A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 383.327, F.S.; requiring birth centers to report certain deaths and stillbirths to the Agency for Health Care Administration; removing a requirement that a certain report be submitted annually to the agency; authorizing the agency to prescribe by rule the frequency at which such report is submitted; amending s. 395.003, F.S.; removing a requirement that specified information be listed on licenses for certain facilities; amending s. 395.1055, F.S.; requiring the agency to adopt specified rules related to ongoing quality improvement programs for certain cardiac programs; amending s. 395.602, F.S.; extending a certain date relating to the designation of certain rural hospitals; repealing s. 395.7015, F.S., relating to an annual assessment on health care entities; amending s. 395.7016, F.S.; conforming a provision to changes made by the act; amending s. 400.19, F.S.; revising provisions requiring the agency to conduct licensure inspections of nursing homes; requiring the agency to conduct biannual licensure surveys under certain circumstances; revising a provision requiring the agency to assess a specified fine for such surveys; amending s. 400.462, F.S.;

revising definitions; amending s. 400.464, F.S.; revising provisions relating to exemptions from licensure requirements for home health agencies; exempting certain persons from such licensure requirements; amending ss. 400.471, 400.492, 400.506, and 400.509, F.S.; revising provisions relating to licensure requirements for home health agencies to conform to changes made by the act; amending s. 400.605, F.S.; removing a requirement that the agency conduct specified inspections of certain licensees; amending s. 400.60501, F.S.; removing an obsolete date and a requirement that the agency develop a specified annual report; amending s. 400.9905, F.S.; revising the definition of the term "clinic"; amending s. 400.991, F.S.; conforming provisions to changes made by the act; removing the option for health care clinics to file a surety bond under certain circumstances; amending s. 400.9935, F.S.; requiring certain clinics to publish and post a schedule of charges; amending s. 408.033, F.S.; conforming a provision to changes made by the act; amending s. 408.05, F.S.; requiring the agency to publish an annual report identifying certain health care services by a specified date; amending s. 408.061, F.S.; revising provisions requiring health care facilities

to submit specified data to the agency; amending s. 408.0611, F.S.; requiring the agency to annually publish a report on the progress of implementation of electronic prescribing on its Internet website; amending s. 408.062, F.S.; requiring the agency to annually publish certain information on its Internet website; removing a requirement that the agency submit certain annual reports to the Governor and Legislature; amending s. 408.063, F.S.; removing a requirement that the agency annually publish certain reports; amending ss. 408.802, 408.820, 408.831, and 408.832, F.S.; conforming provisions to changes made by the act; amending s. 408.803, F.S.; conforming a provision to changes made by the act; providing a definition of the term "low-risk provider"; amending s. 408.806, F.S.; exempting certain low-risk providers from a specified inspection; amending s. 408.808, F.S.; authorizing the issuance of a provisional license to certain applicants; amending s. 408.809, F.S.; revising provisions relating to background screening requirements for certain licensure applicants; removing an obsolete date and provisions relating to certain rescreening requirements; amending s. 408.811, F.S.; authorizing the agency to exempt certain low-risk providers from inspections and

conduct unannounced licensure inspections of such providers under certain circumstances; authorizing the agency to adopt rules to waive routine inspections and grant extended time periods between relicensure inspections under certain conditions; amending s. 408.821, F.S.; revising provisions requiring licensees to have a specified plan; providing requirements for the submission of such plan; amending s. 408.909, F.S.; removing a requirement that the agency and Office of Insurance Regulation evaluate a specified program; amending s. 408.9091, F.S.; removing a requirement that the agency and office jointly submit a specified annual report to the Governor and Legislature; amending s. 409.905, F.S.; providing construction for a provision that requires the agency to discontinue its hospital retrospective review program under certain circumstances; providing legislative intent; amending s. 409.907, F.S.; requiring that a specified background screening be conducted through the agency on certain persons and entities; amending s. 409.908, F.S.; revising provisions related to the prospective payment methodology for certain Medicaid provider reimbursements; amending s. 409.913, F.S.; revising a requirement that the agency and the Medicaid Fraud

Control Unit of the Department of Legal Affairs submit a specified report to the Legislature; authorizing the agency to recover specified costs associated with an audit, investigation, or enforcement action relating to provider fraud under the Medicaid program; amending s. 409.920, F.S.; revising provisions related to prohibited referral practices under the Medicaid program; providing applicability; amending ss. 409.967 and 409.973, F.S.; revising the length of managed care plan and Medicaid prepaid dental health program contracts, respectively, procured by the agency beginning during a specified timeframe; requiring the agency to extend the term of certain existing contracts until a specified date; amending s. 429.11, F.S.; removing an authorization for the issuance of a provisional license to certain facilities; amending s. 429.19, F.S.; removing requirements that the agency develop and disseminate a specified list and the Department of Children and Families disseminate such list to certain providers; amending ss. 429.35, 429.905, and 429.929, F.S.; revising provisions requiring a biennial inspection cycle for specified facilities and centers, respectively; repealing part I of chapter 483, F.S., relating to The Florida Multiphasic Health Testing Center Law; amending ss.

627.6387, 627.6648, and 641.31076, F.S.; revising the definition of the term "shoppable health care service"; revising duties of certain health insurers and health maintenance organizations; amending ss. 20.43, 381.0034, 456.001, 456.057, 456.076, and 456.47, F.S.; conforming cross-references; providing effective dates.

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

Section 1. Subsections (2) and (4) of section 383.327, Florida Statutes, are amended to read:

383.327 Birth and death records; reports.—

(2) Each maternal death, newborn death, and stillbirth shall be reported immediately to the medical examiner and the agency.

(4) A report shall be submitted ~~annually~~ to the agency. The contents of the report and the frequency at which it is submitted shall be prescribed by rule of the agency.

Section 2. Subsection (4) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(4) The agency shall issue a license that ~~which~~ specifies the service categories and the number of hospital beds in each bed category for which a license is received. Such information

shall be listed on the face of the license. ~~All beds which are not covered by any specialty-bed-need methodology shall be specified as general beds.~~ A licensed facility shall not operate a number of hospital beds greater than the number indicated by the agency on the face of the license without approval from the agency under conditions established by rule.

Section 3. Paragraph (g) is added to subsection (18) of section 395.1055, Florida Statutes, to read:

395.1055 Rules and enforcement.—

(18) In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(g) For a hospital licensed for adult diagnostic cardiac catheterization that provides Level I or Level II adult cardiovascular services, demonstration that the hospital is participating in the American College of Cardiology's National Cardiovascular Data Registry or the American Heart Association's Get with the Guidelines–Coronary Artery Disease registry and documentation of an ongoing quality improvement plan ensuring that the licensed cardiac program meets or exceeds national quality and outcome benchmarks reported by the registry in which the hospital participates. A hospital licensed for Level II adult cardiovascular services must also participate in the clinical outcome reporting systems operated by the Society for Thoracic Surgeons.

Section 4. Paragraph (b) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part, the term:

(b) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;

5. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from

the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07.

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2025 ~~2021~~, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 5. Section 395.7015, Florida Statutes, is repealed.

Section 6. Section 395.7016, Florida Statutes, is amended to read:

395.7016 Annual appropriation.—The Legislature shall appropriate each fiscal year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund an amount sufficient to replace the funds lost due to ~~reduction by chapter 2000-256, Laws of Florida, of the assessment on other health care entities under s. 395.7015, and~~ the reduction by chapter 2000-256, Laws of Florida, in the assessment on hospitals under s. 395.701~~,~~ and to maintain federal approval of the reduced amount of funds deposited into the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as state match for the state's Medicaid program.

Section 7. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.—

(3) The agency shall conduct periodic, ~~every 15 months conduct at least one~~ unannounced licensure inspections ~~inspection~~ to determine compliance by the licensee with statutes, and with rules adopted ~~promulgated~~ under ~~the provisions of~~ those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. ~~The survey shall be conducted every 6 months for the next 2-year period~~ If the facility has been cited for a class I deficiency or~~,~~ has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated

complaints within a 6-month period, each resulting in at least one class I or class II deficiency, the agency shall conduct biannual licensure surveys until the facility has two consecutive licensure surveys without a citation for a Class I or a Class II deficiency. In addition to any other fees or fines in this part, the agency shall assess a fine of ~~for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be~~ $6,000 for the biannual licensure surveys~~, one-half to be paid at the completion of each survey~~. The agency may adjust such ~~this~~ fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to ~~the provisions of~~ chapter 110.

Section 8. Subsections (23) through (30) of section 400.462, Florida Statutes, are renumbered as subsections (22) through (29), respectively, and subsections (12), (14), and (17) and present subsection (22) of that section are amended to read:

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

(12) "Home health agency" means a person ~~an organization~~ that provides one or more home health services ~~and staffing services~~.

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

(a) Nursing care.

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

(c) Home health aide services.

(d) Dietetics and nutrition practice and nutrition counseling.

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

(17) "Home infusion therapy provider" means a person ~~an organization~~ that employs, contracts with, or refers a licensed professional who has received advanced training and experience in intravenous infusion therapy and who administers infusion

therapy to a patient in the patient's home or place of residence.

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

Section 9. Subsection (1), paragraphs (a) and (f) of subsection (4), and subsection (5) of section 400.464, Florida Statutes, are amended to read:

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

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and persons or entities licensed or registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license or registration issued by the agency is required in order to operate a home health agency in this state. A license or registration issued on or after July 1,

2018, must specify the home health services the licensee or registrant ~~organization~~ is authorized to perform and indicate whether such specified services are considered skilled care. The provision or advertising of services that require licensure or registration pursuant to this part without such services being specified on the face of the license or registration issued on or after July 1, 2018, constitutes unlicensed activity as prohibited under s. 408.812.

(4)(a) A licensee or registrant ~~An organization~~ that offers or advertises to the public any service for which licensure or registration is required under this part must include in the advertisement the license number or registration number issued to the licensee or registrant ~~organization~~ by the agency. The agency shall assess a fine of not less than $100 to any licensee or registrant that ~~who~~ fails to include the license or registration number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500. The holder of a license or registration issued under this part may not advertise or indicate to the public that it holds a home health agency or nurse registry license or registration other than the one it has been issued.

(f) A ~~Any~~ home health agency that fails to cease operation after agency notification may be fined in accordance with s. 408.812.

(5) The following are exempt from ~~the~~ licensure as a home health agency under ~~requirements of~~ this part:

(a) A home health agency operated by the Federal Government.

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons with developmental disabilities, as defined in s. 393.063.

4. Companion and sitter organizations that were registered under s. 400.509(1) on January 1, 1999, and were authorized to provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding ~~the provisions of~~ this act.

5. The Department of Children and Families.

(c) A health care professional, whether or not incorporated, who is licensed under chapter 457; chapter 458;

chapter 459; part I of chapter 464; chapter 467; part I, part III, part V, or part X of chapter 468; chapter 480; chapter 486; chapter 490; or chapter 491; and who is acting alone within the scope of his or her professional license to provide care to patients in their homes.

(d) A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.

(e) An individual who acts alone, in his or her individual capacity, and who is not employed by or affiliated with a licensed home health agency or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

(f) The delivery of instructional services in home dialysis and home dialysis supplies and equipment.

(g) The delivery of nursing home services for which the nursing home is licensed under part II of this chapter, to serve its residents in its facility.

(h) The delivery of assisted living facility services for which the assisted living facility is licensed under part I of chapter 429, to serve its residents in its facility.

(i) The delivery of hospice services for which the hospice is licensed under part IV of this chapter, to serve hospice patients admitted to its service.

(j) A hospital that provides services for which it is licensed under chapter 395.

(k) The delivery of community residential services for which the community residential home is licensed under chapter 419, to serve the residents in its facility.

(l) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.

(m) Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

(n) The delivery of adult family-care home services for which the adult family-care home is licensed under part II of chapter 429, to serve the residents in its facility.

(o) A person that provides skilled care by health care professionals licensed solely under part I of chapter 464; part I, part III, or part V of chapter 468; or chapter 486. The exemption in this paragraph does not entitle a person to perform home health services without the required professional license.

(p) A person that provides services using only volunteers or individuals related by blood or marriage to the patient or client.

Section 10. Paragraph (g) of subsection (2) of section 400.471, Florida Statutes, is amended to read:

400.471 Application for license; fee.—

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

(g) In the case of an application for initial licensure, an application for a change of ownership, or an application for the addition of skilled care services, documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408. A home health agency that does not provide skilled care is exempt from this paragraph. Notwithstanding s. 408.806, the ~~an initial~~ applicant must provide proof of accreditation that is not conditional or provisional and a survey demonstrating compliance with the requirements of this part, part II of chapter 408, and applicable rules from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408 within 120 days after the date of the agency's receipt of the application for

licensure. Such accreditation must be continuously maintained by the home health agency to maintain licensure. The agency shall accept, in lieu of its own periodic licensure survey, the submission of the survey of an accrediting organization that is recognized by the agency if the accreditation of the licensed home health agency is not provisional and if the licensed home health agency authorizes release of, and the agency receives the report of, the accrediting organization.

Section 11. Section 400.492, Florida Statutes, is amended to read:

400.492 Provision of services during an emergency.—Each home health agency shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national or state accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health services during an emergency that interrupts patient care or services in the patient's home. The plan shall include the means by which the home health agency will continue to provide staff to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation. The plan shall describe how the home health agency establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated;

providing for communication between staff members, county health departments, and local emergency management agencies, including a backup system; identifying resources necessary to continue essential care or services or referrals to other health care providers ~~organizations~~ subject to written agreement; and prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be continued in the event of an emergency or disaster for each patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving

skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records. Home health agencies may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the agency to reach its clients. Home health agencies shall demonstrate a good faith effort to comply with the requirements of this subsection by documenting attempts of staff to follow procedures outlined in the home health agency's comprehensive emergency management plan, and by the patient's record, which support a finding that the provision of continuing care has been attempted for those patients who have been identified as needing care by the home health agency and registered under s. 252.355, in the event of an emergency or disaster under subsection (1).

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county.

Section 12. Subsection (4) of section 400.506, Florida Statutes, is amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(4) A licensee ~~person~~ that provides, offers, or advertises to the public any service for which licensure is required under this section must include in such advertisement the license number issued to it by the Agency for Health Care Administration. The agency shall assess a fine of not less than $100 against a ~~any~~ licensee that ~~who~~ fails to include the license number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500.

Section 13. Subsections (1), (2), and (4) of section 400.509, Florida Statutes, are amended to read:

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

(1) Any person ~~organization~~ that provides companion services or homemaker services and does not provide a home health service to a person is exempt from licensure under this part. However, any person ~~organization~~ that provides companion services or homemaker services must register with the agency. A person ~~An organization~~ under contract with the Agency for Persons with Disabilities which provides companion services only

for persons with a developmental disability, as defined in s. 393.063, is exempt from registration.

(2) The requirements of part II of chapter 408 apply to the provision of services that require registration or licensure pursuant to this section and part II of chapter 408 and entities registered by or applying for such registration from the Agency for Health Care Administration pursuant to this section. Each applicant for registration and each registrant must comply with all provisions of part II of chapter 408. Registration or a license issued by the agency is required for a person to provide ~~the operation of an organization that provides~~ companion services or homemaker services.

(4) Each registrant must obtain the employment or contract history of persons who are employed by or under contract with the person ~~organization~~ and who will have contact at any time with patients or clients in their homes by:

(a) Requiring such persons to submit an employment or contractual history to the registrant; and

(b) Verifying the employment or contractual history, unless through diligent efforts such verification is not possible. The agency shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.

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

Section 14. Subsection (3) of section 400.605, Florida Statutes, is amended to read:

400.605 Administration; forms; fees; rules; inspections; fines.—

(3) In accordance with s. 408.811, the agency shall conduct ~~annual inspections of all licensees, except that licensure inspections may be conducted biennially for hospices having a 3-year record of substantial compliance. The agency shall conduct~~ such inspections and investigations as are necessary in order to determine the state of compliance with ~~the provisions of~~ this part, part II of chapter 408, and applicable rules.

Section 15. Section 400.60501, Florida Statutes, is amended to read:

400.60501 Outcome measures; adoption of federal quality measures; public reporting~~; annual report~~.—

(1) ~~No later than December 31, 2019,~~ The agency shall adopt the national hospice outcome measures and survey data in 42 C.F.R. part 418 to determine the quality and effectiveness of hospice care for hospices licensed in the state.

(2) The agency shall~~:~~

~~(a)~~ make available to the public the national hospice outcome measures and survey data in a format that is comprehensible by a layperson and that allows a consumer to compare such measures of one or more hospices.

~~(b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.~~

Section 16. Paragraphs (a), (b), (c), and (d) of subsection (4) of section 400.9905, Florida Statutes, are amended, and paragraphs (o), (p), and (q) are added to that subsection, to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and

providing only health care services within the scope of services authorized under their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; entities that own, directly or indirectly, entities licensed or

registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; entities that are owned, directly or indirectly, by an

entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; entities that are under common

ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(o) Entities that are, directly or indirectly, under the common ownership of or that are subject to common control by a

mutual insurance holding company, as defined in s. 628.703, with an entity issued a certificate of authority under chapter 624 or chapter 641 which has $1 billion or more in total annual sales in this state.

(p) Entities that are owned by an entity that is a behavioral health care service provider in at least five other states; that, together with its affiliates, have $90 million or more in total annual revenues associated with the provision of behavioral health care services; and wherein one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state, who is responsible for supervising the business activities of the entity, and who is responsible for the entity's compliance with state law for purposes of this part.

(q) Medicaid providers.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

Section 17. Paragraph (c) of subsection (3) of section 400.991, Florida Statutes, is amended to read:

400.991 License requirements; background screenings; prohibitions.—

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

(c) Proof of financial ability to operate as required under ss. 408.8065(1) and ~~s.~~ 408.810(8). ~~As an alternative to submitting proof of financial ability to operate as required under s. 408.810(8), the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic, payable to the agency. The agency may adopt rules to specify related requirements for such surety bond.~~

Section 18. Paragraph (i) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(i) Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule may group services by price levels, listing services in each price level. The schedule must be posted in a conspicuous

place in the reception area of any clinic that is considered an ~~the~~ urgent care center as defined in s. 395.002(29)(b) and must include, but is not limited to, the 50 services most frequently provided by the clinic. ~~The schedule may group services by three price levels, listing services in each price level.~~ The posting may be a sign that must be at least 15 square feet in size or through an electronic messaging board that is at least 3 square feet in size. The failure of a clinic, including a clinic that is considered an urgent care center, to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted.

Section 19. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birth centers, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, and health care clinics~~, and multiphasic testing centers~~ and by assessments on organizations subject to certification by the

agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 20. Effective January 1, 2021, paragraph (l) is added to subsection (3) of section 408.05, Florida Statutes, to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(l) By July 1 of each year, publish a report identifying the health care services with the most significant price variation both statewide and regionally.

Section 21. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(1) The agency shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties and to facilitate transparency in health care pricing data and quality measures.

Specifications for data to be collected under this section shall be developed by the agency and applicable contract vendors, with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to, ~~:~~ case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, including patient- ~~with patient~~ and provider-specific identifiers ~~included~~, actual charge data by diagnostic groups or other bundled groupings as specified by rule, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by

this section. Data may be obtained from documents including ~~such as~~, but not limited to, ~~:~~ leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, and related diagnostic information. ~~Reported~~ Data elements shall be reported electronically in accordance with rules adopted by the agency ~~rule 59E-7.012, Florida Administrative Code~~. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

Section 22. Subsection (4) of section 408.0611, Florida Statutes, is amended to read:

408.0611 Electronic prescribing clearinghouse.—

(4) Pursuant to s. 408.061, the agency shall monitor the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies. ~~By January 31 of each year,~~ The agency shall annually publish a report on the progress of implementation of electronic prescribing on its Internet website ~~to the Governor and the Legislature~~. Information reported pursuant to this subsection shall include federal and private sector electronic prescribing initiatives and, to the extent that data is readily available from organizations that operate electronic prescribing networks, the number of health care practitioners using electronic

prescribing and the number of prescriptions electronically transmitted.

Section 23. Paragraphs (i) and (j) of subsection (1) of section 408.062, Florida Statutes, are amended to read:

408.062 Research, analyses, studies, and reports.—

(1) The agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:

(i) The use of emergency department services by patient acuity level ~~and the implication of increasing hospital cost by providing nonurgent care in emergency departments~~. The agency shall annually publish information ~~submit an annual report~~ based on this monitoring and assessment on its Internet website ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

(j) The making available on its Internet website, and in a hard-copy format upon request, of patient charge, volumes, length of stay, and performance indicators collected from health care facilities pursuant to s. 408.061(1)(a) for specific medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency. In making the determination of specific medical conditions,

surgeries, and procedures to include, the agency shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency. The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The agency shall annually publish information regarding ~~submit an annual status report on~~ the collection of data and publication of health care quality measures on its Internet website ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

Section 24. Subsection (5) of section 408.063, Florida Statutes, is amended to read:

408.063 Dissemination of health care information.—

~~(5) The agency shall publish annually a comprehensive report of state health expenditures. The report shall identify:~~

~~(a) The contribution of health care dollars made by all payors.~~

~~(b) The dollars expended by type of health care service in Florida.~~

Section 25. Section 408.802, Florida Statutes, is amended to read:

408.802 Applicability. ~~The provisions of~~ This part applies ~~apply~~ to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765:

(1) Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102.

(2) Birth centers, as provided under chapter 383.

(3) Abortion clinics, as provided under chapter 390.

(4) Crisis stabilization units, as provided under parts I and IV of chapter 394.

(5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394.

(6) Residential treatment facilities, as provided under part IV of chapter 394.

(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394.

(8) Hospitals, as provided under part I of chapter 395.

(9) Ambulatory surgical centers, as provided under part I of chapter 395.

(10) Nursing homes, as provided under part II of chapter 400.

(11) Assisted living facilities, as provided under part I of chapter 429.

(12) Home health agencies, as provided under part III of chapter 400.

(13) Nurse registries, as provided under part III of chapter 400.

(14) Companion services or homemaker services providers, as provided under part III of chapter 400.

(15) Adult day care centers, as provided under part III of chapter 429.

(16) Hospices, as provided under part IV of chapter 400.

(17) Adult family-care homes, as provided under part II of chapter 429.

(18) Homes for special services, as provided under part V of chapter 400.

(19) Transitional living facilities, as provided under part XI of chapter 400.

(20) Prescribed pediatric extended care centers, as provided under part VI of chapter 400.

(21) Home medical equipment providers, as provided under part VII of chapter 400.

(22) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400.

(23) Health care services pools, as provided under part IX of chapter 400.

(24) Health care clinics, as provided under part X of chapter 400.

~~(25) Multiphasic health testing centers, as provided under part I of chapter 483.~~

(25)~~(26)~~ Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765.

Section 26. Subsections (10) through (14) of section 408.803, Florida Statutes, are renumbered as subsections (11) through (15), respectively, subsection (3) is amended, and a new subsection (10) is added to that section, to read:

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

(3) "Authorizing statute" means the statute authorizing the licensed operation of a provider listed in s. 408.802 and includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765.

(10) "Low-risk provider" means a nonresidential provider, including a nurse registry, a home medical equipment provider, or a health care clinic.

Section 27. Paragraph (b) of subsection (7) of section 408.806, Florida Statutes, is amended to read:

408.806 License application process.—

(7)

(b) An initial inspection is not required for companion services or homemaker services providers~~,~~ as provided under part III of chapter 400, ~~or~~ for health care services pools~~,~~ as provided under part IX of chapter 400, or for low-risk providers as provided in s. 408.811(1)(c).

Section 28. Subsection (2) of section 408.808, Florida Statutes, is amended to read:

408.808 License categories.—

(2) PROVISIONAL LICENSE.—An applicant against whom a proceeding denying or revoking a license is pending at the time of license renewal may be issued a provisional license effective until final action not subject to further appeal. A provisional license may also be issued to an applicant making initial application for licensure or making application ~~applying~~ for a change of ownership. A provisional license must be limited in duration to a specific period of time, up to 12 months, as determined by the agency.

Section 29. Subsections (6) through (9) of section 408.809, Florida Statutes, are renumbered as subsections (5) through (8), respectively, and subsections (2) and (4) and present subsection (5) of that section are amended to read:

408.809 Background screening; prohibited offenses.—

(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person's fingerprints are enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print arrest notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. ~~Until a specified agency is fully implemented in~~

~~the clearinghouse created under s. 435.12,~~ The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of ~~the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Department of Children and Families, or~~ the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:

(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;

(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and

(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an arrest awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo

contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

If, upon rescreening, a person who is currently employed or contracted with a licensee ~~as of June 30, 2014,~~ and was screened and qualified under s. ~~ss. 435.03 and~~ 435.04~~,~~ has a

disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person.

~~(5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on July 31, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015, in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after~~

~~receipt of the rescreening results by the person. The rescreening schedule shall be:~~

~~(a) Individuals for whom the last screening was conducted on or before December 31, 2004, must be rescreened by July 31, 2013.~~

~~(b) Individuals for whom the last screening conducted was between January 1, 2005, and December 31, 2008, must be rescreened by July 31, 2014.~~

~~(c) Individuals for whom the last screening conducted was between January 1, 2009, through July 31, 2011, must be rescreened by July 31, 2015.~~

Section 30. Subsection (1) of section 408.811, Florida Statutes, is amended to read:

408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.—

(1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a

license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.

(a) All inspections shall be unannounced, except as specified in s. 408.806.

(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by this section, authorizing statutes, or applicable rules.

(c) The agency may exempt a low-risk provider from a licensure inspection if the provider or a controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory actions as defined in agency rule. The agency must conduct unannounced licensure inspections on at least 10 percent of the exempt low-risk providers to verify regulatory compliance.

(d) The agency may adopt rules to waive any inspection, including a relicensure inspection, or grant an extended time period between relicensure inspections based upon:

1. An excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory measures.

2. Outcome measures that demonstrate quality performance.

3. Successful participation in a recognized, quality program.

4. Accreditation status.

5. Other measures reflective of quality and safety.

6. The length of time between inspections.

The agency shall continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for an exemption or extended period between relicensure inspections. The agency may conduct an inspection of any provider at any time to verify regulatory compliance.

Section 31. Subsection (24) of section 408.820, Florida Statutes, is amended to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

~~(24) Multiphasic health testing centers, as provided under part I of chapter 483, are exempt from s. 408.810(5)-(10).~~

Section 32. Subsections (1) and (2) of section 408.821, Florida Statutes, are amended to read:

408.821 Emergency management planning; emergency operations; inactive license.—

(1) A licensee required by authorizing statutes and agency rule to have a comprehensive ~~an~~ emergency management ~~operations~~ plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency

management agency, county health department, or Department of Health as follows:

(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.

(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.

(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.

(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.

(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management ~~operations~~ plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.

Section 33. Subsection (3) of section 408.831, Florida Statutes, is amended to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.—

(3) This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 383, 390, 391, 394, 395, 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to those chapters.

Section 34. Section 408.832, Florida Statutes, is amended to read:

408.832 Conflicts.—In case of conflict between ~~the provisions of~~ this part and the authorizing statutes governing the licensure of health care providers by the Agency for Health Care Administration found in s. 112.0455 and chapters 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765, ~~the provisions of~~ this part shall prevail.

Section 35. Subsection (9) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

~~(9) PROGRAM EVALUATION.—The agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall~~

~~use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by January 15, 2016, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.~~

Section 36. Paragraph (d) of subsection (10) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—

(10) PROGRAM EVALUATION.—The agency and the office shall:

~~(d) Jointly submit by March 1, annually, a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides the information specified in paragraphs (a)-(c) and recommendations relating to the successful implementation and administration of the program.~~

Section 37. Effective upon becoming a law, paragraph (a) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to

Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a)1. The agency may implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service;

adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase.

2. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization.

3. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials.

4. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program. However, this subparagraph may not be construed to prevent the agency from conducting retrospective reviews under s. 409.913, including, but not limited to, reviews in which an overpayment is suspected due to a mistake or submission of an improper claim or for other reasons that do not rise to the level of fraud or abuse.

Section 38. It is the intent of the Legislature that s. 409.905(5)(a), Florida Statutes, as amended by this act,

confirms and clarifies existing law. This section shall take effect upon this act becoming a law.

Section 39. Subsection (8) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(8)(a) A level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following:

1. The ~~Each~~ provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity~~, seeking to participate in the Medicaid program must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check~~.

2. Principals of the provider, who include any officer, director, billing agent, managing employee, or affiliated

person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider are those who meet the definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury, to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application.

3. Any person who participates or seeks to participate in the Florida Medicaid program by way of rendering services to Medicaid recipients or having direct access to Medicaid recipients or recipient living areas, or who supervises the

delivery of goods or services to a Medicaid recipient. This subparagraph does not impose additional screening requirements on any providers licensed under part II of chapter 408.

4. Nonemergency transportation drivers who are employed or contracted with transportation companies, transportation network companies, or transportation brokers are not subject to a level 2 background screening, but must comply with a level 1 background screening pursuant to chapter 435 or an equivalent screening as authorized in s. 316.87.

(b) Notwithstanding paragraph (a) ~~the above~~, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime.

(c) ~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:

1. A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide Medicaid services. The actual cost of the state and national criminal history record checks must be borne by the nongovernmental provider or entity; or

2. Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more.

(d) ~~(b)~~ Background screening shall be conducted in accordance with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

Section 40. Paragraph (a) of subsection (1) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the

availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided in s. 409.905(5), except as otherwise provided in this subsection.

1. If authorized by the General Appropriations Act, the agency may modify reimbursement for specific types of services or diagnoses, recipient ages, and hospital provider types.

2. The agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for:

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency has established a global fee.

d. Recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62.

~~e. Class III psychiatric hospitals.~~

3. The agency shall modify reimbursement according to other methodologies recognized in the General Appropriations Act.

The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year

under this paragraph, paragraph (b), or the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature annually by January 1.

Section 41. Section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15 ~~1~~, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a ~~joint~~ report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the

cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the

Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f) "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program

and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing; to ensure that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and to ensure that appropriate care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by

the agency, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to 1 year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days after receipt of complete documentation by the agency for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial of payment within 180 days after receipt of complete documentation by the agency for review.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to

increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

The agency shall deny payment or require repayment for goods or services that are not presented as required in this subsection.

(8) The agency shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician

or other prescribing practitioner who is not enrolled in the Medicaid program. This section does not apply:

(a) In instances involving bona fide emergency medical conditions as determined by the agency;

(b) To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or outpatient setting, or nursing home;

(c) To bona fide pro bono services by preapproved non-Medicaid providers as determined by the agency;

(d) To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program;

(e) To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program;

(f) To other physicians who are not enrolled in the Medicaid program but who provide a medically necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician; or

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal

business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider must keep the agency informed of the location of the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(10) Payments for the services of billing agents or persons participating in the preparation of a Medicaid claim shall not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program.

(11) The agency shall deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

(12) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the agency takes final agency action with respect to the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Attorney General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

(13) The agency shall terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under s. 408.809(4), s. 409.907(10), or s. 435.04(2). If the agency determines that the provider did not participate or acquiesce in the offense, termination will not be imposed. If the agency effects a termination under this subsection, the agency shall take final agency action.

(14) If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's

participation in this state's Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in this state's Medicaid program while such foreign suspension or termination remains in effect. The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's Medicaid program if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program by the Federal Government or any state. This sanction is in addition to all other remedies provided by law.

(15) The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:

(a) The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;

(b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government;

(c) The provider has not furnished or has failed to make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered, authorized, or prescribed the care, services, or supplies has furnished, or ordered or authorized the furnishing of, goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

(g) The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;

(h) The provider or an authorized representative of the provider, or a person who ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims;

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices or an offense referenced in subsection (13). The sanction applied for this reason is limited

to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who ordered, authorized, or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907;

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or

(q) The provider has failed to comply with an agreed-upon repayment schedule.

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

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

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

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

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

services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of paragraph (15)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive followup reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that remain in effect for up to 3 years and that are monitored by the agency every 6 months while in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

If a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation, the agency shall impose the sanction of termination for cause against the provider. The agency's termination with cause is subject to hearing rights as may be provided under chapter 120. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive may not be imposed.

(17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

(18) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a

specific location, rather than or in addition to taking action against an entire group.

(19) The agency shall establish a process for conducting followup reviews of a sampling of providers who have a history of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or abuse on Medicaid costs.

(20) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. The agency may consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This

limitation does not apply to Medicaid cost report audits. This limitation does not preclude consideration by the agency of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note was made contemporaneously with a patient care episode. Notwithstanding the applicable rules of discovery, all documentation to be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or be excluded from consideration.

(23)(a) In an audit, ~~or~~ investigation, or enforcement action for ~~of~~ a violation committed by a provider which is conducted or taken pursuant to this section, the agency or contractor is entitled to recover any and all investigative and~~,~~ legal costs incurred as a result of such audit, investigation, or enforcement action. Such costs may include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by an attorney and other personnel working on the case, and any other expenses incurred by the agency or contractor that are associated with the case, including any~~, and~~ expert witness costs and attorney fees incurred on behalf of the agency or contractor if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

(24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection (15), except paragraphs (15)(e) and (o), upon any provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider who is regulated by another state entity, the agency shall notify that other entity of the imposition of the sanction within 5 business days. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination. Amounts not paid within 14 days accrue interest at the rate of 10 percent per year, beginning after the 14th day.

(b) The agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated

from the Medicaid program or Medicare program by the Federal Government or any state.

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of final determination of the overpayment by the agency, and payment arrangements must be made within 30 days after the date of the final order, which is not subject to further appeal.

(d) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(e) The agency may institute amnesty programs to allow Medicaid providers the opportunity to voluntarily repay overpayments. The agency may adopt rules to administer such programs.

(26) The agency may impose administrative sanctions against a Medicaid recipient, or the agency may seek any other remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has engaged in solicitation in violation of s. 409.920 or that the recipient has otherwise abused the Medicaid program.

(27) When the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the agency, after notice to the provider, shall:

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration.

(b) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

(28) Venue for all Medicaid program integrity cases lies in Leon County, at the discretion of the agency.

(29) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay an agency-imposed fine that has been determined by final order, not subject to further appeal, within 30 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment and fines is due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold reimbursement payments for Medicaid services until the amount due is paid in full.

(32) Duly authorized agents and employees of the agency shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment, or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered, or purchased by a

provider. The agency shall provide at least 2 business days' prior notice of any such inspection. The notice must identify the provider whose records will be inspected, and the inspection shall include only records specifically related to that provider.

(33) In accordance with federal law, Medicaid recipients convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be limited, restricted, or suspended from Medicaid eligibility for a period not to exceed 1 year, as determined by the agency head or designee.

(34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the agency or the Medicaid Fraud Control Unit determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.

(35) The Office of Program Policy Analysis and Government Accountability shall provide a report to the President of the Senate and the Speaker of the House of Representatives on a biennial basis, beginning January 31, 2006, on the agency's

efforts to prevent, detect, and deter, as well as recover funds lost to, fraud and abuse in the Medicaid program.

(36) The agency may provide to a sample of Medicaid recipients or their representatives through the distribution of explanations of benefits information about services reimbursed by the Medicaid program for goods and services to such recipients, including information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation, information on how to report criminal Medicaid fraud to the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

(37) The agency shall post on its website a current list of each Medicaid provider, including any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, who has been terminated for cause from the Medicaid program or sanctioned under this section. The list must be searchable by a variety of search parameters and provide for the creation of formatted lists that may be printed or imported into other

applications, including spreadsheets. The agency shall update the list at least monthly.

(38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the agency shall:

(a) Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;

(b) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the agency, the Department of Health, the Department of Law Enforcement, and the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and specifications for the technical interface between state and federal health care fraud databases;

(c) Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and

(d) Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or

the Federal Government which use technology to prevent or detect health care fraud.

Section 42. Paragraph (a) of subsection (2) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.—

(2)(a) A person may not:

1. Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent or a managed care plan for payment.

2. Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

3. Knowingly charge, solicit, accept, or receive anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fail to credit the agency or its fiscal agent for any payment received from a third-party source.

4. Knowingly make or in any way cause to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the agency to

determine a general or specific rate of payment for an item or service provided by a provider.

5. Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program. This subparagraph does not apply to any discount, payment, waiver of payment, or payment practice not prohibited by 42 U.S.C. s. 1320a-7b(b) or any regulations adopted thereunder.

6. Knowingly submit false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider.

7. Knowingly use or endeavor to use a Medicaid provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

Section 43. Subsection (1) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(1) Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 6-year ~~5-year~~ contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.

Section 44. Paragraph (b) of subsection (5) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(5) PROVISION OF DENTAL SERVICES.—

(b) In the event the Legislature takes no action before July 1, 2017, with respect to the report findings required under subparagraph (a)2., the agency shall implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who must have substantial experience in providing dental care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act

and who meet all agency standards and requirements. To qualify as a provider under the prepaid dental health program, the entity must be licensed as a prepaid limited health service organization under part I of chapter 636 or as a health maintenance organization under part I of chapter 641. The contracts for program providers shall be awarded through a competitive procurement process. Beginning with the contract procurement process initiated during the 2023 calendar year, the contracts must be for 6 ~~5~~ years and may not be renewed; however, the agency may extend the term of a plan contract to cover delays during a transition to a new plan provider. The agency shall include in the contracts a medical loss ratio provision consistent with s. 409.967(4). The agency is authorized to seek any necessary state plan amendment or federal waiver to commence enrollment in the Medicaid prepaid dental health program no later than March 1, 2019. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in October 2017.

Section 45. Subsection (6) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

~~(6) In addition to the license categories available in s. 408.808, a provisional license may be issued to an applicant making initial application for licensure or making application~~

~~for a change of ownership. A provisional license shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency.~~

Section 46. Subsection (9) of section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

~~(9) The agency shall develop and disseminate an annual list of all facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Families, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, the State Long-Term Care Ombudsman Program, and state and local ombudsman councils. The Department of Children and Families shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's Internet site.~~

Section 47. Subsection (2) of section 429.35, Florida Statutes, is amended to read:

429.35 Maintenance of records; reports.—

(2) Within 60 days after the date of an ~~the biennial~~ inspection conducted ~~visit required~~ under s. 408.811 or within 30 days after the date of an ~~any~~ interim visit, the agency shall forward the results of the inspection to the local ombudsman council in the district where the facility is located; to at least one public library or, in the absence of a public library, the county seat in the county in which the inspected assisted living facility is located; and, when appropriate, to the district Adult Services and Mental Health Program Offices.

Section 48. Subsection (2) of section 429.905, Florida Statutes, is amended to read:

429.905 Exemptions; monitoring of adult day care center programs colocated with assisted living facilities or licensed nursing home facilities.—

(2) A licensed assisted living facility, a licensed hospital, or a licensed nursing home facility may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents. Such a facility need not be licensed as an adult day care center; however, the agency must monitor the facility during the regular inspection ~~and at least biennially~~ to ensure adequate space and

sufficient staff. If an assisted living facility, a hospital, or a nursing home holds itself out to the public as an adult day care center, it must be licensed as such and meet all standards prescribed by statute and rule. For the purpose of this subsection, the term "day" means any portion of a 24-hour day.

Section 49. Subsection (2) of section 429.929, Florida Statutes, is amended to read:

429.929 Rules establishing standards.—

~~(2) Pursuant to this part, s. 408.811, and applicable rules, the agency may conduct an abbreviated biennial inspection of key quality-of-care standards, in lieu of a full inspection, of a center that has a record of good performance. However, the agency must conduct a full inspection of a center that has had one or more confirmed complaints within the licensure period immediately preceding the inspection or which has a serious problem identified during the abbreviated inspection. The agency shall develop the key quality-of-care standards, taking into consideration the comments and recommendations of provider groups. These standards shall be included in rules adopted by the agency.~~

Section 50. Part I of chapter 483, Florida Statutes, is repealed, and parts II and III of that chapter are redesignated as parts I and II, respectively.

Section 51. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 627.6387, Florida Statutes, are amended to read:

627.6387 Shared savings incentive program.—

(2) As used in this section, the term:

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 52. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 627.6648, Florida Statutes, are amended to read:

627.6648 Shared savings incentive program.—

(2) As used in this section, the term:

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 53. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 641.31076, Florida Statutes, are amended to read:

641.31076 Shared savings incentive program.—

(2) As used in this section, the term:

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for subscribers under a health maintenance organization's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health maintenance organization may offer a shared savings incentive program to provide incentives to a subscriber when the subscriber obtains a shoppable health care service from the health maintenance organization's shared savings list. A subscriber may not be required to participate in a shared savings incentive program. A health maintenance organization that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the subscriber's account as a return or reduction in premium, or credit the shared savings incentive amount to the subscriber's flexible spending account, health savings account, or health reimbursement account, or reward the subscriber directly with cash or a cash equivalent ~~such that the amount does not constitute income to the subscriber~~.

Section 54. Paragraph (g) of subsection (3) of section 20.43, Florida Statutes, is amended to read:

20.43 Department of Health.—There is created a Department of Health.

(3) The following divisions of the Department of Health are established:

(g) Division of Medical Quality Assurance, which is responsible for the following boards and professions established within the division:

1. The Board of Acupuncture, created under chapter 457.

2. The Board of Medicine, created under chapter 458.

3. The Board of Osteopathic Medicine, created under chapter 459.

4. The Board of Chiropractic Medicine, created under chapter 460.

5. The Board of Podiatric Medicine, created under chapter 461.

6. Naturopathy, as provided under chapter 462.

7. The Board of Optometry, created under chapter 463.

8. The Board of Nursing, created under part I of chapter 464.

9. Nursing assistants, as provided under part II of chapter 464.

10. The Board of Pharmacy, created under chapter 465.

11. The Board of Dentistry, created under chapter 466.

12. Midwifery, as provided under chapter 467.

13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

14. The Board of Nursing Home Administrators, created under part II of chapter 468.

15. The Board of Occupational Therapy, created under part III of chapter 468.

16. Respiratory therapy, as provided under part V of chapter 468.

17. Dietetics and nutrition practice, as provided under part X of chapter 468.

18. The Board of Athletic Training, created under part XIII of chapter 468.

19. The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.

20. Electrolysis, as provided under chapter 478.

21. The Board of Massage Therapy, created under chapter 480.

22. The Board of Clinical Laboratory Personnel, created under part I ~~part II~~ of chapter 483.

23. Medical physicists, as provided under part II ~~part III~~ of chapter 483.

24. The Board of Opticianry, created under part I of chapter 484.

25. The Board of Hearing Aid Specialists, created under part II of chapter 484.

26. The Board of Physical Therapy Practice, created under chapter 486.

27. The Board of Psychology, created under chapter 490.

28. School psychologists, as provided under chapter 490.

29. The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

30. Emergency medical technicians and paramedics, as provided under part III of chapter 401.

Section 55. Subsection (3) of section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on HIV and AIDS.—

(3) The department shall require, as a condition of granting a license under chapter 467 or part I ~~part II~~ of chapter 483, that an applicant making initial application for licensure complete an educational course acceptable to the department on human immunodeficiency virus and acquired immune deficiency syndrome. Upon submission of an affidavit showing good cause, an applicant who has not taken a course at the time of licensure shall be allowed 6 months to complete this requirement.

Section 56. Subsection (4) of section 456.001, Florida Statutes, is amended to read:

456.001 Definitions.—As used in this chapter, the term:

(4) "Health care practitioner" means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

Section 57. Paragraphs (h) and (i) of subsection (2) of section 456.057, Florida Statutes, are amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(h) Clinical laboratory personnel licensed under part I ~~part II~~ of chapter 483.

(i) Medical physicists licensed under part II ~~part III~~ of chapter 483.

Section 58. Paragraph (j) of subsection (1) of section 456.076, Florida Statutes, is amended to read:

456.076 Impaired practitioner programs.—

(1) As used in this section, the term:

(j) "Practitioner" means a person licensed, registered, certified, or regulated by the department under part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478;

chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; or an applicant for a license, registration, or certification under the same laws.

Section 59. Paragraph (b) of subsection (1) of section 456.47, Florida Statutes, is amended to read:

456.47 Use of telehealth to provide services.—

(1) DEFINITIONS.—As used in this section, the term:

(b) "Telehealth provider" means any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; who is licensed under a multistate health care licensure compact of which Florida is a member state; or who is registered under and complies with subsection (4).

Section 60. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2020.