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 for Health Care Administration; removing
6 a requirement that a certain report be submitted
7 annually to the agency; authorizing the agency to
8 prescribe by rule the frequency at which such report
9 is submitted; amending s. 395.003, F.S.; removing a
10 requirement that specified information be listed on
11 licenses for certain facilities; repealing s.
12 395.7015, F.S., relating to an annual assessment on
13 health care entities; amending s. 395.7016, F.S.;
14 conforming a provision to changes made by the act;
15 amending s. 400.19, F.S.; revising provisions
16 requiring the agency to conduct licensure inspections
17 of nursing homes; requiring the agency to conduct
18 additional licensure surveys under certain
19 circumstances; revising a provision requiring the
20 agency to assess a specified fine for such surveys;
21 amending s. 400.462, F.S.; revising definitions;
22 amending ss. 400.464, 400.471, 400.492, 400.506, and
23 400.509, F.S.; revising provisions relating to
24 licensure requirements for home health agencies to
25 conform to changes made by the act; exempting certain

26 persons and entities from such licensure requirements;
27 amending s. 400.605, F.S.; removing a requirement that
28 the agency conduct specified inspections of certain
29 licensees; amending s. 400.60501, F.S.; removing an
30 obsolete date and a requirement that the agency
31 develop a specified annual report; amending s.
32 400.9905, F.S.; revising the definition of the term
33 "clinic"; amending s. 400.991, F.S.; conforming
34 provisions to changes made by the act; removing the
35 option for health care clinics to file a surety bond
36 under certain circumstances; amending s. 400.9935,
37 F.S.; requiring certain clinics to publish and post a
38 schedule of charges; amending s. 408.033, F.S.;
39 conforming a provision to changes made by the act;
40 amending s. 408.061, F.S.; revising provisions
41 requiring health care facilities to submit specified
42 data to the agency; amending s. 408.0611, F.S.;
43 requiring the agency to annually publish a report on
44 the progress of implementation of electronic
45 prescribing on its Internet website; amending s.
46 408.062, F.S.; requiring the agency to annually
47 publish certain information on its Internet website;
48 removing a requirement that the agency submit certain
49 annual reports to the Governor and Legislature;
50 amending s. 408.063, F.S.; removing a requirement that

51 the agency annually publish certain reports; amending
52 ss. 408.802, 408.820, 408.831, and 408.832, F.S.;
53 conforming provisions to changes made by the act;
54 amending s. 408.803, F.S.; conforming a provision to
55 changes made by the act; providing a definition of the
56 term "low-risk provider"; amending s. 408.806, F.S.;
57 exempting certain low-risk providers from a specified
58 inspection; amending s. 408.808, F.S.; authorizing the
59 issuance of a provisional license to certain
60 applicants; amending s. 408.809, F.S.; revising
61 provisions relating to background screening
62 requirements for certain licensure applicants;
63 removing an obsolete date and provisions relating to
64 certain rescreening requirements; amending s. 408.811,
65 F.S.; authorizing the agency to exempt certain low-
66 risk providers from inspections and conduct
67 unannounced licensure inspections of such providers
68 under certain circumstances; authorizing the agency to
69 adopt rules to waive routine inspections and grant
70 extended time periods between relicensure inspections
71 under certain conditions; amending s. 408.821, F.S.;
72 revising provisions requiring licensees to have a
73 specified plan; providing requirements for the
74 submission of such plan; amending s. 408.909, F.S.;
75 removing a requirement that the agency and Office of

76 Insurance Regulation evaluate a specified program;
77 amending s. 408.9091, F.S.; removing a requirement
78 that the agency and office jointly submit a specified
79 annual report to the Governor and Legislature;
80 amending s. 409.905, F.S.; providing construction for
81 a provision that requires the agency to discontinue
82 its hospital retrospective review program under
83 certain circumstances; providing legislative intent;
84 amending s. 409.907, F.S.; requiring that a specified
85 background screening be conducted through the agency
86 on certain persons and entities; amending s. 409.913,
87 F.S.; revising a requirement that the agency and the
88 Medicaid Fraud Control Unit of the Department of Legal
89 Affairs submit a specified report to the Legislature;
90 authorizing the agency to recover specified costs
91 associated with an audit, investigation, or
92 enforcement action relating to provider fraud under
93 the Medicaid program; amending ss. 409.967 and
94 409.973, F.S.; revising the length of managed care
95 plan and Medicaid prepaid dental health program
96 contracts, respectively, procured by the agency
97 beginning during a specified timeframe; requiring the
98 agency to extend the term of certain existing
99 contracts until a specified date; amending s. 429.11,
100 F.S.; removing an authorization for the issuance of a

101 provisional license to certain facilities; amending s.
102 429.19, F.S.; removing requirements that the agency
103 develop and disseminate a specified list and the
104 Department of Children and Families disseminate such
105 list to certain providers; amending ss. 429.35,
106 429.905, and 429.929, F.S.; revising provisions
107 requiring a biennial inspection cycle for specified
108 facilities and centers, respectively; repealing part I
109 of chapter 483, F.S., relating to The Florida
110 Multiphasic Health Testing Center Law; providing
111 effective dates.
112
113 Be It Enacted by the Legislature of the State of Florida:
114
115 Section 1. Subsections (2) and (4) of section 383.327,
116 Florida Statutes, are amended to read:
117 383.327 Birth and death records; reports.—
118 (2) Each maternal death, newborn death, and stillbirth
119 shall be reported immediately to the medical examiner and the
120 agency.
121 (4) A report shall be submitted ~~annually~~ to the agency.
122 The contents of the report and the frequency at which it is
123 submitted shall be prescribed by rule of the agency.
124 Section 2. Subsection (4) of section 395.003, Florida
125 Statutes, is amended to read:

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

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151 Section 5. Subsection (3) of section 400.19, Florida
152 Statutes, is amended to read:
153 400.19 Right of entry and inspection.—
154 (3) The agency shall conduct periodic, ~~every 15 months~~
155 ~~conduct at least one~~ unannounced licensure inspections
156 ~~inspection~~ to determine compliance by the licensee with
157 statutes, and with rules adopted ~~promulgated~~ under ~~the~~
158 ~~provisions of~~ those statutes, governing minimum standards of
159 construction, quality and adequacy of care, and rights of
160 residents. ~~The survey shall be conducted every 6 months for the~~
161 ~~next 2-year period~~ If the facility has been cited for a class I
162 deficiency or~~,~~ has been cited for two or more class II
163 deficiencies arising from separate surveys or investigations
164 within a 60-day period, the agency shall conduct an additional
165 licensure survey ~~or has had three or more substantiated~~
166 ~~complaints within a 6-month period, each resulting in at least~~
167 ~~one class I or class II deficiency~~. In addition to any other
168 fees or fines in this part, the agency shall assess a fine for
169 each facility that is subject to the additional licensure survey
170 ~~6-month survey cycle~~. The fine for the additional licensure
171 survey ~~2-year period~~ shall be $3,000 ~~$6,000, one-half to be paid~~
172 ~~at the completion of each survey~~. The agency may adjust such
173 ~~this~~ fine by the change in the Consumer Price Index, based on
174 the 12 months immediately preceding the increase, to cover the
175 cost of the additional surveys. The agency shall verify through

176 subsequent inspection that any deficiency identified during
177 inspection is corrected. However, the agency may verify the
178 correction of a class III or class IV deficiency unrelated to
179 resident rights or resident care without reinspecting the
180 facility if adequate written documentation has been received
181 from the facility, which provides assurance that the deficiency
182 has been corrected. The giving or causing to be given of advance
183 notice of such unannounced inspections by an employee of the
184 agency to any unauthorized person shall constitute cause for
185 suspension of not fewer than 5 working days according to ~~the~~
186 ~~provisions of~~ chapter 110.
187 Section 6. Subsections (23) through (30) of section
188 400.462, Florida Statutes, are renumbered as subsections (22)
189 through (29), respectively, and subsections (12), (14), (17),
190 and (21) and present subsection (22) of that section are amended
191 to read:
192 400.462 Definitions.—As used in this part, the term:
193 (12) "Home health agency" means a person or entity ~~an~~
194 ~~organization~~ that provides one or more home health services ~~and~~
195 ~~staffing services~~.
196 (14) "Home health services" means health and medical
197 services and medical supplies furnished ~~by an organization~~ to an
198 individual in the individual's home or place of residence. The
199 term includes ~~organizations that provide one or more of~~ the
200 following:

201 (a) Nursing care.
202 (b) Physical, occupational, respiratory, or speech
203 therapy.
204 (c) Home health aide services.
205 (d) Dietetics and nutrition practice and nutrition
206 counseling.
207 (e) Medical supplies, restricted to drugs and biologicals
208 prescribed by a physician.
209 (17) "Home infusion therapy provider" means a person or
210 entity ~~an organization~~ that employs, contracts with, or refers a
211 licensed professional who has received advanced training and
212 experience in intravenous infusion therapy and who administers
213 infusion therapy to a patient in the patient's home or place of
214 residence.
215 (21) "Nurse registry" means a ~~any~~ person or entity that
216 procures, offers, promises, or attempts to secure health-care-
217 related contracts for registered nurses, licensed practical
218 nurses, certified nursing assistants, home health aides,
219 companions, or homemakers, who are compensated by fees as
220 independent contractors, including, but not limited to,
221 contracts for the provision of services to patients and
222 contracts to provide private duty or staffing services to health
223 care facilities licensed under chapter 395, this chapter, or
224 chapter 429 or other business entities.

225 ~~(22) "Organization" means a corporation, government or~~
226 ~~governmental subdivision or agency, partnership or association,~~
227 ~~or any other legal or commercial entity, any of which involve~~
228 ~~more than one health care professional discipline; a health care~~
229 ~~professional and a home health aide or certified nursing~~
230 ~~assistant; more than one home health aide; more than one~~
231 ~~certified nursing assistant; or a home health aide and a~~
232 ~~certified nursing assistant. The term does not include an entity~~
233 ~~that provides services using only volunteers or only individuals~~
234 ~~related by blood or marriage to the patient or client.~~
235 Section 7. Subsections (1), (4), and (5) of section
236 400.464, Florida Statutes, are amended to read:
237 400.464 Home health agencies to be licensed; expiration of
238 license; exemptions; unlawful acts; penalties.—
239 (1) The requirements of part II of chapter 408 apply to
240 the provision of services that require licensure pursuant to
241 this part and part II of chapter 408 and persons or entities
242 licensed or registered by or applying for such licensure or
243 registration from the Agency for Health Care Administration
244 pursuant to this part. A license or registration issued by the
245 agency is required in order to operate a home health agency in
246 this state. A license or registration issued on or after July 1,
247 2018, must specify the home health services the licensee or
248 registrant ~~organization~~ is authorized to perform and indicate
249 whether such specified services are considered skilled care. The

250 provision or advertising of services that require licensure or
251 registration pursuant to this part without such services being
252 specified on the face of the license or registration issued on
253 or after July 1, 2018, constitutes unlicensed activity as
254 prohibited under s. 408.812.
255 (4)(a) A licensee or registrant An organization that
256 offers or advertises to the public any service for which
257 licensure or registration is required under this part must
258 include in the advertisement the license number or registration
259 number issued to the licensee or registrant organization by the
260 agency. The agency shall assess a fine of not less than $100 to
261 any licensee or registrant that who fails to include the license
262 or registration number when submitting the advertisement for
263 publication, broadcast, or printing. The fine for a second or
264 subsequent offense is $500. The holder of a license or
265 registration issued under this part may not advertise or
266 indicate to the public that it holds a home health agency or
267 nurse registry license or registration other than the one it has
268 been issued.
269 (b) The operation or maintenance of an unlicensed home
270 health agency or the performance of any home health services in
271 violation of this part is declared a nuisance, inimical to the
272 public health, welfare, and safety. The agency or any state
273 attorney may, in addition to other remedies provided in this
274 part, bring an action for an injunction to restrain such

275 violation, or to enjoin the future operation or maintenance of
276 the home health agency or the provision of home health services
277 in violation of this part or part II of chapter 408, until
278 compliance with this part or the rules adopted under this part
279 has been demonstrated to the satisfaction of the agency.
280 (c) A person or entity that ~~who~~ violates paragraph (a) is
281 subject to an injunctive proceeding under s. 408.816. A
282 violation of paragraph (a) or s. 408.812 is a deceptive and
283 unfair trade practice and constitutes a violation of the Florida
284 Deceptive and Unfair Trade Practices Act under part II of
285 chapter 501.
286 (d) A person or entity that ~~who~~ violates ~~the provisions of~~
287 paragraph (a) commits a misdemeanor of the second degree,
288 punishable as provided in s. 775.082 or s. 775.083. Any person
289 or entity that ~~who~~ commits a second or subsequent violation
290 commits a misdemeanor of the first degree, punishable as
291 provided in s. 775.082 or s. 775.083. Each day of continuing
292 violation constitutes a separate offense.
293 (e) A ~~Any~~ person or entity that ~~who~~ owns, operates, or
294 maintains an unlicensed home health agency and ~~who~~, after
295 receiving notification from the agency, fails to cease operation
296 and apply for a license under this part commits a misdemeanor of
297 the second degree, punishable as provided in s. 775.082 or s.
298 775.083. Each day of continued operation is a separate offense.

299 (f) A ~~Any~~ home health agency that fails to cease operation
300 after agency notification may be fined in accordance with s.
301 408.812.
302 (5) The following are exempt from ~~the~~ licensure as a home
303 health agency under ~~requirements of~~ this part:
304 (a) A home health agency operated by the Federal
305 Government.
306 (b) Home health services provided by a state agency,
307 either directly or through a contractor with:
308 1. The Department of Elderly Affairs.
309 2. The Department of Health, a community health center, or
310 a rural health network that furnishes home visits for the
311 purpose of providing environmental assessments, case management,
312 health education, personal care services, family planning, or
313 followup treatment, or for the purpose of monitoring and
314 tracking disease.
315 3. Services provided to persons with developmental
316 disabilities, as defined in s. 393.063.
317 4. Companion and sitter organizations that were registered
318 under s. 400.509(1) on January 1, 1999, and were authorized to
319 provide personal services under a developmental services
320 provider certificate on January 1, 1999, may continue to provide
321 such services to past, present, and future clients of the
322 organization who need such services, notwithstanding ~~the~~
323 ~~provisions of~~ this act.

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324 5. The Department of Children and Families.
325 (c) A health care professional, whether or not
326 incorporated, who is licensed under chapter 457; chapter 458;
327 chapter 459; part I of chapter 464; chapter 467; part I, part
328 III, part V, or part X of chapter 468; chapter 480; chapter 486;
329 chapter 490; or chapter 491; and who is acting alone within the
330 scope of his or her professional license to provide care to
331 patients in their homes.
332 (d) A home health aide or certified nursing assistant who
333 is acting in his or her individual capacity, within the
334 definitions and standards of his or her occupation, and who
335 provides hands-on care to patients in their homes.
336 (e) An individual who acts alone, in his or her individual
337 capacity, and who is not employed by or affiliated with a
338 licensed home health agency or registered with a licensed nurse
339 registry. This exemption does not entitle an individual to
340 perform home health services without the required professional
341 license.
342 (f) The delivery of instructional services in home
343 dialysis and home dialysis supplies and equipment.
344 (g) The delivery of nursing home services for which the
345 nursing home is licensed under part II of this chapter, to serve
346 its residents in its facility.

347 (h) The delivery of assisted living facility services for
348 which the assisted living facility is licensed under part I of
349 chapter 429, to serve its residents in its facility.
350 (i) The delivery of hospice services for which the hospice
351 is licensed under part IV of this chapter, to serve hospice
352 patients admitted to its service.
353 (j) A hospital that provides services for which it is
354 licensed under chapter 395.
355 (k) The delivery of community residential services for
356 which the community residential home is licensed under chapter
357 419, to serve the residents in its facility.
358 (l) A not-for-profit, community-based agency that provides
359 early intervention services to infants and toddlers.
360 (m) Certified rehabilitation agencies and comprehensive
361 outpatient rehabilitation facilities that are certified under
362 Title 18 of the Social Security Act.
363 (n) The delivery of adult family-care home services for
364 which the adult family-care home is licensed under part II of
365 chapter 429, to serve the residents in its facility.
366 (o) A person or entity that provides skilled care by
367 health care professionals licensed solely under part I of
368 chapter 464; part I, part III, or part V of chapter 468; or
369 chapter 486.

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370 (p) A person or entity that provides services using only
371 volunteers or individuals related by blood or marriage to the
372 patient or client.
373 Section 8. Paragraph (g) of subsection (2) of section
374 400.471, Florida Statutes, is amended to read:
375 400.471 Application for license; fee.—
376 (2) In addition to the requirements of part II of chapter
377 408, the initial applicant, the applicant for a change of
378 ownership, and the applicant for the addition of skilled care
379 services must file with the application satisfactory proof that
380 the home health agency is in compliance with this part and
381 applicable rules, including:
382 (g) In the case of an application for initial licensure,
383 an application for a change of ownership, or an application for
384 the addition of skilled care services, documentation of
385 accreditation, or an application for accreditation, from an
386 accrediting organization that is recognized by the agency as
387 having standards comparable to those required by this part and
388 part II of chapter 408. A home health agency that does not
389 provide skilled care is exempt from this paragraph.
390 Notwithstanding s. 408.806, the ~~an initial~~ applicant must
391 provide proof of accreditation that is not conditional or
392 provisional and a survey demonstrating compliance with the
393 requirements of this part, part II of chapter 408, and
394 applicable rules from an accrediting organization that is

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395 recognized by the agency as having standards comparable to those
396 required by this part and part II of chapter 408 within 120 days
397 after the date of the agency's receipt of the application for
398 licensure. Such accreditation must be continuously maintained by
399 the home health agency to maintain licensure. The agency shall
400 accept, in lieu of its own periodic licensure survey, the
401 submission of the survey of an accrediting organization that is
402 recognized by the agency if the accreditation of the licensed
403 home health agency is not provisional and if the licensed home
404 health agency authorizes release of, and the agency receives the
405 report of, the accrediting organization.
406 Section 9. Section 400.492, Florida Statutes, is amended
407 to read:
408 400.492 Provision of services during an emergency.—Each
409 home health agency shall prepare and maintain a comprehensive
410 emergency management plan that is consistent with the standards
411 adopted by national or state accreditation organizations and
412 consistent with the local special needs plan. The plan shall be
413 updated annually and shall provide for continuing home health
414 services during an emergency that interrupts patient care or
415 services in the patient's home. The plan shall include the means
416 by which the home health agency will continue to provide staff
417 to perform the same type and quantity of services to their
418 patients who evacuate to special needs shelters that were being
419 provided to those patients prior to evacuation. The plan shall

420 describe how the home health agency establishes and maintains an
421 effective response to emergencies and disasters, including:
422 notifying staff when emergency response measures are initiated;
423 providing for communication between staff members, county health
424 departments, and local emergency management agencies, including
425 a backup system; identifying resources necessary to continue
426 essential care or services or referrals to other health care
427 providers ~~organizations~~ subject to written agreement; and
428 prioritizing and contacting patients who need continued care or
429 services.
430 (1) Each patient record for patients who are listed in the
431 registry established pursuant to s. 252.355 shall include a
432 description of how care or services will be continued in the
433 event of an emergency or disaster. The home health agency shall
434 discuss the emergency provisions with the patient and the
435 patient's caregivers, including where and how the patient is to
436 evacuate, procedures for notifying the home health agency in the
437 event that the patient evacuates to a location other than the
438 shelter identified in the patient record, and a list of
439 medications and equipment which must either accompany the
440 patient or will be needed by the patient in the event of an
441 evacuation.
442 (2) Each home health agency shall maintain a current
443 prioritized list of patients who need continued services during
444 an emergency. The list shall indicate how services shall be

445 continued in the event of an emergency or disaster for each
446 patient and if the patient is to be transported to a special
447 needs shelter, and shall indicate if the patient is receiving
448 skilled nursing services and the patient's medication and
449 equipment needs. The list shall be furnished to county health
450 departments and to local emergency management agencies, upon
451 request.
452 (3) Home health agencies shall not be required to continue
453 to provide care to patients in emergency situations that are
454 beyond their control and that make it impossible to provide
455 services, such as when roads are impassable or when patients do
456 not go to the location specified in their patient records. Home
457 health agencies may establish links to local emergency
458 operations centers to determine a mechanism by which to approach
459 specific areas within a disaster area in order for the agency to
460 reach its clients. Home health agencies shall demonstrate a good
461 faith effort to comply with the requirements of this subsection
462 by documenting attempts of staff to follow procedures outlined
463 in the home health agency's comprehensive emergency management
464 plan, and by the patient's record, which support a finding that
465 the provision of continuing care has been attempted for those
466 patients who have been identified as needing care by the home
467 health agency and registered under s. 252.355, in the event of
468 an emergency or disaster under subsection (1).

469 (4) Notwithstanding the provisions of s. 400.464(2) or any
470 other provision of law to the contrary, a home health agency may
471 provide services in a special needs shelter located in any
472 county.
473 Section 10. Subsection (4) and paragraph (a) of subsection
474 (5) of section 400.506, Florida Statutes, are amended to read:
475 400.506 Licensure of nurse registries; requirements;
476 penalties.—
477 (4) A licensee ~~person~~ that provides, offers, or advertises
478 to the public any service for which licensure is required under
479 this section must include in such advertisement the license
480 number issued to it by the Agency for Health Care
481 Administration. The agency shall assess a fine of not less than
482 $100 against a ~~any~~ licensee that ~~who~~ fails to include the
483 license number when submitting the advertisement for
484 publication, broadcast, or printing. The fine for a second or
485 subsequent offense is $500.
486 (5)(a) In addition to the requirements of s. 408.812, a
487 ~~any~~ person or entity that ~~who~~ owns, operates, or maintains an
488 unlicensed nurse registry and ~~who~~, after receiving notification
489 from the agency, fails to cease operation and apply for a
490 license under this part commits a misdemeanor of the second
491 degree, punishable as provided in s. 775.082 or s. 775.083. Each
492 day of continued operation is a separate offense.

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493 Section 11. Subsections (1), (2), (4), and (5) of section
494 400.509, Florida Statutes, are amended to read:
495 400.509 Registration of particular service providers
496 exempt from licensure; certificate of registration; regulation
497 of registrants.—
498 (1) A person or entity ~~Any organization~~ that provides
499 companion services or homemaker services and does not provide a
500 home health service to a person is exempt from licensure under
501 this part. However, a person or entity ~~any organization~~ that
502 provides companion services or homemaker services must register
503 with the agency. A person or entity ~~An organization~~ under
504 contract with the Agency for Persons with Disabilities that
505 ~~which~~ provides companion services only for persons with a
506 developmental disability, as defined in s. 393.063, is exempt
507 from registration.
508 (2) The requirements of part II of chapter 408 apply to
509 the provision of services that require registration or licensure
510 pursuant to this section and part II of chapter 408 and entities
511 registered by or applying for such registration from the Agency
512 for Health Care Administration pursuant to this section. Each
513 applicant for registration and each registrant must comply with
514 all provisions of part II of chapter 408. Registration or a
515 license issued by the agency is required for the operation of a
516 person or entity ~~an organization~~ that provides companion
517 services or homemaker services.

518 (4) Each registrant must obtain the employment or contract
519 history of persons who are employed by or under contract with
520 the person or entity ~~organization~~ and who will have contact at
521 any time with patients or clients in their homes by:
522 (a) Requiring such persons to submit an employment or
523 contractual history to the registrant; and
524 (b) Verifying the employment or contractual history,
525 unless through diligent efforts such verification is not
526 possible. The agency shall prescribe by rule the minimum
527 requirements for establishing that diligent efforts have been
528 made.
529
530 There is no monetary liability on the part of, and no cause of
531 action for damages arises against, a former employer of a
532 prospective employee of or prospective independent contractor
533 with a registrant who reasonably and in good faith communicates
534 his or her honest opinions about the former employee's or
535 contractor's job performance. This subsection does not affect
536 the official immunity of an officer or employee of a public
537 corporation.
538 (5) A person or entity that offers or advertises to the
539 public a service for which registration is required must include
540 in its advertisement the registration number issued by the
541 Agency for Health Care Administration.

542 Section 12. Subsection (3) of section 400.605, Florida
543 Statutes, is amended to read:
544 400.605 Administration; forms; fees; rules; inspections;
545 fines.—
546 (3) In accordance with s. 408.811, the agency shall
547 conduct ~~annual inspections of all licensees, except that~~
548 ~~licensure inspections may be conducted biennially for hospices~~
549 ~~having a 3-year record of substantial compliance. The agency~~
550 ~~shall conduct~~ such inspections and investigations as are
551 necessary in order to determine the state of compliance with ~~the~~
552 ~~provisions of~~ this part, part II of chapter 408, and applicable
553 rules.
554 Section 13. Section 400.60501, Florida Statutes, is
555 amended to read:
556 400.60501 Outcome measures; adoption of federal quality
557 measures; public reporting~~; annual report~~.—
558 (1) ~~No later than December 31, 2019,~~ The agency shall
559 adopt the national hospice outcome measures and survey data in
560 42 C.F.R. part 418 to determine the quality and effectiveness of
561 hospice care for hospices licensed in the state.
562 (2) The agency shall~~:~~
563 ~~(a)~~ make available to the public the national hospice
564 outcome measures and survey data in a format that is
565 comprehensible by a layperson and that allows a consumer to
566 compare such measures of one or more hospices.

567 ~~(b) Develop an annual report that analyzes and evaluates~~
568 ~~the information collected under this act and any other data~~
569 ~~collection or reporting provisions of law.~~
570 Section 14. Paragraphs (a), (b), (c), and (d) of
571 subsection (4) of section 400.9905, Florida Statutes, are
572 amended, and paragraphs (o), (p), and (q) are added to that
573 subsection, to read:
574 400.9905 Definitions.—
575 (4) "Clinic" means an entity where health care services
576 are provided to individuals and which tenders charges for
577 reimbursement for such services, including a mobile clinic and a
578 portable equipment provider. As used in this part, the term does
579 not include and the licensure requirements of this part do not
580 apply to:
581 (a) Entities licensed or registered by the state under
582 chapter 395; entities licensed or registered by the state and
583 providing only health care services within the scope of services
584 authorized under their respective licenses under ss. 383.30-
585 383.332, chapter 390, chapter 394, chapter 397, this chapter
586 except part X, chapter 429, chapter 463, chapter 465, chapter
587 466, chapter 478, chapter 484, or chapter 651; end-stage renal
588 disease providers authorized under 42 C.F.R. part 494 ~~405,~~
589 ~~subpart U~~; providers certified and providing only health care
590 services within the scope of services authorized under their
591 respective certifications under 42 C.F.R. part 485, subpart B,

592 ~~or~~ subpart H, or subpart J; providers certified and providing
593 only health care services within the scope of services
594 authorized under their respective certifications under 42 C.F.R.
595 part 486, subpart C; providers certified and providing only
596 health care services within the scope of services authorized
597 under their respective certifications under 42 C.F.R. part 491,
598 subpart A; providers certified by the Centers for Medicare and
599 Medicaid services under the federal Clinical Laboratory
600 Improvement Amendments and the federal rules adopted thereunder;
601 or any entity that provides neonatal or pediatric hospital-based
602 health care services or other health care services by licensed
603 practitioners solely within a hospital licensed under chapter
604 395.
605 (b) Entities that own, directly or indirectly, entities
606 licensed or registered by the state pursuant to chapter 395;
607 entities that own, directly or indirectly, entities licensed or
608 registered by the state and providing only health care services
609 within the scope of services authorized pursuant to their
610 respective licenses under ss. 383.30-383.332, chapter 390,
611 chapter 394, chapter 397, this chapter except part X, chapter
612 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter
613 484, or chapter 651; end-stage renal disease providers
614 authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers
615 certified and providing only health care services within the
616 scope of services authorized under their respective

617 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
618 H, or subpart J; providers certified and providing only health
619 care services within the scope of services authorized under
620 their respective certifications under 42 C.F.R. part 486,
621 subpart C; providers certified and providing only health care
622 services within the scope of services authorized under their
623 respective certifications under 42 C.F.R. part 491, subpart A;
624 providers certified by the Centers for Medicare and Medicaid
625 services under the federal Clinical Laboratory Improvement
626 Amendments and the federal rules adopted thereunder; or any
627 entity that provides neonatal or pediatric hospital-based health
628 care services by licensed practitioners solely within a hospital
629 licensed under chapter 395.
630 (c) Entities that are owned, directly or indirectly, by an
631 entity licensed or registered by the state pursuant to chapter
632 395; entities that are owned, directly or indirectly, by an
633 entity licensed or registered by the state and providing only
634 health care services within the scope of services authorized
635 pursuant to their respective licenses under ss. 383.30-383.332,
636 chapter 390, chapter 394, chapter 397, this chapter except part
637 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter
638 478, chapter 484, or chapter 651; end-stage renal disease
639 providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~;
640 providers certified and providing only health care services
641 within the scope of services authorized under their respective

642 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
643 H, or subpart J; providers certified and providing only health
644 care services within the scope of services authorized under
645 their respective certifications under 42 C.F.R. part 486,
646 subpart C; providers certified and providing only health care
647 services within the scope of services authorized under their
648 respective certifications under 42 C.F.R. part 491, subpart A;
649 providers certified by the Centers for Medicare and Medicaid
650 services under the federal Clinical Laboratory Improvement
651 Amendments and the federal rules adopted thereunder; or any
652 entity that provides neonatal or pediatric hospital-based health
653 care services by licensed practitioners solely within a hospital
654 under chapter 395.
655 (d) Entities that are under common ownership, directly or
656 indirectly, with an entity licensed or registered by the state
657 pursuant to chapter 395; entities that are under common
658 ownership, directly or indirectly, with an entity licensed or
659 registered by the state and providing only health care services
660 within the scope of services authorized pursuant to their
661 respective licenses under ss. 383.30-383.332, chapter 390,
662 chapter 394, chapter 397, this chapter except part X, chapter
663 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter
664 484, or chapter 651; end-stage renal disease providers
665 authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers
666 certified and providing only health care services within the

667 scope of services authorized under their respective
668 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
669 H, or subpart J; providers certified and providing only health
670 care services within the scope of services authorized under
671 their respective certifications under 42 C.F.R. part 486,
672 subpart C; providers certified and providing only health care
673 services within the scope of services authorized under their
674 respective certifications under 42 C.F.R. part 491, subpart A;
675 providers certified by the Centers for Medicare and Medicaid
676 services under the federal Clinical Laboratory Improvement
677 Amendments and the federal rules adopted thereunder; or any
678 entity that provides neonatal or pediatric hospital-based health
679 care services by licensed practitioners solely within a hospital
680 licensed under chapter 395.
681 (o) Entities that are, directly or indirectly, under the
682 common ownership of or that are subject to common control by a
683 mutual insurance holding company, as defined in s. 628.703, with
684 an entity licensed or certified under chapter 627 or chapter 641
685 which has $1 billion or more in total annual sales in this
686 state.
687 (p) Entities that are owned by an entity that is a
688 behavioral health care service provider in at least five other
689 states; that, together with its affiliates, have $90 million or
690 more in total annual revenues associated with the provision of
691 behavioral health care services; and wherein one or more of the

692 persons responsible for the operations of the entity is a health
693 care practitioner who is licensed in this state, who is
694 responsible for supervising the business activities of the
695 entity, and who is responsible for the entity's compliance with
696 state law for purposes of this part.
697 (q) Medicaid providers.
698
699 Notwithstanding this subsection, an entity shall be deemed a
700 clinic and must be licensed under this part in order to receive
701 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.
702 627.730-627.7405, unless exempted under s. 627.736(5)(h).
703 Section 15. Paragraph (c) of subsection (3) of section
704 400.991, Florida Statutes, is amended to read:
705 400.991 License requirements; background screenings;
706 prohibitions.—
707 (3) In addition to the requirements of part II of chapter
708 408, the applicant must file with the application satisfactory
709 proof that the clinic is in compliance with this part and
710 applicable rules, including:
711 (c) Proof of financial ability to operate as required
712 under ss. 408.8065(1) and ~~s.~~ 408.810(8). ~~As an alternative to~~
713 ~~submitting proof of financial ability to operate as required~~
714 ~~under s. 408.810(8), the applicant may file a surety bond of at~~
715 ~~least $500,000 which guarantees that the clinic will act in full~~
716 ~~conformity with all legal requirements for operating a clinic,~~

717 ~~payable to the agency. The agency may adopt rules to specify~~
718 ~~related requirements for such surety bond.~~
719 Section 16. Paragraph (i) of subsection (1) of section
720 400.9935, Florida Statutes, is amended to read:
721 400.9935 Clinic responsibilities.—
722 (1) Each clinic shall appoint a medical director or clinic
723 director who shall agree in writing to accept legal
724 responsibility for the following activities on behalf of the
725 clinic. The medical director or the clinic director shall:
726 (i) Ensure that the clinic publishes a schedule of charges
727 for the medical services offered to patients. The schedule must
728 include the prices charged to an uninsured person paying for
729 such services by cash, check, credit card, or debit card. The
730 schedule may group services by price levels, listing services in
731 each price level. The schedule must be posted in a conspicuous
732 place in the reception area of any clinic that is considered an
733 ~~the~~ urgent care center as defined in s. 395.002(29)(b) and must
734 include, but is not limited to, the 50 services most frequently
735 provided by the clinic. ~~The schedule may group services by three~~
736 ~~price levels, listing services in each price level.~~ The posting
737 may be a sign that must be at least 15 square feet in size or
738 through an electronic messaging board that is at least 3 square
739 feet in size. The failure of a clinic, including a clinic that
740 is considered an urgent care center, to publish and post a
741 schedule of charges as required by this section shall result in

742 a fine of not more than $1,000, per day, until the schedule is
743 published and posted.
744 Section 17. Paragraph (a) of subsection (2) of section
745 408.033, Florida Statutes, is amended to read:
746 408.033 Local and state health planning.—
747 (2) FUNDING.—
748 (a) The Legislature intends that the cost of local health
749 councils be borne by assessments on selected health care
750 facilities subject to facility licensure by the Agency for
751 Health Care Administration, including abortion clinics, assisted
752 living facilities, ambulatory surgical centers, birth centers,
753 home health agencies, hospices, hospitals, intermediate care
754 facilities for the developmentally disabled, nursing homes, <u>and</u>
755 health care clinics~~, and multiphasic testing centers~~ and by
756 assessments on organizations subject to certification by the
757 agency pursuant to chapter 641, part III, including health
758 maintenance organizations and prepaid health clinics. Fees
759 assessed may be collected prospectively at the time of licensure
760 renewal and prorated for the licensure period.
761 Section 18. Paragraph (a) of subsection (1) of section
762 408.061, Florida Statutes, is amended to read:
763 408.061 Data collection; uniform systems of financial
764 reporting; information relating to physician charges;
765 confidential information; immunity.—

766 (1) The agency shall require the submission by health care
767 facilities, health care providers, and health insurers of data
768 necessary to carry out the agency's duties and to facilitate
769 transparency in health care pricing data and quality measures.
770 Specifications for data to be collected under this section shall
771 be developed by the agency and applicable contract vendors, with
772 the assistance of technical advisory panels including
773 representatives of affected entities, consumers, purchasers, and
774 such other interested parties as may be determined by the
775 agency.
776 (a) Data submitted by health care facilities, including
777 the facilities as defined in chapter 395, shall include, but are
778 not limited to, ~~:~~ case-mix data, patient admission and discharge
779 data, hospital emergency department data which shall include the
780 number of patients treated in the emergency department of a
781 licensed hospital reported by patient acuity level, data on
782 hospital-acquired infections as specified by rule, data on
783 complications as specified by rule, data on readmissions as
784 specified by rule, including patient- ~~with patient~~ and provider-
785 specific identifiers ~~included~~, actual charge data by diagnostic
786 groups or other bundled groupings as specified by rule,
787 financial data, accounting data, operating expenses, expenses
788 incurred for rendering services to patients who cannot or do not
789 pay, interest charges, depreciation expenses based on the
790 expected useful life of the property and equipment involved, and

791 demographic data. The agency shall adopt nationally recognized
792 risk adjustment methodologies or software consistent with the
793 standards of the Agency for Healthcare Research and Quality and
794 as selected by the agency for all data submitted as required by
795 this section. Data may be obtained from documents including ~~such~~
796 ~~as~~, but not limited to,~~:~~ leases, contracts, debt instruments,
797 itemized patient statements or bills, medical record abstracts,
798 and related diagnostic information. ~~Reported~~ Data elements shall
799 be reported electronically in accordance with rules adopted by
800 the agency ~~rule 59E-7.012, Florida Administrative Code~~. Data
801 submitted shall be certified by the chief executive officer or
802 an appropriate and duly authorized representative or employee of
803 the licensed facility that the information submitted is true and
804 accurate.
805 Section 19. Subsection (4) of section 408.0611, Florida
806 Statutes, is amended to read:
807 408.0611 Electronic prescribing clearinghouse.—
808 (4) Pursuant to s. 408.061, the agency shall monitor the
809 implementation of electronic prescribing by health care
810 practitioners, health care facilities, and pharmacies. ~~By~~
811 ~~January 31 of each year,~~ The agency shall annually publish a
812 report on the progress of implementation of electronic
813 prescribing on its Internet website ~~to the Governor and the~~
814 ~~Legislature~~. Information reported pursuant to this subsection
815 shall include federal and private sector electronic prescribing

816 initiatives and, to the extent that data is readily available
817 from organizations that operate electronic prescribing networks,
818 the number of health care practitioners using electronic
819 prescribing and the number of prescriptions electronically
820 transmitted.
821 Section 20. Paragraphs (i) and (j) of subsection (1) of
822 section 408.062, Florida Statutes, are amended to read:
823 408.062 Research, analyses, studies, and reports.—
824 (1) The agency shall conduct research, analyses, and
825 studies relating to health care costs and access to and quality
826 of health care services as access and quality are affected by
827 changes in health care costs. Such research, analyses, and
828 studies shall include, but not be limited to:
829 (i) The use of emergency department services by patient
830 acuity level ~~and the implication of increasing hospital cost by~~
831 ~~providing nonurgent care in emergency departments~~. The agency
832 shall annually publish information ~~submit an annual report~~ based
833 on this monitoring and assessment on its Internet website ~~to the~~
834 ~~Governor, the Speaker of the House of Representatives, the~~
835 ~~President of the Senate, and the substantive legislative~~
836 ~~committees, due January 1~~.
837 (j) The making available on its Internet website, and in a
838 hard-copy format upon request, of patient charge, volumes,
839 length of stay, and performance indicators collected from health
840 care facilities pursuant to s. 408.061(1)(a) for specific

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841 medical conditions, surgeries, and procedures provided in
842 inpatient and outpatient facilities as determined by the agency.
843 In making the determination of specific medical conditions,
844 surgeries, and procedures to include, the agency shall consider
845 such factors as volume, severity of the illness, urgency of
846 admission, individual and societal costs, and whether the
847 condition is acute or chronic. Performance outcome indicators
848 shall be risk adjusted or severity adjusted, as applicable,
849 using nationally recognized risk adjustment methodologies or
850 software consistent with the standards of the Agency for
851 Healthcare Research and Quality and as selected by the agency.
852 The website shall also provide an interactive search that allows
853 consumers to view and compare the information for specific
854 facilities, a map that allows consumers to select a county or
855 region, definitions of all of the data, descriptions of each
856 procedure, and an explanation about why the data may differ from
857 facility to facility. Such public data shall be updated
858 quarterly. The agency shall annually publish information
859 regarding ~~submit an annual status report on~~ the collection of
860 data and publication of health care quality measures on its
861 Internet website ~~to the Governor, the Speaker of the House of~~
862 ~~Representatives, the President of the Senate, and the~~
863 ~~substantive legislative committees, due January 1~~.
864 Section 21. Subsection (5) of section 408.063, Florida
865 Statutes, is amended to read:

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866 408.063 Dissemination of health care information.—
867 ~~(5) The agency shall publish annually a comprehensive~~
868 ~~report of state health expenditures. The report shall identify:~~
869 ~~(a) The contribution of health care dollars made by all~~
870 ~~payors.~~
871 ~~(b) The dollars expended by type of health care service in~~
872 ~~Florida.~~
873 Section 22. Section 408.802, Florida Statutes, is amended
874 to read:
875 408.802 Applicability.—~~The provisions of~~ This part <u>applies</u>
876 ~~apply~~ to the provision of services that require licensure as
877 defined in this part and to the following entities licensed,
878 registered, or certified by the agency, as described in chapters
879 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765:
880 (1) Laboratories authorized to perform testing under the
881 Drug-Free Workplace Act, as provided under ss. 112.0455 and
882 440.102.
883 (2) Birth centers, as provided under chapter 383.
884 (3) Abortion clinics, as provided under chapter 390.
885 (4) Crisis stabilization units, as provided under parts I
886 and IV of chapter 394.
887 (5) Short-term residential treatment facilities, as
888 provided under parts I and IV of chapter 394.
889 (6) Residential treatment facilities, as provided under
890 part IV of chapter 394.

891 (7) Residential treatment centers for children and
892 adolescents, as provided under part IV of chapter 394.
893 (8) Hospitals, as provided under part I of chapter 395.
894 (9) Ambulatory surgical centers, as provided under part I
895 of chapter 395.
896 (10) Nursing homes, as provided under part II of chapter
897 400.
898 (11) Assisted living facilities, as provided under part I
899 of chapter 429.
900 (12) Home health agencies, as provided under part III of
901 chapter 400.
902 (13) Nurse registries, as provided under part III of
903 chapter 400.
904 (14) Companion services or homemaker services providers,
905 as provided under part III of chapter 400.
906 (15) Adult day care centers, as provided under part III of
907 chapter 429.
908 (16) Hospices, as provided under part IV of chapter 400.
909 (17) Adult family-care homes, as provided under part II of
910 chapter 429.
911 (18) Homes for special services, as provided under part V
912 of chapter 400.
913 (19) Transitional living facilities, as provided under
914 part XI of chapter 400.

915 (20) Prescribed pediatric extended care centers, as
916 provided under part VI of chapter 400.
917 (21) Home medical equipment providers, as provided under
918 part VII of chapter 400.
919 (22) Intermediate care facilities for persons with
920 developmental disabilities, as provided under part VIII of
921 chapter 400.
922 (23) Health care services pools, as provided under part IX
923 of chapter 400.
924 (24) Health care clinics, as provided under part X of
925 chapter 400.
926 ~~(25) Multiphasic health testing centers, as provided under~~
927 ~~part I of chapter 483.~~
928 (25) ~~(26)~~ Organ, tissue, and eye procurement organizations,
929 as provided under part V of chapter 765.
930 Section 23. Subsections (10) through (14) of section
931 408.803, Florida Statutes, are renumbered as subsections (11)
932 through (15), respectively, subsection (3) is amended, and a new
933 subsection (10) is added to that section, to read:
934 408.803 Definitions.—As used in this part, the term:
935 (3) "Authorizing statute" means the statute authorizing
936 the licensed operation of a provider listed in s. 408.802 and
937 includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~
938 and 765.

939 (10) "Low-risk provider" means a nonresidential provider,
940 including a nurse registry, a home medical equipment provider,
941 or a health care clinic.
942 Section 24. Paragraph (b) of subsection (7) of section
943 408.806, Florida Statutes, is amended to read:
944 408.806 License application process.—
945 (7)
946 (b) An initial inspection is not required for companion
947 services or homemaker services providers, as provided under part
948 III of chapter 400, or for health care services pools, as
949 provided under part IX of chapter 400, or for low-risk providers
950 as provided in s. 408.811(1)(c).
951 Section 25. Subsection (2) of section 408.808, Florida
952 Statutes, is amended to read:
953 408.808 License categories.—
954 (2) PROVISIONAL LICENSE.—An applicant against whom a
955 proceeding denying or revoking a license is pending at the time
956 of license renewal may be issued a provisional license effective
957 until final action not subject to further appeal. A provisional
958 license may also be issued to an applicant making initial
959 application for licensure or making application applying for a
960 change of ownership. A provisional license must be limited in
961 duration to a specific period of time, up to 12 months, as
962 determined by the agency.

963 Section 26. Subsections (6) through (9) of section
964 408.809, Florida Statutes, are renumbered as subsections (5)
965 through (8), respectively, and subsections (2) and (4) and
966 present subsection (5) of that section are amended to read:
967 408.809 Background screening; prohibited offenses.—
968 (2) Every 5 years following his or her licensure,
969 employment, or entry into a contract in a capacity that under
970 subsection (1) would require level 2 background screening under
971 chapter 435, each such person must submit to level 2 background
972 rescreening as a condition of retaining such license or
973 continuing in such employment or contractual status. For any
974 such rescreening, the agency shall request the Department of Law
975 Enforcement to forward the person's fingerprints to the Federal
976 Bureau of Investigation for a national criminal history record
977 check unless the person's fingerprints are enrolled in the
978 Federal Bureau of Investigation's national retained print arrest
979 notification program. If the fingerprints of such a person are
980 not retained by the Department of Law Enforcement under s.
981 943.05(2)(g) and (h), the person must submit fingerprints
982 electronically to the Department of Law Enforcement for state
983 processing, and the Department of Law Enforcement shall forward
984 the fingerprints to the Federal Bureau of Investigation for a
985 national criminal history record check. The fingerprints shall
986 be retained by the Department of Law Enforcement under s.
987 943.05(2)(g) and (h) and enrolled in the national retained print

988 arrest notification program when the Department of Law
989 Enforcement begins participation in the program. The cost of the
990 state and national criminal history records checks required by
991 level 2 screening may be borne by the licensee or the person
992 fingerprinted. ~~Until a specified agency is fully implemented in~~
993 ~~the clearinghouse created under s. 435.12,~~ The agency may accept
994 as satisfying the requirements of this section proof of
995 compliance with level 2 screening standards submitted within the
996 previous 5 years to meet any provider or professional licensure
997 requirements of ~~the agency, the Department of Health, the~~
998 ~~Department of Elderly Affairs, the Agency for Persons with~~
999 ~~Disabilities, the Department of Children and Families, or~~ the
1000 Department of Financial Services for an applicant for a
1001 certificate of authority or provisional certificate of authority
1002 to operate a continuing care retirement community under chapter
1003 651, provided that:
1004 (a) The screening standards and disqualifying offenses for
1005 the prior screening are equivalent to those specified in s.
1006 435.04 and this section;
1007 (b) The person subject to screening has not had a break in
1008 service from a position that requires level 2 screening for more
1009 than 90 days; and
1010 (c) Such proof is accompanied, under penalty of perjury,
1011 by an attestation of compliance with chapter 435 and this
1012 section using forms provided by the agency.

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1013 (4) In addition to the offenses listed in s. 435.04, all
1014 persons required to undergo background screening pursuant to
1015 this part or authorizing statutes must not have an arrest
1016 awaiting final disposition for, must not have been found guilty
1017 of, regardless of adjudication, or entered a plea of nolo
1018 contendere or guilty to, and must not have been adjudicated
1019 delinquent and the record not have been sealed or expunged for
1020 any of the following offenses or any similar offense of another
1021 jurisdiction:
1022 (a) Any authorizing statutes, if the offense was a felony.
1023 (b) This chapter, if the offense was a felony.
1024 (c) Section 409.920, relating to Medicaid provider fraud.
1025 (d) Section 409.9201, relating to Medicaid fraud.
1026 (e) Section 741.28, relating to domestic violence.
1027 (f) Section 777.04, relating to attempts, solicitation,
1028 and conspiracy to commit an offense listed in this subsection.
1029 (g) Section 817.034, relating to fraudulent acts through
1030 mail, wire, radio, electromagnetic, photoelectronic, or
1031 photooptical systems.
1032 (h) Section 817.234, relating to false and fraudulent
1033 insurance claims.
1034 (i) Section 817.481, relating to obtaining goods by using
1035 a false or expired credit card or other credit device, if the
1036 offense was a felony.

1037 (j) Section 817.50, relating to fraudulently obtaining
1038 goods or services from a health care provider.
1039 (k) Section 817.505, relating to patient brokering.
1040 (l) Section 817.568, relating to criminal use of personal
1041 identification information.
1042 (m) Section 817.60, relating to obtaining a credit card
1043 through fraudulent means.
1044 (n) Section 817.61, relating to fraudulent use of credit
1045 cards, if the offense was a felony.
1046 (o) Section 831.01, relating to forgery.
1047 (p) Section 831.02, relating to uttering forged
1048 instruments.
1049 (q) Section 831.07, relating to forging bank bills,
1050 checks, drafts, or promissory notes.
1051 (r) Section 831.09, relating to uttering forged bank
1052 bills, checks, drafts, or promissory notes.
1053 (s) Section 831.30, relating to fraud in obtaining
1054 medicinal drugs.
1055 (t) Section 831.31, relating to the sale, manufacture,
1056 delivery, or possession with the intent to sell, manufacture, or
1057 deliver any counterfeit controlled substance, if the offense was
1058 a felony.
1059 (u) Section 895.03, relating to racketeering and
1060 collection of unlawful debts.

1061 (v) Section 896.101, relating to the Florida Money
1062 Laundering Act.
1063
1064 If, upon rescreening, a person who is currently employed or
1065 contracted with a licensee ~~as of June 30, 2014,~~ and was screened
1066 and qualified under <u>s.</u> ~~ss. 435.03 and~~ 435.04~~,~~ has a
1067 disqualifying offense that was not a disqualifying offense at
1068 the time of the last screening, but is a current disqualifying
1069 offense and was committed before the last screening, he or she
1070 may apply for an exemption from the appropriate licensing agency
1071 and, if agreed to by the employer, may continue to perform his
1072 or her duties until the licensing agency renders a decision on
1073 the application for exemption if the person is eligible to apply
1074 for an exemption and the exemption request is received by the
1075 agency no later than 30 days after receipt of the rescreening
1076 results by the person.
1077 ~~(5) A person who serves as a controlling interest of, is~~
1078 ~~employed by, or contracts with a licensee on July 31, 2010, who~~
1079 ~~has been screened and qualified according to standards specified~~
1080 ~~in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,~~
1081 ~~in compliance with the following schedule. If, upon rescreening,~~
1082 ~~such person has a disqualifying offense that was not a~~
1083 ~~disqualifying offense at the time of the last screening, but is~~
1084 ~~a current disqualifying offense and was committed before the~~
1085 ~~last screening, he or she may apply for an exemption from the~~

1086 ~~appropriate licensing agency and, if agreed to by the employer,~~
1087 ~~may continue to perform his or her duties until the licensing~~
1088 ~~agency renders a decision on the application for exemption if~~
1089 ~~the person is eligible to apply for an exemption and the~~
1090 ~~exemption request is received by the agency within 30 days after~~
1091 ~~receipt of the rescreening results by the person. The~~
1092 ~~rescreening schedule shall be:~~
1093 ~~(a) Individuals for whom the last screening was conducted~~
1094 ~~on or before December 31, 2004, must be rescreened by July 31,~~
1095 ~~2013.~~
1096 ~~(b) Individuals for whom the last screening conducted was~~
1097 ~~between January 1, 2005, and December 31, 2008, must be~~
1098 ~~rescreened by July 31, 2014.~~
1099 ~~(c) Individuals for whom the last screening conducted was~~
1100 ~~between January 1, 2009, through July 31, 2011, must be~~
1101 ~~rescreened by July 31, 2015.~~
1102 Section 27. Subsection (1) of section 408.811, Florida
1103 Statutes, is amended to read:
1104 408.811 Right of inspection; copies; inspection reports;
1105 plan for correction of deficiencies.—
1106 (1) An authorized officer or employee of the agency may
1107 make or cause to be made any inspection or investigation deemed
1108 necessary by the agency to determine the state of compliance
1109 with this part, authorizing statutes, and applicable rules. The
1110 right of inspection extends to any business that the agency has

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1111 reason to believe is being operated as a provider without a
1112 license, but inspection of any business suspected of being
1113 operated without the appropriate license may not be made without
1114 the permission of the owner or person in charge unless a warrant
1115 is first obtained from a circuit court. Any application for a
1116 license issued under this part, authorizing statutes, or
1117 applicable rules constitutes permission for an appropriate
1118 inspection to verify the information submitted on or in
1119 connection with the application.
1120 (a) All inspections shall be unannounced, except as
1121 specified in s. 408.806.
1122 (b) Inspections for relicensure shall be conducted
1123 biennially unless otherwise specified by this section,
1124 authorizing statutes, or applicable rules.
1125 (c) The agency may exempt a low-risk provider from a
1126 licensure inspection if the provider or a controlling interest
1127 has an excellent regulatory history with regard to deficiencies,
1128 sanctions, complaints, or other regulatory actions as defined in
1129 agency rule. The agency must conduct unannounced licensure
1130 inspections on at least 10 percent of the exempt low-risk
1131 providers to verify regulatory compliance.
1132 (d) The agency may adopt rules to waive any inspection,
1133 including a relicensure inspection, or grant an extended time
1134 period between relicensure inspections based upon:

1135 1. An excellent regulatory history with regard to
1136 deficiencies, sanctions, complaints, or other regulatory
1137 measures.
1138 2. Outcome measures that demonstrate quality performance.
1139 3. Successful participation in a recognized, quality
1140 program.
1141 4. Accreditation status.
1142 5. Other measures reflective of quality and safety.
1143 6. The length of time between inspections.
1144
1145 The agency shall continue to conduct unannounced licensure
1146 inspections on at least 10 percent of providers that qualify for
1147 an exemption or extended period between relicensure inspections.
1148 The agency may conduct an inspection of any provider at any time
1149 to verify regulatory compliance.
1150 Section 28. Subsection (24) of section 408.820, Florida
1151 Statutes, is amended to read:
1152 408.820 Exemptions.—Except as prescribed in authorizing
1153 statutes, the following exemptions shall apply to specified
1154 requirements of this part:
1155 ~~(24) Multiphasic health testing centers, as provided under~~
1156 ~~part I of chapter 483, are exempt from s. 408.810(5)-(10).~~
1157 Section 29. Subsections (1) and (2) of section 408.821,
1158 Florida Statutes, are amended to read:

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1159 408.821 Emergency management planning; emergency
1160 operations; inactive license.—
1161 (1) A licensee required by authorizing statutes and agency
1162 rule to have a comprehensive ~~an~~ emergency management ~~operations~~
1163 plan must designate a safety liaison to serve as the primary
1164 contact for emergency operations. Such licensee shall submit its
1165 comprehensive emergency management plan to the local emergency
1166 management agency, county health department, or Department of
1167 Health as follows:
1168 (a) Submit the plan within 30 days after initial licensure
1169 and change of ownership, and notify the agency within 30 days
1170 after submission of the plan.
1171 (b) Submit the plan annually and within 30 days after any
1172 significant modification, as defined by agency rule, to a
1173 previously approved plan.
1174 (c) Submit necessary plan revisions within 30 days after
1175 notification that plan revisions are required.
1176 (d) Notify the agency within 30 days after approval of its
1177 plan by the local emergency management agency, county health
1178 department, or Department of Health.
1179 (2) An entity subject to this part may temporarily exceed
1180 its licensed capacity to act as a receiving provider in
1181 accordance with an approved comprehensive emergency management
1182 ~~operations~~ plan for up to 15 days. While in an overcapacity
1183 status, each provider must furnish or arrange for appropriate

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1184 care and services to all clients. In addition, the agency may
1185 approve requests for overcapacity in excess of 15 days, which
1186 approvals may be based upon satisfactory justification and need
1187 as provided by the receiving and sending providers.
1188 Section 30. Subsection (3) of section 408.831, Florida
1189 Statutes, is amended to read:
1190 408.831 Denial, suspension, or revocation of a license,
1191 registration, certificate, or application.—
1192 (3) This section provides standards of enforcement
1193 applicable to all entities licensed or regulated by the Agency
1194 for Health Care Administration. This section controls over any
1195 conflicting provisions of chapters 39, 383, 390, 391, 394, 395,
1196 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to
1197 those chapters.
1198 Section 31. Section 408.832, Florida Statutes, is amended
1199 to read:
1200 408.832 Conflicts.—In case of conflict between ~~the~~
1201 ~~provisions of~~ this part and the authorizing statutes governing
1202 the licensure of health care providers by the Agency for Health
1203 Care Administration found in s. 112.0455 and chapters 383, 390,
1204 394, 395, 400, 429, 440, ~~483,~~ and 765, ~~the provisions of~~ this
1205 part shall prevail.
1206 Section 32. Subsection (9) of section 408.909, Florida
1207 Statutes, is amended to read:
1208 408.909 Health flex plans.—

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1209 ~~(9) PROGRAM EVALUATION.—The agency and the office shall~~
1210 ~~evaluate the pilot program and its effect on the entities that~~
1211 ~~seek approval as health flex plans, on the number of enrollees,~~
1212 ~~and on the scope of the health care coverage offered under a~~
1213 ~~health flex plan; shall provide an assessment of the health flex~~
1214 ~~plans and their potential applicability in other settings; shall~~
1215 ~~use health flex plans to gather more information to evaluate~~
1216 ~~low-income consumer driven benefit packages; and shall, by~~
1217 ~~January 15, 2016, and annually thereafter, jointly submit a~~
1218 ~~report to the Governor, the President of the Senate, and the~~
1219 ~~Speaker of the House of Representatives.~~
1220 Section 33. Paragraph (d) of subsection (10) of section
1221 408.9091, Florida Statutes, is amended to read:
1222 408.9091 Cover Florida Health Care Access Program.—
1223 (10) PROGRAM EVALUATION.—The agency and the office shall:
1224 ~~(d) Jointly submit by March 1, annually, a report to the~~
1225 ~~Governor, the President of the Senate, and the Speaker of the~~
1226 ~~House of Representatives which provides the information~~
1227 ~~specified in paragraphs (a)-(c) and recommendations relating to~~
1228 ~~the successful implementation and administration of the program.~~
1229 Section 34. Effective upon becoming a law, paragraph (a)
1230 of subsection (5) of section 409.905, Florida Statutes, is
1231 amended to read:
1232 409.905 Mandatory Medicaid services.—The agency may make
1233 payments for the following services, which are required of the

1234 state by Title XIX of the Social Security Act, furnished by
1235 Medicaid providers to recipients who are determined to be
1236 eligible on the dates on which the services were provided. Any
1237 service under this section shall be provided only when medically
1238 necessary and in accordance with state and federal law.
1239 Mandatory services rendered by providers in mobile units to
1240 Medicaid recipients may be restricted by the agency. Nothing in
1241 this section shall be construed to prevent or limit the agency
1242 from adjusting fees, reimbursement rates, lengths of stay,
1243 number of visits, number of services, or any other adjustments
1244 necessary to comply with the availability of moneys and any
1245 limitations or directions provided for in the General
1246 Appropriations Act or chapter 216.
1247 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1248 all covered services provided for the medical care and treatment
1249 of a recipient who is admitted as an inpatient by a licensed
1250 physician or dentist to a hospital licensed under part I of
1251 chapter 395. However, the agency shall limit the payment for
1252 inpatient hospital services for a Medicaid recipient 21 years of
1253 age or older to 45 days or the number of days necessary to
1254 comply with the General Appropriations Act.
1255 (a)1. The agency may implement reimbursement and
1256 utilization management reforms in order to comply with any
1257 limitations or directions in the General Appropriations Act,
1258 which may include, but are not limited to: prior authorization

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1259 for inpatient psychiatric days; prior authorization for
1260 nonemergency hospital inpatient admissions for individuals 21
1261 years of age and older; authorization of emergency and urgent-
1262 care admissions within 24 hours after admission; enhanced
1263 utilization and concurrent review programs for highly utilized
1264 services; reduction or elimination of covered days of service;
1265 adjusting reimbursement ceilings for variable costs; adjusting
1266 reimbursement ceilings for fixed and property costs; and
1267 implementing target rates of increase.
1268 2. The agency may limit prior authorization for hospital
1269 inpatient services to selected diagnosis-related groups, based
1270 on an analysis of the cost and potential for unnecessary
1271 hospitalizations represented by certain diagnoses. Admissions
1272 for normal delivery and newborns are exempt from requirements
1273 for prior authorization.
1274 3. In implementing the provisions of this section related
1275 to prior authorization, the agency shall ensure that the process
1276 for authorization is accessible 24 hours per day, 7 days per
1277 week and authorization is automatically granted when not denied
1278 within 4 hours after the request. Authorization procedures must
1279 include steps for review of denials.
1280 4. Upon implementing the prior authorization program for
1281 hospital inpatient services, the agency shall discontinue its
1282 hospital retrospective review program. However, this
1283 subparagraph may not be construed to prevent the agency from

1284 conducting retrospective reviews under s. 409.913, including
1285 reviews in which overpayment is suspected due to improper
1286 claiming, mistake, or any other reason that does not rise to the
1287 level of fraud or abuse.
1288 Section 35. It is the intent of the Legislature that s.
1289 409.905(5)(a), Florida Statutes, as amended by this act, confirm
1290 and clarify existing law.
1291 Section 36. Subsection (8) of section 409.907, Florida
1292 Statutes, is amended to read:
1293 409.907 Medicaid provider agreements.—The agency may make
1294 payments for medical assistance and related services rendered to
1295 Medicaid recipients only to an individual or entity who has a
1296 provider agreement in effect with the agency, who is performing
1297 services or supplying goods in accordance with federal, state,
1298 and local law, and who agrees that no person shall, on the
1299 grounds of handicap, race, color, or national origin, or for any
1300 other reason, be subjected to discrimination under any program
1301 or activity for which the provider receives payment from the
1302 agency.
1303 (8)(a) A level 2 background screening pursuant to chapter
1304 435 must be conducted through the agency on each of the
1305 following:
1306 1. The ~~Each~~ provider, or each principal of the provider if
1307 the provider is a corporation, partnership, association, or
1308 other entity~~, seeking to participate in the Medicaid program~~

1309 ~~must submit a complete set of his or her fingerprints to the~~
1310 ~~agency for the purpose of conducting a criminal history record~~
1311 ~~check~~.
1312 2. Principals of the provider, who include any officer,
1313 director, billing agent, managing employee, or affiliated
1314 person, or any partner or shareholder who has an ownership
1315 interest equal to 5 percent or more in the provider. However,
1316 for a hospital licensed under chapter 395 or a nursing home
1317 licensed under chapter 400, principals of the provider are those
1318 who meet the definition of a controlling interest under s.
1319 408.803. A director of a not-for-profit corporation or
1320 organization is not a principal for purposes of a background
1321 investigation required by this section if the director: serves
1322 solely in a voluntary capacity for the corporation or
1323 organization, does not regularly take part in the day-to-day
1324 operational decisions of the corporation or organization,
1325 receives no remuneration from the not-for-profit corporation or
1326 organization for his or her service on the board of directors,
1327 has no financial interest in the not-for-profit corporation or
1328 organization, and has no family members with a financial
1329 interest in the not-for-profit corporation or organization; and
1330 if the director submits an affidavit, under penalty of perjury,
1331 to this effect to the agency and the not-for-profit corporation
1332 or organization submits an affidavit, under penalty of perjury,

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1333 to this effect to the agency as part of the corporation's or
1334 organization's Medicaid provider agreement application.
1335 3. Any person who participates or seeks to participate in
1336 the Medicaid program by way of rendering services to Medicaid
1337 recipients or having direct access to Medicaid recipients,
1338 recipient living areas, or the financial, medical, or service
1339 records of a Medicaid recipient or who supervises the delivery
1340 of goods or services to a Medicaid recipient. This subparagraph
1341 does not impose additional screening requirements on any
1342 providers licensed under part II of chapter 408.
1343 (b) Notwithstanding paragraph (a) the above, the agency
1344 may require a background check for any person reasonably
1345 suspected by the agency to have been convicted of a crime.
1346 (c)(a) Paragraph (a) This subsection does not apply to:
1347 1. A unit of local government, except that requirements of
1348 this subsection apply to nongovernmental providers and entities
1349 contracting with the local government to provide Medicaid
1350 services. The actual cost of the state and national criminal
1351 history record checks must be borne by the nongovernmental
1352 provider or entity; or
1353 2. Any business that derives more than 50 percent of its
1354 revenue from the sale of goods to the final consumer, and the
1355 business or its controlling parent is required to file a form
1356 10-K or other similar statement with the Securities and Exchange
1357 Commission or has a net worth of $50 million or more.

1358 (d) ~~(b)~~ Background screening shall be conducted in
1359 accordance with chapter 435 and s. 408.809. The cost of the
1360 state and national criminal record check shall be borne by the
1361 provider.
1362 Section 37. Section 409.913, Florida Statutes, is amended
1363 to read:
1364 409.913 Oversight of the integrity of the Medicaid
1365 program.—The agency shall operate a program to oversee the
1366 activities of Florida Medicaid recipients, and providers and
1367 their representatives, to ensure that fraudulent and abusive
1368 behavior and neglect of recipients occur to the minimum extent
1369 possible, and to recover overpayments and impose sanctions as
1370 appropriate. Each January 15 ~~1~~, the agency and the Medicaid
1371 Fraud Control Unit of the Department of Legal Affairs shall
1372 submit a ~~joint~~ report to the Legislature documenting the
1373 effectiveness of the state's efforts to control Medicaid fraud
1374 and abuse and to recover Medicaid overpayments during the
1375 previous fiscal year. The report must describe the number of
1376 cases opened and investigated each year; the sources of the
1377 cases opened; the disposition of the cases closed each year; the
1378 amount of overpayments alleged in preliminary and final audit
1379 letters; the number and amount of fines or penalties imposed;
1380 any reductions in overpayment amounts negotiated in settlement
1381 agreements or by other means; the amount of final agency
1382 determinations of overpayments; the amount deducted from federal

1383 claiming as a result of overpayments; the amount of overpayments
1384 recovered each year; the amount of cost of investigation
1385 recovered each year; the average length of time to collect from
1386 the time the case was opened until the overpayment is paid in
1387 full; the amount determined as uncollectible and the portion of
1388 the uncollectible amount subsequently reclaimed from the Federal
1389 Government; the number of providers, by type, that are
1390 terminated from participation in the Medicaid program as a
1391 result of fraud and abuse; and all costs associated with
1392 discovering and prosecuting cases of Medicaid overpayments and
1393 making recoveries in such cases. The report must also document
1394 actions taken to prevent overpayments and the number of
1395 providers prevented from enrolling in or reenrolling in the
1396 Medicaid program as a result of documented Medicaid fraud and
1397 abuse and must include policy recommendations necessary to
1398 prevent or recover overpayments and changes necessary to prevent
1399 and detect Medicaid fraud. All policy recommendations in the
1400 report must include a detailed fiscal analysis, including, but
1401 not limited to, implementation costs, estimated savings to the
1402 Medicaid program, and the return on investment. The agency must
1403 submit the policy recommendations and fiscal analyses in the
1404 report to the appropriate estimating conference, pursuant to s.
1405 216.137, by February 15 of each year. The agency and the
1406 Medicaid Fraud Control Unit of the Department of Legal Affairs
1407 each must include detailed unit-specific performance standards,

1408 benchmarks, and metrics in the report, including projected cost
1409 savings to the state Medicaid program during the following
1410 fiscal year.
1411 (1) For the purposes of this section, the term:
1412 (a) "Abuse" means:
1413 1. Provider practices that are inconsistent with generally
1414 accepted business or medical practices and that result in an
1415 unnecessary cost to the Medicaid program or in reimbursement for
1416 goods or services that are not medically necessary or that fail
1417 to meet professionally recognized standards for health care.
1418 2. Recipient practices that result in unnecessary cost to
1419 the Medicaid program.
1420 (b) "Complaint" means an allegation that fraud, abuse, or
1421 an overpayment has occurred.
1422 (c) "Fraud" means an intentional deception or
1423 misrepresentation made by a person with the knowledge that the
1424 deception results in unauthorized benefit to herself or himself
1425 or another person. The term includes any act that constitutes
1426 fraud under applicable federal or state law.
1427 (d) "Medical necessity" or "medically necessary" means any
1428 goods or services necessary to palliate the effects of a
1429 terminal condition, or to prevent, diagnose, correct, cure,
1430 alleviate, or preclude deterioration of a condition that
1431 threatens life, causes pain or suffering, or results in illness
1432 or infirmity, which goods or services are provided in accordance

1433 with generally accepted standards of medical practice. For
1434 purposes of determining Medicaid reimbursement, the agency is
1435 the final arbiter of medical necessity. Determinations of
1436 medical necessity must be made by a licensed physician employed
1437 by or under contract with the agency and must be based upon
1438 information available at the time the goods or services are
1439 provided.
1440 (e) "Overpayment" includes any amount that is not
1441 authorized to be paid by the Medicaid program whether paid as a
1442 result of inaccurate or improper cost reporting, improper
1443 claiming, unacceptable practices, fraud, abuse, or mistake.
1444 (f) "Person" means any natural person, corporation,
1445 partnership, association, clinic, group, or other entity,
1446 whether or not such person is enrolled in the Medicaid program
1447 or is a provider of health care.
1448 (2) The agency shall conduct, or cause to be conducted by
1449 contract or otherwise, reviews, investigations, analyses,
1450 audits, or any combination thereof, to determine possible fraud,
1451 abuse, overpayment, or recipient neglect in the Medicaid program
1452 and shall report the findings of any overpayments in audit
1453 reports as appropriate. At least 5 percent of all audits shall
1454 be conducted on a random basis. As part of its ongoing fraud
1455 detection activities, the agency shall identify and monitor, by
1456 contract or otherwise, patterns of overutilization of Medicaid
1457 services based on state averages. The agency shall track

1458 Medicaid provider prescription and billing patterns and evaluate
1459 them against Medicaid medical necessity criteria and coverage
1460 and limitation guidelines adopted by rule. Medical necessity
1461 determination requires that service be consistent with symptoms
1462 or confirmed diagnosis of illness or injury under treatment and
1463 not in excess of the patient's needs. The agency shall conduct
1464 reviews of provider exceptions to peer group norms and shall,
1465 using statistical methodologies, provider profiling, and
1466 analysis of billing patterns, detect and investigate abnormal or
1467 unusual increases in billing or payment of claims for Medicaid
1468 services and medically unnecessary provision of services.
1469 (3) The agency may conduct, or may contract for,
1470 prepayment review of provider claims to ensure cost-effective
1471 purchasing; to ensure that billing by a provider to the agency
1472 is in accordance with applicable provisions of all Medicaid
1473 rules, regulations, handbooks, and policies and in accordance
1474 with federal, state, and local law; and to ensure that
1475 appropriate care is rendered to Medicaid recipients. Such
1476 prepayment reviews may be conducted as determined appropriate by
1477 the agency, without any suspicion or allegation of fraud, abuse,
1478 or neglect, and may last for up to 1 year. Unless the agency has
1479 reliable evidence of fraud, misrepresentation, abuse, or
1480 neglect, claims shall be adjudicated for denial or payment
1481 within 90 days after receipt of complete documentation by the
1482 agency for review. If there is reliable evidence of fraud,

1483 misrepresentation, abuse, or neglect, claims shall be
1484 adjudicated for denial of payment within 180 days after receipt
1485 of complete documentation by the agency for review.
1486 (4) Any suspected criminal violation identified by the
1487 agency must be referred to the Medicaid Fraud Control Unit of
1488 the Office of the Attorney General for investigation. The agency
1489 and the Attorney General shall enter into a memorandum of
1490 understanding, which must include, but need not be limited to, a
1491 protocol for regularly sharing information and coordinating
1492 casework. The protocol must establish a procedure for the
1493 referral by the agency of cases involving suspected Medicaid
1494 fraud to the Medicaid Fraud Control Unit for investigation, and
1495 the return to the agency of those cases where investigation
1496 determines that administrative action by the agency is
1497 appropriate. Offices of the Medicaid program integrity program
1498 and the Medicaid Fraud Control Unit of the Department of Legal
1499 Affairs, shall, to the extent possible, be collocated. The
1500 agency and the Department of Legal Affairs shall periodically
1501 conduct joint training and other joint activities designed to
1502 increase communication and coordination in recovering
1503 overpayments.
1504 (5) A Medicaid provider is subject to having goods and
1505 services that are paid for by the Medicaid program reviewed by
1506 an appropriate peer-review organization designated by the
1507 agency. The written findings of the applicable peer-review

1508 organization are admissible in any court or administrative
1509 proceeding as evidence of medical necessity or the lack thereof.
1510 (6) Any notice required to be given to a provider under
1511 this section is presumed to be sufficient notice if sent to the
1512 address last shown on the provider enrollment file. It is the
1513 responsibility of the provider to furnish and keep the agency
1514 informed of the provider's current address. United States Postal
1515 Service proof of mailing or certified or registered mailing of
1516 such notice to the provider at the address shown on the provider
1517 enrollment file constitutes sufficient proof of notice. Any
1518 notice required to be given to the agency by this section must
1519 be sent to the agency at an address designated by rule.
1520 (7) When presenting a claim for payment under the Medicaid
1521 program, a provider has an affirmative duty to supervise the
1522 provision of, and be responsible for, goods and services claimed
1523 to have been provided, to supervise and be responsible for
1524 preparation and submission of the claim, and to present a claim
1525 that is true and accurate and that is for goods and services
1526 that:
1527 (a) Have actually been furnished to the recipient by the
1528 provider prior to submitting the claim.
1529 (b) Are Medicaid-covered goods or services that are
1530 medically necessary.
1531 (c) Are of a quality comparable to those furnished to the
1532 general public by the provider's peers.

1533 (d) Have not been billed in whole or in part to a
1534 recipient or a recipient's responsible party, except for such
1535 copayments, coinsurance, or deductibles as are authorized by the
1536 agency.
1537 (e) Are provided in accord with applicable provisions of
1538 all Medicaid rules, regulations, handbooks, and policies and in
1539 accordance with federal, state, and local law.
1540 (f) Are documented by records made at the time the goods
1541 or services were provided, demonstrating the medical necessity
1542 for the goods or services rendered. Medicaid goods or services
1543 are excessive or not medically necessary unless both the medical
1544 basis and the specific need for them are fully and properly
1545 documented in the recipient's medical record.
1546
1547 The agency shall deny payment or require repayment for goods or
1548 services that are not presented as required in this subsection.
1549 (8) The agency shall not reimburse any person or entity
1550 for any prescription for medications, medical supplies, or
1551 medical services if the prescription was written by a physician
1552 or other prescribing practitioner who is not enrolled in the
1553 Medicaid program. This section does not apply:
1554 (a) In instances involving bona fide emergency medical
1555 conditions as determined by the agency;

1556 (b) To a provider of medical services to a patient in a
1557 hospital emergency department, hospital inpatient or outpatient
1558 setting, or nursing home;
1559 (c) To bona fide pro bono services by preapproved non-
1560 Medicaid providers as determined by the agency;
1561 (d) To prescribing physicians who are board-certified
1562 specialists treating Medicaid recipients referred for treatment
1563 by a treating physician who is enrolled in the Medicaid program;
1564 (e) To prescriptions written for dually eligible Medicare
1565 beneficiaries by an authorized Medicare provider who is not
1566 enrolled in the Medicaid program;
1567 (f) To other physicians who are not enrolled in the
1568 Medicaid program but who provide a medically necessary service
1569 or prescription not otherwise reasonably available from a
1570 Medicaid-enrolled physician; or
1571 (9) A Medicaid provider shall retain medical,
1572 professional, financial, and business records pertaining to
1573 services and goods furnished to a Medicaid recipient and billed
1574 to Medicaid for a period of 5 years after the date of furnishing
1575 such services or goods. The agency may investigate, review, or
1576 analyze such records, which must be made available during normal
1577 business hours. However, 24-hour notice must be provided if
1578 patient treatment would be disrupted. The provider must keep the
1579 agency informed of the location of the provider's Medicaid-
1580 related records. The authority of the agency to obtain Medicaid-

1581 related records from a provider is neither curtailed nor limited
1582 during a period of litigation between the agency and the
1583 provider.
1584 (10) Payments for the services of billing agents or
1585 persons participating in the preparation of a Medicaid claim
1586 shall not be based on amounts for which they bill nor based on
1587 the amount a provider receives from the Medicaid program.
1588 (11) The agency shall deny payment or require repayment
1589 for inappropriate, medically unnecessary, or excessive goods or
1590 services from the person furnishing them, the person under whose
1591 supervision they were furnished, or the person causing them to
1592 be furnished.
1593 (12) The complaint and all information obtained pursuant
1594 to an investigation of a Medicaid provider, or the authorized
1595 representative or agent of a provider, relating to an allegation
1596 of fraud, abuse, or neglect are confidential and exempt from the
1597 provisions of s. 119.07(1):
1598 (a) Until the agency takes final agency action with
1599 respect to the provider and requires repayment of any
1600 overpayment, or imposes an administrative sanction;
1601 (b) Until the Attorney General refers the case for
1602 criminal prosecution;
1603 (c) Until 10 days after the complaint is determined
1604 without merit; or

1605 (d) At all times if the complaint or information is
1606 otherwise protected by law.
1607 (13) The agency shall terminate participation of a
1608 Medicaid provider in the Medicaid program and may seek civil
1609 remedies or impose other administrative sanctions against a
1610 Medicaid provider, if the provider or any principal, officer,
1611 director, agent, managing employee, or affiliated person of the
1612 provider, or any partner or shareholder having an ownership
1613 interest in the provider equal to 5 percent or greater, has been
1614 convicted of a criminal offense under federal law or the law of
1615 any state relating to the practice of the provider's profession,
1616 or a criminal offense listed under s. 408.809(4), s.
1617 409.907(10), or s. 435.04(2). If the agency determines that the
1618 provider did not participate or acquiesce in the offense,
1619 termination will not be imposed. If the agency effects a
1620 termination under this subsection, the agency shall take final
1621 agency action.
1622 (14) If the provider has been suspended or terminated from
1623 participation in the Medicaid program or the Medicare program by
1624 the Federal Government or any state, the agency must immediately
1625 suspend or terminate, as appropriate, the provider's
1626 participation in this state's Medicaid program for a period no
1627 less than that imposed by the Federal Government or any other
1628 state, and may not enroll such provider in this state's Medicaid
1629 program while such foreign suspension or termination remains in

1630 effect. The agency shall also immediately suspend or terminate,
1631 as appropriate, a provider's participation in this state's
1632 Medicaid program if the provider participated or acquiesced in
1633 any action for which any principal, officer, director, agent,
1634 managing employee, or affiliated person of the provider, or any
1635 partner or shareholder having an ownership interest in the
1636 provider equal to 5 percent or greater, was suspended or
1637 terminated from participating in the Medicaid program or the
1638 Medicare program by the Federal Government or any state. This
1639 sanction is in addition to all other remedies provided by law.
1640 (15) The agency shall seek a remedy provided by law,
1641 including, but not limited to, any remedy provided in
1642 subsections (13) and (16) and s. 812.035, if:
1643 (a) The provider's license has not been renewed, or has
1644 been revoked, suspended, or terminated, for cause, by the
1645 licensing agency of any state;
1646 (b) The provider has failed to make available or has
1647 refused access to Medicaid-related records to an auditor,
1648 investigator, or other authorized employee or agent of the
1649 agency, the Attorney General, a state attorney, or the Federal
1650 Government;
1651 (c) The provider has not furnished or has failed to make
1652 available such Medicaid-related records as the agency has found
1653 necessary to determine whether Medicaid payments are or were due
1654 and the amounts thereof;

1655 (d) The provider has failed to maintain medical records
1656 made at the time of service, or prior to service if prior
1657 authorization is required, demonstrating the necessity and
1658 appropriateness of the goods or services rendered;
1659 (e) The provider is not in compliance with provisions of
1660 Medicaid provider publications that have been adopted by
1661 reference as rules in the Florida Administrative Code; with
1662 provisions of state or federal laws, rules, or regulations; with
1663 provisions of the provider agreement between the agency and the
1664 provider; or with certifications found on claim forms or on
1665 transmittal forms for electronically submitted claims that are
1666 submitted by the provider or authorized representative, as such
1667 provisions apply to the Medicaid program;
1668 (f) The provider or person who ordered, authorized, or
1669 prescribed the care, services, or supplies has furnished, or
1670 ordered or authorized the furnishing of, goods or services to a
1671 recipient which are inappropriate, unnecessary, excessive, or
1672 harmful to the recipient or are of inferior quality;
1673 (g) The provider has demonstrated a pattern of failure to
1674 provide goods or services that are medically necessary;
1675 (h) The provider or an authorized representative of the
1676 provider, or a person who ordered, authorized, or prescribed the
1677 goods or services, has submitted or caused to be submitted false
1678 or a pattern of erroneous Medicaid claims;

1679 (i) The provider or an authorized representative of the
1680 provider, or a person who has ordered, authorized, or prescribed
1681 the goods or services, has submitted or caused to be submitted a
1682 Medicaid provider enrollment application, a request for prior
1683 authorization for Medicaid services, a drug exception request,
1684 or a Medicaid cost report that contains materially false or
1685 incorrect information;
1686 (j) The provider or an authorized representative of the
1687 provider has collected from or billed a recipient or a
1688 recipient's responsible party improperly for amounts that should
1689 not have been so collected or billed by reason of the provider's
1690 billing the Medicaid program for the same service;
1691 (k) The provider or an authorized representative of the
1692 provider has included in a cost report costs that are not
1693 allowable under a Florida Title XIX reimbursement plan after the
1694 provider or authorized representative had been advised in an
1695 audit exit conference or audit report that the costs were not
1696 allowable;
1697 (l) The provider is charged by information or indictment
1698 with fraudulent billing practices or an offense referenced in
1699 subsection (13). The sanction applied for this reason is limited
1700 to suspension of the provider's participation in the Medicaid
1701 program for the duration of the indictment unless the provider
1702 is found guilty pursuant to the information or indictment;

1703 (m) The provider or a person who ordered, authorized, or
1704 prescribed the goods or services is found liable for negligent
1705 practice resulting in death or injury to the provider's patient;
1706 (n) The provider fails to demonstrate that it had
1707 available during a specific audit or review period sufficient
1708 quantities of goods, or sufficient time in the case of services,
1709 to support the provider's billings to the Medicaid program;
1710 (o) The provider has failed to comply with the notice and
1711 reporting requirements of s. 409.907;
1712 (p) The agency has received reliable information of
1713 patient abuse or neglect or of any act prohibited by s. 409.920;
1714 or
1715 (q) The provider has failed to comply with an agreed-upon
1716 repayment schedule.
1717
1718 A provider is subject to sanctions for violations of this
1719 subsection as the result of actions or inactions of the
1720 provider, or actions or inactions of any principal, officer,
1721 director, agent, managing employee, or affiliated person of the
1722 provider, or any partner or shareholder having an ownership
1723 interest in the provider equal to 5 percent or greater, in which
1724 the provider participated or acquiesced.
1725 (16) The agency shall impose any of the following
1726 sanctions or disincentives on a provider or a person for any of
1727 the acts described in subsection (15):

1728 (a) Suspension for a specific period of time of not more
1729 than 1 year. Suspension precludes participation in the Medicaid
1730 program, which includes any action that results in a claim for
1731 payment to the Medicaid program for furnishing, supervising a
1732 person who is furnishing, or causing a person to furnish goods
1733 or services.
1734 (b) Termination for a specific period of time ranging from
1735 more than 1 year to 20 years. Termination precludes
1736 participation in the Medicaid program, which includes any action
1737 that results in a claim for payment to the Medicaid program for
1738 furnishing, supervising a person who is furnishing, or causing a
1739 person to furnish goods or services.
1740 (c) Imposition of a fine of up to $5,000 for each
1741 violation. Each day that an ongoing violation continues, such as
1742 refusing to furnish Medicaid-related records or refusing access
1743 to records, is considered a separate violation. Each instance of
1744 improper billing of a Medicaid recipient; each instance of
1745 including an unallowable cost on a hospital or nursing home
1746 Medicaid cost report after the provider or authorized
1747 representative has been advised in an audit exit conference or
1748 previous audit report of the cost unallowability; each instance
1749 of furnishing a Medicaid recipient goods or professional
1750 services that are inappropriate or of inferior quality as
1751 determined by competent peer judgment; each instance of
1752 knowingly submitting a materially false or erroneous Medicaid

1753 provider enrollment application, request for prior authorization
1754 for Medicaid services, drug exception request, or cost report;
1755 each instance of inappropriate prescribing of drugs for a
1756 Medicaid recipient as determined by competent peer judgment; and
1757 each false or erroneous Medicaid claim leading to an overpayment
1758 to a provider is considered a separate violation.
1759 (d) Immediate suspension, if the agency has received
1760 information of patient abuse or neglect or of any act prohibited
1761 by s. 409.920. Upon suspension, the agency must issue an
1762 immediate final order under s. 120.569(2)(n).
1763 (e) A fine, not to exceed $10,000, for a violation of
1764 paragraph (15)(i).
1765 (f) Imposition of liens against provider assets,
1766 including, but not limited to, financial assets and real
1767 property, not to exceed the amount of fines or recoveries
1768 sought, upon entry of an order determining that such moneys are
1769 due or recoverable.
1770 (g) Prepayment reviews of claims for a specified period of
1771 time.
1772 (h) Comprehensive followup reviews of providers every 6
1773 months to ensure that they are billing Medicaid correctly.
1774 (i) Corrective-action plans that remain in effect for up
1775 to 3 years and that are monitored by the agency every 6 months
1776 while in effect.

1777 (j) Other remedies as permitted by law to effect the
1778 recovery of a fine or overpayment.
1779
1780 If a provider voluntarily relinquishes its Medicaid provider
1781 number or an associated license, or allows the associated
1782 licensure to expire after receiving written notice that the
1783 agency is conducting, or has conducted, an audit, survey,
1784 inspection, or investigation and that a sanction of suspension
1785 or termination will or would be imposed for noncompliance
1786 discovered as a result of the audit, survey, inspection, or
1787 investigation, the agency shall impose the sanction of
1788 termination for cause against the provider. The agency's
1789 termination with cause is subject to hearing rights as may be
1790 provided under chapter 120. The Secretary of Health Care
1791 Administration may make a determination that imposition of a
1792 sanction or disincentive is not in the best interest of the
1793 Medicaid program, in which case a sanction or disincentive may
1794 not be imposed.
1795 (17) In determining the appropriate administrative
1796 sanction to be applied, or the duration of any suspension or
1797 termination, the agency shall consider:
1798 (a) The seriousness and extent of the violation or
1799 violations.
1800 (b) Any prior history of violations by the provider
1801 relating to the delivery of health care programs which resulted

1802 in either a criminal conviction or in administrative sanction or
1803 penalty.
1804 (c) Evidence of continued violation within the provider's
1805 management control of Medicaid statutes, rules, regulations, or
1806 policies after written notification to the provider of improper
1807 practice or instance of violation.
1808 (d) The effect, if any, on the quality of medical care
1809 provided to Medicaid recipients as a result of the acts of the
1810 provider.
1811 (e) Any action by a licensing agency respecting the
1812 provider in any state in which the provider operates or has
1813 operated.
1814 (f) The apparent impact on access by recipients to
1815 Medicaid services if the provider is suspended or terminated, in
1816 the best judgment of the agency.
1817
1818 The agency shall document the basis for all sanctioning actions
1819 and recommendations.
1820 (18) The agency may take action to sanction, suspend, or
1821 terminate a particular provider working for a group provider,
1822 and may suspend or terminate Medicaid participation at a
1823 specific location, rather than or in addition to taking action
1824 against an entire group.
1825 (19) The agency shall establish a process for conducting
1826 followup reviews of a sampling of providers who have a history

1827 of overpayment under the Medicaid program. This process must
1828 consider the magnitude of previous fraud or abuse and the
1829 potential effect of continued fraud or abuse on Medicaid costs.
1830 (20) In making a determination of overpayment to a
1831 provider, the agency must use accepted and valid auditing,
1832 accounting, analytical, statistical, or peer-review methods, or
1833 combinations thereof. Appropriate statistical methods may
1834 include, but are not limited to, sampling and extension to the
1835 population, parametric and nonparametric statistics, tests of
1836 hypotheses, and other generally accepted statistical methods.
1837 Appropriate analytical methods may include, but are not limited
1838 to, reviews to determine variances between the quantities of
1839 products that a provider had on hand and available to be
1840 purveyed to Medicaid recipients during the review period and the
1841 quantities of the same products paid for by the Medicaid program
1842 for the same period, taking into appropriate consideration sales
1843 of the same products to non-Medicaid customers during the same
1844 period. In meeting its burden of proof in any administrative or
1845 court proceeding, the agency may introduce the results of such
1846 statistical methods as evidence of overpayment.
1847 (21) When making a determination that an overpayment has
1848 occurred, the agency shall prepare and issue an audit report to
1849 the provider showing the calculation of overpayments. The
1850 agency's determination must be based solely upon information
1851 available to it before issuance of the audit report and, in the

1852 case of documentation obtained to substantiate claims for
1853 Medicaid reimbursement, based solely upon contemporaneous
1854 records. The agency may consider addenda or modifications to a
1855 note that was made contemporaneously with the patient care
1856 episode if the addenda or modifications are germane to the note.
1857 (22) The audit report, supported by agency work papers,
1858 showing an overpayment to a provider constitutes evidence of the
1859 overpayment. A provider may not present or elicit testimony on
1860 direct examination or cross-examination in any court or
1861 administrative proceeding, regarding the purchase or acquisition
1862 by any means of drugs, goods, or supplies; sales or divestment
1863 by any means of drugs, goods, or supplies; or inventory of
1864 drugs, goods, or supplies, unless such acquisition, sales,
1865 divestment, or inventory is documented by written invoices,
1866 written inventory records, or other competent written
1867 documentary evidence maintained in the normal course of the
1868 provider's business. A provider may not present records to
1869 contest an overpayment or sanction unless such records are
1870 contemporaneous and, if requested during the audit process, were
1871 furnished to the agency or its agent upon request. This
1872 limitation does not apply to Medicaid cost report audits. This
1873 limitation does not preclude consideration by the agency of
1874 addenda or modifications to a note if the addenda or
1875 modifications are made before notification of the audit, the
1876 addenda or modifications are germane to the note, and the note

1877 was made contemporaneously with a patient care episode.
1878 Notwithstanding the applicable rules of discovery, all
1879 documentation to be offered as evidence at an administrative
1880 hearing on a Medicaid overpayment or an administrative sanction
1881 must be exchanged by all parties at least 14 days before the
1882 administrative hearing or be excluded from consideration.
1883 (23)(a) In an audit, ~~or~~ investigation, or enforcement
1884 action for ~~of~~ a violation committed by a provider which is
1885 conducted or taken pursuant to this section, the agency or
1886 contractor is entitled to recover any and all investigative and~~,~~
1887 legal costs incurred as a result of such audit, investigation,
1888 or enforcement action. Such costs may include, but are not
1889 limited to, salaries and benefits of personnel, costs related to
1890 the time spent by an attorney and other personnel working on the
1891 case, and any other expenses incurred by the agency or
1892 contractor that are associated with the case, including any~~, and~~
1893 expert witness costs and attorney fees incurred on behalf of the
1894 agency or contractor if the agency's findings were not contested
1895 by the provider or, if contested, the agency ultimately
1896 prevailed.
1897 (24) If the agency imposes an administrative sanction
1898 pursuant to subsection (13), subsection (14), or subsection
1899 (15), except paragraphs (15)(e) and (o), upon any provider or
1900 any principal, officer, director, agent, managing employee, or
1901 affiliated person of the provider who is regulated by another

1902 state entity, the agency shall notify that other entity of the
1903 imposition of the sanction within 5 business days. Such
1904 notification must include the provider's or person's name and
1905 license number and the specific reasons for sanction.
1906 (25)(a) The agency shall withhold Medicaid payments, in
1907 whole or in part, to a provider upon receipt of reliable
1908 evidence that the circumstances giving rise to the need for a
1909 withholding of payments involve fraud, willful
1910 misrepresentation, or abuse under the Medicaid program, or a
1911 crime committed while rendering goods or services to Medicaid
1912 recipients. If it is determined that fraud, willful
1913 misrepresentation, abuse, or a crime did not occur, the payments
1914 withheld must be paid to the provider within 14 days after such
1915 determination. Amounts not paid within 14 days accrue interest
1916 at the rate of 10 percent per year, beginning after the 14th
1917 day.
1918 (b) The agency shall deny payment, or require repayment,
1919 if the goods or services were furnished, supervised, or caused
1920 to be furnished by a person who has been suspended or terminated
1921 from the Medicaid program or Medicare program by the Federal
1922 Government or any state.
1923 (c) Overpayments owed to the agency bear interest at the
1924 rate of 10 percent per year from the date of final determination
1925 of the overpayment by the agency, and payment arrangements must

1926 be made within 30 days after the date of the final order, which
1927 is not subject to further appeal.
1928 (d) The agency, upon entry of a final agency order, a
1929 judgment or order of a court of competent jurisdiction, or a
1930 stipulation or settlement, may collect the moneys owed by all
1931 means allowable by law, including, but not limited to, notifying
1932 any fiscal intermediary of Medicare benefits that the state has
1933 a superior right of payment. Upon receipt of such written
1934 notification, the Medicare fiscal intermediary shall remit to
1935 the state the sum claimed.
1936 (e) The agency may institute amnesty programs to allow
1937 Medicaid providers the opportunity to voluntarily repay
1938 overpayments. The agency may adopt rules to administer such
1939 programs.
1940 (26) The agency may impose administrative sanctions
1941 against a Medicaid recipient, or the agency may seek any other
1942 remedy provided by law, including, but not limited to, the
1943 remedies provided in s. 812.035, if the agency finds that a
1944 recipient has engaged in solicitation in violation of s. 409.920
1945 or that the recipient has otherwise abused the Medicaid program.
1946 (27) When the Agency for Health Care Administration has
1947 made a probable cause determination and alleged that an
1948 overpayment to a Medicaid provider has occurred, the agency,
1949 after notice to the provider, shall:

1950 (a) Withhold, and continue to withhold during the pendency
1951 of an administrative hearing pursuant to chapter 120, any
1952 medical assistance reimbursement payments until such time as the
1953 overpayment is recovered, unless within 30 days after receiving
1954 notice thereof the provider:
1955 1. Makes repayment in full; or
1956 2. Establishes a repayment plan that is satisfactory to
1957 the Agency for Health Care Administration.
1958 (b) Withhold, and continue to withhold during the pendency
1959 of an administrative hearing pursuant to chapter 120, medical
1960 assistance reimbursement payments if the terms of a repayment
1961 plan are not adhered to by the provider.
1962 (28) Venue for all Medicaid program integrity cases lies
1963 in Leon County, at the discretion of the agency.
1964 (29) Notwithstanding other provisions of law, the agency
1965 and the Medicaid Fraud Control Unit of the Department of Legal
1966 Affairs may review a provider's Medicaid-related and non-
1967 Medicaid-related records in order to determine the total output
1968 of a provider's practice to reconcile quantities of goods or
1969 services billed to Medicaid with quantities of goods or services
1970 used in the provider's total practice.
1971 (30) The agency shall terminate a provider's participation
1972 in the Medicaid program if the provider fails to reimburse an
1973 overpayment or pay an agency-imposed fine that has been
1974 determined by final order, not subject to further appeal, within

1975 30 days after the date of the final order, unless the provider
1976 and the agency have entered into a repayment agreement.
1977 (31) If a provider requests an administrative hearing
1978 pursuant to chapter 120, such hearing must be conducted within
1979 90 days following assignment of an administrative law judge,
1980 absent exceptionally good cause shown as determined by the
1981 administrative law judge or hearing officer. Upon issuance of a
1982 final order, the outstanding balance of the amount determined to
1983 constitute the overpayment and fines is due. If a provider fails
1984 to make payments in full, fails to enter into a satisfactory
1985 repayment plan, or fails to comply with the terms of a repayment
1986 plan or settlement agreement, the agency shall withhold
1987 reimbursement payments for Medicaid services until the amount
1988 due is paid in full.
1989 (32) Duly authorized agents and employees of the agency
1990 shall have the power to inspect, during normal business hours,
1991 the records of any pharmacy, wholesale establishment, or
1992 manufacturer, or any other place in which drugs and medical
1993 supplies are manufactured, packed, packaged, made, stored, sold,
1994 or kept for sale, for the purpose of verifying the amount of
1995 drugs and medical supplies ordered, delivered, or purchased by a
1996 provider. The agency shall provide at least 2 business days'
1997 prior notice of any such inspection. The notice must identify
1998 the provider whose records will be inspected, and the inspection

1999 shall include only records specifically related to that
2000 provider.
2001 (33) In accordance with federal law, Medicaid recipients
2002 convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be
2003 limited, restricted, or suspended from Medicaid eligibility for
2004 a period not to exceed 1 year, as determined by the agency head
2005 or designee.
2006 (34) To deter fraud and abuse in the Medicaid program, the
2007 agency may limit the number of Schedule II and Schedule III
2008 refill prescription claims submitted from a pharmacy provider.
2009 The agency shall limit the allowable amount of reimbursement of
2010 prescription refill claims for Schedule II and Schedule III
2011 pharmaceuticals if the agency or the Medicaid Fraud Control Unit
2012 determines that the specific prescription refill was not
2013 requested by the Medicaid recipient or authorized representative
2014 for whom the refill claim is submitted or was not prescribed by
2015 the recipient's medical provider or physician. Any such refill
2016 request must be consistent with the original prescription.
2017 (35) The Office of Program Policy Analysis and Government
2018 Accountability shall provide a report to the President of the
2019 Senate and the Speaker of the House of Representatives on a
2020 biennial basis, beginning January 31, 2006, on the agency's
2021 efforts to prevent, detect, and deter, as well as recover funds
2022 lost to, fraud and abuse in the Medicaid program.

2023 (36) The agency may provide to a sample of Medicaid
2024 recipients or their representatives through the distribution of
2025 explanations of benefits information about services reimbursed
2026 by the Medicaid program for goods and services to such
2027 recipients, including information on how to report inappropriate
2028 or incorrect billing to the agency or other law enforcement
2029 entities for review or investigation, information on how to
2030 report criminal Medicaid fraud to the Medicaid Fraud Control
2031 Unit's toll-free hotline number, and information about the
2032 rewards available under s. 409.9203. The explanation of benefits
2033 may not be mailed for Medicaid independent laboratory services
2034 as described in s. 409.905(7) or for Medicaid certified match
2035 services as described in ss. 409.9071 and 1011.70.
2036 (37) The agency shall post on its website a current list
2037 of each Medicaid provider, including any principal, officer,
2038 director, agent, managing employee, or affiliated person of the
2039 provider, or any partner or shareholder having an ownership
2040 interest in the provider equal to 5 percent or greater, who has
2041 been terminated for cause from the Medicaid program or
2042 sanctioned under this section. The list must be searchable by a
2043 variety of search parameters and provide for the creation of
2044 formatted lists that may be printed or imported into other
2045 applications, including spreadsheets. The agency shall update
2046 the list at least monthly.

2047 (38) In order to improve the detection of health care
2048 fraud, use technology to prevent and detect fraud, and maximize
2049 the electronic exchange of health care fraud information, the
2050 agency shall:
2051 (a) Compile, maintain, and publish on its website a
2052 detailed list of all state and federal databases that contain
2053 health care fraud information and update the list at least
2054 biannually;
2055 (b) Develop a strategic plan to connect all databases that
2056 contain health care fraud information to facilitate the
2057 electronic exchange of health information between the agency,
2058 the Department of Health, the Department of Law Enforcement, and
2059 the Attorney General's Office. The plan must include recommended
2060 standard data formats, fraud identification strategies, and
2061 specifications for the technical interface between state and
2062 federal health care fraud databases;
2063 (c) Monitor innovations in health information technology,
2064 specifically as it pertains to Medicaid fraud prevention and
2065 detection; and
2066 (d) Periodically publish policy briefs that highlight
2067 available new technology to prevent or detect health care fraud
2068 and projects implemented by other states, the private sector, or
2069 the Federal Government which use technology to prevent or detect
2070 health care fraud.

2071 Section 38. Subsection (1) of section 409.967, Florida
2072 Statutes, is amended to read:
2073 409.967 Managed care plan accountability.—
2074 (1) Beginning with the contract procurement process
2075 initiated during the 2023 calendar year, the agency shall
2076 establish a 6-year ~~5-year~~ contract with each managed care plan
2077 selected through the procurement process described in s.
2078 409.966. A plan contract may not be renewed; however, the agency
2079 may extend the term of a plan contract to cover any delays
2080 during the transition to a new plan. The agency shall extend
2081 until December 31, 2024, the term of existing plan contracts
2082 awarded pursuant to the invitation to negotiate published in
2083 July 2017.
2084 Section 39. Paragraph (b) of subsection (5) of section
2085 409.973, Florida Statutes, is amended to read:
2086 409.973 Benefits.—
2087 (5) PROVISION OF DENTAL SERVICES.—
2088 (b) In the event the Legislature takes no action before
2089 July 1, 2017, with respect to the report findings required under
2090 subparagraph (a)2., the agency shall implement a statewide
2091 Medicaid prepaid dental health program for children and adults
2092 with a choice of at least two licensed dental managed care
2093 providers who must have substantial experience in providing
2094 dental care to Medicaid enrollees and children eligible for
2095 medical assistance under Title XXI of the Social Security Act

2096 and who meet all agency standards and requirements. To qualify
2097 as a provider under the prepaid dental health program, the
2098 entity must be licensed as a prepaid limited health service
2099 organization under part I of chapter 636 or as a health
2100 maintenance organization under part I of chapter 641. The
2101 contracts for program providers shall be awarded through a
2102 competitive procurement process. Beginning with the contract
2103 procurement process initiated during the 2023 calendar year, the
2104 contracts must be for 6 ~~5~~ years and may not be renewed; however,
2105 the agency may extend the term of a plan contract to cover
2106 delays during a transition to a new plan provider. The agency
2107 shall include in the contracts a medical loss ratio provision
2108 consistent with s. 409.967(4). The agency is authorized to seek
2109 any necessary state plan amendment or federal waiver to commence
2110 enrollment in the Medicaid prepaid dental health program no
2111 later than March 1, 2019. The agency shall extend until December
2112 31, 2024, the term of existing plan contracts awarded pursuant
2113 to the invitation to negotiate published in October 2017.
2114 Section 40. Subsection (6) of section 429.11, Florida
2115 Statutes, is amended to read:
2116 429.11 Initial application for license; provisional
2117 license.—
2118 ~~(6) In addition to the license categories available in s.~~
2119 ~~408.808, a provisional license may be issued to an applicant~~
2120 ~~making initial application for licensure or making application~~

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

2121 ~~for a change of ownership. A provisional license shall be~~
2122 ~~limited in duration to a specific period of time not to exceed 6~~
2123 ~~months, as determined by the agency.~~
2124 Section 41. Subsection (9) of section 429.19, Florida
2125 Statutes, is amended to read:
2126 429.19 Violations; imposition of administrative fines;
2127 grounds.—
2128 ~~(9) The agency shall develop and disseminate an annual~~
2129 ~~list of all facilities sanctioned or fined for violations of~~
2130 ~~state standards, the number and class of violations involved,~~
2131 ~~the penalties imposed, and the current status of cases. The list~~
2132 ~~shall be disseminated, at no charge, to the Department of~~
2133 ~~Elderly Affairs, the Department of Health, the Department of~~
2134 ~~Children and Families, the Agency for Persons with Disabilities,~~
2135 ~~the area agencies on aging, the Florida Statewide Advocacy~~
2136 ~~Council, the State Long-Term Care Ombudsman Program, and state~~
2137 ~~and local ombudsman councils. The Department of Children and~~
2138 ~~Families shall disseminate the list to service providers under~~
2139 ~~contract to the department who are responsible for referring~~
2140 ~~persons to a facility for residency. The agency may charge a fee~~
2141 ~~commensurate with the cost of printing and postage to other~~
2142 ~~interested parties requesting a copy of this list. This~~
2143 ~~information may be provided electronically or through the~~
2144 ~~agency's Internet site.~~

2145 Section 42. Subsection (2) of section 429.35, Florida
2146 Statutes, is amended to read:
2147 429.35 Maintenance of records; reports.—
2148 (2) Within 60 days after the date of an ~~the biennial~~
2149 inspection conducted ~~visit required~~ under s. 408.811 or within
2150 30 days after the date of an ~~any~~ interim visit, the agency shall
2151 forward the results of the inspection to the local ombudsman
2152 council in the district where the facility is located; to at
2153 least one public library or, in the absence of a public library,
2154 the county seat in the county in which the inspected assisted
2155 living facility is located; and, when appropriate, to the
2156 district Adult Services and Mental Health Program Offices.
2157 Section 43. Subsection (2) of section 429.905, Florida
2158 Statutes, is amended to read:
2159 429.905 Exemptions; monitoring of adult day care center
2160 programs colocated with assisted living facilities or licensed
2161 nursing home facilities.—
2162 (2) A licensed assisted living facility, a licensed
2163 hospital, or a licensed nursing home facility may provide
2164 services during the day which include, but are not limited to,
2165 social, health, therapeutic, recreational, nutritional, and
2166 respite services, to adults who are not residents. Such a
2167 facility need not be licensed as an adult day care center;
2168 however, the agency must monitor the facility during the regular
2169 inspection ~~and at least biennially~~ to ensure adequate space and

2170 sufficient staff. If an assisted living facility, a hospital, or
2171 a nursing home holds itself out to the public as an adult day
2172 care center, it must be licensed as such and meet all standards
2173 prescribed by statute and rule. For the purpose of this
2174 subsection, the term "day" means any portion of a 24-hour day.
2175 Section 44. Subsection (2) of section 429.929, Florida
2176 Statutes, is amended to read:
2177 429.929 Rules establishing standards.—
2178 ~~(2) Pursuant to this part, s. 408.811, and applicable~~
2179 ~~rules, the agency may conduct an abbreviated biennial inspection~~
2180 ~~of key quality-of-care standards, in lieu of a full inspection,~~
2181 ~~of a center that has a record of good performance. However, the~~
2182 ~~agency must conduct a full inspection of a center that has had~~
2183 ~~one or more confirmed complaints within the licensure period~~
2184 ~~immediately preceding the inspection or which has a serious~~
2185 ~~problem identified during the abbreviated inspection. The agency~~
2186 ~~shall develop the key quality-of-care standards, taking into~~
2187 ~~consideration the comments and recommendations of provider~~
2188 ~~groups. These standards shall be included in rules adopted by~~
2189 ~~the agency.~~
2190 Section 45. Part I of chapter 483, Florida Statutes, is
2191 repealed.
2192 Section 46. Except as otherwise expressly provided in this
2193 act and except for this section, which shall take effect upon
2194 this act becoming a law, this act shall take effect July 1,

2195 2020.