1
2 An act relating to the Agency for Health Care
3 Administration; amending s. 381.915, F.S.; revising
4 time limits for Tier 3 cancer center designations
5 within the Florida Consortium of National Cancer
6 Institute Centers Program; amending s. 383.327, F.S.;
7 requiring birth centers to report certain deaths and
8 stillbirths to the Agency for Health Care
9 Administration; removing a requirement that a certain
10 report be submitted annually to the agency;
11 authorizing the agency to prescribe by rule the
12 frequency at which such report is submitted; amending
13 s. 395.003, F.S.; removing a requirement that
14 specified information be listed on licenses for
15 certain facilities; amending s. 395.1055, F.S.;
16 requiring the agency to adopt specified rules related
17 to ongoing quality improvement programs for certain
18 cardiac programs; amending s. 395.602, F.S.; extending
19 a certain date relating to the designation of certain
20 rural hospitals; repealing s. 395.7015, F.S., relating
21 to an annual assessment on health care entities;
22 amending s. 395.7016, F.S.; conforming a provision to
23 changes made by the act; amending s. 400.19, F.S.;
24 revising provisions requiring the agency to conduct
25 licensure inspections of nursing homes; requiring the

26 agency to conduct biannual licensure surveys under
27 certain circumstances; revising a provision requiring
28 the agency to assess a specified fine for such
29 surveys; amending s. 400.462, F.S.; revising
30 definitions; amending s. 400.464, F.S.; revising
31 provisions relating to exemptions from licensure
32 requirements for home health agencies; exempting
33 certain persons from such licensure requirements;
34 amending ss. 400.471, 400.492, 400.506, and 400.509,
35 F.S.; revising provisions relating to licensure
36 requirements for home health agencies to conform to
37 changes made by the act; amending s. 400.605, F.S.;
38 removing a requirement that the agency conduct
39 specified inspections of certain licensees; amending
40 s. 400.60501, F.S.; removing an obsolete date and a
41 requirement that the agency develop a specified annual
42 report; amending s. 400.9905, F.S.; revising the
43 definition of the term "clinic"; amending s. 400.991,
44 F.S.; conforming provisions to changes made by the
45 act; removing the option for health care clinics to
46 file a surety bond under certain circumstances;
47 amending s. 400.9935, F.S.; requiring certain clinics
48 to publish and post a schedule of charges; amending s.
49 408.033, F.S.; conforming a provision to changes made
50 by the act; amending s. 408.05, F.S.; requiring the

51 agency to publish an annual report identifying certain
52 health care services by a specified date; amending s.
53 408.061, F.S.; revising provisions requiring health
54 care facilities to submit specified data to the
55 agency; amending s. 408.0611, F.S.; requiring the
56 agency to annually publish a report on the progress of
57 implementation of electronic prescribing on its
58 Internet website; amending s. 408.062, F.S.; requiring
59 the agency to annually publish certain information on
60 its Internet website; removing a requirement that the
61 agency submit certain annual reports to the Governor
62 and Legislature; amending s. 408.063, F.S.; removing a
63 requirement that the agency annually publish certain
64 reports; amending ss. 408.802, 408.820, 408.831, and
65 408.832, F.S.; conforming provisions to changes made
66 by the act; amending s. 408.803, F.S.; conforming a
67 provision to changes made by the act; providing a
68 definition of the term "low-risk provider"; amending
69 s. 408.806, F.S.; exempting certain low-risk providers
70 from a specified inspection; amending s. 408.808,
71 F.S.; authorizing the issuance of a provisional
72 license to certain applicants; amending s. 408.809,
73 F.S.; revising provisions relating to background
74 screening requirements for certain licensure
75 applicants; removing an obsolete date and provisions

76 relating to certain rescreening requirements; amending
77 s. 408.811, F.S.; authorizing the agency to exempt
78 certain low-risk providers from inspections and
79 conduct unannounced licensure inspections of such
80 providers under certain circumstances; authorizing the
81 agency to adopt rules to waive routine inspections and
82 grant extended time periods between relicensure
83 inspections under certain conditions; amending s.
84 408.821, F.S.; revising provisions requiring licensees
85 to have a specified plan; providing requirements for
86 the submission of such plan; amending s. 408.909,
87 F.S.; removing a requirement that the agency and
88 Office of Insurance Regulation evaluate a specified
89 program; amending s. 408.9091, F.S.; removing a
90 requirement that the agency and office jointly submit
91 a specified annual report to the Governor and
92 Legislature; amending s. 409.905, F.S.; providing
93 construction for a provision that requires the agency
94 to discontinue its hospital retrospective review
95 program under certain circumstances; providing
96 legislative intent; amending s. 409.907, F.S.;
97 requiring that a specified background screening be
98 conducted through the agency on certain persons and
99 entities; amending s. 409.908, F.S.; revising
100 provisions related to the prospective payment

101 methodology for certain Medicaid provider
102 reimbursements; amending s. 409.913, F.S.; revising a
103 requirement that the agency and the Medicaid Fraud
104 Control Unit of the Department of Legal Affairs submit
105 a specified report to the Legislature; authorizing the
106 agency to recover specified costs associated with an
107 audit, investigation, or enforcement action relating
108 to provider fraud under the Medicaid program; amending
109 s. 409.920, F.S.; revising provisions related to
110 prohibited referral practices under the Medicaid
111 program; providing applicability; amending ss. 409.967
112 and 409.973, F.S.; revising the length of managed care
113 plan and Medicaid prepaid dental health program
114 contracts, respectively, procured by the agency
115 beginning during a specified timeframe; requiring the
116 agency to extend the term of certain existing
117 contracts until a specified date; amending s. 429.11,
118 F.S.; removing an authorization for the issuance of a
119 provisional license to certain facilities; amending s.
120 429.19, F.S.; removing requirements that the agency
121 develop and disseminate a specified list and the
122 Department of Children and Families disseminate such
123 list to certain providers; amending ss. 429.35,
124 429.905, and 429.929, F.S.; revising provisions
125 requiring a biennial inspection cycle for specified

126 facilities and centers, respectively; repealing part I
127 of chapter 483, F.S., relating to The Florida
128 Multiphasic Health Testing Center Law; amending ss.
129 627.6387, 627.6648, and 641.31076, F.S.; revising the
130 definition of the term "shoppable health care
131 service"; revising duties of certain health insurers
132 and health maintenance organizations; amending ss.
133 20.43, 381.0034, 456.001, 456.057, 456.076, and
134 456.47, F.S.; conforming cross-references; providing
135 effective dates.
136
137 Be It Enacted by the Legislature of the State of Florida:
138
139 Section 1. Paragraph (c) of subsection (4) of section
140 381.915, Florida Statutes, is amended to read:
141 381.915 Florida Consortium of National Cancer Institute
142 Centers Program.—
143 (4) Tier designations and corresponding weights within the
144 Florida Consortium of National Cancer Institute Centers Program
145 are as follows:
146 (c) Tier 3: Florida-based cancer centers seeking
147 designation as either a NCI-designated cancer center or NCI-
148 designated comprehensive cancer center, which shall be weighted
149 at 1.0.
150 1. A cancer center shall meet the following minimum

151 criteria to be considered eligible for Tier 3 designation in any
152 given fiscal year:
153 a. Conducting cancer-related basic scientific research and
154 cancer-related population scientific research;
155 b. Offering and providing the full range of diagnostic and
156 treatment services on site, as determined by the Commission on
157 Cancer of the American College of Surgeons;
158 c. Hosting or conducting cancer-related interventional
159 clinical trials that are registered with the NCI's Clinical
160 Trials Reporting Program;
161 d. Offering degree-granting programs or affiliating with
162 universities through degree-granting programs accredited or
163 approved by a nationally recognized agency and offered through
164 the center or through the center in conjunction with another
165 institution accredited by the Commission on Colleges of the
166 Southern Association of Colleges and Schools;
167 e. Providing training to clinical trainees, medical
168 trainees accredited by the Accreditation Council for Graduate
169 Medical Education or the American Osteopathic Association, and
170 postdoctoral fellows recently awarded a doctorate degree; and
171 f. Having more than $5 million in annual direct costs
172 associated with their total NCI peer-reviewed grant funding.
173 2. The General Appropriations Act or accompanying
174 legislation may limit the number of cancer centers which shall
175 receive Tier 3 designations or provide additional criteria for

176 such designation.

177 3. A cancer center's participation in Tier 3 <u>may not</u>
178 <u>extend beyond June 30, 2024</u> ~~shall be limited to 6 years~~.

179 4. A cancer center that qualifies as a designated Tier 3
180 center under the criteria provided in subparagraph 1. by July 1,
181 2014, is authorized to pursue NCI designation as a cancer center
182 or a comprehensive cancer center <u>until June 30, 2024</u> ~~for 6 years~~
183 ~~after qualification~~.

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

186 383.327 Birth and death records; reports.—

187 (2) Each maternal death, newborn death, and stillbirth
188 shall be reported immediately to the medical examiner <u>and the</u>
189 <u>agency</u>.

190 (4) A report shall be submitted ~~annually~~ to the agency.
191 The contents of the report <u>and the frequency at which it is</u>
192 <u>submitted</u> shall be prescribed by rule of the agency.

193 Section 3. Subsection (4) of section 395.003, Florida
194 Statutes, is amended to read:

195 395.003 Licensure; denial, suspension, and revocation.—

196 (4) The agency shall issue a license <u>that</u> ~~which~~ specifies
197 the service categories and the number of hospital beds in each
198 bed category for which a license is received. Such information
199 shall be listed on the face of the license. ~~All beds which are~~
200 ~~not covered by any specialty-bed-need methodology shall be~~

201 ~~specified as general beds.~~ A licensed facility shall not operate
202 a number of hospital beds greater than the number indicated by
203 the agency on the face of the license without approval from the
204 agency under conditions established by rule.
205 Section 4. Paragraph (g) is added to subsection (18) of
206 section 395.1055, Florida Statutes, to read:
207 395.1055 Rules and enforcement.—
208 (18) In establishing rules for adult cardiovascular
209 services, the agency shall include provisions that allow for:
210 (g) For a hospital licensed for adult diagnostic cardiac
211 catheterization that provides Level I or Level II adult
212 cardiovascular services, demonstration that the hospital is
213 participating in the American College of Cardiology's National
214 Cardiovascular Data Registry or the American Heart Association's
215 Get with the Guidelines-Coronary Artery Disease registry and
216 documentation of an ongoing quality improvement plan ensuring
217 that the licensed cardiac program meets or exceeds national
218 quality and outcome benchmarks reported by the registry in which
219 the hospital participates. A hospital licensed for Level II
220 adult cardiovascular services must also participate in the
221 clinical outcome reporting systems operated by the Society for
222 Thoracic Surgeons.
223 Section 5. Paragraph (b) of subsection (2) of section
224 395.602, Florida Statutes, is amended to read:
225 395.602 Rural hospitals.—

226 (2) DEFINITIONS.—As used in this part, the term:
227 (b) "Rural hospital" means an acute care hospital licensed
228 under this chapter, having 100 or fewer licensed beds and an
229 emergency room, which is:
230 1. The sole provider within a county with a population
231 density of up to 100 persons per square mile;
232 2. An acute care hospital, in a county with a population
233 density of up to 100 persons per square mile, which is at least
234 30 minutes of travel time, on normally traveled roads under
235 normal traffic conditions, from any other acute care hospital
236 within the same county;
237 3. A hospital supported by a tax district or subdistrict
238 whose boundaries encompass a population of up to 100 persons per
239 square mile;
240 4. A hospital classified as a sole community hospital
241 under 42 C.F.R. s. 412.92, regardless of the number of licensed
242 beds;
243 5. A hospital with a service area that has a population of
244 up to 100 persons per square mile. As used in this subparagraph,
245 the term "service area" means the fewest number of zip codes
246 that account for 75 percent of the hospital's discharges for the
247 most recent 5-year period, based on information available from
248 the hospital inpatient discharge database in the Florida Center
249 for Health Information and Transparency at the agency; or

250 6. A hospital designated as a critical access hospital, as
251 defined in s. 408.07.
252
253 Population densities used in this paragraph must be based upon
254 the most recently completed United States census. A hospital
255 that received funds under s. 409.9116 for a quarter beginning no
256 later than July 1, 2002, is deemed to have been and shall
257 continue to be a rural hospital from that date through June 30,
258 2021, if the hospital continues to have up to 100 licensed beds
259 and an emergency room. An acute care hospital that has not
260 previously been designated as a rural hospital and that meets
261 the criteria of this paragraph shall be granted such designation
262 upon application, including supporting documentation, to the
263 agency. A hospital that was licensed as a rural hospital during
264 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
265 rural hospital from the date of designation through June 30,
266 2025 ~~2021~~, if the hospital continues to have up to 100 licensed
267 beds and an emergency room.
268 Section 6. Section 395.7015, Florida Statutes, is
269 repealed.
270 Section 7. Section 395.7016, Florida Statutes, is amended
271 to read:
272 395.7016 Annual appropriation.—The Legislature shall
273 appropriate each fiscal year from either the General Revenue
274 Fund or the Agency for Health Care Administration Tobacco

275 Settlement Trust Fund an amount sufficient to replace the funds
276 lost due to ~~reduction by chapter 2000-256, Laws of Florida, of~~
277 ~~the assessment on other health care entities under s. 395.7015,~~
278 ~~and~~ the reduction by chapter 2000-256, Laws of Florida, in the
279 assessment on hospitals under s. 395.701~~,~~ and to maintain
280 federal approval of the reduced amount of funds deposited into
281 the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as
282 state match for the state's Medicaid program.
283 Section 8. Subsection (3) of section 400.19, Florida
284 Statutes, is amended to read:
285 400.19 Right of entry and inspection.—
286 (3) The agency shall conduct periodic, ~~every 15 months~~
287 ~~conduct at least one~~ unannounced licensure inspections
288 ~~inspection~~ to determine compliance by the licensee with
289 statutes, and with rules adopted ~~promulgated~~ under ~~the~~
290 ~~provisions of~~ those statutes, governing minimum standards of
291 construction, quality and adequacy of care, and rights of
292 residents. ~~The survey shall be conducted every 6 months for the~~
293 ~~next 2-year period~~ If the facility has been cited for a class I
294 deficiency or~~,~~ has been cited for two or more class II
295 deficiencies arising from separate surveys or investigations
296 within a 60-day period, or has had three or more substantiated
297 complaints within a 6-month period, each resulting in at least
298 one class I or class II deficiency, the agency shall conduct
299 biannual licensure surveys until the facility has two

300 <u>consecutive licensure surveys without a citation for a Class I</u>
301 <u>or a Class II deficiency</u>. In addition to any other fees or fines
302 in this part, the agency shall assess a fine <u>of</u> ~~for each~~
303 ~~facility that is subject to the 6-month survey cycle. The fine~~
304 ~~for the 2-year period shall be~~ $6,000 <u>for the biannual licensure</u>
305 <u>surveys</u>~~, one-half to be paid at the completion of each survey~~.
306 The agency may adjust <u>such</u> ~~this~~ fine by the change in the
307 Consumer Price Index, based on the 12 months immediately
308 preceding the increase, to cover the cost of the additional
309 surveys. The agency shall verify through subsequent inspection
310 that any deficiency identified during inspection is corrected.
311 However, the agency may verify the correction of a class III or
312 class IV deficiency unrelated to resident rights or resident
313 care without reinspecting the facility if adequate written
314 documentation has been received from the facility, which
315 provides assurance that the deficiency has been corrected. The
316 giving or causing to be given of advance notice of such
317 unannounced inspections by an employee of the agency to any
318 unauthorized person shall constitute cause for suspension of not
319 fewer than 5 working days according to ~~the provisions of~~ chapter
320 110.
321 Section 9. Subsections (23) through (30) of section
322 400.462, Florida Statutes, are renumbered as subsections (22)
323 through (29), respectively, and subsections (12), (14), and (17)
324 and present subsection (22) of that section are amended to read:

325 400.462 Definitions.—As used in this part, the term:
326 (12) "Home health agency" means a person ~~an organization~~
327 that provides one or more home health services ~~and staffing~~
328 ~~services~~.
329 (14) "Home health services" means health and medical
330 services and medical supplies furnished ~~by an organization~~ to an
331 individual in the individual's home or place of residence. The
332 term includes ~~organizations that provide one or more of~~ the
333 following:
334 (a) Nursing care.
335 (b) Physical, occupational, respiratory, or speech
336 therapy.
337 (c) Home health aide services.
338 (d) Dietetics and nutrition practice and nutrition
339 counseling.
340 (e) Medical supplies, restricted to drugs and biologicals
341 prescribed by a physician.
342 (17) "Home infusion therapy provider" means a person ~~an~~
343 ~~organization~~ that employs, contracts with, or refers a licensed
344 professional who has received advanced training and experience
345 in intravenous infusion therapy and who administers infusion
346 therapy to a patient in the patient's home or place of
347 residence.
348 ~~(22) "Organization" means a corporation, government or~~
349 ~~governmental subdivision or agency, partnership or association,~~

350 ~~or any other legal or commercial entity, any of which involve~~
351 ~~more than one health care professional discipline; a health care~~
352 ~~professional and a home health aide or certified nursing~~
353 ~~assistant; more than one home health aide; more than one~~
354 ~~certified nursing assistant; or a home health aide and a~~
355 ~~certified nursing assistant. The term does not include an entity~~
356 ~~that provides services using only volunteers or only individuals~~
357 ~~related by blood or marriage to the patient or client.~~
358 Section 10. Subsection (1), paragraphs (a) and (f) of
359 subsection (4), and subsection (5) of section 400.464, Florida
360 Statutes, are amended to read:
361 400.464 Home health agencies to be licensed; expiration of
362 license; exemptions; unlawful acts; penalties.—
363 (1) The requirements of part II of chapter 408 apply to
364 the provision of services that require licensure pursuant to
365 this part and part II of chapter 408 and persons or entities
366 licensed or registered by or applying for such licensure or
367 registration from the Agency for Health Care Administration
368 pursuant to this part. A license or registration issued by the
369 agency is required in order to operate a home health agency in
370 this state. A license or registration issued on or after July 1,
371 2018, must specify the home health services the licensee or
372 registrant ~~organization~~ is authorized to perform and indicate
373 whether such specified services are considered skilled care. The
374 provision or advertising of services that require licensure or

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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.

400 (b) Home health services provided by a state agency,
401 either directly or through a contractor with:
402 1. The Department of Elderly Affairs.
403 2. The Department of Health, a community health center, or
404 a rural health network that furnishes home visits for the
405 purpose of providing environmental assessments, case management,
406 health education, personal care services, family planning, or
407 followup treatment, or for the purpose of monitoring and
408 tracking disease.
409 3. Services provided to persons with developmental
410 disabilities, as defined in s. 393.063.
411 4. Companion and sitter organizations that were registered
412 under s. 400.509(1) on January 1, 1999, and were authorized to
413 provide personal services under a developmental services
414 provider certificate on January 1, 1999, may continue to provide
415 such services to past, present, and future clients of the
416 organization who need such services, notwithstanding ~~the~~
417 ~~provisions of~~ this act.
418 5. The Department of Children and Families.
419 (c) A health care professional, whether or not
420 incorporated, who is licensed under chapter 457; chapter 458;
421 chapter 459; part I of chapter 464; chapter 467; part I, part
422 III, part V, or part X of chapter 468; chapter 480; chapter 486;
423 chapter 490; or chapter 491; and who is acting alone within the

424 scope of his or her professional license to provide care to
425 patients in their homes.
426 (d) A home health aide or certified nursing assistant who
427 is acting in his or her individual capacity, within the
428 definitions and standards of his or her occupation, and who
429 provides hands-on care to patients in their homes.
430 (e) An individual who acts alone, in his or her individual
431 capacity, and who is not employed by or affiliated with a
432 licensed home health agency or registered with a licensed nurse
433 registry. This exemption does not entitle an individual to
434 perform home health services without the required professional
435 license.
436 (f) The delivery of instructional services in home
437 dialysis and home dialysis supplies and equipment.
438 (g) The delivery of nursing home services for which the
439 nursing home is licensed under part II of this chapter, to serve
440 its residents in its facility.
441 (h) The delivery of assisted living facility services for
442 which the assisted living facility is licensed under part I of
443 chapter 429, to serve its residents in its facility.
444 (i) The delivery of hospice services for which the hospice
445 is licensed under part IV of this chapter, to serve hospice
446 patients admitted to its service.
447 (j) A hospital that provides services for which it is
448 licensed under chapter 395.

449 (k) The delivery of community residential services for
450 which the community residential home is licensed under chapter
451 419, to serve the residents in its facility.
452 (l) A not-for-profit, community-based agency that provides
453 early intervention services to infants and toddlers.
454 (m) Certified rehabilitation agencies and comprehensive
455 outpatient rehabilitation facilities that are certified under
456 Title 18 of the Social Security Act.
457 (n) The delivery of adult family-care home services for
458 which the adult family-care home is licensed under part II of
459 chapter 429, to serve the residents in its facility.
460 (o) A person that provides skilled care by health care
461 professionals licensed solely under part I of chapter 464; part
462 I, part III, or part V of chapter 468; or chapter 486. The
463 exemption in this paragraph does not entitle a person to perform
464 home health services without the required professional license.
465 (p) A person that provides services using only volunteers
466 or individuals related by blood or marriage to the patient or
467 client.
468 Section 11. Paragraph (g) of subsection (2) of section
469 400.471, Florida Statutes, is amended to read:
470 400.471 Application for license; fee.—
471 (2) In addition to the requirements of part II of chapter
472 408, the initial applicant, the applicant for a change of
473 ownership, and the applicant for the addition of skilled care

474 services must file with the application satisfactory proof that
475 the home health agency is in compliance with this part and
476 applicable rules, including:
477 (g) In the case of an application for initial licensure,
478 an application for a change of ownership, or an application for
479 the addition of skilled care services, documentation of
480 accreditation, or an application for accreditation, from an
481 accrediting organization that is recognized by the agency as
482 having standards comparable to those required by this part and
483 part II of chapter 408. A home health agency that does not
484 provide skilled care is exempt from this paragraph.
485 Notwithstanding s. 408.806, the ~~an initial~~ applicant must
486 provide proof of accreditation that is not conditional or
487 provisional and a survey demonstrating compliance with the
488 requirements of this part, part II of chapter 408, and
489 applicable rules from an accrediting organization that is
490 recognized by the agency as having standards comparable to those
491 required by this part and part II of chapter 408 within 120 days
492 after the date of the agency's receipt of the application for
493 licensure. Such accreditation must be continuously maintained by
494 the home health agency to maintain licensure. The agency shall
495 accept, in lieu of its own periodic licensure survey, the
496 submission of the survey of an accrediting organization that is
497 recognized by the agency if the accreditation of the licensed
498 home health agency is not provisional and if the licensed home

499 health agency authorizes release of, and the agency receives the
500 report of, the accrediting organization.
501 Section 12. Section 400.492, Florida Statutes, is amended
502 to read:
503 400.492 Provision of services during an emergency.—Each
504 home health agency shall prepare and maintain a comprehensive
505 emergency management plan that is consistent with the standards
506 adopted by national or state accreditation organizations and
507 consistent with the local special needs plan. The plan shall be
508 updated annually and shall provide for continuing home health
509 services during an emergency that interrupts patient care or
510 services in the patient's home. The plan shall include the means
511 by which the home health agency will continue to provide staff
512 to perform the same type and quantity of services to their
513 patients who evacuate to special needs shelters that were being
514 provided to those patients prior to evacuation. The plan shall
515 describe how the home health agency establishes and maintains an
516 effective response to emergencies and disasters, including:
517 notifying staff when emergency response measures are initiated;
518 providing for communication between staff members, county health
519 departments, and local emergency management agencies, including
520 a backup system; identifying resources necessary to continue
521 essential care or services or referrals to other health care
522 providers ~~organizations~~ subject to written agreement; and

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523 prioritizing and contacting patients who need continued care or
524 services.
525 (1) Each patient record for patients who are listed in the
526 registry established pursuant to s. 252.355 shall include a
527 description of how care or services will be continued in the
528 event of an emergency or disaster. The home health agency shall
529 discuss the emergency provisions with the patient and the
530 patient's caregivers, including where and how the patient is to
531 evacuate, procedures for notifying the home health agency in the
532 event that the patient evacuates to a location other than the
533 shelter identified in the patient record, and a list of
534 medications and equipment which must either accompany the
535 patient or will be needed by the patient in the event of an
536 evacuation.
537 (2) Each home health agency shall maintain a current
538 prioritized list of patients who need continued services during
539 an emergency. The list shall indicate how services shall be
540 continued in the event of an emergency or disaster for each
541 patient and if the patient is to be transported to a special
542 needs shelter, and shall indicate if the patient is receiving
543 skilled nursing services and the patient's medication and
544 equipment needs. The list shall be furnished to county health
545 departments and to local emergency management agencies, upon
546 request.

547 (3) Home health agencies shall not be required to continue
548 to provide care to patients in emergency situations that are
549 beyond their control and that make it impossible to provide
550 services, such as when roads are impassable or when patients do
551 not go to the location specified in their patient records. Home
552 health agencies may establish links to local emergency
553 operations centers to determine a mechanism by which to approach
554 specific areas within a disaster area in order for the agency to
555 reach its clients. Home health agencies shall demonstrate a good
556 faith effort to comply with the requirements of this subsection
557 by documenting attempts of staff to follow procedures outlined
558 in the home health agency's comprehensive emergency management
559 plan, and by the patient's record, which support a finding that
560 the provision of continuing care has been attempted for those
561 patients who have been identified as needing care by the home
562 health agency and registered under s. 252.355, in the event of
563 an emergency or disaster under subsection (1).
564 (4) Notwithstanding the provisions of s. 400.464(2) or any
565 other provision of law to the contrary, a home health agency may
566 provide services in a special needs shelter located in any
567 county.
568 Section 13. Subsection (4) of section 400.506, Florida
569 Statutes, is amended to read:
570 400.506 Licensure of nurse registries; requirements;
571 penalties.—

572 (4) A licensee ~~person~~ that provides, offers, or advertises
573 to the public any service for which licensure is required under
574 this section must include in such advertisement the license
575 number issued to it by the Agency for Health Care
576 Administration. The agency shall assess a fine of not less than
577 $100 against a ~~any~~ licensee that ~~who~~ fails to include the
578 license number when submitting the advertisement for
579 publication, broadcast, or printing. The fine for a second or
580 subsequent offense is $500.
581 Section 14. Subsections (1), (2), and (4) of section
582 400.509, Florida Statutes, are amended to read:
583 400.509 Registration of particular service providers
584 exempt from licensure; certificate of registration; regulation
585 of registrants.—
586 (1) Any person ~~organization~~ that provides companion
587 services or homemaker services and does not provide a home
588 health service to a person is exempt from licensure under this
589 part. However, any person ~~organization~~ that provides companion
590 services or homemaker services must register with the agency. A
591 person ~~An organization~~ under contract with the Agency for
592 Persons with Disabilities which provides companion services only
593 for persons with a developmental disability, as defined in s.
594 393.063, is exempt from registration.
595 (2) The requirements of part II of chapter 408 apply to
596 the provision of services that require registration or licensure

597 pursuant to this section and part II of chapter 408 and entities
598 registered by or applying for such registration from the Agency
599 for Health Care Administration pursuant to this section. Each
600 applicant for registration and each registrant must comply with
601 all provisions of part II of chapter 408. Registration or a
602 license issued by the agency is required for a person to provide
603 ~~the operation of an organization that provides~~ companion
604 services or homemaker services.
605 (4) Each registrant must obtain the employment or contract
606 history of persons who are employed by or under contract with
607 the person ~~organization~~ and who will have contact at any time
608 with patients or clients in their homes by:
609 (a) Requiring such persons to submit an employment or
610 contractual history to the registrant; and
611 (b) Verifying the employment or contractual history,
612 unless through diligent efforts such verification is not
613 possible. The agency shall prescribe by rule the minimum
614 requirements for establishing that diligent efforts have been
615 made.
616
617 There is no monetary liability on the part of, and no cause of
618 action for damages arises against, a former employer of a
619 prospective employee of or prospective independent contractor
620 with a registrant who reasonably and in good faith communicates
621 his or her honest opinions about the former employee's or

622 contractor's job performance. This subsection does not affect
623 the official immunity of an officer or employee of a public
624 corporation.
625 Section 15. Subsection (3) of section 400.605, Florida
626 Statutes, is amended to read:
627 400.605 Administration; forms; fees; rules; inspections;
628 fines.—
629 (3) In accordance with s. 408.811, the agency shall
630 conduct ~~annual inspections of all licensees, except that~~
631 ~~licensure inspections may be conducted biennially for hospices~~
632 ~~having a 3-year record of substantial compliance. The agency~~
633 ~~shall conduct~~ such inspections and investigations as are
634 necessary in order to determine the state of compliance with ~~the~~
635 ~~provisions of~~ this part, part II of chapter 408, and applicable
636 rules.
637 Section 16. Section 400.60501, Florida Statutes, is
638 amended to read:
639 400.60501 Outcome measures; adoption of federal quality
640 measures; public reporting~~; annual report~~.—
641 (1) ~~No later than December 31, 2019,~~ The agency shall
642 adopt the national hospice outcome measures and survey data in
643 42 C.F.R. part 418 to determine the quality and effectiveness of
644 hospice care for hospices licensed in the state.
645 (2) The agency shall~~:~~

646 ~~(a)~~ make available to the public the national hospice
647 outcome measures and survey data in a format that is
648 comprehensible by a layperson and that allows a consumer to
649 compare such measures of one or more hospices.
650 ~~(b) Develop an annual report that analyzes and evaluates~~
651 ~~the information collected under this act and any other data~~
652 ~~collection or reporting provisions of law.~~
653 Section 17. Paragraphs (a), (b), (c), and (d) of
654 subsection (4) of section 400.9905, Florida Statutes, are
655 amended, and paragraphs (o), (p), and (q) are added to that
656 subsection, to read:
657 400.9905 Definitions.—
658 (4) "Clinic" means an entity where health care services
659 are provided to individuals and which tenders charges for
660 reimbursement for such services, including a mobile clinic and a
661 portable equipment provider. As used in this part, the term does
662 not include and the licensure requirements of this part do not
663 apply to:
664 (a) Entities licensed or registered by the state under
665 chapter 395; entities licensed or registered by the state and
666 providing only health care services within the scope of services
667 authorized under their respective licenses under ss. 383.30-
668 383.332, chapter 390, chapter 394, chapter 397, this chapter
669 except part X, chapter 429, chapter 463, chapter 465, chapter
670 466, chapter 478, chapter 484, or chapter 651; end-stage renal

671 disease providers authorized under 42 C.F.R. part 494 ~~405,~~
672 ~~subpart U~~; providers certified and providing only health care
673 services within the scope of services authorized under their
674 respective certifications under 42 C.F.R. part 485, subpart B,
675 ~~or~~ subpart H, or subpart J; providers certified and providing
676 only health care services within the scope of services
677 authorized under their respective certifications under 42 C.F.R.
678 part 486, subpart C; providers certified and providing only
679 health care services within the scope of services authorized
680 under their respective certifications under 42 C.F.R. part 491,
681 subpart A; providers certified by the Centers for Medicare and
682 Medicaid services under the federal Clinical Laboratory
683 Improvement Amendments and the federal rules adopted thereunder;
684 or any entity that provides neonatal or pediatric hospital-based
685 health care services or other health care services by licensed
686 practitioners solely within a hospital licensed under chapter
687 395.
688 (b) Entities that own, directly or indirectly, entities
689 licensed or registered by the state pursuant to chapter 395;
690 entities that own, directly or indirectly, entities licensed or
691 registered by the state and providing only health care services
692 within the scope of services authorized pursuant to their
693 respective licenses under ss. 383.30-383.332, chapter 390,
694 chapter 394, chapter 397, this chapter except part X, chapter
695 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter

696 484, or chapter 651; end-stage renal disease providers
697 authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers
698 certified and providing only health care services within the
699 scope of services authorized under their respective
700 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
701 H, or subpart J; providers certified and providing only health
702 care services within the scope of services authorized under
703 their respective certifications under 42 C.F.R. part 486,
704 subpart C; providers certified and providing only health care
705 services within the scope of services authorized under their
706 respective certifications under 42 C.F.R. part 491, subpart A;
707 providers certified by the Centers for Medicare and Medicaid
708 services under the federal Clinical Laboratory Improvement
709 Amendments and the federal rules adopted thereunder; or any
710 entity that provides neonatal or pediatric hospital-based health
711 care services by licensed practitioners solely within a hospital
712 licensed under chapter 395.
713 (c) Entities that are owned, directly or indirectly, by an
714 entity licensed or registered by the state pursuant to chapter
715 395; entities that are owned, directly or indirectly, by an
716 entity licensed or registered by the state and providing only
717 health care services within the scope of services authorized
718 pursuant to their respective licenses under ss. 383.30-383.332,
719 chapter 390, chapter 394, chapter 397, this chapter except part
720 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter

721 478, chapter 484, or chapter 651; end-stage renal disease
722 providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~;
723 providers certified and providing only health care services
724 within the scope of services authorized under their respective
725 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
726 H, or subpart J; providers certified and providing only health
727 care services within the scope of services authorized under
728 their respective certifications under 42 C.F.R. part 486,
729 subpart C; providers certified and providing only health care
730 services within the scope of services authorized under their
731 respective certifications under 42 C.F.R. part 491, subpart A;
732 providers certified by the Centers for Medicare and Medicaid
733 services under the federal Clinical Laboratory Improvement
734 Amendments and the federal rules adopted thereunder; or any
735 entity that provides neonatal or pediatric hospital-based health
736 care services by licensed practitioners solely within a hospital
737 under chapter 395.
738 (d) Entities that are under common ownership, directly or
739 indirectly, with an entity licensed or registered by the state
740 pursuant to chapter 395; entities that are under common
741 ownership, directly or indirectly, with an entity licensed or
742 registered by the state and providing only health care services
743 within the scope of services authorized pursuant to their
744 respective licenses under ss. 383.30-383.332, chapter 390,
745 chapter 394, chapter 397, this chapter except part X, chapter

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746 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter
747 484, or chapter 651; end-stage renal disease providers
748 authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers
749 certified and providing only health care services within the
750 scope of services authorized under their respective
751 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart
752 H, or subpart J; providers certified and providing only health
753 care services within the scope of services authorized under
754 their respective certifications under 42 C.F.R. part 486,
755 subpart C; providers certified and providing only health care
756 services within the scope of services authorized under their
757 respective certifications under 42 C.F.R. part 491, subpart A;
758 providers certified by the Centers for Medicare and Medicaid
759 services under the federal Clinical Laboratory Improvement
760 Amendments and the federal rules adopted thereunder; or any
761 entity that provides neonatal or pediatric hospital-based health
762 care services by licensed practitioners solely within a hospital
763 licensed under chapter 395.
764 (o) Entities that are, directly or indirectly, under the
765 common ownership of or that are subject to common control by a
766 mutual insurance holding company, as defined in s. 628.703, with
767 an entity issued a certificate of authority under chapter 624 or
768 chapter 641 which has $1 billion or more in total annual sales
769 in this state.

770 (p) Entities that are owned by an entity that is a
771 behavioral health care service provider in at least five other
772 states; that, together with its affiliates, have $90 million or
773 more in total annual revenues associated with the provision of
774 behavioral health care services; and wherein one or more of the
775 persons responsible for the operations of the entity is a health
776 care practitioner who is licensed in this state, who is
777 responsible for supervising the business activities of the
778 entity, and who is responsible for the entity's compliance with
779 state law for purposes of this part.
780 (q) Medicaid providers.
781
782 Notwithstanding this subsection, an entity shall be deemed a
783 clinic and must be licensed under this part in order to receive
784 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.
785 627.730-627.7405, unless exempted under s. 627.736(5)(h).
786 Section 18. Paragraph (c) of subsection (3) of section
787 400.991, Florida Statutes, is amended to read:
788 400.991 License requirements; background screenings;
789 prohibitions.—
790 (3) In addition to the requirements of part II of chapter
791 408, the applicant must file with the application satisfactory
792 proof that the clinic is in compliance with this part and
793 applicable rules, including:

794 (c) Proof of financial ability to operate as required
795 under ss. 408.8065(1) and s. 408.810(8). As an alternative to
796 submitting proof of financial ability to operate as required
797 under s. 408.810(8), the applicant may file a surety bond of at
798 least $500,000 which guarantees that the clinic will act in full
799 conformity with all legal requirements for operating a clinic,
800 payable to the agency. The agency may adopt rules to specify
801 related requirements for such surety bond.
802 Section 19. Paragraph (i) of subsection (1) of section
803 400.9935, Florida Statutes, is amended to read:
804 400.9935 Clinic responsibilities.—
805 (1) Each clinic shall appoint a medical director or clinic
806 director who shall agree in writing to accept legal
807 responsibility for the following activities on behalf of the
808 clinic. The medical director or the clinic director shall:
809 (i) Ensure that the clinic publishes a schedule of charges
810 for the medical services offered to patients. The schedule must
811 include the prices charged to an uninsured person paying for
812 such services by cash, check, credit card, or debit card. The
813 schedule may group services by price levels, listing services in
814 each price level. The schedule must be posted in a conspicuous
815 place in the reception area of any clinic that is considered an
816 the urgent care center as defined in s. 395.002(29)(b) and must
817 include, but is not limited to, the 50 services most frequently
818 provided by the clinic. The schedule may group services by three

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819 ~~price levels, listing services in each price level.~~ The posting
820 may be a sign that must be at least 15 square feet in size or
821 through an electronic messaging board that is at least 3 square
822 feet in size. The failure of a clinic, including a clinic that
823 is considered an urgent care center, to publish and post a
824 schedule of charges as required by this section shall result in
825 a fine of not more than $1,000, per day, until the schedule is
826 published and posted.
827 Section 20. Paragraph (a) of subsection (2) of section
828 408.033, Florida Statutes, is amended to read:
829 408.033 Local and state health planning.—
830 (2) FUNDING.—
831 (a) The Legislature intends that the cost of local health
832 councils be borne by assessments on selected health care
833 facilities subject to facility licensure by the Agency for
834 Health Care Administration, including abortion clinics, assisted
835 living facilities, ambulatory surgical centers, birth centers,
836 home health agencies, hospices, hospitals, intermediate care
837 facilities for the developmentally disabled, nursing homes, and
838 health care clinics~~, and multiphasic testing centers~~ and by
839 assessments on organizations subject to certification by the
840 agency pursuant to chapter 641, part III, including health
841 maintenance organizations and prepaid health clinics. Fees
842 assessed may be collected prospectively at the time of licensure
843 renewal and prorated for the licensure period.

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844 Section 21. Effective January 1, 2021, paragraph (l) is
845 added to subsection (3) of section 408.05, Florida Statutes, to
846 read:
847 408.05 Florida Center for Health Information and
848 Transparency.—
849 (3) HEALTH INFORMATION TRANSPARENCY.—In order to
850 disseminate and facilitate the availability of comparable and
851 uniform health information, the agency shall perform the
852 following functions:
853 (l) By July 1 of each year, publish a report identifying
854 the health care services with the most significant price
855 variation both statewide and regionally.
856 Section 22. Paragraph (a) of subsection (1) of section
857 408.061, Florida Statutes, is amended to read:
858 408.061 Data collection; uniform systems of financial
859 reporting; information relating to physician charges;
860 confidential information; immunity.—
861 (1) The agency shall require the submission by health care
862 facilities, health care providers, and health insurers of data
863 necessary to carry out the agency's duties and to facilitate
864 transparency in health care pricing data and quality measures.
865 Specifications for data to be collected under this section shall
866 be developed by the agency and applicable contract vendors, with
867 the assistance of technical advisory panels including
868 representatives of affected entities, consumers, purchasers, and

869 such other interested parties as may be determined by the
870 agency.
871 (a) Data submitted by health care facilities, including
872 the facilities as defined in chapter 395, shall include, but are
873 not limited to,~~:~~ case-mix data, patient admission and discharge
874 data, hospital emergency department data which shall include the
875 number of patients treated in the emergency department of a
876 licensed hospital reported by patient acuity level, data on
877 hospital-acquired infections as specified by rule, data on
878 complications as specified by rule, data on readmissions as
879 specified by rule, including patient- ~~with patient~~ and provider-
880 specific identifiers ~~included~~, actual charge data by diagnostic
881 groups or other bundled groupings as specified by rule,
882 financial data, accounting data, operating expenses, expenses
883 incurred for rendering services to patients who cannot or do not
884 pay, interest charges, depreciation expenses based on the
885 expected useful life of the property and equipment involved, and
886 demographic data. The agency shall adopt nationally recognized
887 risk adjustment methodologies or software consistent with the
888 standards of the Agency for Healthcare Research and Quality and
889 as selected by the agency for all data submitted as required by
890 this section. Data may be obtained from documents including ~~such~~
891 ~~as~~, but not limited to,~~:~~ leases, contracts, debt instruments,
892 itemized patient statements or bills, medical record abstracts,
893 and related diagnostic information. ~~Reported~~ Data elements shall

894 be reported electronically in accordance with <u>rules adopted by</u>
895 <u>the agency</u> ~~rule 59E-7.012, Florida Administrative Code~~. Data
896 submitted shall be certified by the chief executive officer or
897 an appropriate and duly authorized representative or employee of
898 the licensed facility that the information submitted is true and
899 accurate.
900 Section 23. Subsection (4) of section 408.0611, Florida
901 Statutes, is amended to read:
902 408.0611 Electronic prescribing clearinghouse.—
903 (4) Pursuant to s. 408.061, the agency shall monitor the
904 implementation of electronic prescribing by health care
905 practitioners, health care facilities, and pharmacies. ~~By~~
906 ~~January 31 of each year,~~ The agency shall <u>annually publish a</u>
907 report on the progress of implementation of electronic
908 prescribing <u>on its Internet website</u> ~~to the Governor and the~~
909 ~~Legislature~~. Information reported pursuant to this subsection
910 shall include federal and private sector electronic prescribing
911 initiatives and, to the extent that data is readily available
912 from organizations that operate electronic prescribing networks,
913 the number of health care practitioners using electronic
914 prescribing and the number of prescriptions electronically
915 transmitted.
916 Section 24. Paragraphs (i) and (j) of subsection (1) of
917 section 408.062, Florida Statutes, are amended to read:
918 408.062 Research, analyses, studies, and reports.—

919 (1) The agency shall conduct research, analyses, and
920 studies relating to health care costs and access to and quality
921 of health care services as access and quality are affected by
922 changes in health care costs. Such research, analyses, and
923 studies shall include, but not be limited to:
924 (i) The use of emergency department services by patient
925 acuity level ~~and the implication of increasing hospital cost by~~
926 ~~providing nonurgent care in emergency departments~~. The agency
927 shall annually publish information ~~submit an annual report~~ based
928 on this monitoring and assessment on its Internet website ~~to the~~
929 ~~Governor, the Speaker of the House of Representatives, the~~
930 ~~President of the Senate, and the substantive legislative~~
931 ~~committees, due January 1~~.
932 (j) The making available on its Internet website, and in a
933 hard-copy format upon request, of patient charge, volumes,
934 length of stay, and performance indicators collected from health
935 care facilities pursuant to s. 408.061(1)(a) for specific
936 medical conditions, surgeries, and procedures provided in
937 inpatient and outpatient facilities as determined by the agency.
938 In making the determination of specific medical conditions,
939 surgeries, and procedures to include, the agency shall consider
940 such factors as volume, severity of the illness, urgency of
941 admission, individual and societal costs, and whether the
942 condition is acute or chronic. Performance outcome indicators
943 shall be risk adjusted or severity adjusted, as applicable,

944 using nationally recognized risk adjustment methodologies or
945 software consistent with the standards of the Agency for
946 Healthcare Research and Quality and as selected by the agency.
947 The website shall also provide an interactive search that allows
948 consumers to view and compare the information for specific
949 facilities, a map that allows consumers to select a county or
950 region, definitions of all of the data, descriptions of each
951 procedure, and an explanation about why the data may differ from
952 facility to facility. Such public data shall be updated
953 quarterly. The agency shall <u>annually publish information</u>
954 <u>regarding</u> ~~submit an annual status report on~~ the collection of
955 data and publication of health care quality measures <u>on its</u>
956 <u>Internet website</u> ~~to the Governor, the Speaker of the House of~~
957 ~~Representatives, the President of the Senate, and the~~
958 ~~substantive legislative committees, due January 1~~.
959 Section 25. Subsection (5) of section 408.063, Florida
960 Statutes, is amended to read:
961 408.063 Dissemination of health care information.—
962 ~~(5) The agency shall publish annually a comprehensive~~
963 ~~report of state health expenditures. The report shall identify:~~
964 ~~(a) The contribution of health care dollars made by all~~
965 ~~payors.~~
966 ~~(b) The dollars expended by type of health care service in~~
967 ~~Florida.~~

968 Section 26. Section 408.802, Florida Statutes, is amended
969 to read:
970 408.802 Applicability.~~—The provisions of~~ This part <u>applies</u>
971 ~~apply~~ to the provision of services that require licensure as
972 defined in this part and to the following entities licensed,
973 registered, or certified by the agency, as described in chapters
974 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765:
975 (1) Laboratories authorized to perform testing under the
976 Drug-Free Workplace Act, as provided under ss. 112.0455 and
977 440.102.
978 (2) Birth centers, as provided under chapter 383.
979 (3) Abortion clinics, as provided under chapter 390.
980 (4) Crisis stabilization units, as provided under parts I
981 and IV of chapter 394.
982 (5) Short-term residential treatment facilities, as
983 provided under parts I and IV of chapter 394.
984 (6) Residential treatment facilities, as provided under
985 part IV of chapter 394.
986 (7) Residential treatment centers for children and
987 adolescents, as provided under part IV of chapter 394.
988 (8) Hospitals, as provided under part I of chapter 395.
989 (9) Ambulatory surgical centers, as provided under part I
990 of chapter 395.
991 (10) Nursing homes, as provided under part II of chapter
992 400.

993 (11) Assisted living facilities, as provided under part I
994 of chapter 429.
995 (12) Home health agencies, as provided under part III of
996 chapter 400.
997 (13) Nurse registries, as provided under part III of
998 chapter 400.
999 (14) Companion services or homemaker services providers,
1000 as provided under part III of chapter 400.
1001 (15) Adult day care centers, as provided under part III of
1002 chapter 429.
1003 (16) Hospices, as provided under part IV of chapter 400.
1004 (17) Adult family-care homes, as provided under part II of
1005 chapter 429.
1006 (18) Homes for special services, as provided under part V
1007 of chapter 400.
1008 (19) Transitional living facilities, as provided under
1009 part XI of chapter 400.
1010 (20) Prescribed pediatric extended care centers, as
1011 provided under part VI of chapter 400.
1012 (21) Home medical equipment providers, as provided under
1013 part VII of chapter 400.
1014 (22) Intermediate care facilities for persons with
1015 developmental disabilities, as provided under part VIII of
1016 chapter 400.

1017 (23) Health care services pools, as provided under part IX
1018 of chapter 400.
1019 (24) Health care clinics, as provided under part X of
1020 chapter 400.
1021 ~~(25) Multiphasic health testing centers, as provided under~~
1022 ~~part I of chapter 483.~~
1023 (25) ~~(26)~~ Organ, tissue, and eye procurement organizations,
1024 as provided under part V of chapter 765.
1025 Section 27. Subsections (10) through (14) of section
1026 408.803, Florida Statutes, are renumbered as subsections (11)
1027 through (15), respectively, subsection (3) is amended, and a new
1028 subsection (10) is added to that section, to read:
1029 408.803 Definitions.—As used in this part, the term:
1030 (3) "Authorizing statute" means the statute authorizing
1031 the licensed operation of a provider listed in s. 408.802 and
1032 includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~
1033 and 765.
1034 (10) "Low-risk provider" means a nonresidential provider,
1035 including a nurse registry, a home medical equipment provider,
1036 or a health care clinic.
1037 Section 28. Paragraph (b) of subsection (7) of section
1038 408.806, Florida Statutes, is amended to read:
1039 408.806 License application process.—
1040 (7)

1041 (b) An initial inspection is not required for companion
1042 services or homemaker services providers~~,~~ as provided under part
1043 III of chapter 400, ~~or~~ for health care services pools~~,~~ as
1044 provided under part IX of chapter 400, or for low-risk providers
1045 as provided in s. 408.811(1)(c).
1046 Section 29. Subsection (2) of section 408.808, Florida
1047 Statutes, is amended to read:
1048 408.808 License categories.—
1049 (2) PROVISIONAL LICENSE.—An applicant against whom a
1050 proceeding denying or revoking a license is pending at the time
1051 of license renewal may be issued a provisional license effective
1052 until final action not subject to further appeal. A provisional
1053 license may also be issued to an applicant making initial
1054 application for licensure or making application ~~applying~~ for a
1055 change of ownership. A provisional license must be limited in
1056 duration to a specific period of time, up to 12 months, as
1057 determined by the agency.
1058 Section 30. Subsections (6) through (9) of section
1059 408.809, Florida Statutes, are renumbered as subsections (5)
1060 through (8), respectively, and subsections (2) and (4) and
1061 present subsection (5) of that section are amended to read:
1062 408.809 Background screening; prohibited offenses.—
1063 (2) Every 5 years following his or her licensure,
1064 employment, or entry into a contract in a capacity that under
1065 subsection (1) would require level 2 background screening under

1066 chapter 435, each such person must submit to level 2 background
1067 rescreening as a condition of retaining such license or
1068 continuing in such employment or contractual status. For any
1069 such rescreening, the agency shall request the Department of Law
1070 Enforcement to forward the person's fingerprints to the Federal
1071 Bureau of Investigation for a national criminal history record
1072 check unless the person's fingerprints are enrolled in the
1073 Federal Bureau of Investigation's national retained print arrest
1074 notification program. If the fingerprints of such a person are
1075 not retained by the Department of Law Enforcement under s.
1076 943.05(2)(g) and (h), the person must submit fingerprints
1077 electronically to the Department of Law Enforcement for state
1078 processing, and the Department of Law Enforcement shall forward
1079 the fingerprints to the Federal Bureau of Investigation for a
1080 national criminal history record check. The fingerprints shall
1081 be retained by the Department of Law Enforcement under s.
1082 943.05(2)(g) and (h) and enrolled in the national retained print
1083 arrest notification program when the Department of Law
1084 Enforcement begins participation in the program. The cost of the
1085 state and national criminal history records checks required by
1086 level 2 screening may be borne by the licensee or the person
1087 fingerprinted. ~~Until a specified agency is fully implemented in~~
1088 ~~the clearinghouse created under s. 435.12,~~ The agency may accept
1089 as satisfying the requirements of this section proof of
1090 compliance with level 2 screening standards submitted within the

1091 previous 5 years to meet any provider or professional licensure
1092 requirements of ~~the agency, the Department of Health, the~~
1093 ~~Department of Elderly Affairs, the Agency for Persons with~~
1094 ~~Disabilities, the Department of Children and Families, or~~ the
1095 Department of Financial Services for an applicant for a
1096 certificate of authority or provisional certificate of authority
1097 to operate a continuing care retirement community under chapter
1098 651, provided that:
1099 (a) The screening standards and disqualifying offenses for
1100 the prior screening are equivalent to those specified in s.
1101 435.04 and this section;
1102 (b) The person subject to screening has not had a break in
1103 service from a position that requires level 2 screening for more
1104 than 90 days; and
1105 (c) Such proof is accompanied, under penalty of perjury,
1106 by an attestation of compliance with chapter 435 and this
1107 section using forms provided by the agency.
1108 (4) In addition to the offenses listed in s. 435.04, all
1109 persons required to undergo background screening pursuant to
1110 this part or authorizing statutes must not have an arrest
1111 awaiting final disposition for, must not have been found guilty
1112 of, regardless of adjudication, or entered a plea of nolo
1113 contendere or guilty to, and must not have been adjudicated
1114 delinquent and the record not have been sealed or expunged for

1115 any of the following offenses or any similar offense of another
1116 jurisdiction:
1117 (a) Any authorizing statutes, if the offense was a felony.
1118 (b) This chapter, if the offense was a felony.
1119 (c) Section 409.920, relating to Medicaid provider fraud.
1120 (d) Section 409.9201, relating to Medicaid fraud.
1121 (e) Section 741.28, relating to domestic violence.
1122 (f) Section 777.04, relating to attempts, solicitation,
1123 and conspiracy to commit an offense listed in this subsection.
1124 (g) Section 817.034, relating to fraudulent acts through
1125 mail, wire, radio, electromagnetic, photoelectronic, or
1126 photooptical systems.
1127 (h) Section 817.234, relating to false and fraudulent
1128 insurance claims.
1129 (i) Section 817.481, relating to obtaining goods by using
1130 a false or expired credit card or other credit device, if the
1131 offense was a felony.
1132 (j) Section 817.50, relating to fraudulently obtaining
1133 goods or services from a health care provider.
1134 (k) Section 817.505, relating to patient brokering.
1135 (l) Section 817.568, relating to criminal use of personal
1136 identification information.
1137 (m) Section 817.60, relating to obtaining a credit card
1138 through fraudulent means.

1139 (n) Section 817.61, relating to fraudulent use of credit
1140 cards, if the offense was a felony.
1141 (o) Section 831.01, relating to forgery.
1142 (p) Section 831.02, relating to uttering forged
1143 instruments.
1144 (q) Section 831.07, relating to forging bank bills,
1145 checks, drafts, or promissory notes.
1146 (r) Section 831.09, relating to uttering forged bank
1147 bills, checks, drafts, or promissory notes.
1148 (s) Section 831.30, relating to fraud in obtaining
1149 medicinal drugs.
1150 (t) Section 831.31, relating to the sale, manufacture,
1151 delivery, or possession with the intent to sell, manufacture, or
1152 deliver any counterfeit controlled substance, if the offense was
1153 a felony.
1154 (u) Section 895.03, relating to racketeering and
1155 collection of unlawful debts.
1156 (v) Section 896.101, relating to the Florida Money
1157 Laundering Act.
1158
1159 If, upon rescreening, a person who is currently employed or
1160 contracted with a licensee ~~as of June 30, 2014,~~ and was screened
1161 and qualified under s. ~~ss. 435.03 and~~ 435.04~~,~~ has a
1162 disqualifying offense that was not a disqualifying offense at
1163 the time of the last screening, but is a current disqualifying

1164 offense and was committed before the last screening, he or she
1165 may apply for an exemption from the appropriate licensing agency
1166 and, if agreed to by the employer, may continue to perform his
1167 or her duties until the licensing agency renders a decision on
1168 the application for exemption if the person is eligible to apply
1169 for an exemption and the exemption request is received by the
1170 agency no later than 30 days after receipt of the rescreening
1171 results by the person.
1172 ~~(5) A person who serves as a controlling interest of, is~~
1173 ~~employed by, or contracts with a licensee on July 31, 2010, who~~
1174 ~~has been screened and qualified according to standards specified~~
1175 ~~in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,~~
1176 ~~in compliance with the following schedule. If, upon rescreening,~~
1177 ~~such person has a disqualifying offense that was not a~~
1178 ~~disqualifying offense at the time of the last screening, but is~~
1179 ~~a current disqualifying offense and was committed before the~~
1180 ~~last screening, he or she may apply for an exemption from the~~
1181 ~~appropriate licensing agency and, if agreed to by the employer,~~
1182 ~~may continue to perform his or her duties until the licensing~~
1183 ~~agency renders a decision on the application for exemption if~~
1184 ~~the person is eligible to apply for an exemption and the~~
1185 ~~exemption request is received by the agency within 30 days after~~
1186 ~~receipt of the rescreening results by the person. The~~
1187 ~~rescreening schedule shall be:~~

1188 ~~(a) Individuals for whom the last screening was conducted~~
1189 ~~on or before December 31, 2004, must be rescreened by July 31,~~
1190 ~~2013.~~
1191 ~~(b) Individuals for whom the last screening conducted was~~
1192 ~~between January 1, 2005, and December 31, 2008, must be~~
1193 ~~rescreened by July 31, 2014.~~
1194 ~~(c) Individuals for whom the last screening conducted was~~
1195 ~~between January 1, 2009, through July 31, 2011, must be~~
1196 ~~rescreened by July 31, 2015.~~
1197 Section 31. Subsection (1) of section 408.811, Florida
1198 Statutes, is amended to read:
1199 408.811 Right of inspection; copies; inspection reports;
1200 plan for correction of deficiencies.—
1201 (1) An authorized officer or employee of the agency may
1202 make or cause to be made any inspection or investigation deemed
1203 necessary by the agency to determine the state of compliance
1204 with this part, authorizing statutes, and applicable rules. The
1205 right of inspection extends to any business that the agency has
1206 reason to believe is being operated as a provider without a
1207 license, but inspection of any business suspected of being
1208 operated without the appropriate license may not be made without
1209 the permission of the owner or person in charge unless a warrant
1210 is first obtained from a circuit court. Any application for a
1211 license issued under this part, authorizing statutes, or
1212 applicable rules constitutes permission for an appropriate

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

1213 inspection to verify the information submitted on or in
1214 connection with the application.
1215 (a) All inspections shall be unannounced, except as
1216 specified in s. 408.806.
1217 (b) Inspections for relicensure shall be conducted
1218 biennially unless otherwise specified by this section,
1219 authorizing statutes, or applicable rules.
1220 (c) The agency may exempt a low-risk provider from a
1221 licensure inspection if the provider or a controlling interest
1222 has an excellent regulatory history with regard to deficiencies,
1223 sanctions, complaints, or other regulatory actions as defined in
1224 agency rule. The agency must conduct unannounced licensure
1225 inspections on at least 10 percent of the exempt low-risk
1226 providers to verify regulatory compliance.
1227 (d) The agency may adopt rules to waive any inspection,
1228 including a relicensure inspection, or grant an extended time
1229 period between relicensure inspections based upon:
1230 1. An excellent regulatory history with regard to
1231 deficiencies, sanctions, complaints, or other regulatory
1232 measures.
1233 2. Outcome measures that demonstrate quality performance.
1234 3. Successful participation in a recognized, quality
1235 program.
1236 4. Accreditation status.
1237 5. Other measures reflective of quality and safety.

1238 6. The length of time between inspections.
1239
1240 The agency shall continue to conduct unannounced licensure
1241 inspections on at least 10 percent of providers that qualify for
1242 an exemption or extended period between relicensure inspections.
1243 The agency may conduct an inspection of any provider at any time
1244 to verify regulatory compliance.
1245 Section 32. Subsection (24) of section 408.820, Florida
1246 Statutes, is amended to read:
1247 408.820 Exemptions.—Except as prescribed in authorizing
1248 statutes, the following exemptions shall apply to specified
1249 requirements of this part:
1250 ~~(24) Multiphasic health testing centers, as provided under~~
1251 ~~part I of chapter 483, are exempt from s. 408.810(5)-(10).~~
1252 Section 33. Subsections (1) and (2) of section 408.821,
1253 Florida Statutes, are amended to read:
1254 408.821 Emergency management planning; emergency
1255 operations; inactive license.—
1256 (1) A licensee required by authorizing statutes and agency
1257 rule to have a comprehensive ~~an~~ emergency management ~~operations~~
1258 plan must designate a safety liaison to serve as the primary
1259 contact for emergency operations. Such licensee shall submit its
1260 comprehensive emergency management plan to the local emergency
1261 management agency, county health department, or Department of
1262 Health as follows:

1263 (a) Submit the plan within 30 days after initial licensure
1264 and change of ownership, and notify the agency within 30 days
1265 after submission of the plan.
1266 (b) Submit the plan annually and within 30 days after any
1267 significant modification, as defined by agency rule, to a
1268 previously approved plan.
1269 (c) Submit necessary plan revisions within 30 days after
1270 notification that plan revisions are required.
1271 (d) Notify the agency within 30 days after approval of its
1272 plan by the local emergency management agency, county health
1273 department, or Department of Health.
1274 (2) An entity subject to this part may temporarily exceed
1275 its licensed capacity to act as a receiving provider in
1276 accordance with an approved comprehensive emergency management
1277 ~~operations~~ plan for up to 15 days. While in an overcapacity
1278 status, each provider must furnish or arrange for appropriate
1279 care and services to all clients. In addition, the agency may
1280 approve requests for overcapacity in excess of 15 days, which
1281 approvals may be based upon satisfactory justification and need
1282 as provided by the receiving and sending providers.
1283 Section 34. Subsection (3) of section 408.831, Florida
1284 Statutes, is amended to read:
1285 408.831 Denial, suspension, or revocation of a license,
1286 registration, certificate, or application.—

1287 (3) This section provides standards of enforcement
1288 applicable to all entities licensed or regulated by the Agency
1289 for Health Care Administration. This section controls over any
1290 conflicting provisions of chapters 39, 383, 390, 391, 394, 395,
1291 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to
1292 those chapters.
1293 Section 35. Section 408.832, Florida Statutes, is amended
1294 to read:
1295 408.832 Conflicts.—In case of conflict between ~~the~~
1296 ~~provisions of~~ this part and the authorizing statutes governing
1297 the licensure of health care providers by the Agency for Health
1298 Care Administration found in s. 112.0455 and chapters 383, 390,
1299 394, 395, 400, 429, 440, ~~483,~~ and 765, ~~the provisions of~~ this
1300 part shall prevail.
1301 Section 36. Subsection (9) of section 408.909, Florida
1302 Statutes, is amended to read:
1303 408.909 Health flex plans.—
1304 ~~(9) PROGRAM EVALUATION.—The agency and the office shall~~
1305 ~~evaluate the pilot program and its effect on the entities that~~
1306 ~~seek approval as health flex plans, on the number of enrollees,~~
1307 ~~and on the scope of the health care coverage offered under a~~
1308 ~~health flex plan; shall provide an assessment of the health flex~~
1309 ~~plans and their potential applicability in other settings; shall~~
1310 ~~use health flex plans to gather more information to evaluate~~
1311 ~~low-income consumer driven benefit packages; and shall, by~~

1312 ~~January 15, 2016, and annually thereafter, jointly submit a~~
1313 ~~report to the Governor, the President of the Senate, and the~~
1314 ~~Speaker of the House of Representatives.~~
1315 Section 37. Paragraph (d) of subsection (10) of section
1316 408.9091, Florida Statutes, is amended to read:
1317 408.9091 Cover Florida Health Care Access Program.—
1318 (10) PROGRAM EVALUATION.—The agency and the office shall:
1319 ~~(d) Jointly submit by March 1, annually, a report to the~~
1320 ~~Governor, the President of the Senate, and the Speaker of the~~
1321 ~~House of Representatives which provides the information~~
1322 ~~specified in paragraphs (a)-(c) and recommendations relating to~~
1323 ~~the successful implementation and administration of the program.~~
1324 Section 38. Effective upon becoming a law, paragraph (a)
1325 of subsection (5) of section 409.905, Florida Statutes, is
1326 amended to read:
1327 409.905 Mandatory Medicaid services.—The agency may make
1328 payments for the following services, which are required of the
1329 state by Title XIX of the Social Security Act, furnished by
1330 Medicaid providers to recipients who are determined to be
1331 eligible on the dates on which the services were provided. Any
1332 service under this section shall be provided only when medically
1333 necessary and in accordance with state and federal law.
1334 Mandatory services rendered by providers in mobile units to
1335 Medicaid recipients may be restricted by the agency. Nothing in
1336 this section shall be construed to prevent or limit the agency

1337 from adjusting fees, reimbursement rates, lengths of stay,
1338 number of visits, number of services, or any other adjustments
1339 necessary to comply with the availability of moneys and any
1340 limitations or directions provided for in the General
1341 Appropriations Act or chapter 216.
1342 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1343 all covered services provided for the medical care and treatment
1344 of a recipient who is admitted as an inpatient by a licensed
1345 physician or dentist to a hospital licensed under part I of
1346 chapter 395. However, the agency shall limit the payment for
1347 inpatient hospital services for a Medicaid recipient 21 years of
1348 age or older to 45 days or the number of days necessary to
1349 comply with the General Appropriations Act.
1350 (a)1. The agency may implement reimbursement and
1351 utilization management reforms in order to comply with any
1352 limitations or directions in the General Appropriations Act,
1353 which may include, but are not limited to: prior authorization
1354 for inpatient psychiatric days; prior authorization for
1355 nonemergency hospital inpatient admissions for individuals 21
1356 years of age and older; authorization of emergency and urgent-
1357 care admissions within 24 hours after admission; enhanced
1358 utilization and concurrent review programs for highly utilized
1359 services; reduction or elimination of covered days of service;
1360 adjusting reimbursement ceilings for variable costs; adjusting

1361 reimbursement ceilings for fixed and property costs; and
1362 implementing target rates of increase.
1363 2. The agency may limit prior authorization for hospital
1364 inpatient services to selected diagnosis-related groups, based
1365 on an analysis of the cost and potential for unnecessary
1366 hospitalizations represented by certain diagnoses. Admissions
1367 for normal delivery and newborns are exempt from requirements
1368 for prior authorization.
1369 3. In implementing the provisions of this section related
1370 to prior authorization, the agency shall ensure that the process
1371 for authorization is accessible 24 hours per day, 7 days per
1372 week and authorization is automatically granted when not denied
1373 within 4 hours after the request. Authorization procedures must
1374 include steps for review of denials.
1375 4. Upon implementing the prior authorization program for
1376 hospital inpatient services, the agency shall discontinue its
1377 hospital retrospective review program. However, this
1378 subparagraph may not be construed to prevent the agency from
1379 conducting retrospective reviews under s. 409.913, including,
1380 but not limited to, reviews in which an overpayment is suspected
1381 due to a mistake or submission of an improper claim or for other
1382 reasons that do not rise to the level of fraud or abuse.
1383 Section 39. It is the intent of the Legislature that s.
1384 409.905(5)(a), Florida Statutes, as amended by this act,

1385 confirms and clarifies existing law. This section shall take
1386 effect upon this act becoming a law.
1387 Section 40. Subsection (8) of section 409.907, Florida
1388 Statutes, is amended to read:
1389 409.907 Medicaid provider agreements.—The agency may make
1390 payments for medical assistance and related services rendered to
1391 Medicaid recipients only to an individual or entity who has a
1392 provider agreement in effect with the agency, who is performing
1393 services or supplying goods in accordance with federal, state,
1394 and local law, and who agrees that no person shall, on the
1395 grounds of handicap, race, color, or national origin, or for any
1396 other reason, be subjected to discrimination under any program
1397 or activity for which the provider receives payment from the
1398 agency.
1399 (8)(a) A level 2 background screening pursuant to chapter
1400 435 must be conducted through the agency on each of the
1401 following:
1402 1. The ~~Each~~ provider, or each principal of the provider if
1403 the provider is a corporation, partnership, association, or
1404 other entity~~, seeking to participate in the Medicaid program~~
1405 ~~must submit a complete set of his or her fingerprints to the~~
1406 ~~agency for the purpose of conducting a criminal history record~~
1407 ~~check~~.
1408 2. Principals of the provider, who include any officer,
1409 director, billing agent, managing employee, or affiliated

1410 person, or any partner or shareholder who has an ownership
1411 interest equal to 5 percent or more in the provider. However,
1412 for a hospital licensed under chapter 395 or a nursing home
1413 licensed under chapter 400, principals of the provider are those
1414 who meet the definition of a controlling interest under s.
1415 408.803. A director of a not-for-profit corporation or
1416 organization is not a principal for purposes of a background
1417 investigation required by this section if the director: serves
1418 solely in a voluntary capacity for the corporation or
1419 organization, does not regularly take part in the day-to-day
1420 operational decisions of the corporation or organization,
1421 receives no remuneration from the not-for-profit corporation or
1422 organization for his or her service on the board of directors,
1423 has no financial interest in the not-for-profit corporation or
1424 organization, and has no family members with a financial
1425 interest in the not-for-profit corporation or organization; and
1426 if the director submits an affidavit, under penalty of perjury,
1427 to this effect to the agency and the not-for-profit corporation
1428 or organization submits an affidavit, under penalty of perjury,
1429 to this effect to the agency as part of the corporation's or
1430 organization's Medicaid provider agreement application.
1431 3. Any person who participates or seeks to participate in
1432 the Florida Medicaid program by way of rendering services to
1433 Medicaid recipients or having direct access to Medicaid
1434 recipients or recipient living areas, or who supervises the

1435 delivery of goods or services to a Medicaid recipient. This
1436 subparagraph does not impose additional screening requirements
1437 on any providers licensed under part II of chapter 408.
1438 4. Nonemergency transportation drivers who are employed or
1439 contracted with transportation companies, transportation network
1440 companies, or transportation brokers are not subject to a level
1441 2 background screening, but must comply with a level 1
1442 background screening pursuant to chapter 435 or an equivalent
1443 screening as authorized in s. 316.87.
1444 (b) Notwithstanding paragraph (a) ~~the above~~, the agency
1445 may require a background check for any person reasonably
1446 suspected by the agency to have been convicted of a crime.
1447 (c) ~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:
1448 1. A unit of local government, except that requirements of
1449 this subsection apply to nongovernmental providers and entities
1450 contracting with the local government to provide Medicaid
1451 services. The actual cost of the state and national criminal
1452 history record checks must be borne by the nongovernmental
1453 provider or entity; or
1454 2. Any business that derives more than 50 percent of its
1455 revenue from the sale of goods to the final consumer, and the
1456 business or its controlling parent is required to file a form
1457 10-K or other similar statement with the Securities and Exchange
1458 Commission or has a net worth of $50 million or more.

1459 (d) ~~(b)~~ Background screening shall be conducted in
1460 accordance with chapter 435 and s. 408.809. The cost of the
1461 state and national criminal record check shall be borne by the
1462 provider.
1463 Section 41. Paragraph (a) of subsection (1) of section
1464 409.908, Florida Statutes, is amended to read:
1465 409.908 Reimbursement of Medicaid providers.—Subject to
1466 specific appropriations, the agency shall reimburse Medicaid
1467 providers, in accordance with state and federal law, according
1468 to methodologies set forth in the rules of the agency and in
1469 policy manuals and handbooks incorporated by reference therein.
1470 These methodologies may include fee schedules, reimbursement
1471 methods based on cost reporting, negotiated fees, competitive
1472 bidding pursuant to s. 287.057, and other mechanisms the agency
1473 considers efficient and effective for purchasing services or
1474 goods on behalf of recipients. If a provider is reimbursed based
1475 on cost reporting and submits a cost report late and that cost
1476 report would have been used to set a lower reimbursement rate
1477 for a rate semester, then the provider's rate for that semester
1478 shall be retroactively calculated using the new cost report, and
1479 full payment at the recalculated rate shall be effected
1480 retroactively. Medicare-granted extensions for filing cost
1481 reports, if applicable, shall also apply to Medicaid cost
1482 reports. Payment for Medicaid compensable services made on
1483 behalf of Medicaid eligible persons is subject to the

1484 availability of moneys and any limitations or directions
1485 provided for in the General Appropriations Act or chapter 216.
1486 Further, nothing in this section shall be construed to prevent
1487 or limit the agency from adjusting fees, reimbursement rates,
1488 lengths of stay, number of visits, or number of services, or
1489 making any other adjustments necessary to comply with the
1490 availability of moneys and any limitations or directions
1491 provided for in the General Appropriations Act, provided the
1492 adjustment is consistent with legislative intent.
1493 (1) Reimbursement to hospitals licensed under part I of
1494 chapter 395 must be made prospectively or on the basis of
1495 negotiation.
1496 (a) Reimbursement for inpatient care is limited as
1497 provided in s. 409.905(5), except as otherwise provided in this
1498 subsection.
1499 1. If authorized by the General Appropriations Act, the
1500 agency may modify reimbursement for specific types of services
1501 or diagnoses, recipient ages, and hospital provider types.
1502 2. The agency may establish an alternative methodology to
1503 the DRG-based prospective payment system to set reimbursement
1504 rates for:
1505 a. State-owned psychiatric hospitals.
1506 b. Newborn hearing screening services.
1507 c. Transplant services for which the agency has
1508 established a global fee.

1509 d. Recipients who have tuberculosis that is resistant to
1510 therapy who are in need of long-term, hospital-based treatment
1511 pursuant to s. 392.62.
1512 ~~e. Class III psychiatric hospitals.~~
1513 3. The agency shall modify reimbursement according to
1514 other methodologies recognized in the General Appropriations
1515 Act.
1516
1517 The agency may receive funds from state entities, including, but
1518 not limited to, the Department of Health, local governments, and
1519 other local political subdivisions, for the purpose of making
1520 special exception payments, including federal matching funds,
1521 through the Medicaid inpatient reimbursement methodologies.
1522 Funds received for this purpose shall be separately accounted
1523 for and may not be commingled with other state or local funds in
1524 any manner. The agency may certify all local governmental funds
1525 used as state match under Title XIX of the Social Security Act,
1526 to the extent and in the manner authorized under the General
1527 Appropriations Act and pursuant to an agreement between the
1528 agency and the local governmental entity. In order for the
1529 agency to certify such local governmental funds, a local
1530 governmental entity must submit a final, executed letter of
1531 agreement to the agency, which must be received by October 1 of
1532 each fiscal year and provide the total amount of local
1533 governmental funds authorized by the entity for that fiscal year

1534 under this paragraph, paragraph (b), or the General
1535 Appropriations Act. The local governmental entity shall use a
1536 certification form prescribed by the agency. At a minimum, the
1537 certification form must identify the amount being certified and
1538 describe the relationship between the certifying local
1539 governmental entity and the local health care provider. The
1540 agency shall prepare an annual statement of impact which
1541 documents the specific activities undertaken during the previous
1542 fiscal year pursuant to this paragraph, to be submitted to the
1543 Legislature annually by January 1.
1544 Section 42. Section 409.913, Florida Statutes, is amended
1545 to read:
1546 409.913 Oversight of the integrity of the Medicaid
1547 program.—The agency shall operate a program to oversee the
1548 activities of Florida Medicaid recipients, and providers and
1549 their representatives, to ensure that fraudulent and abusive
1550 behavior and neglect of recipients occur to the minimum extent
1551 possible, and to recover overpayments and impose sanctions as
1552 appropriate. Each January 15 ~~1~~, the agency and the Medicaid
1553 Fraud Control Unit of the Department of Legal Affairs shall
1554 submit a ~~joint~~ report to the Legislature documenting the
1555 effectiveness of the state's efforts to control Medicaid fraud
1556 and abuse and to recover Medicaid overpayments during the
1557 previous fiscal year. The report must describe the number of
1558 cases opened and investigated each year; the sources of the

1559 cases opened; the disposition of the cases closed each year; the
1560 amount of overpayments alleged in preliminary and final audit
1561 letters; the number and amount of fines or penalties imposed;
1562 any reductions in overpayment amounts negotiated in settlement
1563 agreements or by other means; the amount of final agency
1564 determinations of overpayments; the amount deducted from federal
1565 claiming as a result of overpayments; the amount of overpayments
1566 recovered each year; the amount of cost of investigation
1567 recovered each year; the average length of time to collect from
1568 the time the case was opened until the overpayment is paid in
1569 full; the amount determined as uncollectible and the portion of
1570 the uncollectible amount subsequently reclaimed from the Federal
1571 Government; the number of providers, by type, that are
1572 terminated from participation in the Medicaid program as a
1573 result of fraud and abuse; and all costs associated with
1574 discovering and prosecuting cases of Medicaid overpayments and
1575 making recoveries in such cases. The report must also document
1576 actions taken to prevent overpayments and the number of
1577 providers prevented from enrolling in or reenrolling in the
1578 Medicaid program as a result of documented Medicaid fraud and
1579 abuse and must include policy recommendations necessary to
1580 prevent or recover overpayments and changes necessary to prevent
1581 and detect Medicaid fraud. All policy recommendations in the
1582 report must include a detailed fiscal analysis, including, but
1583 not limited to, implementation costs, estimated savings to the

1584 Medicaid program, and the return on investment. The agency must
1585 submit the policy recommendations and fiscal analyses in the
1586 report to the appropriate estimating conference, pursuant to s.
1587 216.137, by February 15 of each year. The agency and the
1588 Medicaid Fraud Control Unit of the Department of Legal Affairs
1589 each must include detailed unit-specific performance standards,
1590 benchmarks, and metrics in the report, including projected cost
1591 savings to the state Medicaid program during the following
1592 fiscal year.
1593 (1) For the purposes of this section, the term:
1594 (a) "Abuse" means:
1595 1. Provider practices that are inconsistent with generally
1596 accepted business or medical practices and that result in an
1597 unnecessary cost to the Medicaid program or in reimbursement for
1598 goods or services that are not medically necessary or that fail
1599 to meet professionally recognized standards for health care.
1600 2. Recipient practices that result in unnecessary cost to
1601 the Medicaid program.
1602 (b) "Complaint" means an allegation that fraud, abuse, or
1603 an overpayment has occurred.
1604 (c) "Fraud" means an intentional deception or
1605 misrepresentation made by a person with the knowledge that the
1606 deception results in unauthorized benefit to herself or himself
1607 or another person. The term includes any act that constitutes
1608 fraud under applicable federal or state law.

1609 (d) "Medical necessity" or "medically necessary" means any
1610 goods or services necessary to palliate the effects of a
1611 terminal condition, or to prevent, diagnose, correct, cure,
1612 alleviate, or preclude deterioration of a condition that
1613 threatens life, causes pain or suffering, or results in illness
1614 or infirmity, which goods or services are provided in accordance
1615 with generally accepted standards of medical practice. For
1616 purposes of determining Medicaid reimbursement, the agency is
1617 the final arbiter of medical necessity. Determinations of
1618 medical necessity must be made by a licensed physician employed
1619 by or under contract with the agency and must be based upon
1620 information available at the time the goods or services are
1621 provided.
1622 (e) "Overpayment" includes any amount that is not
1623 authorized to be paid by the Medicaid program whether paid as a
1624 result of inaccurate or improper cost reporting, improper
1625 claiming, unacceptable practices, fraud, abuse, or mistake.
1626 (f) "Person" means any natural person, corporation,
1627 partnership, association, clinic, group, or other entity,
1628 whether or not such person is enrolled in the Medicaid program
1629 or is a provider of health care.
1630 (2) The agency shall conduct, or cause to be conducted by
1631 contract or otherwise, reviews, investigations, analyses,
1632 audits, or any combination thereof, to determine possible fraud,
1633 abuse, overpayment, or recipient neglect in the Medicaid program

1634 and shall report the findings of any overpayments in audit
1635 reports as appropriate. At least 5 percent of all audits shall
1636 be conducted on a random basis. As part of its ongoing fraud
1637 detection activities, the agency shall identify and monitor, by
1638 contract or otherwise, patterns of overutilization of Medicaid
1639 services based on state averages. The agency shall track
1640 Medicaid provider prescription and billing patterns and evaluate
1641 them against Medicaid medical necessity criteria and coverage
1642 and limitation guidelines adopted by rule. Medical necessity
1643 determination requires that service be consistent with symptoms
1644 or confirmed diagnosis of illness or injury under treatment and
1645 not in excess of the patient's needs. The agency shall conduct
1646 reviews of provider exceptions to peer group norms and shall,
1647 using statistical methodologies, provider profiling, and
1648 analysis of billing patterns, detect and investigate abnormal or
1649 unusual increases in billing or payment of claims for Medicaid
1650 services and medically unnecessary provision of services.
1651 (3) The agency may conduct, or may contract for,
1652 prepayment review of provider claims to ensure cost-effective
1653 purchasing; to ensure that billing by a provider to the agency
1654 is in accordance with applicable provisions of all Medicaid
1655 rules, regulations, handbooks, and policies and in accordance
1656 with federal, state, and local law; and to ensure that
1657 appropriate care is rendered to Medicaid recipients. Such
1658 prepayment reviews may be conducted as determined appropriate by

1659 the agency, without any suspicion or allegation of fraud, abuse,
1660 or neglect, and may last for up to 1 year. Unless the agency has
1661 reliable evidence of fraud, misrepresentation, abuse, or
1662 neglect, claims shall be adjudicated for denial or payment
1663 within 90 days after receipt of complete documentation by the
1664 agency for review. If there is reliable evidence of fraud,
1665 misrepresentation, abuse, or neglect, claims shall be
1666 adjudicated for denial of payment within 180 days after receipt
1667 of complete documentation by the agency for review.
1668 (4) Any suspected criminal violation identified by the
1669 agency must be referred to the Medicaid Fraud Control Unit of
1670 the Office of the Attorney General for investigation. The agency
1671 and the Attorney General shall enter into a memorandum of
1672 understanding, which must include, but need not be limited to, a
1673 protocol for regularly sharing information and coordinating
1674 casework. The protocol must establish a procedure for the
1675 referral by the agency of cases involving suspected Medicaid
1676 fraud to the Medicaid Fraud Control Unit for investigation, and
1677 the return to the agency of those cases where investigation
1678 determines that administrative action by the agency is
1679 appropriate. Offices of the Medicaid program integrity program
1680 and the Medicaid Fraud Control Unit of the Department of Legal
1681 Affairs, shall, to the extent possible, be collocated. The
1682 agency and the Department of Legal Affairs shall periodically
1683 conduct joint training and other joint activities designed to

1684 increase communication and coordination in recovering
1685 overpayments.
1686 (5) A Medicaid provider is subject to having goods and
1687 services that are paid for by the Medicaid program reviewed by
1688 an appropriate peer-review organization designated by the
1689 agency. The written findings of the applicable peer-review
1690 organization are admissible in any court or administrative
1691 proceeding as evidence of medical necessity or the lack thereof.
1692 (6) Any notice required to be given to a provider under
1693 this section is presumed to be sufficient notice if sent to the
1694 address last shown on the provider enrollment file. It is the
1695 responsibility of the provider to furnish and keep the agency
1696 informed of the provider's current address. United States Postal
1697 Service proof of mailing or certified or registered mailing of
1698 such notice to the provider at the address shown on the provider
1699 enrollment file constitutes sufficient proof of notice. Any
1700 notice required to be given to the agency by this section must
1701 be sent to the agency at an address designated by rule.
1702 (7) When presenting a claim for payment under the Medicaid
1703 program, a provider has an affirmative duty to supervise the
1704 provision of, and be responsible for, goods and services claimed
1705 to have been provided, to supervise and be responsible for
1706 preparation and submission of the claim, and to present a claim
1707 that is true and accurate and that is for goods and services
1708 that:

1709 (a) Have actually been furnished to the recipient by the
1710 provider prior to submitting the claim.
1711 (b) Are Medicaid-covered goods or services that are
1712 medically necessary.
1713 (c) Are of a quality comparable to those furnished to the
1714 general public by the provider's peers.
1715 (d) Have not been billed in whole or in part to a
1716 recipient or a recipient's responsible party, except for such
1717 copayments, coinsurance, or deductibles as are authorized by the
1718 agency.
1719 (e) Are provided in accord with applicable provisions of
1720 all Medicaid rules, regulations, handbooks, and policies and in
1721 accordance with federal, state, and local law.
1722 (f) Are documented by records made at the time the goods
1723 or services were provided, demonstrating the medical necessity
1724 for the goods or services rendered. Medicaid goods or services
1725 are excessive or not medically necessary unless both the medical
1726 basis and the specific need for them are fully and properly
1727 documented in the recipient's medical record.
1728
1729 The agency shall deny payment or require repayment for goods or
1730 services that are not presented as required in this subsection.
1731 (8) The agency shall not reimburse any person or entity
1732 for any prescription for medications, medical supplies, or
1733 medical services if the prescription was written by a physician

1734 or other prescribing practitioner who is not enrolled in the
1735 Medicaid program. This section does not apply:
1736 (a) In instances involving bona fide emergency medical
1737 conditions as determined by the agency;
1738 (b) To a provider of medical services to a patient in a
1739 hospital emergency department, hospital inpatient or outpatient
1740 setting, or nursing home;
1741 (c) To bona fide pro bono services by preapproved non-
1742 Medicaid providers as determined by the agency;
1743 (d) To prescribing physicians who are board-certified
1744 specialists treating Medicaid recipients referred for treatment
1745 by a treating physician who is enrolled in the Medicaid program;
1746 (e) To prescriptions written for dually eligible Medicare
1747 beneficiaries by an authorized Medicare provider who is not
1748 enrolled in the Medicaid program;
1749 (f) To other physicians who are not enrolled in the
1750 Medicaid program but who provide a medically necessary service
1751 or prescription not otherwise reasonably available from a
1752 Medicaid-enrolled physician; or
1753 (9) A Medicaid provider shall retain medical,
1754 professional, financial, and business records pertaining to
1755 services and goods furnished to a Medicaid recipient and billed
1756 to Medicaid for a period of 5 years after the date of furnishing
1757 such services or goods. The agency may investigate, review, or
1758 analyze such records, which must be made available during normal

1759 business hours. However, 24-hour notice must be provided if
1760 patient treatment would be disrupted. The provider must keep the
1761 agency informed of the location of the provider's Medicaid-
1762 related records. The authority of the agency to obtain Medicaid-
1763 related records from a provider is neither curtailed nor limited
1764 during a period of litigation between the agency and the
1765 provider.
1766 (10) Payments for the services of billing agents or
1767 persons participating in the preparation of a Medicaid claim
1768 shall not be based on amounts for which they bill nor based on
1769 the amount a provider receives from the Medicaid program.
1770 (11) The agency shall deny payment or require repayment
1771 for inappropriate, medically unnecessary, or excessive goods or
1772 services from the person furnishing them, the person under whose
1773 supervision they were furnished, or the person causing them to
1774 be furnished.
1775 (12) The complaint and all information obtained pursuant
1776 to an investigation of a Medicaid provider, or the authorized
1777 representative or agent of a provider, relating to an allegation
1778 of fraud, abuse, or neglect are confidential and exempt from the
1779 provisions of s. 119.07(1):
1780 (a) Until the agency takes final agency action with
1781 respect to the provider and requires repayment of any
1782 overpayment, or imposes an administrative sanction;

1783 (b) Until the Attorney General refers the case for
1784 criminal prosecution;
1785 (c) Until 10 days after the complaint is determined
1786 without merit; or
1787 (d) At all times if the complaint or information is
1788 otherwise protected by law.
1789 (13) The agency shall terminate participation of a
1790 Medicaid provider in the Medicaid program and may seek civil
1791 remedies or impose other administrative sanctions against a
1792 Medicaid provider, if the provider or any principal, officer,
1793 director, agent, managing employee, or affiliated person of the
1794 provider, or any partner or shareholder having an ownership
1795 interest in the provider equal to 5 percent or greater, has been
1796 convicted of a criminal offense under federal law or the law of
1797 any state relating to the practice of the provider's profession,
1798 or a criminal offense listed under s. 408.809(4), s.
1799 409.907(10), or s. 435.04(2). If the agency determines that the
1800 provider did not participate or acquiesce in the offense,
1801 termination will not be imposed. If the agency effects a
1802 termination under this subsection, the agency shall take final
1803 agency action.
1804 (14) If the provider has been suspended or terminated from
1805 participation in the Medicaid program or the Medicare program by
1806 the Federal Government or any state, the agency must immediately
1807 suspend or terminate, as appropriate, the provider's

1808 participation in this state's Medicaid program for a period no
1809 less than that imposed by the Federal Government or any other
1810 state, and may not enroll such provider in this state's Medicaid
1811 program while such foreign suspension or termination remains in
1812 effect. The agency shall also immediately suspend or terminate,
1813 as appropriate, a provider's participation in this state's
1814 Medicaid program if the provider participated or acquiesced in
1815 any action for which any principal, officer, director, agent,
1816 managing employee, or affiliated person of the provider, or any
1817 partner or shareholder having an ownership interest in the
1818 provider equal to 5 percent or greater, was suspended or
1819 terminated from participating in the Medicaid program or the
1820 Medicare program by the Federal Government or any state. This
1821 sanction is in addition to all other remedies provided by law.
1822 (15) The agency shall seek a remedy provided by law,
1823 including, but not limited to, any remedy provided in
1824 subsections (13) and (16) and s. 812.035, if:
1825 (a) The provider's license has not been renewed, or has
1826 been revoked, suspended, or terminated, for cause, by the
1827 licensing agency of any state;
1828 (b) The provider has failed to make available or has
1829 refused access to Medicaid-related records to an auditor,
1830 investigator, or other authorized employee or agent of the
1831 agency, the Attorney General, a state attorney, or the Federal
1832 Government;

1833 (c) The provider has not furnished or has failed to make
1834 available such Medicaid-related records as the agency has found
1835 necessary to determine whether Medicaid payments are or were due
1836 and the amounts thereof;
1837 (d) The provider has failed to maintain medical records
1838 made at the time of service, or prior to service if prior
1839 authorization is required, demonstrating the necessity and
1840 appropriateness of the goods or services rendered;
1841 (e) The provider is not in compliance with provisions of
1842 Medicaid provider publications that have been adopted by
1843 reference as rules in the Florida Administrative Code; with
1844 provisions of state or federal laws, rules, or regulations; with
1845 provisions of the provider agreement between the agency and the
1846 provider; or with certifications found on claim forms or on
1847 transmittal forms for electronically submitted claims that are
1848 submitted by the provider or authorized representative, as such
1849 provisions apply to the Medicaid program;
1850 (f) The provider or person who ordered, authorized, or
1851 prescribed the care, services, or supplies has furnished, or
1852 ordered or authorized the furnishing of, goods or services to a
1853 recipient which are inappropriate, unnecessary, excessive, or
1854 harmful to the recipient or are of inferior quality;
1855 (g) The provider has demonstrated a pattern of failure to
1856 provide goods or services that are medically necessary;

1857 (h) The provider or an authorized representative of the
1858 provider, or a person who ordered, authorized, or prescribed the
1859 goods or services, has submitted or caused to be submitted false
1860 or a pattern of erroneous Medicaid claims;
1861 (i) The provider or an authorized representative of the
1862 provider, or a person who has ordered, authorized, or prescribed
1863 the goods or services, has submitted or caused to be submitted a
1864 Medicaid provider enrollment application, a request for prior
1865 authorization for Medicaid services, a drug exception request,
1866 or a Medicaid cost report that contains materially false or
1867 incorrect information;
1868 (j) The provider or an authorized representative of the
1869 provider has collected from or billed a recipient or a
1870 recipient's responsible party improperly for amounts that should
1871 not have been so collected or billed by reason of the provider's
1872 billing the Medicaid program for the same service;
1873 (k) The provider or an authorized representative of the
1874 provider has included in a cost report costs that are not
1875 allowable under a Florida Title XIX reimbursement plan after the
1876 provider or authorized representative had been advised in an
1877 audit exit conference or audit report that the costs were not
1878 allowable;
1879 (l) The provider is charged by information or indictment
1880 with fraudulent billing practices or an offense referenced in
1881 subsection (13). The sanction applied for this reason is limited

1882 to suspension of the provider's participation in the Medicaid
1883 program for the duration of the indictment unless the provider
1884 is found guilty pursuant to the information or indictment;
1885 (m) The provider or a person who ordered, authorized, or
1886 prescribed the goods or services is found liable for negligent
1887 practice resulting in death or injury to the provider's patient;
1888 (n) The provider fails to demonstrate that it had
1889 available during a specific audit or review period sufficient
1890 quantities of goods, or sufficient time in the case of services,
1891 to support the provider's billings to the Medicaid program;
1892 (o) The provider has failed to comply with the notice and
1893 reporting requirements of s. 409.907;
1894 (p) The agency has received reliable information of
1895 patient abuse or neglect or of any act prohibited by s. 409.920;
1896 or
1897 (q) The provider has failed to comply with an agreed-upon
1898 repayment schedule.
1899
1900 A provider is subject to sanctions for violations of this
1901 subsection as the result of actions or inactions of the
1902 provider, or actions or inactions of any principal, officer,
1903 director, agent, managing employee, or affiliated person of the
1904 provider, or any partner or shareholder having an ownership
1905 interest in the provider equal to 5 percent or greater, in which
1906 the provider participated or acquiesced.

1907 (16) The agency shall impose any of the following
1908 sanctions or disincentives on a provider or a person for any of
1909 the acts described in subsection (15):
1910 (a) Suspension for a specific period of time of not more
1911 than 1 year. Suspension precludes participation in the Medicaid
1912 program, which includes any action that results in a claim for
1913 payment to the Medicaid program for furnishing, supervising a
1914 person who is furnishing, or causing a person to furnish goods
1915 or services.
1916 (b) Termination for a specific period of time ranging from
1917 more than 1 year to 20 years. Termination precludes
1918 participation in the Medicaid program, which includes any action
1919 that results in a claim for payment to the Medicaid program for
1920 furnishing, supervising a person who is furnishing, or causing a
1921 person to furnish goods or services.
1922 (c) Imposition of a fine of up to $5,000 for each
1923 violation. Each day that an ongoing violation continues, such as
1924 refusing to furnish Medicaid-related records or refusing access
1925 to records, is considered a separate violation. Each instance of
1926 improper billing of a Medicaid recipient; each instance of
1927 including an unallowable cost on a hospital or nursing home
1928 Medicaid cost report after the provider or authorized
1929 representative has been advised in an audit exit conference or
1930 previous audit report of the cost unallowability; each instance
1931 of furnishing a Medicaid recipient goods or professional

1932 services that are inappropriate or of inferior quality as
1933 determined by competent peer judgment; each instance of
1934 knowingly submitting a materially false or erroneous Medicaid
1935 provider enrollment application, request for prior authorization
1936 for Medicaid services, drug exception request, or cost report;
1937 each instance of inappropriate prescribing of drugs for a
1938 Medicaid recipient as determined by competent peer judgment; and
1939 each false or erroneous Medicaid claim leading to an overpayment
1940 to a provider is considered a separate violation.
1941 (d) Immediate suspension, if the agency has received
1942 information of patient abuse or neglect or of any act prohibited
1943 by s. 409.920. Upon suspension, the agency must issue an
1944 immediate final order under s. 120.569(2)(n).
1945 (e) A fine, not to exceed $10,000, for a violation of
1946 paragraph (15)(i).
1947 (f) Imposition of liens against provider assets,
1948 including, but not limited to, financial assets and real
1949 property, not to exceed the amount of fines or recoveries
1950 sought, upon entry of an order determining that such moneys are
1951 due or recoverable.
1952 (g) Prepayment reviews of claims for a specified period of
1953 time.
1954 (h) Comprehensive followup reviews of providers every 6
1955 months to ensure that they are billing Medicaid correctly.

1956 (i) Corrective-action plans that remain in effect for up
1957 to 3 years and that are monitored by the agency every 6 months
1958 while in effect.
1959 (j) Other remedies as permitted by law to effect the
1960 recovery of a fine or overpayment.
1961
1962 If a provider voluntarily relinquishes its Medicaid provider
1963 number or an associated license, or allows the associated
1964 licensure to expire after receiving written notice that the
1965 agency is conducting, or has conducted, an audit, survey,
1966 inspection, or investigation and that a sanction of suspension
1967 or termination will or would be imposed for noncompliance
1968 discovered as a result of the audit, survey, inspection, or
1969 investigation, the agency shall impose the sanction of
1970 termination for cause against the provider. The agency's
1971 termination with cause is subject to hearing rights as may be
1972 provided under chapter 120. The Secretary of Health Care
1973 Administration may make a determination that imposition of a
1974 sanction or disincentive is not in the best interest of the
1975 Medicaid program, in which case a sanction or disincentive may
1976 not be imposed.
1977 (17) In determining the appropriate administrative
1978 sanction to be applied, or the duration of any suspension or
1979 termination, the agency shall consider:

1980 (a) The seriousness and extent of the violation or
1981 violations.
1982 (b) Any prior history of violations by the provider
1983 relating to the delivery of health care programs which resulted
1984 in either a criminal conviction or in administrative sanction or
1985 penalty.
1986 (c) Evidence of continued violation within the provider's
1987 management control of Medicaid statutes, rules, regulations, or
1988 policies after written notification to the provider of improper
1989 practice or instance of violation.
1990 (d) The effect, if any, on the quality of medical care
1991 provided to Medicaid recipients as a result of the acts of the
1992 provider.
1993 (e) Any action by a licensing agency respecting the
1994 provider in any state in which the provider operates or has
1995 operated.
1996 (f) The apparent impact on access by recipients to
1997 Medicaid services if the provider is suspended or terminated, in
1998 the best judgment of the agency.
1999
2000 The agency shall document the basis for all sanctioning actions
2001 and recommendations.
2002 (18) The agency may take action to sanction, suspend, or
2003 terminate a particular provider working for a group provider,
2004 and may suspend or terminate Medicaid participation at a

2005 specific location, rather than or in addition to taking action
2006 against an entire group.
2007 (19) The agency shall establish a process for conducting
2008 followup reviews of a sampling of providers who have a history
2009 of overpayment under the Medicaid program. This process must
2010 consider the magnitude of previous fraud or abuse and the
2011 potential effect of continued fraud or abuse on Medicaid costs.
2012 (20) In making a determination of overpayment to a
2013 provider, the agency must use accepted and valid auditing,
2014 accounting, analytical, statistical, or peer-review methods, or
2015 combinations thereof. Appropriate statistical methods may
2016 include, but are not limited to, sampling and extension to the
2017 population, parametric and nonparametric statistics, tests of
2018 hypotheses, and other generally accepted statistical methods.
2019 Appropriate analytical methods may include, but are not limited
2020 to, reviews to determine variances between the quantities of
2021 products that a provider had on hand and available to be
2022 purveyed to Medicaid recipients during the review period and the
2023 quantities of the same products paid for by the Medicaid program
2024 for the same period, taking into appropriate consideration sales
2025 of the same products to non-Medicaid customers during the same
2026 period. In meeting its burden of proof in any administrative or
2027 court proceeding, the agency may introduce the results of such
2028 statistical methods as evidence of overpayment.

2029 (21) When making a determination that an overpayment has
2030 occurred, the agency shall prepare and issue an audit report to
2031 the provider showing the calculation of overpayments. The
2032 agency's determination must be based solely upon information
2033 available to it before issuance of the audit report and, in the
2034 case of documentation obtained to substantiate claims for
2035 Medicaid reimbursement, based solely upon contemporaneous
2036 records. The agency may consider addenda or modifications to a
2037 note that was made contemporaneously with the patient care
2038 episode if the addenda or modifications are germane to the note.
2039 (22) The audit report, supported by agency work papers,
2040 showing an overpayment to a provider constitutes evidence of the
2041 overpayment. A provider may not present or elicit testimony on
2042 direct examination or cross-examination in any court or
2043 administrative proceeding, regarding the purchase or acquisition
2044 by any means of drugs, goods, or supplies; sales or divestment
2045 by any means of drugs, goods, or supplies; or inventory of
2046 drugs, goods, or supplies, unless such acquisition, sales,
2047 divestment, or inventory is documented by written invoices,
2048 written inventory records, or other competent written
2049 documentary evidence maintained in the normal course of the
2050 provider's business. A provider may not present records to
2051 contest an overpayment or sanction unless such records are
2052 contemporaneous and, if requested during the audit process, were
2053 furnished to the agency or its agent upon request. This

2054 limitation does not apply to Medicaid cost report audits. This
2055 limitation does not preclude consideration by the agency of
2056 addenda or modifications to a note if the addenda or
2057 modifications are made before notification of the audit, the
2058 addenda or modifications are germane to the note, and the note
2059 was made contemporaneously with a patient care episode.
2060 Notwithstanding the applicable rules of discovery, all
2061 documentation to be offered as evidence at an administrative
2062 hearing on a Medicaid overpayment or an administrative sanction
2063 must be exchanged by all parties at least 14 days before the
2064 administrative hearing or be excluded from consideration.
2065 (23)(a) In an audit, ~~or~~ investigation, or enforcement
2066 action for ~~of~~ a violation committed by a provider which is
2067 conducted or taken pursuant to this section, the agency or
2068 contractor is entitled to recover any and all investigative and~~,~~
2069 legal costs incurred as a result of such audit, investigation,
2070 or enforcement action. Such costs may include, but are not
2071 limited to, salaries and benefits of personnel, costs related to
2072 the time spent by an attorney and other personnel working on the
2073 case, and any other expenses incurred by the agency or
2074 contractor that are associated with the case, including any~~, and~~
2075 expert witness costs and attorney fees incurred on behalf of the
2076 agency or contractor if the agency's findings were not contested
2077 by the provider or, if contested, the agency ultimately
2078 prevailed.

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

2079 (b) The agency has the burden of documenting the costs,
2080 which include salaries and employee benefits and out-of-pocket
2081 expenses. The amount of costs that may be recovered must be
2082 reasonable in relation to the seriousness of the violation and
2083 must be set taking into consideration the financial resources,
2084 earning ability, and needs of the provider, who has the burden
2085 of demonstrating such factors.
2086 (c) The provider may pay the costs over a period to be
2087 determined by the agency if the agency determines that an
2088 extreme hardship would result to the provider from immediate
2089 full payment. Any default in payment of costs may be collected
2090 by any means authorized by law.
2091 (24) If the agency imposes an administrative sanction
2092 pursuant to subsection (13), subsection (14), or subsection
2093 (15), except paragraphs (15)(e) and (o), upon any provider or
2094 any principal, officer, director, agent, managing employee, or
2095 affiliated person of the provider who is regulated by another
2096 state entity, the agency shall notify that other entity of the
2097 imposition of the sanction within 5 business days. Such
2098 notification must include the provider's or person's name and
2099 license number and the specific reasons for sanction.
2100 (25)(a) The agency shall withhold Medicaid payments, in
2101 whole or in part, to a provider upon receipt of reliable
2102 evidence that the circumstances giving rise to the need for a
2103 withholding of payments involve fraud, willful

2104 misrepresentation, or abuse under the Medicaid program, or a
2105 crime committed while rendering goods or services to Medicaid
2106 recipients. If it is determined that fraud, willful
2107 misrepresentation, abuse, or a crime did not occur, the payments
2108 withheld must be paid to the provider within 14 days after such
2109 determination. Amounts not paid within 14 days accrue interest
2110 at the rate of 10 percent per year, beginning after the 14th
2111 day.
2112 (b) The agency shall deny payment, or require repayment,
2113 if the goods or services were furnished, supervised, or caused
2114 to be furnished by a person who has been suspended or terminated
2115 from the Medicaid program or Medicare program by the Federal
2116 Government or any state.
2117 (c) Overpayments owed to the agency bear interest at the
2118 rate of 10 percent per year from the date of final determination
2119 of the overpayment by the agency, and payment arrangements must
2120 be made within 30 days after the date of the final order, which
2121 is not subject to further appeal.
2122 (d) The agency, upon entry of a final agency order, a
2123 judgment or order of a court of competent jurisdiction, or a
2124 stipulation or settlement, may collect the moneys owed by all
2125 means allowable by law, including, but not limited to, notifying
2126 any fiscal intermediary of Medicare benefits that the state has
2127 a superior right of payment. Upon receipt of such written

2128 notification, the Medicare fiscal intermediary shall remit to
2129 the state the sum claimed.
2130 (e) The agency may institute amnesty programs to allow
2131 Medicaid providers the opportunity to voluntarily repay
2132 overpayments. The agency may adopt rules to administer such
2133 programs.
2134 (26) The agency may impose administrative sanctions
2135 against a Medicaid recipient, or the agency may seek any other
2136 remedy provided by law, including, but not limited to, the
2137 remedies provided in s. 812.035, if the agency finds that a
2138 recipient has engaged in solicitation in violation of s. 409.920
2139 or that the recipient has otherwise abused the Medicaid program.
2140 (27) When the Agency for Health Care Administration has
2141 made a probable cause determination and alleged that an
2142 overpayment to a Medicaid provider has occurred, the agency,
2143 after notice to the provider, shall:
2144 (a) Withhold, and continue to withhold during the pendency
2145 of an administrative hearing pursuant to chapter 120, any
2146 medical assistance reimbursement payments until such time as the
2147 overpayment is recovered, unless within 30 days after receiving
2148 notice thereof the provider:
2149 1. Makes repayment in full; or
2150 2. Establishes a repayment plan that is satisfactory to
2151 the Agency for Health Care Administration.

2152 (b) Withhold, and continue to withhold during the pendency
2153 of an administrative hearing pursuant to chapter 120, medical
2154 assistance reimbursement payments if the terms of a repayment
2155 plan are not adhered to by the provider.
2156 (28) Venue for all Medicaid program integrity cases lies
2157 in Leon County, at the discretion of the agency.
2158 (29) Notwithstanding other provisions of law, the agency
2159 and the Medicaid Fraud Control Unit of the Department of Legal
2160 Affairs may review a provider's Medicaid-related and non-
2161 Medicaid-related records in order to determine the total output
2162 of a provider's practice to reconcile quantities of goods or
2163 services billed to Medicaid with quantities of goods or services
2164 used in the provider's total practice.
2165 (30) The agency shall terminate a provider's participation
2166 in the Medicaid program if the provider fails to reimburse an
2167 overpayment or pay an agency-imposed fine that has been
2168 determined by final order, not subject to further appeal, within
2169 30 days after the date of the final order, unless the provider
2170 and the agency have entered into a repayment agreement.
2171 (31) If a provider requests an administrative hearing
2172 pursuant to chapter 120, such hearing must be conducted within
2173 90 days following assignment of an administrative law judge,
2174 absent exceptionally good cause shown as determined by the
2175 administrative law judge or hearing officer. Upon issuance of a
2176 final order, the outstanding balance of the amount determined to

2177 constitute the overpayment and fines is due. If a provider fails
2178 to make payments in full, fails to enter into a satisfactory
2179 repayment plan, or fails to comply with the terms of a repayment
2180 plan or settlement agreement, the agency shall withhold
2181 reimbursement payments for Medicaid services until the amount
2182 due is paid in full.
2183 (32) Duly authorized agents and employees of the agency
2184 shall have the power to inspect, during normal business hours,
2185 the records of any pharmacy, wholesale establishment, or
2186 manufacturer, or any other place in which drugs and medical
2187 supplies are manufactured, packed, packaged, made, stored, sold,
2188 or kept for sale, for the purpose of verifying the amount of
2189 drugs and medical supplies ordered, delivered, or purchased by a
2190 provider. The agency shall provide at least 2 business days'
2191 prior notice of any such inspection. The notice must identify
2192 the provider whose records will be inspected, and the inspection
2193 shall include only records specifically related to that
2194 provider.
2195 (33) In accordance with federal law, Medicaid recipients
2196 convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be
2197 limited, restricted, or suspended from Medicaid eligibility for
2198 a period not to exceed 1 year, as determined by the agency head
2199 or designee.
2200 (34) To deter fraud and abuse in the Medicaid program, the
2201 agency may limit the number of Schedule II and Schedule III

2202 refill prescription claims submitted from a pharmacy provider.
2203 The agency shall limit the allowable amount of reimbursement of
2204 prescription refill claims for Schedule II and Schedule III
2205 pharmaceuticals if the agency or the Medicaid Fraud Control Unit
2206 determines that the specific prescription refill was not
2207 requested by the Medicaid recipient or authorized representative
2208 for whom the refill claim is submitted or was not prescribed by
2209 the recipient's medical provider or physician. Any such refill
2210 request must be consistent with the original prescription.
2211 (35) The Office of Program Policy Analysis and Government
2212 Accountability shall provide a report to the President of the
2213 Senate and the Speaker of the House of Representatives on a
2214 biennial basis, beginning January 31, 2006, on the agency's
2215 efforts to prevent, detect, and deter, as well as recover funds
2216 lost to, fraud and abuse in the Medicaid program.
2217 (36) The agency may provide to a sample of Medicaid
2218 recipients or their representatives through the distribution of
2219 explanations of benefits information about services reimbursed
2220 by the Medicaid program for goods and services to such
2221 recipients, including information on how to report inappropriate
2222 or incorrect billing to the agency or other law enforcement
2223 entities for review or investigation, information on how to
2224 report criminal Medicaid fraud to the Medicaid Fraud Control
2225 Unit's toll-free hotline number, and information about the
2226 rewards available under s. 409.9203. The explanation of benefits

2227 may not be mailed for Medicaid independent laboratory services
2228 as described in s. 409.905(7) or for Medicaid certified match
2229 services as described in ss. 409.9071 and 1011.70.
2230 (37) The agency shall post on its website a current list
2231 of each Medicaid provider, including any principal, officer,
2232 director, agent, managing employee, or affiliated person of the
2233 provider, or any partner or shareholder having an ownership
2234 interest in the provider equal to 5 percent or greater, who has
2235 been terminated for cause from the Medicaid program or
2236 sanctioned under this section. The list must be searchable by a
2237 variety of search parameters and provide for the creation of
2238 formatted lists that may be printed or imported into other
2239 applications, including spreadsheets. The agency shall update
2240 the list at least monthly.
2241 (38) In order to improve the detection of health care
2242 fraud, use technology to prevent and detect fraud, and maximize
2243 the electronic exchange of health care fraud information, the
2244 agency shall:
2245 (a) Compile, maintain, and publish on its website a
2246 detailed list of all state and federal databases that contain
2247 health care fraud information and update the list at least
2248 biannually;
2249 (b) Develop a strategic plan to connect all databases that
2250 contain health care fraud information to facilitate the
2251 electronic exchange of health information between the agency,

2252 the Department of Health, the Department of Law Enforcement, and
2253 the Attorney General's Office. The plan must include recommended
2254 standard data formats, fraud identification strategies, and
2255 specifications for the technical interface between state and
2256 federal health care fraud databases;
2257 (c) Monitor innovations in health information technology,
2258 specifically as it pertains to Medicaid fraud prevention and
2259 detection; and
2260 (d) Periodically publish policy briefs that highlight
2261 available new technology to prevent or detect health care fraud
2262 and projects implemented by other states, the private sector, or
2263 the Federal Government which use technology to prevent or detect
2264 health care fraud.
2265 Section 43. Paragraph (a) of subsection (2) of section
2266 409.920, Florida Statutes, is amended to read:
2267 409.920 Medicaid provider fraud.—
2268 (2)(a) A person may not:
2269 1. Knowingly make, cause to be made, or aid and abet in
2270 the making of any false statement or false representation of a
2271 material fact, by commission or omission, in any claim submitted
2272 to the agency or its fiscal agent or a managed care plan for
2273 payment.
2274 2. Knowingly make, cause to be made, or aid and abet in
2275 the making of a claim for items or services that are not
2276 authorized to be reimbursed by the Medicaid program.

2277 3. Knowingly charge, solicit, accept, or receive anything
2278 of value, other than an authorized copayment from a Medicaid
2279 recipient, from any source in addition to the amount legally
2280 payable for an item or service provided to a Medicaid recipient
2281 under the Medicaid program or knowingly fail to credit the
2282 agency or its fiscal agent for any payment received from a
2283 third-party source.
2284 4. Knowingly make or in any way cause to be made any false
2285 statement or false representation of a material fact, by
2286 commission or omission, in any document containing items of
2287 income and expense that is or may be used by the agency to
2288 determine a general or specific rate of payment for an item or
2289 service provided by a provider.
2290 5. Knowingly solicit, offer, pay, or receive any
2291 remuneration, including any kickback, bribe, or rebate, directly
2292 or indirectly, overtly or covertly, in cash or in kind, in
2293 return for referring an individual to a person for the
2294 furnishing or arranging for the furnishing of any item or
2295 service for which payment may be made, in whole or in part,
2296 under the Medicaid program, or in return for obtaining,
2297 purchasing, leasing, ordering, or arranging for or recommending,
2298 obtaining, purchasing, leasing, or ordering any goods, facility,
2299 item, or service, for which payment may be made, in whole or in
2300 part, under the Medicaid program. This subparagraph does not
2301 apply to any discount, payment, waiver of payment, or payment

2302 practice not prohibited by 42 U.S.C. s. 1320a-7b(b) or any
2303 regulations adopted thereunder.
2304 6. Knowingly submit false or misleading information or
2305 statements to the Medicaid program for the purpose of being
2306 accepted as a Medicaid provider.
2307 7. Knowingly use or endeavor to use a Medicaid provider's
2308 identification number or a Medicaid recipient's identification
2309 number to make, cause to be made, or aid and abet in the making
2310 of a claim for items or services that are not authorized to be
2311 reimbursed by the Medicaid program.
2312 Section 44. Subsection (1) of section 409.967, Florida
2313 Statutes, is amended to read:
2314 409.967 Managed care plan accountability.—
2315 (1) Beginning with the contract procurement process
2316 initiated during the 2023 calendar year, the agency shall
2317 establish a 6-year ~~5-year~~ contract with each managed care plan
2318 selected through the procurement process described in s.
2319 409.966. A plan contract may not be renewed; however, the agency
2320 may extend the term of a plan contract to cover any delays
2321 during the transition to a new plan. The agency shall extend
2322 until December 31, 2024, the term of existing plan contracts
2323 awarded pursuant to the invitation to negotiate published in
2324 July 2017.
2325 Section 45. Paragraph (b) of subsection (5) of section
2326 409.973, Florida Statutes, is amended to read:

2327 409.973 Benefits.—
2328 (5) PROVISION OF DENTAL SERVICES.—
2329 (b) In the event the Legislature takes no action before
2330 July 1, 2017, with respect to the report findings required under
2331 subparagraph (a)2., the agency shall implement a statewide
2332 Medicaid prepaid dental health program for children and adults
2333 with a choice of at least two licensed dental managed care
2334 providers who must have substantial experience in providing
2335 dental care to Medicaid enrollees and children eligible for
2336 medical assistance under Title XXI of the Social Security Act
2337 and who meet all agency standards and requirements. To qualify
2338 as a provider under the prepaid dental health program, the
2339 entity must be licensed as a prepaid limited health service
2340 organization under part I of chapter 636 or as a health
2341 maintenance organization under part I of chapter 641. The
2342 contracts for program providers shall be awarded through a
2343 competitive procurement process. Beginning with the contract
2344 procurement process initiated during the 2023 calendar year, the
2345 contracts must be for 6 ~~5~~ years and may not be renewed; however,
2346 the agency may extend the term of a plan contract to cover
2347 delays during a transition to a new plan provider. The agency
2348 shall include in the contracts a medical loss ratio provision
2349 consistent with s. 409.967(4). The agency is authorized to seek
2350 any necessary state plan amendment or federal waiver to commence
2351 enrollment in the Medicaid prepaid dental health program no

2352 later than March 1, 2019. The agency shall extend until December
2353 31, 2024, the term of existing plan contracts awarded pursuant
2354 to the invitation to negotiate published in October 2017.
2355 Section 46. Subsection (6) of section 429.11, Florida
2356 Statutes, is amended to read:
2357 429.11 Initial application for license; provisional
2358 license.—
2359 (6) In addition to the license categories available in s.
2360 408.808, a provisional license may be issued to an applicant
2361 making initial application for licensure or making application
2362 for a change of ownership. A provisional license shall be
2363 limited in duration to a specific period of time not to exceed 6
2364 months, as determined by the agency.
2365 Section 47. Subsection (9) of section 429.19, Florida
2366 Statutes, is amended to read:
2367 429.19 Violations; imposition of administrative fines;
2368 grounds.—
2369 (9) The agency shall develop and disseminate an annual
2370 list of all facilities sanctioned or fined for violations of
2371 state standards, the number and class of violations involved,
2372 the penalties imposed, and the current status of cases. The list
2373 shall be disseminated, at no charge, to the Department of
2374 Elderly Affairs, the Department of Health, the Department of
2375 Children and Families, the Agency for Persons with Disabilities,
2376 the area agencies on aging, the Florida Statewide Advocacy

2377 ~~Council, the State Long-Term Care Ombudsman Program, and state~~
2378 ~~and local ombudsman councils. The Department of Children and~~
2379 ~~Families shall disseminate the list to service providers under~~
2380 ~~contract to the department who are responsible for referring~~
2381 ~~persons to a facility for residency. The agency may charge a fee~~
2382 ~~commensurate with the cost of printing and postage to other~~
2383 ~~interested parties requesting a copy of this list. This~~
2384 ~~information may be provided electronically or through the~~
2385 ~~agency's Internet site.~~
2386 Section 48. Subsection (2) of section 429.35, Florida
2387 Statutes, is amended to read:
2388 429.35 Maintenance of records; reports.—
2389 (2) Within 60 days after the date of <u>an</u> ~~the biennial~~
2390 inspection <u>conducted</u> ~~visit required~~ under s. 408.811 or within
2391 30 days after the date of <u>an</u> ~~any~~ interim visit, the agency shall
2392 forward the results of the inspection to the local ombudsman
2393 council in the district where the facility is located; to at
2394 least one public library or, in the absence of a public library,
2395 the county seat in the county in which the inspected assisted
2396 living facility is located; and, when appropriate, to the
2397 district Adult Services and Mental Health Program Offices.
2398 Section 49. Subsection (2) of section 429.905, Florida
2399 Statutes, is amended to read:

2400 429.905 Exemptions; monitoring of adult day care center
2401 programs colocated with assisted living facilities or licensed
2402 nursing home facilities.—
2403 (2) A licensed assisted living facility, a licensed
2404 hospital, or a licensed nursing home facility may provide
2405 services during the day which include, but are not limited to,
2406 social, health, therapeutic, recreational, nutritional, and
2407 respite services, to adults who are not residents. Such a
2408 facility need not be licensed as an adult day care center;
2409 however, the agency must monitor the facility during the regular
2410 inspection ~~and at least biennially~~ to ensure adequate space and
2411 sufficient staff. If an assisted living facility, a hospital, or
2412 a nursing home holds itself out to the public as an adult day
2413 care center, it must be licensed as such and meet all standards
2414 prescribed by statute and rule. For the purpose of this
2415 subsection, the term "day" means any portion of a 24-hour day.
2416 Section 50. Subsection (2) of section 429.929, Florida
2417 Statutes, is amended to read:
2418 429.929 Rules establishing standards.—
2419 ~~(2) Pursuant to this part, s. 408.811, and applicable~~
2420 ~~rules, the agency may conduct an abbreviated biennial inspection~~
2421 ~~of key quality-of-care standards, in lieu of a full inspection,~~
2422 ~~of a center that has a record of good performance. However, the~~
2423 ~~agency must conduct a full inspection of a center that has had~~
2424 ~~one or more confirmed complaints within the licensure period~~

2425 ~~immediately preceding the inspection or which has a serious~~
2426 ~~problem identified during the abbreviated inspection. The agency~~
2427 ~~shall develop the key quality-of-care standards, taking into~~
2428 ~~consideration the comments and recommendations of provider~~
2429 ~~groups. These standards shall be included in rules adopted by~~
2430 ~~the agency.~~
2431 Section 51. Part I of chapter 483, Florida Statutes, is
2432 repealed, and parts II and III of that chapter are redesignated
2433 as parts I and II, respectively.
2434 Section 52. Effective January 1, 2021, paragraph (e) of
2435 subsection (2) and paragraph (e) of subsection (3) of section
2436 627.6387, Florida Statutes, are amended to read:
2437 627.6387 Shared savings incentive program.—
2438 (2) As used in this section, the term:
2439 (e) "Shoppable health care service" means a lower-cost,
2440 high-quality nonemergency health care service for which a shared
2441 savings incentive is available for insureds under a health
2442 insurer's shared savings incentive program. Shoppable health
2443 care services may be provided within or outside this state and
2444 include, but are not limited to:
2445 1. Clinical laboratory services.
2446 2. Infusion therapy.
2447 3. Inpatient and outpatient surgical procedures.
2448 4. Obstetrical and gynecological services.

2449 5. Inpatient and outpatient nonsurgical diagnostic tests
2450 and procedures.
2451 6. Physical and occupational therapy services.
2452 7. Radiology and imaging services.
2453 8. Prescription drugs.
2454 9. Services provided through telehealth.
2455 10. Any additional services published by the Agency for
2456 Health Care Administration that have the most significant price
2457 variation pursuant to s. 408.05(3)(l).
2458 (3) A health insurer may offer a shared savings incentive
2459 program to provide incentives to an insured when the insured
2460 obtains a shoppable health care service from the health
2461 insurer's shared savings list. An insured may not be required to
2462 participate in a shared savings incentive program. A health
2463 insurer that offers a shared savings incentive program must:
2464 (e) At least quarterly, credit or deposit the shared
2465 savings incentive amount to the insured's account as a return or
2466 reduction in premium, or credit the shared savings incentive
2467 amount to the insured's flexible spending account, health
2468 savings account, or health reimbursement account, or reward the
2469 insured directly with cash or a cash equivalent ~~such that the~~
2470 ~~amount does not constitute income to the insured~~.
2471 Section 53. Effective January 1, 2021, paragraph (e) of
2472 subsection (2) and paragraph (e) of subsection (3) of section
2473 627.6648, Florida Statutes, are amended to read:

2474 627.6648 Shared savings incentive program.—
2475 (2) As used in this section, the term:
2476 (e) "Shoppable health care service" means a lower-cost,
2477 high-quality nonemergency health care service for which a shared
2478 savings incentive is available for insureds under a health
2479 insurer's shared savings incentive program. Shoppable health
2480 care services may be provided within or outside this state and
2481 include, but are not limited to:
2482 1. Clinical laboratory services.
2483 2. Infusion therapy.
2484 3. Inpatient and outpatient surgical procedures.
2485 4. Obstetrical and gynecological services.
2486 5. Inpatient and outpatient nonsurgical diagnostic tests
2487 and procedures.
2488 6. Physical and occupational therapy services.
2489 7. Radiology and imaging services.
2490 8. Prescription drugs.
2491 9. Services provided through telehealth.
2492 10. Any additional services published by the Agency for
2493 Health Care Administration that have the most significant price
2494 variation pursuant to s. 408.05(3)(l).
2495 (3) A health insurer may offer a shared savings incentive
2496 program to provide incentives to an insured when the insured
2497 obtains a shoppable health care service from the health
2498 insurer's shared savings list. An insured may not be required to

2499 participate in a shared savings incentive program. A health
2500 insurer that offers a shared savings incentive program must:
2501 (e) At least quarterly, credit or deposit the shared
2502 savings incentive amount to the insured's account as a return or
2503 reduction in premium, or credit the shared savings incentive
2504 amount to the insured's flexible spending account, health
2505 savings account, or health reimbursement account, or reward the
2506 insured directly with cash or a cash equivalent ~~such that the~~
2507 ~~amount does not constitute income to the insured~~.
2508 Section 54. Effective January 1, 2021, paragraph (e) of
2509 subsection (2) and paragraph (e) of subsection (3) of section
2510 641.31076, Florida Statutes, are amended to read:
2511 641.31076 Shared savings incentive program.—
2512 (2) As used in this section, the term:
2513 (e) "Shoppable health care service" means a lower-cost,
2514 high-quality nonemergency health care service for which a shared
2515 savings incentive is available for subscribers under a health
2516 maintenance organization's shared savings incentive program.
2517 Shoppable health care services may be provided within or outside
2518 this state and include, but are not limited to:
2519 1. Clinical laboratory services.
2520 2. Infusion therapy.
2521 3. Inpatient and outpatient surgical procedures.
2522 4. Obstetrical and gynecological services.

2523 5. Inpatient and outpatient nonsurgical diagnostic tests
2524 and procedures.
2525 6. Physical and occupational therapy services.
2526 7. Radiology and imaging services.
2527 8. Prescription drugs.
2528 9. Services provided through telehealth.
2529 10. Any additional services published by the Agency for
2530 Health Care Administration that have the most significant price
2531 variation pursuant to s. 408.05(3)(l).
2532 (3) A health maintenance organization may offer a shared
2533 savings incentive program to provide incentives to a subscriber
2534 when the subscriber obtains a shoppable health care service from
2535 the health maintenance organization's shared savings list. A
2536 subscriber may not be required to participate in a shared
2537 savings incentive program. A health maintenance organization
2538 that offers a shared savings incentive program must:
2539 (e) At least quarterly, credit or deposit the shared
2540 savings incentive amount to the subscriber's account as a return
2541 or reduction in premium, or credit the shared savings incentive
2542 amount to the subscriber's flexible spending account, health
2543 savings account, or health reimbursement account, or reward the
2544 subscriber directly with cash or a cash equivalent ~~such that the~~
2545 ~~amount does not constitute income to the subscriber~~.
2546 Section 55. Paragraph (g) of subsection (3) of section
2547 20.43, Florida Statutes, is amended to read:

2548 20.43 Department of Health.—There is created a Department
2549 of Health.
2550 (3) The following divisions of the Department of Health
2551 are established:
2552 (g) Division of Medical Quality Assurance, which is
2553 responsible for the following boards and professions established
2554 within the division:
2555 1. The Board of Acupuncture, created under chapter 457.
2556 2. The Board of Medicine, created under chapter 458.
2557 3. The Board of Osteopathic Medicine, created under
2558 chapter 459.
2559 4. The Board of Chiropractic Medicine, created under
2560 chapter 460.
2561 5. The Board of Podiatric Medicine, created under chapter
2562 461.
2563 6. Naturopathy, as provided under chapter 462.
2564 7. The Board of Optometry, created under chapter 463.
2565 8. The Board of Nursing, created under part I of chapter
2566 464.
2567 9. Nursing assistants, as provided under part II of
2568 chapter 464.
2569 10. The Board of Pharmacy, created under chapter 465.
2570 11. The Board of Dentistry, created under chapter 466.
2571 12. Midwifery, as provided under chapter 467.

2572 13. The Board of Speech-Language Pathology and Audiology,
2573 created under part I of chapter 468.
2574 14. The Board of Nursing Home Administrators, created
2575 under part II of chapter 468.
2576 15. The Board of Occupational Therapy, created under part
2577 III of chapter 468.
2578 16. Respiratory therapy, as provided under part V of
2579 chapter 468.
2580 17. Dietetics and nutrition practice, as provided under
2581 part X of chapter 468.
2582 18. The Board of Athletic Training, created under part
2583 XIII of chapter 468.
2584 19. The Board of Orthotists and Prosthetists, created
2585 under part XIV of chapter 468.
2586 20. Electrolysis, as provided under chapter 478.
2587 21. The Board of Massage Therapy, created under chapter
2588 480.
2589 22. The Board of Clinical Laboratory Personnel, created
2590 under part I ~~part II~~ of chapter 483.
2591 23. Medical physicists, as provided under part II ~~part III~~
2592 of chapter 483.
2593 24. The Board of Opticianry, created under part I of
2594 chapter 484.
2595 25. The Board of Hearing Aid Specialists, created under
2596 part II of chapter 484.

2597 26. The Board of Physical Therapy Practice, created under
2598 chapter 486.
2599 27. The Board of Psychology, created under chapter 490.
2600 28. School psychologists, as provided under chapter 490.
2601 29. The Board of Clinical Social Work, Marriage and Family
2602 Therapy, and Mental Health Counseling, created under chapter
2603 491.
2604 30. Emergency medical technicians and paramedics, as
2605 provided under part III of chapter 401.
2606 Section 56. Subsection (3) of section 381.0034, Florida
2607 Statutes, is amended to read:
2608 381.0034 Requirement for instruction on HIV and AIDS.—
2609 (3) The department shall require, as a condition of
2610 granting a license under chapter 467 or part I ~~part II~~ of
2611 chapter 483, that an applicant making initial application for
2612 licensure complete an educational course acceptable to the
2613 department on human immunodeficiency virus and acquired immune
2614 deficiency syndrome. Upon submission of an affidavit showing
2615 good cause, an applicant who has not taken a course at the time
2616 of licensure shall be allowed 6 months to complete this
2617 requirement.
2618 Section 57. Subsection (4) of section 456.001, Florida
2619 Statutes, is amended to read:
2620 456.001 Definitions.—As used in this chapter, the term:

2621 (4) "Health care practitioner" means any person licensed
2622 under chapter 457; chapter 458; chapter 459; chapter 460;
2623 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;
2624 chapter 466; chapter 467; part I, part II, part III, part V,
2625 part X, part XIII, or part XIV of chapter 468; chapter 478;
2626 chapter 480; part I or part II ~~part II or part III~~ of chapter
2627 483; chapter 484; chapter 486; chapter 490; or chapter 491.
2628 Section 58. Paragraphs (h) and (i) of subsection (2) of
2629 section 456.057, Florida Statutes, are amended to read:
2630 456.057 Ownership and control of patient records; report
2631 or copies of records to be furnished; disclosure of
2632 information.—
2633 (2) As used in this section, the terms "records owner,"
2634 "health care practitioner," and "health care practitioner's
2635 employer" do not include any of the following persons or
2636 entities; furthermore, the following persons or entities are not
2637 authorized to acquire or own medical records, but are authorized
2638 under the confidentiality and disclosure requirements of this
2639 section to maintain those documents required by the part or
2640 chapter under which they are licensed or regulated:
2641 (h) Clinical laboratory personnel licensed under part I
2642 ~~part II~~ of chapter 483.
2643 (i) Medical physicists licensed under part II ~~part III~~ of
2644 chapter 483.

2645 Section 59. Paragraph (j) of subsection (1) of section
2646 456.076, Florida Statutes, is amended to read:
2647 456.076 Impaired practitioner programs.—
2648 (1) As used in this section, the term:
2649 (j) "Practitioner" means a person licensed, registered,
2650 certified, or regulated by the department under part III of
2651 chapter 401; chapter 457; chapter 458; chapter 459; chapter 460;
2652 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;
2653 chapter 466; chapter 467; part I, part II, part III, part V,
2654 part X, part XIII, or part XIV of chapter 468; chapter 478;
2655 chapter 480; part I or part II ~~part II or part III~~ of chapter
2656 483; chapter 484; chapter 486; chapter 490; or chapter 491; or
2657 an applicant for a license, registration, or certification under
2658 the same laws.
2659 Section 60. Paragraph (b) of subsection (1) of section
2660 456.47, Florida Statutes, is amended to read:
2661 456.47 Use of telehealth to provide services.—
2662 (1) DEFINITIONS.—As used in this section, the term:
2663 (b) "Telehealth provider" means any individual who
2664 provides health care and related services using telehealth and
2665 who is licensed or certified under s. 393.17; part III of
2666 chapter 401; chapter 457; chapter 458; chapter 459; chapter 460;
2667 chapter 461; chapter 463; chapter 464; chapter 465; chapter 466;
2668 chapter 467; part I, part III, part IV, part V, part X, part
2669 XIII, or part XIV of chapter 468; chapter 478; chapter 480; part

2670 I or part II ~~part II or part III~~ of chapter 483; chapter 484;
2671 chapter 486; chapter 490; or chapter 491; who is licensed under
2672 a multistate health care licensure compact of which Florida is a
2673 member state; or who is registered under and complies with
2674 subsection (4).
2675 Section 61. Except as otherwise expressly provided in this
2676 act and except for this section, which shall take effect upon
2677 this act becoming a law, this act shall take effect July 1,
2678 2020.