

1 A bill to be entitled
2 An act relating to health care fraud and abuse; amending
3 s. 400.462, F.S.; revising definitions; amending s.
4 400.464, F.S.; authorizing a home infusion therapy
5 provider to be licensed as a nurse registry; deleting
6 provisions relating to Medicare reimbursement; amending s.
7 400.471, F.S.; requiring an applicant for a home health
8 agency license to submit to the Agency for Health Care
9 Administration a business plan and evidence of contingency
10 funding and disclose other controlling ownership interests
11 in health care entities; requiring certain standards in
12 documentation demonstrating financial ability to operate;
13 requiring home health agencies to maintain certain
14 accreditation to maintain licensure; permitting certain
15 accrediting organizations to submit surveys regarding
16 licensure of home health agencies; prohibiting the agency
17 from issuing an initial license to a home health agency
18 licensure applicant located within 10 miles of a licensed
19 home health agency that has common controlling interests;
20 prohibiting the transfer of an application to another home
21 health agency prior to issuance of the license; requiring
22 submission of an initial application to relocate a
23 licensed home health agency to another geographic service
24 area; amending s. 400.474, F.S.; providing additional
25 grounds under which the agency may take disciplinary
26 action against a home health agency; providing for a fine;
27 creating s. 400.476, F.S.; establishing staffing
28 requirements for home health agencies; reducing the number

29 of home health agencies that an administrator or director
30 of nursing may serve; requiring that an alternate
31 administrator be designated in writing; limiting the
32 period that a home health agency that provides skilled
33 nursing care may operate without a director of nursing;
34 requiring notification upon the termination and
35 replacement of a director of nursing; requiring the agency
36 to take administrative enforcement action against a home
37 health agency for noncompliance with the notification and
38 staffing requirements for a director of nursing; providing
39 for fines; exempting a home health agency that is not
40 Medicare or Medicaid certified and does not provide
41 skilled care or provides only physical, occupational, or
42 speech therapy from requirements related to a director of
43 nursing; providing training requirements for certified
44 nursing assistants and home health aides; amending s.
45 400.484, F.S.; requiring the agency to impose
46 administrative fines for certain deficiencies; increasing
47 the administrative fines imposed for certain deficiencies;
48 amending s. 400.491, F.S.; extending the period that a
49 home health agency must retain records of the nonskilled
50 care it provides; amending s. 400.497, F.S.; requiring
51 that the agency adopt rules related to standards for the
52 director of nursing of a home health agency, requirements
53 for a director of nursing to submit certified staff
54 activity logs pursuant to an agency request, quality
55 assurance programs, and inspections related to an
56 application for a change in ownership; amending s.

57 | 400.506, F.S.; providing training requirements for
58 | certified nursing assistants and home health aides
59 | referred for contract by a nurse registry; amending s,
60 | 409.901, F.S.; defining the term "change of ownership";
61 | amending s. 409.907, F.S.; revising provisions relating to
62 | change of ownership of Medicaid provider agreements;
63 | providing for continuing financial liability of a
64 | transferor under certain circumstances; defining the term
65 | "outstanding overpayment"; requiring the transferor to
66 | provide notice of change of ownership to the agency within
67 | a specified time period; requiring the transferee to
68 | submit a Medicaid provider enrollment application to the
69 | agency; providing for joint and several liability under
70 | certain circumstances; requiring a written payment plan
71 | for certain outstanding financial obligations; providing
72 | conditions under which additional enrollment effective
73 | dates apply; amending s. 409.910, F.S.; conforming a
74 | cross-reference; amending s. 409.912, F.S.; requiring the
75 | agency to limit its network of Medicaid durable medical
76 | equipment and medical supply providers; prohibiting
77 | reimbursement for dates of service after January 1, 2009;
78 | requiring accreditation; requiring direct provision of
79 | services or supplies; authorizing provider to store
80 | nebulizers at a physician's office under certain
81 | circumstances; imposing certain physical location
82 | requirements; requiring providers to maintain a certain
83 | stock of equipment and supplies; requiring a surety bond;

84 requiring background screening of employees; providing for
 85 certain exemptions; providing an effective date.

86

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

88

89 Section 1. Subsections (1), (5), (10), (14), and (25) of
 90 section 400.462, Florida Statutes, are amended to read:

91 400.462 Definitions.--As used in this part, the term:

92 (1) "Administrator" means a direct employee, as defined in
 93 subsection (9), who is. ~~The administrator must be a licensed~~
 94 ~~physician, physician assistant, or registered nurse licensed to~~
 95 ~~practice in this state or an individual having at least 1 year~~
 96 ~~of supervisory or administrative experience in home health care~~
 97 ~~or in a facility licensed under chapter 395, under part II of~~
 98 ~~this chapter, or under part I of chapter 429. An administrator~~
 99 ~~may manage a maximum of five licensed home health agencies~~
 100 ~~located within one agency service district or within an~~
 101 ~~immediately contiguous county. If the home health agency is~~
 102 ~~licensed under this chapter and is part of a retirement~~
 103 ~~community that provides multiple levels of care, an employee of~~
 104 ~~the retirement community may administer the home health agency~~
 105 ~~and up to a maximum of four entities licensed under this chapter~~
 106 ~~or chapter 429 that are owned, operated, or managed by the same~~
 107 ~~corporate entity. An administrator shall designate, in writing,~~
 108 ~~for each licensed entity, a qualified alternate administrator to~~
 109 ~~serve during absences.~~

110 (5) "Certified nursing assistant" means any person who has
 111 been issued a certificate under part II of chapter 464. ~~The~~

112 ~~licensed home health agency or licensed nurse registry shall~~
 113 ~~ensure that the certified nursing assistant employed by or under~~
 114 ~~contract with the home health agency or licensed nurse registry~~
 115 ~~is adequately trained to perform the tasks of a home health aide~~
 116 ~~in the home setting.~~

117 (10) "Director of nursing" means a registered nurse who is
 118 a direct employee, as defined in subsection (9), of the agency
 119 and who is a graduate of an approved school of nursing and is
 120 licensed in this state; who has at least 1 year of supervisory
 121 experience as a registered nurse; and who is responsible for
 122 overseeing the professional nursing and home health aid delivery
 123 of services of the agency. ~~A director of nursing may be the~~
 124 ~~director of a maximum of five licensed home health agencies~~
 125 ~~operated by a related business entity and located within one~~
 126 ~~agency service district or within an immediately contiguous~~
 127 ~~county. If the home health agency is licensed under this chapter~~
 128 ~~and is part of a retirement community that provides multiple~~
 129 ~~levels of care, an employee of the retirement community may~~
 130 ~~serve as the director of nursing of the home health agency and~~
 131 ~~of up to four entities licensed under this chapter or chapter~~
 132 ~~429 which are owned, operated, or managed by the same corporate~~
 133 ~~entity.~~

134 (14) "Home health aide" means a person who is trained or
 135 qualified, as provided by rule, and who provides hands-on
 136 personal care, performs simple procedures as an extension of
 137 therapy or nursing services, assists in ambulation or exercises,
 138 or assists in administering medications as permitted in rule and
 139 for which the person has received training established by the

140 agency under s. 400.497(1). ~~The licensed home health agency or~~
 141 ~~licensed nurse registry shall ensure that the home health aide~~
 142 ~~employed by or under contract with the home health agency or~~
 143 ~~licensed nurse registry is adequately trained to perform the~~
 144 ~~tasks of a home health aide in the home setting.~~

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

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

155 400.464 Home health agencies to be licensed; expiration of
 156 license; exemptions; unlawful acts; penalties.--

157 (3) A ~~Any~~ home infusion therapy provider must ~~shall~~ be
 158 licensed as a home health agency or nurse registry. ~~Any infusion~~
 159 ~~therapy provider currently authorized to receive Medicare~~
 160 ~~reimbursement under a DME Part B Provider number for the~~
 161 ~~provision of infusion therapy shall be licensed as a~~
 162 ~~noncertified home health agency. Such a provider shall continue~~
 163 ~~to receive that specified Medicare reimbursement without being~~
 164 ~~certified so long as the reimbursement is limited to those items~~
 165 ~~authorized pursuant to the DME Part B Provider Agreement and~~
 166 ~~the agency is licensed in compliance with the other provisions~~
 167 ~~of this part.~~

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

172 400.471 Application for license; fee.--

173 (2) In addition to the requirements of part II of chapter
174 408, the initial applicant must file with the application
175 satisfactory proof that the home health agency is in compliance
176 with this part and applicable rules, including:

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

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

182 (f) A balance sheet, income and expense statement, and
183 statement of cash flows for the first 2 years of operation which
184 provide evidence of having sufficient assets, credit, and
185 projected revenues to cover liabilities and expenses. The
186 applicant has demonstrated financial ability to operate if the
187 applicant's assets, credit, and projected revenues meet or
188 exceed projected liabilities and expenses. An applicant may not
189 project an operating margin of 15 percent or greater for any
190 month in the first year of operation. All documents required
191 under this paragraph must be prepared in accordance with
192 generally accepted accounting principles and compiled and signed
193 by a certified public accountant.

194 (g) All other ownership interests in health care entities
 195 for each controlling interest, as defined in part II of chapter
 196 408.

197 (h) In the case of an application for initial licensure,
 198 documentation of accreditation, or an application for
 199 accreditation, from an accrediting organization that is
 200 recognized by the agency as having standards comparable to those
 201 required by this part and part II of chapter 408.

202 Notwithstanding s. 408.806, an applicant that has applied for
 203 accreditation must provided proof of accreditation that is not
 204 conditional or provisional within 120 days after the date of the
 205 agency's receipt of the application for licensure or the
 206 application shall be withdrawn from further consideration. Such
 207 accreditation must be maintained by the home health agency to
 208 maintain licensure. The agency shall accept, in lieu of its own
 209 periodic licensure survey, the submission of the survey of an
 210 accrediting organization that is recognized by the agency if the
 211 accreditation of the licensed home health agency is not
 212 provisional and if the licensed home health agency authorizes
 213 releases of, and the agency receives the report of, the
 214 accrediting organization.

215 (7) The agency may not issue an initial license to a home
 216 health agency licensure applicant if the applicant shares common
 217 controlling interests with another licensed home health agency
 218 that is located within 10 miles of the applicant and is in the
 219 same county. The agency must return the application and fees to
 220 the applicant.

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

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

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

230 400.474 Administrative penalties.--

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

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

236 1. Documents of training for home health aides or
 237 certified nursing assistants; or

238 2. Health statements for staff providing direct care to
 239 patients.

240
 241 A pattern may be demonstrated by a showing of at least three
 242 fraudulent entries or documents. The fine shall be imposed for
 243 each fraudulent document or, if multiple staff members are
 244 included on one document, for each fraudulent entry on the
 245 document.

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

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

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

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

258 (d) Preparing or maintaining fraudulent patient records,
259 such as, but not limited to, charting ahead, recording vital
260 signs or symptoms that were not personally obtained or observed
261 by the home health agency's staff at the time indicated,
262 borrowing patients or patient records from other home health
263 agencies to pass a survey or inspection, or falsifying
264 signatures.

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

267 (3)(a) In addition to the requirements of s. 408.813, any
268 person, partnership, or corporation that violates s. 408.813 and
269 that previously operated a licensed home health agency or
270 concurrently operates both a licensed home health agency and an
271 unlicensed home health agency commits a felony of the third
272 degree punishable as provided in s. 775.082, s. 775.083, or s.
273 775.084.

274 (b) If any home health agency is found to be operating
275 without a license and that home health agency has received any
276 government reimbursement for services, the agency shall make a

277 fraud referral to the appropriate government reimbursement
278 program.

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

281 400.476 Staffing requirements; notifications; limitations
282 on staffing services.--

283 (1) ADMINISTRATOR.--

284 (a) An administrator may manage only one home health
285 agency, except that an administrator may manage up to five home
286 health agencies if all five home health agencies have identical
287 controlling interests as defined in s. 408.803 and are located
288 within one agency geographic service area or within an
289 immediately contiguous county. If the home health agency is
290 licensed under this chapter and is part of a retirement
291 community that provides multiple levels of care, an employee of
292 the retirement community may administer the home health agency
293 and up to a maximum of four entities licensed under this chapter
294 or chapter 429 which all have identical controlling interests as
295 defined in s. 408.803. An administrator shall designate, in
296 writing, for each licensed entity, a qualified alternate
297 administrator to serve during the administrator's absence.

298 (b) An administrator of a home health agency who is a
299 licensed physician, physician assistant, or registered nurse
300 licensed to practice in this state may also be the director of
301 nursing for a home health agency. An administrator may serve as
302 a director of nursing for up to the number of entities
303 authorized in subsection (2) only if there are 10 or fewer full-

304 time equivalent employees and contracted personnel in each home
 305 health agency.

306 (2) DIRECTOR OF NURSING.--

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

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

313 2. Up to five licensed home health agencies if:

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

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

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

324
 325 If a home health agency licensed under this chapter is part of a
 326 retirement community that provides multiple levels of care, an
 327 employee of the retirement community may serve as the director
 328 of nursing of the home health agency and up to a maximum of four
 329 entities, other than home health agencies, licensed under this
 330 chapter or chapter 429 which all have identical controlling
 331 interests as defined in s. 408.803.

332 (b) A home health agency that provides skilled nursing
333 care may not operate for more than 30 calendar days without a
334 director of nursing. A home health agency that provides skilled
335 nursing care and the director of nursing of the home health
336 agency must notify the agency within 10 business days after
337 termination of the services of the director of nursing for the
338 home health agency. A home health agency that provides skilled
339 nursing care must notify the agency of the identity and
340 qualifications of the new director of nursing within 10 days
341 after the new director is hired. If a home health agency that
342 provides skilled nursing care operates for more than 30 calendar
343 days without a director of nursing, the home health agency
344 commits a class II deficiency. In addition to the fine for a
345 class II deficiency, the agency may issue a moratorium in
346 accordance with s. 408.814 or revoke the license. The agency
347 shall fine a home health agency that fails to notify the agency
348 as required in this paragraph \$1,000 for the first violation and
349 \$2,000 for a repeat violation. The agency may not take
350 administrative action against a home health agency if the
351 director of nursing fails to notify the department upon
352 termination of services as the director of nursing for the home
353 health agency.

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

358 (3) TRAINING.--A home health agency shall ensure that each
359 certified nursing assistant employed by or under contract with

360 the home health agency and each home health aide employed by or
 361 under contract with the home health agency is adequately trained
 362 to perform the tasks of a home health aide in the home setting.

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

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

367 400.484 Right of inspection; deficiencies; fines.--

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

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

374 (a) A class I deficiency is any act, omission, or practice
 375 that results in a patient's death, disablement, or permanent
 376 injury, or places a patient at imminent risk of death,
 377 disablement, or permanent injury. Upon finding a class I
 378 deficiency, the agency shall ~~may~~ impose an administrative fine
 379 in the amount of \$15,000 ~~\$5,000~~ for each occurrence and each day
 380 that the deficiency exists.

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

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

394 (d) A class IV deficiency is any act, omission, or
 395 practice related to required reports, forms, or documents which
 396 does not have the potential of negatively affecting patients.
 397 These violations are of a type that the agency determines do not
 398 threaten the health, safety, or security of patients. Upon
 399 finding an uncorrected or repeated class IV deficiency, the
 400 agency shall ~~may~~ impose an administrative fine not to exceed
 401 \$500 ~~\$200~~ for each occurrence and each day that the uncorrected
 402 or repeated deficiency exists.

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

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

409 400.491 Clinical records.--

410 (2) The home health agency must maintain for each client
 411 who receives nonskilled care a service provision plan. Such
 412 records must be maintained by the home health agency for 3 years
 413 ~~1 year~~ following termination of services.

414 Section 8. Subsections (5), (6), (7), and (8) of section
415 400.497, Florida Statutes, are renumbered as subsections (7),
416 (8), (9), and (10), respectively, and new subsections (5) and
417 (6) are added to that section to read:

418 400.497 Rules establishing minimum standards.--The agency
419 shall adopt, publish, and enforce rules to implement part II of
420 chapter 408 and this part, including, as applicable, ss. 400.506
421 and 400.509, which must provide reasonable and fair minimum
422 standards relating to:

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

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

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

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

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

440 Section 9. Paragraph (a) of subsection (6) of section
441 400.506, Florida Statutes, is amended to read:

442 400.506 Licensure of nurse registries; requirements;
 443 penalties.--

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

459 Section 10. Subsections (5) through (27) of section
 460 409.901, Florida Statutes, are renumbered as subsections (6)
 461 through (28), respectively, and a new subsection (5) is added to
 462 that section to read:

463 409.901 Definitions; ss. 409.901-409.920.--As used in ss.
 464 409.901-409.920, except as otherwise specifically provided, the
 465 term:

466 (5) "Change of ownership" means an event in which the
 467 provider changes to a different legal entity or in which 45
 468 percent or more of the ownership, voting shares, or controlling
 469 interest in a corporation whose shares are not publicly traded

470 on a recognized stock exchange is transferred or assigned,
471 including the final transfer or assignment of multiple transfers
472 or assignments over a 2-year period that cumulatively total 45
473 percent or greater. A change solely in the management company or
474 board of directors is not a change of ownership.

475 Section 11. Subsections (6) and (9) of section 409.907,
476 Florida Statutes, are amended to read:

477 409.907 Medicaid provider agreements.--The agency may make
478 payments for medical assistance and related services rendered to
479 Medicaid recipients only to an individual or entity who has a
480 provider agreement in effect with the agency, who is performing
481 services or supplying goods in accordance with federal, state,
482 and local law, and who agrees that no person shall, on the
483 grounds of handicap, race, color, or national origin, or for any
484 other reason, be subjected to discrimination under any program
485 or activity for which the provider receives payment from the
486 agency.

487 (6) A Medicaid provider agreement may be revoked, at the
488 option of the agency, as the result of a change of ownership of
489 any facility, association, partnership, or other entity named as
490 the provider in the provider agreement. ~~A provider shall give~~
491 ~~the agency 60 days' notice before making any change in ownership~~
492 ~~of the entity named in the provider agreement as the provider.~~

493 (a) In the event of a change of ownership, the transferor
494 shall remain liable for all outstanding overpayments,
495 administrative fines, and any other moneys owed to the agency
496 prior to the effective date of the change of ownership. In
497 addition to the continuing liability of the transferor, the

498 transferee shall be liable to the agency for all outstanding
 499 overpayments identified by the agency on or before the effective
 500 date of the change of ownership. For purposes of this
 501 subsection, the term "outstanding overpayment" includes any
 502 amount identified in a preliminary audit report issued to the
 503 transferor by the agency on or before the effective date of the
 504 change of ownership. In the event of a change of ownership for a
 505 skilled nursing facility or intermediate care facility, the
 506 Medicaid provider agreement shall be assigned to the transferee
 507 if the transferee meets all other Medicaid provider
 508 qualifications. In the event of a change of ownership involving
 509 a skilled nursing facility licensed under part II of chapter
 510 400, liability for all outstanding overpayments, administrative
 511 finances, and any moneys owed to the agency prior to the effective
 512 date of the change of ownership shall be determined in
 513 accordance with the provisions of s. 400.179.

514 (b) At least 60 days prior to the anticipated date of the
 515 change of ownership, the transferor shall notify the agency of
 516 the intended change of ownership and the transferee shall submit
 517 to the agency a Medicaid provider enrollment application. In the
 518 event a change of ownership occurs without compliance with the
 519 notice requirements of this subsection, the transferor and
 520 transferee shall be jointly and severally liable for all
 521 overpayments, administrative fines, and other moneys due to the
 522 agency, regardless of whether the agency identified the
 523 overpayments, administrative fines, or other moneys before or
 524 after the effective date of the change of ownership. The agency
 525 shall not approve a transferee's Medicaid provider enrollment

526 application if the transferee or transferor has not paid or
 527 agreed in writing to a payment plan for all outstanding
 528 overpayments, administrative fines, and other moneys due to the
 529 agency. This subsection does not preclude the agency from
 530 seeking any other legal or equitable remedies available to the
 531 agency for the recovery of moneys owed to the Medicaid program.
 532 In the event of a change of ownership involving a skilled
 533 nursing facility licensed under part II of chapter 400,
 534 liability for all outstanding overpayments, administrative
 535 fines, and any moneys owed to the agency prior to the effective
 536 date of the change of ownership shall be determined in
 537 accordance with the provisions of s. 400.179 if the Medicaid
 538 provider enrollment application for change of ownership is
 539 submitted prior to the change of ownership.

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

544 (a) Enroll the applicant as a Medicaid provider upon
 545 approval of the provider application. The enrollment effective
 546 date shall be the date the agency receives the provider
 547 application. With respect to a provider that requires a Medicare
 548 certification survey, the enrollment effective date shall be the
 549 date the certification is awarded. With respect to a provider
 550 that completes a change of ownership, the effective date shall
 551 be the date the agency received the application, the date the
 552 change of ownership was complete, or the date the applicant
 553 became eligible to provide services under Medicaid, whichever

554 date is later. With respect to a provider of emergency medical
555 services transportation or emergency services and care, the
556 effective date is the date the services were rendered. Payment
557 for any claims for services provided to Medicaid recipients
558 between the date of receipt of the application and the date of
559 approval is contingent on applying any and all applicable audits
560 and edits contained in the agency's claims adjudication and
561 payment processing systems; or

562 (b) Deny the application if the agency finds that it is in
563 the best interest of the Medicaid program to do so. The agency
564 may consider the factors listed in subsection (10), as well as
565 any other factor that could affect the effective and efficient
566 administration of the program, including, but not limited to,
567 the applicant's demonstrated ability to provide services,
568 conduct business, and operate a financially viable concern; the
569 current availability of medical care, services, or supplies to
570 recipients, taking into account geographic location and
571 reasonable travel time; the number of providers of the same type
572 already enrolled in the same geographic area; and the
573 credentials, experience, success, and patient outcomes of the
574 provider for the services that it is making application to
575 provide in the Medicaid program. The agency shall deny the
576 application if the agency finds that a provider; any officer,
577 director, agent, managing employee, or affiliated person; or any
578 partner or shareholder having an ownership interest equal to 5
579 percent or greater in the provider if the provider is a
580 corporation, partnership, or other business entity, has failed
581 to pay all outstanding fines or overpayments assessed by final

582 order of the agency or final order of the Centers for Medicare
 583 and Medicaid Services, not subject to further appeal, unless the
 584 provider agrees to a repayment plan that includes withholding
 585 Medicaid reimbursement until the amount due is paid in full.

586 Section 12. Subsection (20) of section 409.910, Florida
 587 Statutes, is amended to read:

588 409.910 Responsibility for payments on behalf of Medicaid-
 589 eligible persons when other parties are liable.--

590 (20) Entities providing health insurance as defined in s.
 591 624.603, health maintenance organizations and prepaid health
 592 clinics as defined in chapter 641, and, on behalf of their
 593 clients, third-party administrators and pharmacy benefits
 594 managers as defined in s. 409.901(27)~~(26)~~ shall provide such
 595 records and information as are necessary to accomplish the
 596 purpose of this section, unless such requirement results in an
 597 unreasonable burden.

598 (a) The director of the agency and the Director of the
 599 Office of Insurance Regulation of the Financial Services
 600 Commission shall enter into a cooperative agreement for
 601 requesting and obtaining information necessary to effect the
 602 purpose and objective of this section.

603 1. The agency shall request only that information
 604 necessary to determine whether health insurance as defined
 605 pursuant to s. 624.603, or those health services provided
 606 pursuant to chapter 641, could be, should be, or have been
 607 claimed and paid with respect to items of medical care and
 608 services furnished to any person eligible for services under
 609 this section.

610 2. All information obtained pursuant to subparagraph 1. is
611 confidential and exempt from s. 119.07(1).

612 3. The cooperative agreement or rules adopted under this
613 subsection may include financial arrangements to reimburse the
614 reporting entities for reasonable costs or a portion thereof
615 incurred in furnishing the requested information. Neither the
616 cooperative agreement nor the rules shall require the automation
617 of manual processes to provide the requested information.

618 (b) The agency and the Financial Services Commission
619 jointly shall adopt rules for the development and administration
620 of the cooperative agreement. The rules shall include the
621 following:

622 1. A method for identifying those entities subject to
623 furnishing information under the cooperative agreement.

624 2. A method for furnishing requested information.

625 3. Procedures for requesting exemption from the
626 cooperative agreement based on an unreasonable burden to the
627 reporting entity.

628 Section 13. Subsection (48) of section 409.912, Florida
629 Statutes, is amended to read:

630 409.912 Cost-effective purchasing of health care.--The
631 agency shall purchase goods and services for Medicaid recipients
632 in the most cost-effective manner consistent with the delivery
633 of quality medical care. To ensure that medical services are
634 effectively utilized, the agency may, in any case, require a
635 confirmation or second physician's opinion of the correct
636 diagnosis for purposes of authorizing future services under the
637 Medicaid program. This section does not restrict access to

638 emergency services or poststabilization care services as defined
639 in 42 C.F.R. part 438.114. Such confirmation or second opinion
640 shall be rendered in a manner approved by the agency. The agency
641 shall maximize the use of prepaid per capita and prepaid
642 aggregate fixed-sum basis services when appropriate and other
643 alternative service delivery and reimbursement methodologies,
644 including competitive bidding pursuant to s. 287.057, designed
645 to facilitate the cost-effective purchase of a case-managed
646 continuum of care. The agency shall also require providers to
647 minimize the exposure of recipients to the need for acute
648 inpatient, custodial, and other institutional care and the
649 inappropriate or unnecessary use of high-cost services. The
650 agency shall contract with a vendor to monitor and evaluate the
651 clinical practice patterns of providers in order to identify
652 trends that are outside the normal practice patterns of a
653 provider's professional peers or the national guidelines of a
654 provider's professional association. The vendor must be able to
655 provide information and counseling to a provider whose practice
656 patterns are outside the norms, in consultation with the agency,
657 to improve patient care and reduce inappropriate utilization.
658 The agency may mandate prior authorization, drug therapy
659 management, or disease management participation for certain
660 populations of Medicaid beneficiaries, certain drug classes, or
661 particular drugs to prevent fraud, abuse, overuse, and possible
662 dangerous drug interactions. The Pharmaceutical and Therapeutics
663 Committee shall make recommendations to the agency on drugs for
664 which prior authorization is required. The agency shall inform
665 the Pharmaceutical and Therapeutics Committee of its decisions

666 regarding drugs subject to prior authorization. The agency is
667 authorized to limit the entities it contracts with or enrolls as
668 Medicaid providers by developing a provider network through
669 provider credentialing. The agency may competitively bid single-
670 source-provider contracts if procurement of goods or services
671 results in demonstrated cost savings to the state without
672 limiting access to care. The agency may limit its network based
673 on the assessment of beneficiary access to care, provider
674 availability, provider quality standards, time and distance
675 standards for access to care, the cultural competence of the
676 provider network, demographic characteristics of Medicaid
677 beneficiaries, practice and provider-to-beneficiary standards,
678 appointment wait times, beneficiary use of services, provider
679 turnover, provider profiling, provider licensure history,
680 previous program integrity investigations and findings, peer
681 review, provider Medicaid policy and billing compliance records,
682 clinical and medical record audits, and other factors. Providers
683 shall not be entitled to enrollment in the Medicaid provider
684 network. The agency shall determine instances in which allowing
685 Medicaid beneficiaries to purchase durable medical equipment and
686 other goods is less expensive to the Medicaid program than long-
687 term rental of the equipment or goods. The agency may establish
688 rules to facilitate purchases in lieu of long-term rentals in
689 order to protect against fraud and abuse in the Medicaid program
690 as defined in s. 409.913. The agency may seek federal waivers
691 necessary to administer these policies.

692 (48) (a) A provider is not entitled to enrollment in the
693 Medicaid provider network. The agency may implement a Medicaid

694 fee-for-service provider network controls, including, but not
695 limited to, competitive procurement and provider credentialing.
696 If a credentialing process is used, the agency may limit its
697 provider network based upon the following considerations:
698 beneficiary access to care, provider availability, provider
699 quality standards and quality assurance processes, cultural
700 competency, demographic characteristics of beneficiaries,
701 practice standards, service wait times, provider turnover,
702 provider licensure and accreditation history, program integrity
703 history, peer review, Medicaid policy and billing compliance
704 records, clinical and medical record audit findings, and such
705 other areas that are considered necessary by the agency to
706 ensure the integrity of the program.

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

712 1. Providers must be accredited by a Centers for Medicare
713 and Medicaid Services Deemed Accreditation Organization for
714 suppliers of durable medical equipment, prosthetics, orthotics,
715 and supplies. The provider must maintain accreditation and shall
716 be subject to unannounced reviews by the accrediting
717 organization.

718 2. Providers must provide the services or supplies
719 directly to the Medicaid recipient or caregiver at the provider
720 location or recipient's residence or send the supplies directly
721 to the recipient's residence with receipt of mailed delivery.

722 Subcontracting or consignment of the service or supply to a
723 third party is prohibited.

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

728 a. The physician must document the medical necessity and
729 need to prevent further deterioration of the patient's
730 respiratory status by the timely delivery of the nebulizer in
731 the physician's office.

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

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

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

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

750 4. Providers must have a physical business location and a
751 functional landline business phone. The location shall be within
752 the state of Florida or no more than fifty miles from the
753 Florida state line. The agency may make exceptions for providers
754 of durable medical equipment or supplies not otherwise available
755 from other enrolled providers located within the state.

756 5. Physical business locations must be clearly identified
757 as a business that furnishes durable medical equipment or
758 medical supplies by signage which can be read from 20 feet away.
759 The location must be readily accessible to the public during
760 normal, scheduled, posted business hours and must operate no
761 less than five hours per day and no less than five days per
762 week, with the exception of scheduled and posted holidays. The
763 location shall not be located within or at the same numbered
764 street address as another enrolled Medicaid durable medical
765 equipment or medical supply provider or as an enrolled Medicaid
766 pharmacy that is also enrolled as a durable medical equipment
767 provider. A licensed orthotist or prosthetist that provides only
768 orthotic or prosthetic devices as a Medicaid durable medical
769 equipment provider is exempt from the provisions in this
770 paragraph.

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

775 7. Providers must provide a surety bond of \$50,000 for each
776 provider location, up to a maximum of five bonds statewide or an
777 aggregate bond of \$250,000 statewide, as identified by Federal

778 Employer Identification Number. Providers who post a statewide
779 or an aggregate bond must identify all of their locations in any
780 Medicaid durable medical equipment and medical supply provider
781 enrollment application or bond renewal. Each provider location's
782 surety bond must be renewed annually, and the provider must
783 submit proof of renewal even if the original bond is a
784 continuous bond. A licensed orthotist or prosthetist that
785 provides only orthotic or prosthetic devices as a Medicaid
786 durable medical equipment provider is exempt from the provisions
787 in this paragraph.

788 8. Providers must obtain a level 2 background screening,
789 as provided under s. 435.04, for each provider employee in
790 direct contact with or providing direct services to recipients
791 of durable medical equipment and medical supplies in their
792 homes. This requirement includes, but is not limited to, repair
793 and service technicians, fitters, and delivery staff. The cost
794 of the background screening shall be borne by the provider.

795 9. The following providers are exempt from the
796 requirements of subparagraphs 1. and 6.:

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

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

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

805 Section 14. This act shall take effect July 1, 2008.