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LEGISLATIVE ACTION

Senate	.	House
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04/23/2009 05:18 PM	.	
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Senator Gaetz moved the following:

Senate Amendment (with directory and title amendments)

Delete lines 411 - 715

and insert:

interest has been administratively sanctioned by the agency during the two years prior to the submission of the licensure renewal application for one or more of the following acts:

(a) An intentional or negligent act that materially affects the health or safety of a client of the provider;

(b) Knowingly providing home health services in an unlicensed assisted living facility or unlicensed adult family-care home, unless the home health agency or employee reports the

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unlicensed facility or home to the agency within 72 hours after providing the services;

(c) Preparing or maintaining fraudulent patient records, such as, but not limited to, charting ahead, recording vital signs or symptoms which were not personally obtained or observed by the home health agency's staff at the time indicated, borrowing patients or patient records from other home health agencies to pass a survey or inspection, or falsifying signatures;

(d) Failing to provide at least one service directly to a patient for a period of 60 days;

(e) Demonstrating a pattern of falsifying documents relating to the training of home health aides or certified nursing assistants or demonstrating a pattern of falsifying health statements for staff who provide direct care to patients. A pattern may be demonstrated by a showing of at least three fraudulent entries or documents;

(f) Demonstrating a pattern of billing any payor for services not provided. A pattern may be demonstrated by a showing of at least three billings for services not provided within a 12-month period;

(g) Demonstrating a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, unless a reduction in service is mandated by Medicare, Medicaid, or a state program or as provided in s. 400.492(3). A pattern may be demonstrated by a showing of at least three incidents, regardless of the patient or service, in which the home health agency did not provide a service specified


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in a written agreement or plan of care during a 3-month period;

(h) Giving remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395, chapter 429, or this chapter from whom the home health agency receives referrals or gives remuneration as prohibited in s. 400.474(6)(a);

(i) Giving cash, or its equivalent, to a Medicare or Medicaid beneficiary;

(j) Demonstrating a pattern of billing the Medicaid program for services to Medicaid recipients which are medically unnecessary as determined by a final order. A pattern may be demonstrated by a showing of at least two such medically unnecessary services within one Medicaid program integrity audit period;

(k) Providing services to residents in an assisted living facility for which the home health agency does not receive fair market value remuneration; or

(l) Providing staffing to an assisted living facility for which the home health agency does not receive fair market value remuneration.

(11) The agency may not issue an initial or change of ownership license to a home health agency under part III of chapter 400 or this part for the purpose of opening a new home health agency until July 1, 2010, in any county that has at least one actively licensed home health agency and a population of persons 65 years of age or older, as indicated in the most recent population estimates published by the Executive Office of the Governor, of fewer than 1,200 per home health agency. In

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such counties, for any application received by the agency prior to July 1, 2009, which has been deemed by the agency to be complete except for proof of accreditation, the agency may issue an initial or a change of ownership license only if the applicant has applied for accreditation before May 1, 2009, from an accrediting organization that is recognized by the agency.

Section 5. Subsection (6) of section 400.474, Florida Statutes, is amended to read:

400.474 Administrative penalties.—

(6) The agency may deny, revoke, or suspend the license of a home health agency and shall impose a fine of $5,000 against a home health agency that:

(a) Gives remuneration for staffing services to:

1. Another home health agency with which it has formal or informal patient-referral transactions or arrangements; or

2. A health services pool with which it has formal or informal patient-referral transactions or arrangements,

unless the home health agency has activated its comprehensive emergency management plan in accordance with s. 400.492. This paragraph does not apply to a Medicare-certified home health agency that provides fair market value remuneration for staffing services to a non-Medicare-certified home health agency that is part of a continuing care facility licensed under chapter 651 for providing services to its own residents if each resident receiving home health services pursuant to this arrangement attests in writing that he or she made a decision without influence from staff of the facility to select, from a list of Medicare-certified home health agencies provided by the


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facility, that Medicare-certified home health agency to provide the services.

(b) Provides services to residents in an assisted living facility for which the home health agency does not receive fair market value remuneration.

(c) Provides staffing to an assisted living facility for which the home health agency does not receive fair market value remuneration.

(d) Fails to provide the agency, upon request, with copies of all contracts with assisted living facilities which were executed within 5 years before the request.

(e) Gives remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395, chapter 429, or this chapter from whom the home health agency receives referrals.

(f) Fails to submit to the agency, within 15 days after the end of each calendar quarter, a written report that includes the following data based on data as it existed on the last day of the quarter:

1. The number of insulin-dependent diabetic patients receiving insulin-injection services from the home health agency;

2. The number of patients receiving both home health services from the home health agency and hospice services;

3. The number of patients receiving home health services from that home health agency; and

4. The names and license numbers of nurses whose primary job responsibility is to provide home health services to

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patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.

(g) Gives cash, or its equivalent, to a Medicare or Medicaid beneficiary.

(h) Has more than one medical director contract in effect at one time or more than one medical director contract and one contract with a physician-specialist whose services are mandated for the home health agency in order to qualify to participate in a federal or state health care program at one time.

(i) Gives remuneration to a physician without a medical director contract being in effect. The contract must:

1. Be in writing and signed by both parties;

2. Provide for remuneration that is at fair market value for an hourly rate, which must be supported by invoices submitted by the medical director describing the work performed, the dates on which that work was performed, and the duration of that work; and

3. Be for a term of at least 1 year.

The hourly rate specified in the contract may not be increased during the term of the contract. The home health agency may not execute a subsequent contract with that physician which has an increased hourly rate and covers any portion of the term that was in the original contract.

(j) Gives remuneration to:

1. A physician, and the home health agency is in violation of paragraph (h) or paragraph (i);

2. A member of the physician’s office staff; or

3. An immediate family member of the physician,


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if the home health agency has received a patient referral in the preceding 12 months from that physician or physician's office staff.

(k) Fails to provide to the agency, upon request, copies of all contracts with a medical director which were executed within 5 years before the request.

(l) Demonstrates a pattern of billing the Medicaid program for services to Medicaid recipients which are medically unnecessary as determined by a final order. A pattern may be demonstrated by a showing of at least two such medically unnecessary services within one Medicaid program integrity audit period.

Nothing in paragraph (e) or paragraph (j) shall be interpreted as applying to or precluding any discount, compensation, waiver of payment, or payment practice permitted by 52 U.S.C. s. 1320a-7(b) or regulations adopted thereunder, including 42 C.F.R. s. 1001.952, or 42 U.S.C. s. 1395nn or regulations adopted thereunder.

Section 6. Section 408.8065, Florida Statutes, is created to read:

408.8065 Additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics.—

(1) An applicant for initial licensure, or initial licensure due to a change of ownership, as a home health agency, home medical equipment provider, or health care clinic shall:

(a) Demonstrate financial ability to operate, as required

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under s. 408.810(8) and this section. If the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses, and the applicant provides independent evidence that the funds necessary for startup costs, working capital, and contingency financing exist and will be available as needed, the applicant has demonstrated the financial ability to operate.

(b) Submit pro forma financial statements, including a balance sheet, income and expense statement, and a statement of cash flows for the first 2 years of operation which provide evidence that the applicant has sufficient assets, credit, and projected revenues to cover liabilities and expenses.

(c) Submit a statement of the applicant's estimated startup costs and sources of funds through the break-even point in operations demonstrating that the applicant has the ability to fund all startup costs, working capital, and contingency financing. The statement must show that the applicant has at a minimum 3 months of average projected expenses to cover startup costs, working capital, and contingency financing. The minimum amount for contingency funding may not be less than 1 month of average projected expenses.

All documents required under this subsection must be prepared in accordance with generally accepted accounting principles and may be in a compilation form. The financial statements must be signed by a certified public accountant.

(2) For initial, renewal, or change of ownership licenses for a home health agency, a home medical equipment provider, or a health care clinic, applicants and controlling interests who

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are nonimmigrant aliens, as described in 8 U.S.C. s. 1101, must file a surety bond of at least $500,000, payable to the agency, which guarantees that the home health agency, home medical equipment provider, or health care clinic will act in full conformity with all legal requirements for operation.

(3) In addition to the requirements of s. 408.812, any person who offers services that require licensure under part VII or part X of chapter 400, or who offers skilled services that require licensure under part III of chapter 400, without obtaining a valid license; any person who knowingly files a false or or misleading license or license renewal application or who submits false or misleading information related to such application, and any person who violates or conspires to violate this section, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 7. Subsection (3) and paragraph (a) of subsection (5) of section 408.810, Florida Statutes, are amended to read:

408.810 Minimum licensure requirements.—In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(3) Unless otherwise specified in this part, authorizing statutes, or applicable rules, any information required to be reported to the agency must be submitted within 21 calendar days after the report period or effective date of the information, whichever is earlier, including, but not limited to, any change of:

(a) Information contained in the most recent application

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for licensure.

(b) Required insurance or bonds.

(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

1. Complaints. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "To report a complaint regarding the services you receive, please call toll-free (phone number)."

2. Abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free (phone number)."

3. Medicaid fraud. An agency-written description of Medicaid fraud and the statewide toll-free telephone number for the central Medicaid fraud hotline must be provided to clients in a manner that is clearly legible and must include the words: "To report suspected Medicaid fraud, please call toll-free (phone number)."

The agency shall publish a minimum of a 90-day advance notice of a change in the toll-free telephone numbers.

Section 8. Subsection (4) is added to section 408.815, Florida Statutes, to read:

408.815 License or application denial; revocation.—

(4) In addition to the grounds provided in authorizing


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statutes, the agency shall deny an application for a license or license renewal if the applicant or a person having a controlling interest in an applicant has been:

(a) Convicted of, or enters a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such convictions or plea ended more than fifteen years prior to the date of the application;

(b) Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent five years; or

(c) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from the federal Medicare program or from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years and the termination occurred at least 20 years prior to the date of the application.

Section 9. Subsection (4) of section 409.905, Florida Statutes, is amended to read:

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


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

(4) HOME HEALTH CARE SERVICES.—The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to this subsection shall be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(a) In providing home health care services, the agency may require prior authorization of care based on diagnosis, utilization rates, or billing rates. The agency shall require prior authorization for visits for home health services that are not associated with a skilled nursing visit when the home health agency billing rates exceed the state average by 50 percent or more. The home health agency must submit the recipient’s plan of care and documentation that supports the recipient’s diagnosis to the agency when requesting prior authorization.

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all

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private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents. When implemented, the private duty nursing utilization management program shall replace the current authorization program used by the Agency for Health Care Administration and the Children's Medical Services program of the Department of Health. The agency may competitively bid on a contract to select a qualified organization to provide utilization management of private duty nursing services. The agency is authorized to seek federal waivers to implement this initiative.

(c) The agency may not pay for home health services, unless the services are medically necessary, and:

1. The services are ordered by a physician.

2. The written prescription for the services is signed and dated by the recipient's physician before the development of a plan of care and before any request requiring prior authorization.

3. The physician ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services. However, this subparagraph

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does not apply to a home health agency affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed under part II of chapter 400, or an apartment or single-family home for independent living.

4. The physician ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and, for skilled nursing services, the frequency and duration of the services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

Section 10. Paragraph (a) of subsection (9) of section 409.907, Florida Statutes, is amended to read:

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

(a) Enroll the applicant as a Medicaid provider upon approval of the provider application. The enrollment effective date shall be the date the agency receives the provider application. With respect to a provider that requires a Medicare certification survey, the enrollment effective date is the date


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the certification is awarded. With respect to a provider that completes a change of ownership, the effective date is the date the agency received the application, the date the change of ownership was complete, or the date the applicant became eligible to provide services under Medicaid, whichever date is later. With respect to a provider of emergency medical services transportation or emergency services and care, the effective date is the date the services were rendered. Payment for any claims for services provided to Medicaid recipients between the date of receipt of the application and the date of approval is contingent on applying any and all applicable audits and edits contained in the agency's claims adjudication and payment processing systems. The agency may enroll a provider located outside the State of Florida if the provider's location is no more than 50 miles from the Florida state line, and the agency determines a need for that provider type to ensure adequate access to care; or

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:
Delete line 402
and insert:
Section 4. Subsections (10) and (11) are added to section 400.471

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:
Delete lines 16 - 27
and insert:


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certain misconduct; providing limitations on licensing of home health agencies in certain counties; amending s. 400.474, F.S.; authorizing the Agency for Health Care Administration to deny, revoke, or suspend the license of or fine a home health agency that provides remuneration to certain facilities or bills the Medicaid program for medically unnecessary services; providing that certain discounts, compensations, waivers of payments, or payment practices; creating s. 408.8065, F.S.; providing additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics; requiring the posting of a surety bond in a specified minimum amount under certain circumstances;