551 Statutes, is amended to read:

552 400.9905 Definitions.—
553 (4) "Clinic" means an entity where health care services are
554 provided to individuals and which tenders charges for
555 reimbursement for such services, including a mobile clinic and a
556 portable equipment provider. As used in this part, the term does
557 not include and the licensure requirements of this part do not
558 apply to:
559 (a) Entities licensed or registered by the state under
560 chapter 395; entities licensed or registered by the state and
561 providing only health care services within the scope of services
562 authorized under their respective licenses under ss. 383.30-
563 383.332, chapter 390, chapter 394, chapter 397, this chapter
564 except part X, chapter 429, chapter 463, chapter 465, chapter
565 466, chapter 478, chapter 484, or chapter 651; end-stage renal
566 disease providers authorized under 42 C.F.R. part 405, subpart
567 U; providers certified and providing only health care services
568 within the scope of services authorized under their respective
569 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
570 H, or subpart J; providers certified and providing only health
571 care services within the scope of services authorized under
572 their respective certifications under 42 C.F.R. part 486,
573 subpart C; providers certified and providing only health care
574 services within the scope of services authorized under their
575 respective certifications under 42 C.F.R. part 491, subpart A;
576 providers certified by the Centers for Medicare and Medicaid
577 services under the federal Clinical Laboratory Improvement
578 Amendments and the federal rules adopted thereunder; or any
579 entity that provides neonatal or pediatric hospital-based health
580 care services or other health care services by licensed

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581 practitioners solely within a hospital licensed under chapter
582 395.
583 (b) Entities that own, directly or indirectly, entities
584 licensed or registered by the state pursuant to chapter 395;
585 entities that own, directly or indirectly, entities licensed or
586 registered by the state and providing only health care services
587 within the scope of services authorized pursuant to their
588 respective licenses under ss. 383.30-383.332, chapter 390,
589 chapter 394, chapter 397, this chapter except part X, chapter
590 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter
591 484, or chapter 651; end-stage renal disease providers
592 authorized under 42 C.F.R. part 405, subpart U; providers
593 certified and providing only health care services within the
594 scope of services authorized under their respective
595 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
596 H, or subpart J; providers certified and providing only health
597 care services within the scope of services authorized under
598 their respective certifications under 42 C.F.R. part 486,
599 subpart C; providers certified and providing only health care
600 services within the scope of services authorized under their
601 respective certifications under 42 C.F.R. part 491, subpart A;
602 providers certified by the Centers for Medicare and Medicaid
603 services under the federal Clinical Laboratory Improvement
604 Amendments and the federal rules adopted thereunder; or any
605 entity that provides neonatal or pediatric hospital-based health
606 care services by licensed practitioners solely within a hospital
607 licensed under chapter 395.
608 (c) Entities that are owned, directly or indirectly, by an
609 entity licensed or registered by the state pursuant to chapter

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610 395; entities that are owned, directly or indirectly, by an
611 entity licensed or registered by the state and providing only
612 health care services within the scope of services authorized
613 pursuant to their respective licenses under ss. 383.30-383.332,
614 chapter 390, chapter 394, chapter 397, this chapter except part
615 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter
616 478, chapter 484, or chapter 651; end-stage renal disease
617 providers authorized under 42 C.F.R. part 405, subpart U;
618 providers certified and providing only health care services
619 within the scope of services authorized under their respective
620 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
621 H, or subpart J; providers certified and providing only health
622 care services within the scope of services authorized under
623 their respective certifications under 42 C.F.R. part 486,
624 subpart C; providers certified and providing only health care
625 services within the scope of services authorized under their
626 respective certifications under 42 C.F.R. part 491, subpart A;
627 providers certified by the Centers for Medicare and Medicaid
628 services under the federal Clinical Laboratory Improvement
629 Amendments and the federal rules adopted thereunder; or any
630 entity that provides neonatal or pediatric hospital-based health
631 care services by licensed practitioners solely within a hospital
632 under chapter 395.
633 (d) Entities that are under common ownership, directly or
634 indirectly, with an entity licensed or registered by the state
635 pursuant to chapter 395; entities that are under common
636 ownership, directly or indirectly, with an entity licensed or
637 registered by the state and providing only health care services
638 within the scope of services authorized pursuant to their

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639 respective licenses under ss. 383.30-383.332, chapter 390,
640 chapter 394, chapter 397, this chapter except part X, chapter
641 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter
642 484, or chapter 651; end-stage renal disease providers
643 authorized under 42 C.F.R. part 405, subpart U; providers
644 certified and providing only health care services within the
645 scope of services authorized under their respective
646 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
647 H, or subpart J; providers certified and providing only health
648 care services within the scope of services authorized under
649 their respective certifications under 42 C.F.R. part 486,
650 subpart C; providers certified and providing only health care
651 services within the scope of services authorized under their
652 respective certifications under 42 C.F.R. part 491, subpart A;
653 providers certified by the Centers for Medicare and Medicaid
654 services under the federal Clinical Laboratory Improvement
655 Amendments and the federal rules adopted thereunder; or any
656 entity that provides neonatal or pediatric hospital-based health
657 care services by licensed practitioners solely within a hospital
658 licensed under chapter 395.
659 (e) An entity that is exempt from federal taxation under 26
660 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
661 under 26 U.S.C. s. 409 that has a board of trustees at least
662 two-thirds of which are Florida-licensed health care
663 practitioners and provides only physical therapy services under
664 physician orders, any community college or university clinic,
665 and any entity owned or operated by the federal or state
666 government, including agencies, subdivisions, or municipalities
667 thereof.

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668 (f) A sole proprietorship, group practice, partnership, or
669 corporation that provides health care services by physicians
670 covered by s. 627.419, that is directly supervised by one or
671 more of such physicians, and that is wholly owned by one or more
672 of those physicians or by a physician and the spouse, parent,
673 child, or sibling of that physician.
674 (g) A sole proprietorship, group practice, partnership, or
675 corporation that provides health care services by licensed
676 health care practitioners under chapter 457, chapter 458,
677 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
678 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
679 chapter 490, chapter 491, or part I, part III, part X, part
680 XIII, or part XIV of chapter 468, or s. 464.012, and that is
681 wholly owned by one or more licensed health care practitioners,
682 or the licensed health care practitioners set forth in this
683 paragraph and the spouse, parent, child, or sibling of a
684 licensed health care practitioner if one of the owners who is a
685 licensed health care practitioner is supervising the business
686 activities and is legally responsible for the entity's
687 compliance with all federal and state laws. However, a health
688 care practitioner may not supervise services beyond the scope of
689 the practitioner's license, except that, for the purposes of
690 this part, a clinic owned by a licensee in s. 456.053(3)(b)
691 which provides only services authorized pursuant to s.
692 456.053(3)(b) may be supervised by a licensee specified in s.
693 456.053(3)(b).
694 (h) Clinical facilities affiliated with an accredited
695 medical school at which training is provided for medical
696 students, residents, or fellows.

697 (i) Entities that provide only oncology or radiation
698 therapy services by physicians licensed under chapter 458 or
699 chapter 459 or entities that provide oncology or radiation
700 therapy services by physicians licensed under chapter 458 or
701 chapter 459 which are owned by a corporation whose shares are
702 publicly traded on a recognized stock exchange.
703 (j) Clinical facilities affiliated with a college of
704 chiropractic accredited by the Council on Chiropractic Education
705 at which training is provided for chiropractic students.
706 (k) Entities that provide licensed practitioners to staff
707 emergency departments or to deliver anesthesia services in
708 facilities licensed under chapter 395 and that derive at least
709 90 percent of their gross annual revenues from the provision of
710 such services. Entities claiming an exemption from licensure
711 under this paragraph must provide documentation demonstrating
712 compliance.
713 (l) Orthotic, prosthetic, pediatric cardiology, or
714 perinatology clinical facilities or anesthesia clinical
715 facilities that are not otherwise exempt under paragraph (a) or
716 paragraph (k) and that are a publicly traded corporation or are
717 wholly owned, directly or indirectly, by a publicly traded
718 corporation. As used in this paragraph, a publicly traded
719 corporation is a corporation that issues securities traded on an
720 exchange registered with the United States Securities and
721 Exchange Commission as a national securities exchange.
722 (m) Entities that are owned by a corporation that has $250
723 million or more in total annual sales of health care services
724 provided by licensed health care practitioners where one or more
725 of the persons responsible for the operations of the entity is a

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726 health care practitioner who is licensed in this state and who
727 is responsible for supervising the business activities of the
728 entity and is responsible for the entity's compliance with state
729 law for purposes of this part.
730 (n) Entities that employ 50 or more licensed health care
731 practitioners licensed under chapter 458 or chapter 459 where
732 the billing for medical services is under a single tax
733 identification number. The application for exemption under this
734 subsection shall contain information that includes: the name,
735 residence, and business address and phone number of the entity
736 that owns the practice; a complete list of the names and contact
737 information of all the officers and directors of the
738 corporation; the name, residence address, business address, and
739 medical license number of each licensed Florida health care
740 practitioner employed by the entity; the corporate tax
741 identification number of the entity seeking an exemption; a
742 listing of health care services to be provided by the entity at
743 the health care clinics owned or operated by the entity and a
744 certified statement prepared by an independent certified public
745 accountant which states that the entity and the health care
746 clinics owned or operated by the entity have not received
747 payment for health care services under personal injury
748 protection insurance coverage for the preceding year. If the
749 agency determines that an entity which is exempt under this
750 subsection has received payments for medical services under
751 personal injury protection insurance coverage, the agency may
752 deny or revoke the exemption from licensure under this
753 subsection.
754 (o) Entities that are, directly or indirectly, under the

755 common ownership of or that are subject to common control by a
756 mutual insurance holding company, as defined in s. 628.703, with
757 an entity licensed or certified under chapter 624 or chapter 641
758 which has $1 billion or more in total annual sales in this
759 state.
760 (p) Entities that are owned by an entity that is a
761 behavioral health service provider in at least 5 states other
762 than Florida and that, together with its affiliates, has $90
763 million or more in total annual revenues associated with the
764 provision of behavioral health services and where one or more of
765 the persons responsible for the operations of the entity is a
766 health care practitioner who is licensed in this state and who
767 is responsible for supervising the business activities of the
768 entity and who is responsible for the entity’s compliance with
769 state law for purposes of this part.
770 (q) Medicaid providers.
771
772 Notwithstanding this subsection, an entity shall be deemed a
773 clinic and must be licensed under this part in order to receive
774 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.
775 627.730-627.7405, unless exempted under s. 627.736(5)(h).
776 Section 15. Paragraph (c) of subsection (3) of section
777 400.991, Florida Statutes, is amended to read:
778 400.991 License requirements; background screenings;
779 prohibitions.—
780 (3) In addition to the requirements of part II of chapter
781 408, the applicant must file with the application satisfactory
782 proof that the clinic is in compliance with this part and
783 applicable rules, including:

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784 (c) Proof of financial ability to operate as required under
785 ss. 408.8065(1) and 408.810(8) s. 408.810(8). As an alternative
786 to submitting proof of financial ability to operate as required
787 under s. 408.810(8), the applicant may file a surety bond of at
788 least $500,000 which guarantees that the clinic will act in full
789 conformity with all legal requirements for operating a clinic,
790 payable to the agency. The agency may adopt rules to specify
791 related requirements for such surety bond.
792 Section 16. Paragraph (i) of subsection (1) of section
793 400.9935, Florida Statutes, is amended to read:
794 400.9935 Clinic responsibilities.—
795 (1) Each clinic shall appoint a medical director or clinic
796 director who shall agree in writing to accept legal
797 responsibility for the following activities on behalf of the
798 clinic. The medical director or the clinic director shall:
799 (i) Ensure that the clinic publishes a schedule of charges
800 for the medical services offered to patients. The schedule must
801 include the prices charged to an uninsured person paying for
802 such services by cash, check, credit card, or debit card. The
803 schedule may group services by price levels, listing services in
804 each price level. The schedule must be posted in a conspicuous
805 place in the reception area of any clinic that is an the urgent
806 care center as defined in s. 395.002(29)(b) and must include,
807 but is not limited to, the 50 services most frequently provided
808 by the clinic. The schedule may group services by three price
809 levels, listing services in each price level. The posting may be
810 a sign that must be at least 15 square feet in size or through
811 an electronic messaging board that is at least 3 square feet in
812 size. The failure of a clinic, including a clinic that is an

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813 urgent care center, to publish and post a schedule of charges as
814 required by this section shall result in a fine of not more than
815 $1,000, per day, until the schedule is published and posted.
816 Section 17. Paragraph (a) of subsection (2) of section
817 408.033, Florida Statutes, is amended to read:
818 408.033 Local and state health planning.—
819 (2) FUNDING.—
820 (a) The Legislature intends that the cost of local health
821 councils be borne by assessments on selected health care
822 facilities subject to facility licensure by the Agency for
823 Health Care Administration, including abortion clinics, assisted
824 living facilities, ambulatory surgical centers, birth centers,
825 home health agencies, hospices, hospitals, intermediate care
826 facilities for the developmentally disabled, nursing homes, and
827 health care clinics, ~~and multiphasic testing centers~~ and by
828 assessments on organizations subject to certification by the
829 agency pursuant to chapter 641, part III, including health
830 maintenance organizations and prepaid health clinics. Fees
831 assessed may be collected prospectively at the time of licensure
832 renewal and prorated for the licensure period.
833 Section 18. Paragraph (a) of subsection (1) of section
834 408.061, Florida Statutes, is amended to read:
835 408.061 Data collection; uniform systems of financial
836 reporting; information relating to physician charges;
837 confidential information; immunity.—
838 (1) The agency shall require the submission by health care
839 facilities, health care providers, and health insurers of data
840 necessary to carry out the agency's duties and to facilitate
841 transparency in health care pricing data and quality measures.

842 Specifications for data to be collected under this section shall
843 be developed by the agency and applicable contract vendors, with
844 the assistance of technical advisory panels including
845 representatives of affected entities, consumers, purchasers, and
846 such other interested parties as may be determined by the
847 agency.
848 (a) Data submitted by health care facilities, including the
849 facilities as defined in chapter 395, shall include, but are not
850 limited to,~~:~~ case-mix data, patient admission and discharge
851 data, hospital emergency department data which shall include the
852 number of patients treated in the emergency department of a
853 licensed hospital reported by patient acuity level, data on
854 hospital-acquired infections as specified by rule, data on
855 complications as specified by rule, data on readmissions as
856 specified by rule, including patient- ~~with patient~~ and provider-
857 specific identifiers ~~included~~, actual charge data by diagnostic
858 groups or other bundled groupings as specified by rule,
859 financial data, accounting data, operating expenses, expenses
860 incurred for rendering services to patients who cannot or do not
861 pay, interest charges, depreciation expenses based on the
862 expected useful life of the property and equipment involved, and
863 demographic data. The agency shall adopt nationally recognized
864 risk adjustment methodologies or software consistent with the
865 standards of the Agency for Healthcare Research and Quality and
866 as selected by the agency for all data submitted as required by
867 this section. Data may be obtained from documents including ~~such~~
868 ~~as~~, but not limited to,~~:~~ leases, contracts, debt instruments,
869 itemized patient statements or bills, medical record abstracts,
870 and related diagnostic information. ~~Reported~~ Data elements shall

871 be reported electronically in accordance with the inpatient data
872 reporting instructions as prescribed by agency rule ~~59E-7.012,~~
873 ~~Florida Administrative Code~~. Data submitted shall be certified
874 by the chief executive officer or an appropriate and duly
875 authorized representative or employee of the licensed facility
876 that the information submitted is true and accurate.
877 Section 19. Subsection (4) of section 408.0611, Florida
878 Statutes, is amended to read:
879 408.0611 Electronic prescribing clearinghouse.—
880 (4) Pursuant to s. 408.061, the agency shall monitor the
881 implementation of electronic prescribing by health care
882 practitioners, health care facilities, and pharmacies. ~~By~~
883 ~~January 31 of each year,~~ The agency shall report annually on its
884 website on the progress of implementation of electronic
885 prescribing ~~to the Governor and the Legislature~~. Information
886 reported pursuant to this subsection must ~~shall~~ include federal
887 and private sector electronic prescribing initiatives and, to
888 the extent that data is readily available from organizations
889 that operate electronic prescribing networks, the number of
890 health care practitioners using electronic prescribing and the
891 number of prescriptions electronically transmitted.
892 Section 20. Paragraphs (i) and (j) of subsection (1) of
893 section 408.062, Florida Statutes, are amended to read:
894 408.062 Research, analyses, studies, and reports.—
895 (1) The agency shall conduct research, analyses, and
896 studies relating to health care costs and access to and quality
897 of health care services as access and quality are affected by
898 changes in health care costs. Such research, analyses, and
899 studies shall include, but not be limited to:

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900 (i) The use of emergency department services by patient
901 acuity level ~~and the implication of increasing hospital cost by~~
902 ~~providing nonurgent care in emergency departments~~. The agency
903 shall <u>publish annually on its website information</u> ~~submit an~~
904 ~~annual report~~ based on this monitoring and assessment ~~to the~~
905 ~~Governor, the Speaker of the House of Representatives, the~~
906 ~~President of the Senate, and the substantive legislative~~
907 ~~committees, due January 1~~.
908 (j) The making available on its Internet website, and in a
909 hard-copy format upon request, of patient charge, volumes,
910 length of stay, and performance indicators collected from health
911 care facilities pursuant to s. 408.061(1)(a) for specific
912 medical conditions, surgeries, and procedures provided in
913 inpatient and outpatient facilities as determined by the agency.
914 In making the determination of specific medical conditions,
915 surgeries, and procedures to include, the agency shall consider
916 such factors as volume, severity of the illness, urgency of
917 admission, individual and societal costs, and whether the
918 condition is acute or chronic. Performance outcome indicators
919 shall be risk adjusted or severity adjusted, as applicable,
920 using nationally recognized risk adjustment methodologies or
921 software consistent with the standards of the Agency for
922 Healthcare Research and Quality and as selected by the agency.
923 The website shall also provide an interactive search that allows
924 consumers to view and compare the information for specific
925 facilities, a map that allows consumers to select a county or
926 region, definitions of all of the data, descriptions of each
927 procedure, and an explanation about why the data may differ from
928 facility to facility. Such public data shall be updated

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929 quarterly. The agency shall publish annually on its website
930 information ~~submit an annual status report~~ on the collection of
931 data and publication of health care quality measures ~~to the~~
932 ~~Governor, the Speaker of the House of Representatives, the~~
933 ~~President of the Senate, and the substantive legislative~~
934 ~~committees, due January 1~~.
935 Section 21. Subsection (5) of section 408.063, Florida
936 Statutes, is amended to read:
937 408.063 Dissemination of health care information.—
938 ~~(5) The agency shall publish annually a comprehensive~~
939 ~~report of state health expenditures. The report shall identify:~~
940 ~~(a) The contribution of health care dollars made by all~~
941 ~~payors.~~
942 ~~(b) The dollars expended by type of health care service in~~
943 ~~Florida.~~
944 Section 22. Section 408.802, Florida Statutes, is amended
945 to read:
946 408.802 Applicability.—~~The provisions of~~ This part applies
947 ~~apply~~ to the provision of services that require licensure as
948 defined in this part and to the following entities licensed,
949 registered, or certified by the agency, as described in chapters
950 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765:
951 (1) Laboratories authorized to perform testing under the
952 Drug-Free Workplace Act, as provided under ss. 112.0455 and
953 440.102.
954 (2) Birth centers, as provided under chapter 383.
955 (3) Abortion clinics, as provided under chapter 390.
956 (4) Crisis stabilization units, as provided under parts I
957 and IV of chapter 394.

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958 (5) Short-term residential treatment facilities, as
959 provided under parts I and IV of chapter 394.
960 (6) Residential treatment facilities, as provided under
961 part IV of chapter 394.
962 (7) Residential treatment centers for children and
963 adolescents, as provided under part IV of chapter 394.
964 (8) Hospitals, as provided under part I of chapter 395.
965 (9) Ambulatory surgical centers, as provided under part I
966 of chapter 395.
967 (10) Nursing homes, as provided under part II of chapter
968 400.
969 (11) Assisted living facilities, as provided under part I
970 of chapter 429.
971 (12) Home health agencies, as provided under part III of
972 chapter 400.
973 (13) Nurse registries, as provided under part III of
974 chapter 400.
975 (14) Companion services or homemaker services providers, as
976 provided under part III of chapter 400.
977 (15) Adult day care centers, as provided under part III of
978 chapter 429.
979 (16) Hospices, as provided under part IV of chapter 400.
980 (17) Adult family-care homes, as provided under part II of
981 chapter 429.
982 (18) Homes for special services, as provided under part V
983 of chapter 400.
984 (19) Transitional living facilities, as provided under part
985 XI of chapter 400.
986 (20) Prescribed pediatric extended care centers, as

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987 provided under part VI of chapter 400.
988 (21) Home medical equipment providers, as provided under
989 part VII of chapter 400.
990 (22) Intermediate care facilities for persons with
991 developmental disabilities, as provided under part VIII of
992 chapter 400.
993 (23) Health care services pools, as provided under part IX
994 of chapter 400.
995 (24) Health care clinics, as provided under part X of
996 chapter 400.
997 ~~(25) Multiphasic health testing centers, as provided under~~
998 ~~part I of chapter 483.~~
999 (25)~~(26)~~ Organ, tissue, and eye procurement organizations,
1000 as provided under part V of chapter 765.
1001 Section 23. Present subsections (10) through (14) of
1002 section 408.803, Florida Statutes, are redesignated as
1003 subsections (11) through (15), respectively, a new subsection
1004 (10) is added to that section, and subsection (3) of that
1005 section is amended, to read:
1006 408.803 Definitions.—As used in this part, the term:
1007 (3) "Authorizing statute" means the statute authorizing the
1008 licensed operation of a provider listed in s. 408.802 and
1009 includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~
1010 and 765.
1011 (10) "Low-risk provider" means nurse registries, home
1012 medical equipment providers, and health care clinics.
1013 Section 24. Paragraph (b) of subsection (7) of section
1014 408.806, Florida Statutes, is amended to read:
1015 408.806 License application process.—

1016 (7)
1017 (b) An initial inspection is not required for companion
1018 services or homemaker services providers~~,~~ as provided under part
1019 III of chapter 400, ~~or~~ for health care services pools~~,~~ as
1020 provided under part IX of chapter 400, or for low-risk providers
1021 as provided under s. 408.811.
1022 Section 25. Subsection (2) of section 408.808, Florida
1023 Statutes, is amended to read:
1024 408.808 License categories.—
1025 (2) PROVISIONAL LICENSE.—An applicant against whom a
1026 proceeding denying or revoking a license is pending at the time
1027 of license renewal may be issued a provisional license effective
1028 until final action not subject to further appeal. A provisional
1029 license may also be issued to an applicant for initial licensure
1030 or applying for a change of ownership. A provisional license
1031 must be limited in duration to a specific period of time, up to
1032 12 months, as determined by the agency.
1033 Section 26. Subsections (2) and (5) of section 408.809,
1034 Florida Statutes, are amended to read:
1035 408.809 Background screening; prohibited offenses.—
1036 (2) Every 5 years following his or her licensure,
1037 employment, or entry into a contract in a capacity that under
1038 subsection (1) would require level 2 background screening under
1039 chapter 435, each such person must submit to level 2 background
1040 rescreening as a condition of retaining such license or
1041 continuing in such employment or contractual status. For any
1042 such rescreening, the agency shall request the Department of Law
1043 Enforcement to forward the person’s fingerprints to the Federal
1044 Bureau of Investigation for a national criminal history record

1045 check unless the person's fingerprints are enrolled in the
1046 Federal Bureau of Investigation's national retained print arrest
1047 notification program. If the fingerprints of such a person are
1048 not retained by the Department of Law Enforcement under s.
1049 943.05(2)(g) and (h), the person must submit fingerprints
1050 electronically to the Department of Law Enforcement for state
1051 processing, and the Department of Law Enforcement shall forward
1052 the fingerprints to the Federal Bureau of Investigation for a
1053 national criminal history record check. The fingerprints shall
1054 be retained by the Department of Law Enforcement under s.
1055 943.05(2)(g) and (h) and enrolled in the national retained print
1056 arrest notification program when the Department of Law
1057 Enforcement begins participation in the program. The cost of the
1058 state and national criminal history records checks required by
1059 level 2 screening may be borne by the licensee or the person
1060 fingerprinted. ~~Until a specified agency is fully implemented in~~
1061 ~~the clearinghouse created under s. 435.12,~~ The agency may accept
1062 as satisfying the requirements of this section proof of
1063 compliance with level 2 screening standards submitted within the
1064 previous 5 years to meet any provider or professional licensure
1065 requirements of ~~the agency, the Department of Health, the~~
1066 ~~Department of Elderly Affairs, the Agency for Persons with~~
1067 ~~Disabilities, the Department of Children and Families, or~~ the
1068 Department of Financial Services for an applicant for a
1069 certificate of authority or provisional certificate of authority
1070 to operate a continuing care retirement community under chapter
1071 651, provided that:
1072 (a) The screening standards and disqualifying offenses for
1073 the prior screening are equivalent to those specified in s.

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1074 435.04 and this section;
1075 (b) The person subject to screening has not had a break in
1076 service from a position that requires level 2 screening for more
1077 than 90 days; and
1078 (c) Such proof is accompanied, under penalty of perjury, by
1079 an attestation of compliance with chapter 435 and this section
1080 using forms provided by the agency.
1081 ~~(5) A person who serves as a controlling interest of, is~~
1082 ~~employed by, or contracts with a licensee on July 31, 2010, who~~
1083 ~~has been screened and qualified according to standards specified~~
1084 ~~in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,~~
1085 ~~in compliance with the following schedule. If, upon rescreening,~~
1086 ~~such person has a disqualifying offense that was not a~~
1087 ~~disqualifying offense at the time of the last screening, but is~~
1088 ~~a current disqualifying offense and was committed before the~~
1089 ~~last screening, he or she may apply for an exemption from the~~
1090 ~~appropriate licensing agency and, if agreed to by the employer,~~
1091 ~~may continue to perform his or her duties until the licensing~~
1092 ~~agency renders a decision on the application for exemption if~~
1093 ~~the person is eligible to apply for an exemption and the~~
1094 ~~exemption request is received by the agency within 30 days after~~
1095 ~~receipt of the rescreening results by the person. The~~
1096 ~~rescreening schedule shall be:~~
1097 ~~(a) Individuals for whom the last screening was conducted~~
1098 ~~on or before December 31, 2004, must be rescreened by July 31,~~
1099 ~~2013.~~
1100 ~~(b) Individuals for whom the last screening conducted was~~
1101 ~~between January 1, 2005, and December 31, 2008, must be~~
1102 ~~rescreened by July 31, 2014.~~

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1103 ~~(c) Individuals for whom the last screening conducted was~~
1104 ~~between January 1, 2009, through July 31, 2011, must be~~
1105 ~~rescreened by July 31, 2015.~~
1106 Section 27. Subsection (1) of section 408.811, Florida
1107 Statutes, is amended to read:
1108 408.811 Right of inspection; copies; inspection reports;
1109 plan for correction of deficiencies.—
1110 (1) An authorized officer or employee of the agency may
1111 make or cause to be made any inspection or investigation deemed
1112 necessary by the agency to determine the state of compliance
1113 with this part, authorizing statutes, and applicable rules. The
1114 right of inspection extends to any business that the agency has
1115 reason to believe is being operated as a provider without a
1116 license, but inspection of any business suspected of being
1117 operated without the appropriate license may not be made without
1118 the permission of the owner or person in charge unless a warrant
1119 is first obtained from a circuit court. Any application for a
1120 license issued under this part, authorizing statutes, or
1121 applicable rules constitutes permission for an appropriate
1122 inspection to verify the information submitted on or in
1123 connection with the application.
1124 (a) All inspections shall be unannounced, except as
1125 specified in s. 408.806.
1126 (b) Inspections for relicensure shall be conducted
1127 biennially unless otherwise specified by this section,
1128 authorizing statutes, or applicable rules.
1129 (c) The agency may exempt a low-risk provider from
1130 licensure inspection if the provider or controlling interest has
1131 an excellent regulatory history with regard to deficiencies,

1132 sanctions, complaints, and other regulatory actions, as defined
1133 by rule. The agency shall continue to conduct unannounced
1134 licensure inspections for at least 10 percent of exempt low-risk
1135 providers to verify compliance.
1136 (d) The agency may adopt rules to waive a routine
1137 inspection, including inspection for relicensure, or allow for
1138 an extended period between relicensure inspections for specific
1139 providers based upon:
1140 1. A favorable regulatory history with regard to
1141 deficiencies, sanctions, complaints, and other regulatory
1142 measures.
1143 2. Outcome measures that demonstrate quality performance.
1144 3. Successful participation in a recognized quality
1145 assurance program.
1146 4. Accreditation status.
1147 5. Other measures reflective of quality and safety.
1148 6. The length of time between inspections.
1149
1150 The agency shall continue to conduct unannounced licensure
1151 inspections for at least 10 percent of providers that qualify
1152 for a waiver or extended period between relicensure inspections.
1153 (e) The agency maintains the authority to conduct an
1154 inspection of any provider at any time to determine regulatory
1155 compliance.
1156 Section 28. Subsection (24) of section 408.820, Florida
1157 Statutes, is amended to read:
1158 408.820 Exemptions.—Except as prescribed in authorizing
1159 statutes, the following exemptions shall apply to specified
1160 requirements of this part:

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1161 ~~(24) Multiphasic health testing centers, as provided under~~
1162 ~~part I of chapter 483, are exempt from s. 408.810(5)-(10).~~
1163 Section 29. Subsections (1) and (2) of section 408.821,
1164 Florida Statutes, are amended to read:
1165 408.821 Emergency management planning; emergency
1166 operations; inactive license.—
1167 (1) A licensee required by authorizing statutes and agency
1168 rule to have a comprehensive ~~an~~ emergency management ~~operations~~
1169 plan must designate a safety liaison to serve as the primary
1170 contact for emergency operations. Such licensee shall submit its
1171 comprehensive emergency management plan to the local emergency
1172 management agency, county health department, or Department of
1173 Health as follows:
1174 (a) Submit the plan within 30 days after initial licensure
1175 and change of ownership, and notify the agency within 30 days
1176 after submission of the plan.
1177 (b) Submit the plan annually and within 30 days after any
1178 significant modification, as defined by agency rule, to a
1179 previously approved plan.
1180 (c) Respond with necessary plan revisions within 30 days
1181 after notification that plan revisions are required.
1182 (d) Notify the agency within 30 days after approval of its
1183 plan by the local emergency management agency, county health
1184 department, or Department of Health.
1185 (2) An entity subject to this part may temporarily exceed
1186 its licensed capacity to act as a receiving provider in
1187 accordance with an approved comprehensive emergency management
1188 ~~operations~~ plan for up to 15 days. While in an overcapacity
1189 status, each provider must furnish or arrange for appropriate

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1190 care and services to all clients. In addition, the agency may
1191 approve requests for overcapacity in excess of 15 days, which
1192 approvals may be based upon satisfactory justification and need
1193 as provided by the receiving and sending providers.
1194 Section 30. Subsection (3) of section 408.831, Florida
1195 Statutes, is amended to read:
1196 408.831 Denial, suspension, or revocation of a license,
1197 registration, certificate, or application.—
1198 (3) This section provides standards of enforcement
1199 applicable to all entities licensed or regulated by the Agency
1200 for Health Care Administration. This section controls over any
1201 conflicting provisions of chapters 39, 383, 390, 391, 394, 395,
1202 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to
1203 those chapters.
1204 Section 31. Section 408.832, Florida Statutes, is amended
1205 to read:
1206 408.832 Conflicts.—In case of conflict between the
1207 provisions of this part and the authorizing statutes governing
1208 the licensure of health care providers by the Agency for Health
1209 Care Administration found in s. 112.0455 and chapters 383, 390,
1210 394, 395, 400, 429, 440, ~~483,~~ and 765, the provisions of this
1211 part shall prevail.
1212 Section 32. Subsection (9) of section 408.909, Florida
1213 Statutes, is amended to read:
1214 408.909 Health flex plans.—
1215 ~~(9) PROGRAM EVALUATION.—The agency and the office shall~~
1216 ~~evaluate the pilot program and its effect on the entities that~~
1217 ~~seek approval as health flex plans, on the number of enrollees,~~
1218 ~~and on the scope of the health care coverage offered under a~~

1219 ~~health flex plan; shall provide an assessment of the health flex~~
1220 ~~plans and their potential applicability in other settings; shall~~
1221 ~~use health flex plans to gather more information to evaluate~~
1222 ~~low-income consumer driven benefit packages; and shall, by~~
1223 ~~January 15, 2016, and annually thereafter, jointly submit a~~
1224 ~~report to the Governor, the President of the Senate, and the~~
1225 ~~Speaker of the House of Representatives.~~
1226 Section 33. Paragraph (d) of subsection (10) of section
1227 408.9091, Florida Statutes, is amended to read:
1228 408.9091 Cover Florida Health Care Access Program.—
1229 (10) PROGRAM EVALUATION.—The agency and the office shall:
1230 ~~(d) Jointly submit by March 1, annually, a report to the~~
1231 ~~Governor, the President of the Senate, and the Speaker of the~~
1232 ~~House of Representatives which provides the information~~
1233 ~~specified in paragraphs (a)-(c) and recommendations relating to~~
1234 ~~the successful implementation and administration of the program.~~
1235 Section 34. Paragraph (a) of subsection (5) of section
1236 409.905, Florida Statutes, is amended to read:
1237 409.905 Mandatory Medicaid services.—The agency may make
1238 payments for the following services, which are required of the
1239 state by Title XIX of the Social Security Act, furnished by
1240 Medicaid providers to recipients who are determined to be
1241 eligible on the dates on which the services were provided. Any
1242 service under this section shall be provided only when medically
1243 necessary and in accordance with state and federal law.
1244 Mandatory services rendered by providers in mobile units to
1245 Medicaid recipients may be restricted by the agency. Nothing in
1246 this section shall be construed to prevent or limit the agency
1247 from adjusting fees, reimbursement rates, lengths of stay,

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1248 number of visits, number of services, or any other adjustments
1249 necessary to comply with the availability of moneys and any
1250 limitations or directions provided for in the General
1251 Appropriations Act or chapter 216.
1252 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1253 all covered services provided for the medical care and treatment
1254 of a recipient who is admitted as an inpatient by a licensed
1255 physician or dentist to a hospital licensed under part I of
1256 chapter 395. However, the agency shall limit the payment for
1257 inpatient hospital services for a Medicaid recipient 21 years of
1258 age or older to 45 days or the number of days necessary to
1259 comply with the General Appropriations Act.
1260 (a) The agency may implement reimbursement and utilization
1261 management reforms in order to comply with any limitations or
1262 directions in the General Appropriations Act, which may include,
1263 but are not limited to: prior authorization for inpatient
1264 psychiatric days; prior authorization for nonemergency hospital
1265 inpatient admissions for individuals 21 years of age and older;
1266 authorization of emergency and urgent-care admissions within 24
1267 hours after admission; enhanced utilization and concurrent
1268 review programs for highly utilized services; reduction or
1269 elimination of covered days of service; adjusting reimbursement
1270 ceilings for variable costs; adjusting reimbursement ceilings
1271 for fixed and property costs; and implementing target rates of
1272 increase. The agency may limit prior authorization for hospital
1273 inpatient services to selected diagnosis-related groups, based
1274 on an analysis of the cost and potential for unnecessary
1275 hospitalizations represented by certain diagnoses. Admissions
1276 for normal delivery and newborns are exempt from requirements

1277 for prior authorization. In implementing the provisions of this
1278 section related to prior authorization, the agency shall ensure
1279 that the process for authorization is accessible 24 hours per
1280 day, 7 days per week and authorization is automatically granted
1281 when not denied within 4 hours after the request. Authorization
1282 procedures must include steps for review of denials. ~~Upon~~
1283 ~~implementing the prior authorization program for hospital~~
1284 ~~inpatient services, the agency shall discontinue its hospital~~
1285 ~~retrospective review program.~~
1286 Section 35. Subsection (8) of section 409.907, Florida
1287 Statutes, is amended to read:
1288 409.907 Medicaid provider agreements.—The agency may make
1289 payments for medical assistance and related services rendered to
1290 Medicaid recipients only to an individual or entity who has a
1291 provider agreement in effect with the agency, who is performing
1292 services or supplying goods in accordance with federal, state,
1293 and local law, and who agrees that no person shall, on the
1294 grounds of handicap, race, color, or national origin, or for any
1295 other reason, be subjected to discrimination under any program
1296 or activity for which the provider receives payment from the
1297 agency.
1298 (8)(a) A level 2 background screening pursuant to chapter
1299 435 must be conducted through the agency on each of the
1300 following:
1301 1. The ~~Each~~ provider, or each principal of the provider if
1302 the provider is a corporation, partnership, association, or
1303 other entity~~, seeking to participate in the Medicaid program~~
1304 ~~must submit a complete set of his or her fingerprints to the~~
1305 ~~agency for the purpose of conducting a criminal history record~~

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1306 ~~check~~.
1307 2. Principals of the provider, who include any officer,
1308 director, billing agent, managing employee, or affiliated
1309 person, or any partner or shareholder who has an ownership
1310 interest equal to 5 percent or more in the provider. However,
1311 for a hospital licensed under chapter 395 or a nursing home
1312 licensed under chapter 400, principals of the provider are those
1313 who meet the definition of a controlling interest under s.
1314 408.803. A director of a not-for-profit corporation or
1315 organization is not a principal for purposes of a background
1316 investigation required by this section if the director: serves
1317 solely in a voluntary capacity for the corporation or
1318 organization, does not regularly take part in the day-to-day
1319 operational decisions of the corporation or organization,
1320 receives no remuneration from the not-for-profit corporation or
1321 organization for his or her service on the board of directors,
1322 has no financial interest in the not-for-profit corporation or
1323 organization, and has no family members with a financial
1324 interest in the not-for-profit corporation or organization; and
1325 if the director submits an affidavit, under penalty of perjury,
1326 to this effect to the agency and the not-for-profit corporation
1327 or organization submits an affidavit, under penalty of perjury,
1328 to this effect to the agency as part of the corporation's or
1329 organization's Medicaid provider agreement application.
1330 3. Any person who participates or seeks to participate in
1331 the Florida Medicaid program by way of rendering services to
1332 Medicaid recipients or having direct access to Medicaid
1333 recipients, recipient living areas, or the financial, medical,
1334 or service records of a Medicaid recipient or who supervises the

1335 delivery of goods or services to a Medicaid recipient. This
1336 subparagraph does not impose additional screening requirements
1337 on any providers licensed under part II of chapter 408.
1338 (b) Notwithstanding paragraph (a) ~~the above~~, the agency may
1339 require a background check for any person reasonably suspected
1340 by the agency to have been convicted of a crime.
1341 (c)~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:
1342 1. A unit of local government, except that requirements of
1343 this subsection apply to nongovernmental providers and entities
1344 contracting with the local government to provide Medicaid
1345 services. The actual cost of the state and national criminal
1346 history record checks must be borne by the nongovernmental
1347 provider or entity; or
1348 2. Any business that derives more than 50 percent of its
1349 revenue from the sale of goods to the final consumer, and the
1350 business or its controlling parent is required to file a form
1351 10-K or other similar statement with the Securities and Exchange
1352 Commission or has a net worth of $50 million or more.
1353 (d)~~(b)~~ Background screening shall be conducted in
1354 accordance with chapter 435 and s. 408.809. The cost of the
1355 state and national criminal record check shall be borne by the
1356 provider.
1357 Section 36. Section 409.913, Florida Statutes, is amended
1358 to read:
1359 409.913 Oversight of the integrity of the Medicaid
1360 program.—The agency shall operate a program to oversee the
1361 activities of Florida Medicaid recipients, and providers and
1362 their representatives, to ensure that fraudulent and abusive
1363 behavior and neglect of recipients occur to the minimum extent

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1364 possible, and to recover overpayments and impose sanctions as
1365 appropriate. Each January 15 ~~January 1~~, the agency and the
1366 Medicaid Fraud Control Unit of the Department of Legal Affairs
1367 shall submit reports ~~a joint report~~ to the Legislature
1368 documenting the effectiveness of the state's efforts to control
1369 Medicaid fraud and abuse and to recover Medicaid overpayments
1370 during the previous fiscal year. The report must describe the
1371 number of cases opened and investigated each year; the sources
1372 of the cases opened; the disposition of the cases closed each
1373 year; the amount of overpayments alleged in preliminary and
1374 final audit letters; the number and amount of fines or penalties
1375 imposed; any reductions in overpayment amounts negotiated in
1376 settlement agreements or by other means; the amount of final
1377 agency determinations of overpayments; the amount deducted from
1378 federal claiming as a result of overpayments; the amount of
1379 overpayments recovered each year; the amount of cost of
1380 investigation recovered each year; the average length of time to
1381 collect from the time the case was opened until the overpayment
1382 is paid in full; the amount determined as uncollectible and the
1383 portion of the uncollectible amount subsequently reclaimed from
1384 the Federal Government; the number of providers, by type, that
1385 are terminated from participation in the Medicaid program as a
1386 result of fraud and abuse; and all costs associated with
1387 discovering and prosecuting cases of Medicaid overpayments and
1388 making recoveries in such cases. The report must also document
1389 actions taken to prevent overpayments and the number of
1390 providers prevented from enrolling in or reenrolling in the
1391 Medicaid program as a result of documented Medicaid fraud and
1392 abuse and must include policy recommendations necessary to

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1393 prevent or recover overpayments and changes necessary to prevent
1394 and detect Medicaid fraud. All policy recommendations in the
1395 report must include a detailed fiscal analysis, including, but
1396 not limited to, implementation costs, estimated savings to the
1397 Medicaid program, and the return on investment. The agency must
1398 submit the policy recommendations and fiscal analyses in the
1399 report to the appropriate estimating conference, pursuant to s.
1400 216.137, by February 15 of each year. The agency and the
1401 Medicaid Fraud Control Unit of the Department of Legal Affairs
1402 each must include detailed unit-specific performance standards,
1403 benchmarks, and metrics in the report, including projected cost
1404 savings to the state Medicaid program during the following
1405 fiscal year.
1406 (1) For the purposes of this section, the term:
1407 (a) "Abuse" means:
1408 1. Provider practices that are inconsistent with generally
1409 accepted business or medical practices and that result in an
1410 unnecessary cost to the Medicaid program or in reimbursement for
1411 goods or services that are not medically necessary or that fail
1412 to meet professionally recognized standards for health care.
1413 2. Recipient practices that result in unnecessary cost to
1414 the Medicaid program.
1415 (b) "Complaint" means an allegation that fraud, abuse, or
1416 an overpayment has occurred.
1417 (c) "Fraud" means an intentional deception or
1418 misrepresentation made by a person with the knowledge that the
1419 deception results in unauthorized benefit to herself or himself
1420 or another person. The term includes any act that constitutes
1421 fraud under applicable federal or state law.

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1422 (d) “Medical necessity” or “medically necessary” means any
1423 goods or services necessary to palliate the effects of a
1424 terminal condition, or to prevent, diagnose, correct, cure,
1425 alleviate, or preclude deterioration of a condition that
1426 threatens life, causes pain or suffering, or results in illness
1427 or infirmity, which goods or services are provided in accordance
1428 with generally accepted standards of medical practice. For
1429 purposes of determining Medicaid reimbursement, the agency is
1430 the final arbiter of medical necessity. Determinations of
1431 medical necessity must be made by a licensed physician employed
1432 by or under contract with the agency and must be based upon
1433 information available at the time the goods or services are
1434 provided.
1435 (e) “Overpayment” includes any amount that is not
1436 authorized to be paid by the Medicaid program whether paid as a
1437 result of inaccurate or improper cost reporting, improper
1438 claiming, unacceptable practices, fraud, abuse, or mistake.
1439 (f) “Person” means any natural person, corporation,
1440 partnership, association, clinic, group, or other entity,
1441 whether or not such person is enrolled in the Medicaid program
1442 or is a provider of health care.
1443 (2) The agency shall conduct, or cause to be conducted by
1444 contract or otherwise, reviews, investigations, analyses,
1445 audits, or any combination thereof, to determine possible fraud,
1446 abuse, overpayment, or recipient neglect in the Medicaid program
1447 and shall report the findings of any overpayments in audit
1448 reports as appropriate. At least 5 percent of all audits shall
1449 be conducted on a random basis. As part of its ongoing fraud
1450 detection activities, the agency shall identify and monitor, by

1451 contract or otherwise, patterns of overutilization of Medicaid
1452 services based on state averages. The agency shall track
1453 Medicaid provider prescription and billing patterns and evaluate
1454 them against Medicaid medical necessity criteria and coverage
1455 and limitation guidelines adopted by rule. Medical necessity
1456 determination requires that service be consistent with symptoms
1457 or confirmed diagnosis of illness or injury under treatment and
1458 not in excess of the patient's needs. The agency shall conduct
1459 reviews of provider exceptions to peer group norms and shall,
1460 using statistical methodologies, provider profiling, and
1461 analysis of billing patterns, detect and investigate abnormal or
1462 unusual increases in billing or payment of claims for Medicaid
1463 services and medically unnecessary provision of services.
1464 (3) The agency may conduct, or may contract for, prepayment
1465 review of provider claims to ensure cost-effective purchasing;
1466 to ensure that billing by a provider to the agency is in
1467 accordance with applicable provisions of all Medicaid rules,
1468 regulations, handbooks, and policies and in accordance with
1469 federal, state, and local law; and to ensure that appropriate
1470 care is rendered to Medicaid recipients. Such prepayment reviews
1471 may be conducted as determined appropriate by the agency,
1472 without any suspicion or allegation of fraud, abuse, or neglect,
1473 and may last for up to 1 year. Unless the agency has reliable
1474 evidence of fraud, misrepresentation, abuse, or neglect, claims
1475 shall be adjudicated for denial or payment within 90 days after
1476 receipt of complete documentation by the agency for review. If
1477 there is reliable evidence of fraud, misrepresentation, abuse,
1478 or neglect, claims shall be adjudicated for denial of payment
1479 within 180 days after receipt of complete documentation by the

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1480 agency for review.
1481 (4) Any suspected criminal violation identified by the
1482 agency must be referred to the Medicaid Fraud Control Unit of
1483 the Office of the Attorney General for investigation. The agency
1484 and the Attorney General shall enter into a memorandum of
1485 understanding, which must include, but need not be limited to, a
1486 protocol for regularly sharing information and coordinating
1487 casework. The protocol must establish a procedure for the
1488 referral by the agency of cases involving suspected Medicaid
1489 fraud to the Medicaid Fraud Control Unit for investigation, and
1490 the return to the agency of those cases where investigation
1491 determines that administrative action by the agency is
1492 appropriate. Offices of the Medicaid program integrity program
1493 and the Medicaid Fraud Control Unit of the Department of Legal
1494 Affairs, shall, to the extent possible, be collocated. The
1495 agency and the Department of Legal Affairs shall periodically
1496 conduct joint training and other joint activities designed to
1497 increase communication and coordination in recovering
1498 overpayments.
1499 (5) A Medicaid provider is subject to having goods and
1500 services that are paid for by the Medicaid program reviewed by
1501 an appropriate peer-review organization designated by the
1502 agency. The written findings of the applicable peer-review
1503 organization are admissible in any court or administrative
1504 proceeding as evidence of medical necessity or the lack thereof.
1505 (6) Any notice required to be given to a provider under
1506 this section is presumed to be sufficient notice if sent to the
1507 address last shown on the provider enrollment file. It is the
1508 responsibility of the provider to furnish and keep the agency

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1509 informed of the provider's current address. United States Postal
1510 Service proof of mailing or certified or registered mailing of
1511 such notice to the provider at the address shown on the provider
1512 enrollment file constitutes sufficient proof of notice. Any
1513 notice required to be given to the agency by this section must
1514 be sent to the agency at an address designated by rule.
1515 (7) When presenting a claim for payment under the Medicaid
1516 program, a provider has an affirmative duty to supervise the
1517 provision of, and be responsible for, goods and services claimed
1518 to have been provided, to supervise and be responsible for
1519 preparation and submission of the claim, and to present a claim
1520 that is true and accurate and that is for goods and services
1521 that:
1522 (a) Have actually been furnished to the recipient by the
1523 provider prior to submitting the claim.
1524 (b) Are Medicaid-covered goods or services that are
1525 medically necessary.
1526 (c) Are of a quality comparable to those furnished to the
1527 general public by the provider's peers.
1528 (d) Have not been billed in whole or in part to a recipient
1529 or a recipient's responsible party, except for such copayments,
1530 coinsurance, or deductibles as are authorized by the agency.
1531 (e) Are provided in accord with applicable provisions of
1532 all Medicaid rules, regulations, handbooks, and policies and in
1533 accordance with federal, state, and local law.
1534 (f) Are documented by records made at the time the goods or
1535 services were provided, demonstrating the medical necessity for
1536 the goods or services rendered. Medicaid goods or services are
1537 excessive or not medically necessary unless both the medical

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1538 basis and the specific need for them are fully and properly
1539 documented in the recipient’s medical record.
1540
1541 The agency shall deny payment or require repayment for goods or
1542 services that are not presented as required in this subsection.
1543 (8) The agency shall not reimburse any person or entity for
1544 any prescription for medications, medical supplies, or medical
1545 services if the prescription was written by a physician or other
1546 prescribing practitioner who is not enrolled in the Medicaid
1547 program. This section does not apply:
1548 (a) In instances involving bona fide emergency medical
1549 conditions as determined by the agency;
1550 (b) To a provider of medical services to a patient in a
1551 hospital emergency department, hospital inpatient or outpatient
1552 setting, or nursing home;
1553 (c) To bona fide pro bono services by preapproved non-
1554 Medicaid providers as determined by the agency;
1555 (d) To prescribing physicians who are board-certified
1556 specialists treating Medicaid recipients referred for treatment
1557 by a treating physician who is enrolled in the Medicaid program;
1558 (e) To prescriptions written for dually eligible Medicare
1559 beneficiaries by an authorized Medicare provider who is not
1560 enrolled in the Medicaid program;
1561 (f) To other physicians who are not enrolled in the
1562 Medicaid program but who provide a medically necessary service
1563 or prescription not otherwise reasonably available from a
1564 Medicaid-enrolled physician; or
1565 (9) A Medicaid provider shall retain medical, professional,
1566 financial, and business records pertaining to services and goods

1567 furnished to a Medicaid recipient and billed to Medicaid for a
1568 period of 5 years after the date of furnishing such services or
1569 goods. The agency may investigate, review, or analyze such
1570 records, which must be made available during normal business
1571 hours. However, 24-hour notice must be provided if patient
1572 treatment would be disrupted. The provider must keep the agency
1573 informed of the location of the provider's Medicaid-related
1574 records. The authority of the agency to obtain Medicaid-related
1575 records from a provider is neither curtailed nor limited during
1576 a period of litigation between the agency and the provider.
1577 (10) Payments for the services of billing agents or persons
1578 participating in the preparation of a Medicaid claim shall not
1579 be based on amounts for which they bill nor based on the amount
1580 a provider receives from the Medicaid program.
1581 (11) The agency shall deny payment or require repayment for
1582 inappropriate, medically unnecessary, or excessive goods or
1583 services from the person furnishing them, the person under whose
1584 supervision they were furnished, or the person causing them to
1585 be furnished.
1586 (12) The complaint and all information obtained pursuant to
1587 an investigation of a Medicaid provider, or the authorized
1588 representative or agent of a provider, relating to an allegation
1589 of fraud, abuse, or neglect are confidential and exempt from the
1590 provisions of s. 119.07(1):
1591 (a) Until the agency takes final agency action with respect
1592 to the provider and requires repayment of any overpayment, or
1593 imposes an administrative sanction;
1594 (b) Until the Attorney General refers the case for criminal
1595 prosecution;

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1596 (c) Until 10 days after the complaint is determined without
1597 merit; or
1598 (d) At all times if the complaint or information is
1599 otherwise protected by law.
1600 (13) The agency shall terminate participation of a Medicaid
1601 provider in the Medicaid program and may seek civil remedies or
1602 impose other administrative sanctions against a Medicaid
1603 provider, if the provider or any principal, officer, director,
1604 agent, managing employee, or affiliated person of the provider,
1605 or any partner or shareholder having an ownership interest in
1606 the provider equal to 5 percent or greater, has been convicted
1607 of a criminal offense under federal law or the law of any state
1608 relating to the practice of the provider's profession, or a
1609 criminal offense listed under s. 408.809(4), s. 409.907(10), or
1610 s. 435.04(2). If the agency determines that the provider did not
1611 participate or acquiesce in the offense, termination will not be
1612 imposed. If the agency effects a termination under this
1613 subsection, the agency shall take final agency action.
1614 (14) If the provider has been suspended or terminated from
1615 participation in the Medicaid program or the Medicare program by
1616 the Federal Government or any state, the agency must immediately
1617 suspend or terminate, as appropriate, the provider's
1618 participation in this state's Medicaid program for a period no
1619 less than that imposed by the Federal Government or any other
1620 state, and may not enroll such provider in this state's Medicaid
1621 program while such foreign suspension or termination remains in
1622 effect. The agency shall also immediately suspend or terminate,
1623 as appropriate, a provider's participation in this state's
1624 Medicaid program if the provider participated or acquiesced in

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1625 any action for which any principal, officer, director, agent,
1626 managing employee, or affiliated person of the provider, or any
1627 partner or shareholder having an ownership interest in the
1628 provider equal to 5 percent or greater, was suspended or
1629 terminated from participating in the Medicaid program or the
1630 Medicare program by the Federal Government or any state. This
1631 sanction is in addition to all other remedies provided by law.
1632 (15) The agency shall seek a remedy provided by law,
1633 including, but not limited to, any remedy provided in
1634 subsections (13) and (16) and s. 812.035, if:
1635 (a) The provider's license has not been renewed, or has
1636 been revoked, suspended, or terminated, for cause, by the
1637 licensing agency of any state;
1638 (b) The provider has failed to make available or has
1639 refused access to Medicaid-related records to an auditor,
1640 investigator, or other authorized employee or agent of the
1641 agency, the Attorney General, a state attorney, or the Federal
1642 Government;
1643 (c) The provider has not furnished or has failed to make
1644 available such Medicaid-related records as the agency has found
1645 necessary to determine whether Medicaid payments are or were due
1646 and the amounts thereof;
1647 (d) The provider has failed to maintain medical records
1648 made at the time of service, or prior to service if prior
1649 authorization is required, demonstrating the necessity and
1650 appropriateness of the goods or services rendered;
1651 (e) The provider is not in compliance with provisions of
1652 Medicaid provider publications that have been adopted by
1653 reference as rules in the Florida Administrative Code; with

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1654 provisions of state or federal laws, rules, or regulations; with
1655 provisions of the provider agreement between the agency and the
1656 provider; or with certifications found on claim forms or on
1657 transmittal forms for electronically submitted claims that are
1658 submitted by the provider or authorized representative, as such
1659 provisions apply to the Medicaid program;
1660 (f) The provider or person who ordered, authorized, or
1661 prescribed the care, services, or supplies has furnished, or
1662 ordered or authorized the furnishing of, goods or services to a
1663 recipient which are inappropriate, unnecessary, excessive, or
1664 harmful to the recipient or are of inferior quality;
1665 (g) The provider has demonstrated a pattern of failure to
1666 provide goods or services that are medically necessary;
1667 (h) The provider or an authorized representative of the
1668 provider, or a person who ordered, authorized, or prescribed the
1669 goods or services, has submitted or caused to be submitted false
1670 or a pattern of erroneous Medicaid claims;
1671 (i) The provider or an authorized representative of the
1672 provider, or a person who has ordered, authorized, or prescribed
1673 the goods or services, has submitted or caused to be submitted a
1674 Medicaid provider enrollment application, a request for prior
1675 authorization for Medicaid services, a drug exception request,
1676 or a Medicaid cost report that contains materially false or
1677 incorrect information;
1678 (j) The provider or an authorized representative of the
1679 provider has collected from or billed a recipient or a
1680 recipient’s responsible party improperly for amounts that should
1681 not have been so collected or billed by reason of the provider’s
1682 billing the Medicaid program for the same service;

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1683 (k) The provider or an authorized representative of the
1684 provider has included in a cost report costs that are not
1685 allowable under a Florida Title XIX reimbursement plan after the
1686 provider or authorized representative had been advised in an
1687 audit exit conference or audit report that the costs were not
1688 allowable;
1689 (l) The provider is charged by information or indictment
1690 with fraudulent billing practices or an offense referenced in
1691 subsection (13). The sanction applied for this reason is limited
1692 to suspension of the provider's participation in the Medicaid
1693 program for the duration of the indictment unless the provider
1694 is found guilty pursuant to the information or indictment;
1695 (m) The provider or a person who ordered, authorized, or
1696 prescribed the goods or services is found liable for negligent
1697 practice resulting in death or injury to the provider's patient;
1698 (n) The provider fails to demonstrate that it had available
1699 during a specific audit or review period sufficient quantities
1700 of goods, or sufficient time in the case of services, to support
1701 the provider's billings to the Medicaid program;
1702 (o) The provider has failed to comply with the notice and
1703 reporting requirements of s. 409.907;
1704 (p) The agency has received reliable information of patient
1705 abuse or neglect or of any act prohibited by s. 409.920; or
1706 (q) The provider has failed to comply with an agreed-upon
1707 repayment schedule.
1708
1709 A provider is subject to sanctions for violations of this
1710 subsection as the result of actions or inactions of the
1711 provider, or actions or inactions of any principal, officer,

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1712 director, agent, managing employee, or affiliated person of the
1713 provider, or any partner or shareholder having an ownership
1714 interest in the provider equal to 5 percent or greater, in which
1715 the provider participated or acquiesced.

1716 (16) The agency shall impose any of the following sanctions
1717 or disincentives on a provider or a person for any of the acts
1718 described in subsection (15):

1719 (a) Suspension for a specific period of time of not more
1720 than 1 year. Suspension precludes participation in the Medicaid
1721 program, which includes any action that results in a claim for
1722 payment to the Medicaid program for furnishing, supervising a
1723 person who is furnishing, or causing a person to furnish goods
1724 or services.

1725 (b) Termination for a specific period of time ranging from
1726 more than 1 year to 20 years. Termination precludes
1727 participation in the Medicaid program, which includes any action
1728 that results in a claim for payment to the Medicaid program for
1729 furnishing, supervising a person who is furnishing, or causing a
1730 person to furnish goods or services.

1731 (c) Imposition of a fine of up to $5,000 for each
1732 violation. Each day that an ongoing violation continues, such as
1733 refusing to furnish Medicaid-related records or refusing access
1734 to records, is considered a separate violation. Each instance of
1735 improper billing of a Medicaid recipient; each instance of
1736 including an unallowable cost on a hospital or nursing home
1737 Medicaid cost report after the provider or authorized
1738 representative has been advised in an audit exit conference or
1739 previous audit report of the cost unallowability; each instance
1740 of furnishing a Medicaid recipient goods or professional

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1741 services that are inappropriate or of inferior quality as
1742 determined by competent peer judgment; each instance of
1743 knowingly submitting a materially false or erroneous Medicaid
1744 provider enrollment application, request for prior authorization
1745 for Medicaid services, drug exception request, or cost report;
1746 each instance of inappropriate prescribing of drugs for a
1747 Medicaid recipient as determined by competent peer judgment; and
1748 each false or erroneous Medicaid claim leading to an overpayment
1749 to a provider is considered a separate violation.
1750 (d) Immediate suspension, if the agency has received
1751 information of patient abuse or neglect or of any act prohibited
1752 by s. 409.920. Upon suspension, the agency must issue an
1753 immediate final order under s. 120.569(2)(n).
1754 (e) A fine, not to exceed $10,000, for a violation of
1755 paragraph (15)(i).
1756 (f) Imposition of liens against provider assets, including,
1757 but not limited to, financial assets and real property, not to
1758 exceed the amount of fines or recoveries sought, upon entry of
1759 an order determining that such moneys are due or recoverable.
1760 (g) Prepayment reviews of claims for a specified period of
1761 time.
1762 (h) Comprehensive followup reviews of providers every 6
1763 months to ensure that they are billing Medicaid correctly.
1764 (i) Corrective-action plans that remain in effect for up to
1765 3 years and that are monitored by the agency every 6 months
1766 while in effect.
1767 (j) Other remedies as permitted by law to effect the
1768 recovery of a fine or overpayment.
1769

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1770 If a provider voluntarily relinquishes its Medicaid provider
1771 number or an associated license, or allows the associated
1772 licensure to expire after receiving written notice that the
1773 agency is conducting, or has conducted, an audit, survey,
1774 inspection, or investigation and that a sanction of suspension
1775 or termination will or would be imposed for noncompliance
1776 discovered as a result of the audit, survey, inspection, or
1777 investigation, the agency shall impose the sanction of
1778 termination for cause against the provider. The agency's
1779 termination with cause is subject to hearing rights as may be
1780 provided under chapter 120. The Secretary of Health Care
1781 Administration may make a determination that imposition of a
1782 sanction or disincentive is not in the best interest of the
1783 Medicaid program, in which case a sanction or disincentive may
1784 not be imposed.
1785 (17) In determining the appropriate administrative sanction
1786 to be applied, or the duration of any suspension or termination,
1787 the agency shall consider:
1788 (a) The seriousness and extent of the violation or
1789 violations.
1790 (b) Any prior history of violations by the provider
1791 relating to the delivery of health care programs which resulted
1792 in either a criminal conviction or in administrative sanction or
1793 penalty.
1794 (c) Evidence of continued violation within the provider's
1795 management control of Medicaid statutes, rules, regulations, or
1796 policies after written notification to the provider of improper
1797 practice or instance of violation.
1798 (d) The effect, if any, on the quality of medical care

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1799 provided to Medicaid recipients as a result of the acts of the
1800 provider.
1801 (e) Any action by a licensing agency respecting the
1802 provider in any state in which the provider operates or has
1803 operated.
1804 (f) The apparent impact on access by recipients to Medicaid
1805 services if the provider is suspended or terminated, in the best
1806 judgment of the agency.
1807
1808 The agency shall document the basis for all sanctioning actions
1809 and recommendations.
1810 (18) The agency may take action to sanction, suspend, or
1811 terminate a particular provider working for a group provider,
1812 and may suspend or terminate Medicaid participation at a
1813 specific location, rather than or in addition to taking action
1814 against an entire group.
1815 (19) The agency shall establish a process for conducting
1816 followup reviews of a sampling of providers who have a history
1817 of overpayment under the Medicaid program. This process must
1818 consider the magnitude of previous fraud or abuse and the
1819 potential effect of continued fraud or abuse on Medicaid costs.
1820 (20) In making a determination of overpayment to a
1821 provider, the agency must use accepted and valid auditing,
1822 accounting, analytical, statistical, or peer-review methods, or
1823 combinations thereof. Appropriate statistical methods may
1824 include, but are not limited to, sampling and extension to the
1825 population, parametric and nonparametric statistics, tests of
1826 hypotheses, and other generally accepted statistical methods.
1827 Appropriate analytical methods may include, but are not limited

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1828 to, reviews to determine variances between the quantities of
1829 products that a provider had on hand and available to be
1830 purveyed to Medicaid recipients during the review period and the
1831 quantities of the same products paid for by the Medicaid program
1832 for the same period, taking into appropriate consideration sales
1833 of the same products to non-Medicaid customers during the same
1834 period. In meeting its burden of proof in any administrative or
1835 court proceeding, the agency may introduce the results of such
1836 statistical methods as evidence of overpayment.
1837 (21) When making a determination that an overpayment has
1838 occurred, the agency shall prepare and issue an audit report to
1839 the provider showing the calculation of overpayments. The
1840 agency's determination must be based solely upon information
1841 available to it before issuance of the audit report and, in the
1842 case of documentation obtained to substantiate claims for
1843 Medicaid reimbursement, based solely upon contemporaneous
1844 records. The agency may consider addenda or modifications to a
1845 note that was made contemporaneously with the patient care
1846 episode if the addenda or modifications are germane to the note.
1847 (22) The audit report, supported by agency work papers,
1848 showing an overpayment to a provider constitutes evidence of the
1849 overpayment. A provider may not present or elicit testimony on
1850 direct examination or cross-examination in any court or
1851 administrative proceeding, regarding the purchase or acquisition
1852 by any means of drugs, goods, or supplies; sales or divestment
1853 by any means of drugs, goods, or supplies; or inventory of
1854 drugs, goods, or supplies, unless such acquisition, sales,
1855 divestment, or inventory is documented by written invoices,
1856 written inventory records, or other competent written

1857 documentary evidence maintained in the normal course of the
1858 provider’s business. A provider may not present records to
1859 contest an overpayment or sanction unless such records are
1860 contemporaneous and, if requested during the audit process, were
1861 furnished to the agency or its agent upon request. This
1862 limitation does not apply to Medicaid cost report audits. This
1863 limitation does not preclude consideration by the agency of
1864 addenda or modifications to a note if the addenda or
1865 modifications are made before notification of the audit, the
1866 addenda or modifications are germane to the note, and the note
1867 was made contemporaneously with a patient care episode.
1868 Notwithstanding the applicable rules of discovery, all
1869 documentation to be offered as evidence at an administrative
1870 hearing on a Medicaid overpayment or an administrative sanction
1871 must be exchanged by all parties at least 14 days before the
1872 administrative hearing or be excluded from consideration.
1873 (23)(a) In an audit, ~~or~~ investigation, or enforcement
1874 action taken for ~~of~~ a violation committed by a provider which is
1875 conducted pursuant to this section, the agency is entitled to
1876 recover all investigative and~~,~~ legal costs incurred as a result
1877 of such audit, investigation, or enforcement action. The costs
1878 associated with an investigation, audit, or enforcement action
1879 may include, but are not limited to, salaries and benefits of
1880 personnel, costs related to the time spent by an attorney and
1881 other personnel working on the case, and any other expenses
1882 incurred by the agency or contractor which are associated with
1883 the case, including any~~, and~~ expert witness costs and attorney
1884 fees incurred on behalf of the agency or contractor if the
1885 agency’s findings were not contested by the provider or, if

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1886 contested, the agency ultimately prevailed.
1887 (b) The agency has the burden of documenting the costs,
1888 which include salaries and employee benefits and out-of-pocket
1889 expenses. The amount of costs that may be recovered must be
1890 reasonable in relation to the seriousness of the violation and
1891 must be set taking into consideration the financial resources,
1892 earning ability, and needs of the provider, who has the burden
1893 of demonstrating such factors.
1894 (c) The provider may pay the costs over a period to be
1895 determined by the agency if the agency determines that an
1896 extreme hardship would result to the provider from immediate
1897 full payment. Any default in payment of costs may be collected
1898 by any means authorized by law.
1899 (24) If the agency imposes an administrative sanction
1900 pursuant to subsection (13), subsection (14), or subsection
1901 (15), except paragraphs (15)(e) and (o), upon any provider or
1902 any principal, officer, director, agent, managing employee, or
1903 affiliated person of the provider who is regulated by another
1904 state entity, the agency shall notify that other entity of the
1905 imposition of the sanction within 5 business days. Such
1906 notification must include the provider's or person's name and
1907 license number and the specific reasons for sanction.
1908 (25)(a) The agency shall withhold Medicaid payments, in
1909 whole or in part, to a provider upon receipt of reliable
1910 evidence that the circumstances giving rise to the need for a
1911 withholding of payments involve fraud, willful
1912 misrepresentation, or abuse under the Medicaid program, or a
1913 crime committed while rendering goods or services to Medicaid
1914 recipients. If it is determined that fraud, willful

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1915 misrepresentation, abuse, or a crime did not occur, the payments
1916 withheld must be paid to the provider within 14 days after such
1917 determination. Amounts not paid within 14 days accrue interest
1918 at the rate of 10 percent per year, beginning after the 14th
1919 day.
1920 (b) The agency shall deny payment, or require repayment, if
1921 the goods or services were furnished, supervised, or caused to
1922 be furnished by a person who has been suspended or terminated
1923 from the Medicaid program or Medicare program by the Federal
1924 Government or any state.
1925 (c) Overpayments owed to the agency bear interest at the
1926 rate of 10 percent per year from the date of final determination
1927 of the overpayment by the agency, and payment arrangements must
1928 be made within 30 days after the date of the final order, which
1929 is not subject to further appeal.
1930 (d) The agency, upon entry of a final agency order, a
1931 judgment or order of a court of competent jurisdiction, or a
1932 stipulation or settlement, may collect the moneys owed by all
1933 means allowable by law, including, but not limited to, notifying
1934 any fiscal intermediary of Medicare benefits that the state has
1935 a superior right of payment. Upon receipt of such written
1936 notification, the Medicare fiscal intermediary shall remit to
1937 the state the sum claimed.
1938 (e) The agency may institute amnesty programs to allow
1939 Medicaid providers the opportunity to voluntarily repay
1940 overpayments. The agency may adopt rules to administer such
1941 programs.
1942 (26) The agency may impose administrative sanctions against
1943 a Medicaid recipient, or the agency may seek any other remedy

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1944 provided by law, including, but not limited to, the remedies
1945 provided in s. 812.035, if the agency finds that a recipient has
1946 engaged in solicitation in violation of s. 409.920 or that the
1947 recipient has otherwise abused the Medicaid program.
1948 (27) When the Agency for Health Care Administration has
1949 made a probable cause determination and alleged that an
1950 overpayment to a Medicaid provider has occurred, the agency,
1951 after notice to the provider, shall:
1952 (a) Withhold, and continue to withhold during the pendency
1953 of an administrative hearing pursuant to chapter 120, any
1954 medical assistance reimbursement payments until such time as the
1955 overpayment is recovered, unless within 30 days after receiving
1956 notice thereof the provider:
1957 1. Makes repayment in full; or
1958 2. Establishes a repayment plan that is satisfactory to the
1959 Agency for Health Care Administration.
1960 (b) Withhold, and continue to withhold during the pendency
1961 of an administrative hearing pursuant to chapter 120, medical
1962 assistance reimbursement payments if the terms of a repayment
1963 plan are not adhered to by the provider.
1964 (28) Venue for all Medicaid program integrity cases lies in
1965 Leon County, at the discretion of the agency.
1966 (29) Notwithstanding other provisions of law, the agency
1967 and the Medicaid Fraud Control Unit of the Department of Legal
1968 Affairs may review a provider’s Medicaid-related and non-
1969 Medicaid-related records in order to determine the total output
1970 of a provider’s practice to reconcile quantities of goods or
1971 services billed to Medicaid with quantities of goods or services
1972 used in the provider’s total practice.

1973 (30) The agency shall terminate a provider’s participation
1974 in the Medicaid program if the provider fails to reimburse an
1975 overpayment or pay an agency-imposed fine that has been
1976 determined by final order, not subject to further appeal, within
1977 30 days after the date of the final order, unless the provider
1978 and the agency have entered into a repayment agreement.
1979 (31) If a provider requests an administrative hearing
1980 pursuant to chapter 120, such hearing must be conducted within
1981 90 days following assignment of an administrative law judge,
1982 absent exceptionally good cause shown as determined by the
1983 administrative law judge or hearing officer. Upon issuance of a
1984 final order, the outstanding balance of the amount determined to
1985 constitute the overpayment and fines is due. If a provider fails
1986 to make payments in full, fails to enter into a satisfactory
1987 repayment plan, or fails to comply with the terms of a repayment
1988 plan or settlement agreement, the agency shall withhold
1989 reimbursement payments for Medicaid services until the amount
1990 due is paid in full.
1991 (32) Duly authorized agents and employees of the agency
1992 shall have the power to inspect, during normal business hours,
1993 the records of any pharmacy, wholesale establishment, or
1994 manufacturer, or any other place in which drugs and medical
1995 supplies are manufactured, packed, packaged, made, stored, sold,
1996 or kept for sale, for the purpose of verifying the amount of
1997 drugs and medical supplies ordered, delivered, or purchased by a
1998 provider. The agency shall provide at least 2 business days’
1999 prior notice of any such inspection. The notice must identify
2000 the provider whose records will be inspected, and the inspection
2001 shall include only records specifically related to that

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2002 provider.
2003 (33) In accordance with federal law, Medicaid recipients
2004 convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be
2005 limited, restricted, or suspended from Medicaid eligibility for
2006 a period not to exceed 1 year, as determined by the agency head
2007 or designee.
2008 (34) To deter fraud and abuse in the Medicaid program, the
2009 agency may limit the number of Schedule II and Schedule III
2010 refill prescription claims submitted from a pharmacy provider.
2011 The agency shall limit the allowable amount of reimbursement of
2012 prescription refill claims for Schedule II and Schedule III
2013 pharmaceuticals if the agency or the Medicaid Fraud Control Unit
2014 determines that the specific prescription refill was not
2015 requested by the Medicaid recipient or authorized representative
2016 for whom the refill claim is submitted or was not prescribed by
2017 the recipient's medical provider or physician. Any such refill
2018 request must be consistent with the original prescription.
2019 (35) The Office of Program Policy Analysis and Government
2020 Accountability shall provide a report to the President of the
2021 Senate and the Speaker of the House of Representatives on a
2022 biennial basis, beginning January 31, 2006, on the agency's
2023 efforts to prevent, detect, and deter, as well as recover funds
2024 lost to, fraud and abuse in the Medicaid program.
2025 (36) The agency may provide to a sample of Medicaid
2026 recipients or their representatives through the distribution of
2027 explanations of benefits information about services reimbursed
2028 by the Medicaid program for goods and services to such
2029 recipients, including information on how to report inappropriate
2030 or incorrect billing to the agency or other law enforcement

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2031 entities for review or investigation, information on how to
2032 report criminal Medicaid fraud to the Medicaid Fraud Control
2033 Unit's toll-free hotline number, and information about the
2034 rewards available under s. 409.9203. The explanation of benefits
2035 may not be mailed for Medicaid independent laboratory services
2036 as described in s. 409.905(7) or for Medicaid certified match
2037 services as described in ss. 409.9071 and 1011.70.
2038 (37) The agency shall post on its website a current list of
2039 each Medicaid provider, including any principal, officer,
2040 director, agent, managing employee, or affiliated person of the
2041 provider, or any partner or shareholder having an ownership
2042 interest in the provider equal to 5 percent or greater, who has
2043 been terminated for cause from the Medicaid program or
2044 sanctioned under this section. The list must be searchable by a
2045 variety of search parameters and provide for the creation of
2046 formatted lists that may be printed or imported into other
2047 applications, including spreadsheets. The agency shall update
2048 the list at least monthly.
2049 (38) In order to improve the detection of health care
2050 fraud, use technology to prevent and detect fraud, and maximize
2051 the electronic exchange of health care fraud information, the
2052 agency shall:
2053 (a) Compile, maintain, and publish on its website a
2054 detailed list of all state and federal databases that contain
2055 health care fraud information and update the list at least
2056 biannually;
2057 (b) Develop a strategic plan to connect all databases that
2058 contain health care fraud information to facilitate the
2059 electronic exchange of health information between the agency,

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2060 the Department of Health, the Department of Law Enforcement, and
2061 the Attorney General's Office. The plan must include recommended
2062 standard data formats, fraud identification strategies, and
2063 specifications for the technical interface between state and
2064 federal health care fraud databases;
2065 (c) Monitor innovations in health information technology,
2066 specifically as it pertains to Medicaid fraud prevention and
2067 detection; and
2068 (d) Periodically publish policy briefs that highlight
2069 available new technology to prevent or detect health care fraud
2070 and projects implemented by other states, the private sector, or
2071 the Federal Government which use technology to prevent or detect
2072 health care fraud.
2073 Section 37. Subsection (6) of section 429.11, Florida
2074 Statutes, is amended to read:
2075 429.11 Initial application for license; provisional
2076 license.—
2077 ~~(6) In addition to the license categories available in s.~~
2078 ~~408.808, a provisional license may be issued to an applicant~~
2079 ~~making initial application for licensure or making application~~
2080 ~~for a change of ownership. A provisional license shall be~~
2081 ~~limited in duration to a specific period of time not to exceed 6~~
2082 ~~months, as determined by the agency.~~
2083 Section 38. Subsection (9) of section 429.19, Florida
2084 Statutes, is amended to read:
2085 429.19 Violations; imposition of administrative fines;
2086 grounds.—
2087 ~~(9) The agency shall develop and disseminate an annual list~~
2088 ~~of all facilities sanctioned or fined for violations of state~~

2089 ~~standards, the number and class of violations involved, the~~
2090 ~~penalties imposed, and the current status of cases. The list~~
2091 ~~shall be disseminated, at no charge, to the Department of~~
2092 ~~Elderly Affairs, the Department of Health, the Department of~~
2093 ~~Children and Families, the Agency for Persons with Disabilities,~~
2094 ~~the area agencies on aging, the Florida Statewide Advocacy~~
2095 ~~Council, the State Long-Term Care Ombudsman Program, and state~~
2096 ~~and local ombudsman councils. The Department of Children and~~
2097 ~~Families shall disseminate the list to service providers under~~
2098 ~~contract to the department who are responsible for referring~~
2099 ~~persons to a facility for residency. The agency may charge a fee~~
2100 ~~commensurate with the cost of printing and postage to other~~
2101 ~~interested parties requesting a copy of this list. This~~
2102 ~~information may be provided electronically or through the~~
2103 ~~agency's Internet site.~~
2104 Section 39. Subsection (2) of section 429.35, Florida
2105 Statutes, is amended to read:
2106 429.35 Maintenance of records; reports.—
2107 (2) Within 60 days after the date of an ~~the biennial~~
2108 inspection conducted ~~visit required~~ under s. 408.811 or within
2109 30 days after the date of an ~~any~~ interim visit, the agency shall
2110 forward the results of the inspection to the local ombudsman
2111 council in the district where the facility is located; to at
2112 least one public library or, in the absence of a public library,
2113 the county seat in the county in which the inspected assisted
2114 living facility is located; and, when appropriate, to the
2115 district Adult Services and Mental Health Program Offices.
2116 Section 40. Subsection (2) of section 429.905, Florida
2117 Statutes, is amended to read:

2118 429.905 Exemptions; monitoring of adult day care center
2119 programs colocated with assisted living facilities or licensed
2120 nursing home facilities.—
2121 (2) A licensed assisted living facility, a licensed
2122 hospital, or a licensed nursing home facility may provide
2123 services during the day which include, but are not limited to,
2124 social, health, therapeutic, recreational, nutritional, and
2125 respite services, to adults who are not residents. Such a
2126 facility need not be licensed as an adult day care center;
2127 however, the agency must monitor the facility during the regular
2128 inspection ~~and at least biennially~~ to ensure adequate space and
2129 sufficient staff. If an assisted living facility, a hospital, or
2130 a nursing home holds itself out to the public as an adult day
2131 care center, it must be licensed as such and meet all standards
2132 prescribed by statute and rule. For the purpose of this
2133 subsection, the term "day" means any portion of a 24-hour day.
2134 Section 41. Section 429.929, Florida Statutes, is amended
2135 to read:
2136 429.929 Rules establishing standards.—
2137 ~~(1)~~ The agency shall adopt rules to implement this part.
2138 The rules must include reasonable and fair standards. Any
2139 conflict between these standards and those that may be set forth
2140 in local, county, or municipal ordinances shall be resolved in
2141 favor of those having statewide effect. Such standards must
2142 relate to:
2143 <u>(1)</u>~~(a)~~ The maintenance of adult day care centers with
2144 respect to plumbing, heating, lighting, ventilation, and other
2145 building conditions, including adequate meeting space, to ensure
2146 the health, safety, and comfort of participants and protection

2147 from fire hazard. Such standards may not conflict with chapter
2148 553 and must be based upon the size of the structure and the
2149 number of participants.
2150 <u>(2)</u>~~(b)~~ The number and qualifications of all personnel
2151 employed by adult day care centers who have responsibilities for
2152 the care of participants.
2153 <u>(3)</u>~~(c)~~ All sanitary conditions within adult day care
2154 centers and their surroundings, including water supply, sewage
2155 disposal, food handling, and general hygiene, and maintenance of
2156 sanitary conditions, to ensure the health and comfort of
2157 participants.
2158 <u>(4)</u>~~(d)~~ Basic services provided by adult day care centers.
2159 <u>(5)</u>~~(e)~~ Supportive and optional services provided by adult
2160 day care centers.
2161 <u>(6)</u>~~(f)~~ Data and information relative to participants and
2162 programs of adult day care centers, including, but not limited
2163 to, the physical and mental capabilities and needs of the
2164 participants, the availability, frequency, and intensity of
2165 basic services and of supportive and optional services provided,
2166 the frequency of participation, the distances traveled by
2167 participants, the hours of operation, the number of referrals to
2168 other centers or elsewhere, and the incidence of illness.
2169 <u>(7)</u>~~(g)~~ Components of a comprehensive emergency management
2170 plan, developed in consultation with the Department of Health
2171 and the Division of Emergency Management.
2172 ~~(2) Pursuant to this part, s. 408.811, and applicable~~
2173 ~~rules, the agency may conduct an abbreviated biennial inspection~~
2174 ~~of key quality-of-care standards, in lieu of a full inspection,~~
2175 ~~of a center that has a record of good performance. However, the~~

2176 ~~agency must conduct a full inspection of a center that has had~~
2177 ~~one or more confirmed complaints within the licensure period~~
2178 ~~immediately preceding the inspection or which has a serious~~
2179 ~~problem identified during the abbreviated inspection. The agency~~
2180 ~~shall develop the key quality-of-care standards, taking into~~
2181 ~~consideration the comments and recommendations of provider~~
2182 ~~groups. These standards shall be included in rules adopted by~~
2183 ~~the agency.~~
2184 Section 42. Part I of chapter 483, Florida Statutes, is
2185 repealed, and part II and part III of that chapter are
2186 redesignated as part I and part II, respectively.
2187 Section 43. Paragraph (g) of subsection (3) of section
2188 20.43, Florida Statutes, is amended to read:
2189 20.43 Department of Health.—There is created a Department
2190 of Health.
2191 (3) The following divisions of the Department of Health are
2192 established:
2193 (g) Division of Medical Quality Assurance, which is
2194 responsible for the following boards and professions established
2195 within the division:
2196 1. The Board of Acupuncture, created under chapter 457.
2197 2. The Board of Medicine, created under chapter 458.
2198 3. The Board of Osteopathic Medicine, created under chapter
2199 459.
2200 4. The Board of Chiropractic Medicine, created under
2201 chapter 460.
2202 5. The Board of Podiatric Medicine, created under chapter
2203 461.
2204 6. Naturopathy, as provided under chapter 462.

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

2205 7. The Board of Optometry, created under chapter 463.
2206 8. The Board of Nursing, created under part I of chapter
2207 464.
2208 9. Nursing assistants, as provided under part II of chapter
2209 464.
2210 10. The Board of Pharmacy, created under chapter 465.
2211 11. The Board of Dentistry, created under chapter 466.
2212 12. Midwifery, as provided under chapter 467.
2213 13. The Board of Speech-Language Pathology and Audiology,
2214 created under part I of chapter 468.
2215 14. The Board of Nursing Home Administrators, created under
2216 part II of chapter 468.
2217 15. The Board of Occupational Therapy, created under part
2218 III of chapter 468.
2219 16. Respiratory therapy, as provided under part V of
2220 chapter 468.
2221 17. Dietetics and nutrition practice, as provided under
2222 part X of chapter 468.
2223 18. The Board of Athletic Training, created under part XIII
2224 of chapter 468.
2225 19. The Board of Orthotists and Prosthetists, created under
2226 part XIV of chapter 468.
2227 20. Electrolysis, as provided under chapter 478.
2228 21. The Board of Massage Therapy, created under chapter
2229 480.
2230 22. The Board of Clinical Laboratory Personnel, created
2231 under part I ~~part II~~ of chapter 483.
2232 23. Medical physicists, as provided under part II ~~part III~~
2233 of chapter 483.

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

2234 24. The Board of Opticianry, created under part I of
2235 chapter 484.
2236 25. The Board of Hearing Aid Specialists, created under
2237 part II of chapter 484.
2238 26. The Board of Physical Therapy Practice, created under
2239 chapter 486.
2240 27. The Board of Psychology, created under chapter 490.
2241 28. School psychologists, as provided under chapter 490.
2242 29. The Board of Clinical Social Work, Marriage and Family
2243 Therapy, and Mental Health Counseling, created under chapter
2244 491.
2245 30. Emergency medical technicians and paramedics, as
2246 provided under part III of chapter 401.
2247 Section 44. Subsection (3) of section 381.0034, Florida
2248 Statutes, is amended to read:
2249 381.0034 Requirement for instruction on HIV and AIDS.—
2250 (3) The department shall require, as a condition of
2251 granting a license under chapter 467 or part I ~~part II~~ of
2252 chapter 483, that an applicant making initial application for
2253 licensure complete an educational course acceptable to the
2254 department on human immunodeficiency virus and acquired immune
2255 deficiency syndrome. Upon submission of an affidavit showing
2256 good cause, an applicant who has not taken a course at the time
2257 of licensure shall be allowed 6 months to complete this
2258 requirement.
2259 Section 45. Subsection (4) of section 456.001, Florida
2260 Statutes, is amended to read:
2261 456.001 Definitions.—As used in this chapter, the term:
2262 (4) “Health care practitioner” means any person licensed

2263 under chapter 457; chapter 458; chapter 459; chapter 460;
2264 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;
2265 chapter 466; chapter 467; part I, part II, part III, part V,
2266 part X, part XIII, or part XIV of chapter 468; chapter 478;
2267 chapter 480; part I or part II ~~part II or part III~~ of chapter
2268 483; chapter 484; chapter 486; chapter 490; or chapter 491.
2269 Section 46. Paragraphs (h) and (i) of subsection (2) of
2270 section 456.057, Florida Statutes, are amended to read:
2271 456.057 Ownership and control of patient records; report or
2272 copies of records to be furnished; disclosure of information.—
2273 (2) As used in this section, the terms "records owner,"
2274 "health care practitioner," and "health care practitioner's
2275 employer" do not include any of the following persons or
2276 entities; furthermore, the following persons or entities are not
2277 authorized to acquire or own medical records, but are authorized
2278 under the confidentiality and disclosure requirements of this
2279 section to maintain those documents required by the part or
2280 chapter under which they are licensed or regulated:
2281 (h) Clinical laboratory personnel licensed under part I
2282 ~~part II~~ of chapter 483.
2283 (i) Medical physicists licensed under part II ~~part III~~ of
2284 chapter 483.
2285 Section 47. Paragraph (j) of subsection (1) of section
2286 456.076, Florida Statutes, is amended to read:
2287 456.076 Impaired practitioner programs.—
2288 (1) As used in this section, the term:
2289 (j) "Practitioner" means a person licensed, registered,
2290 certified, or regulated by the department under part III of
2291 chapter 401; chapter 457; chapter 458; chapter 459; chapter 460;

2292 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;
2293 chapter 466; chapter 467; part I, part II, part III, part V,
2294 part X, part XIII, or part XIV of chapter 468; chapter 478;
2295 chapter 480; part I or part II ~~part II or part III~~ of chapter
2296 483; chapter 484; chapter 486; chapter 490; or chapter 491; or
2297 an applicant for a license, registration, or certification under
2298 the same laws.
2299 Section 48. Paragraph (b) of subsection (1) of section
2300 456.47, Florida Statutes, is amended to read:
2301 456.47 Use of telehealth to provide services.—
2302 (1) DEFINITIONS.—As used in this section, the term:
2303 (b) "Telehealth provider" means any individual who provides
2304 health care and related services using telehealth and who is
2305 licensed or certified under s. 393.17; part III of chapter 401;
2306 chapter 457; chapter 458; chapter 459; chapter 460; chapter 461;
2307 chapter 463; chapter 464; chapter 465; chapter 466; chapter 467;
2308 part I, part III, part IV, part V, part X, part XIII, or part
2309 XIV of chapter 468; chapter 478; chapter 480; part I or part II
2310 ~~part II or part III~~ of chapter 483; chapter 484; chapter 486;
2311 chapter 490; or chapter 491; who is licensed under a multistate
2312 health care licensure compact of which Florida is a member
2313 state; or who is registered under and complies with subsection
2314 (4).
2315 Section 49. This act shall take effect July 1, 2020.