

20091986er

1  
2 An act relating to health care; providing legislative  
3 findings; designating Miami-Dade County as a health  
4 care fraud area of concern; amending s. 68.085, F.S.;  
5 allocating certain funds recovered under the Florida  
6 False Claims Act to fund rewards for persons who  
7 report and provide information relating to Medicaid  
8 fraud; amending s. 68.086, F.S.; providing that a  
9 defendant who prevails in an action under the Florida  
10 False Claims Act may be awarded attorney's fees and  
11 costs against the person bringing the action under  
12 certain circumstances; amending s. 395.003, F.S.;  
13 authorizing a specialty-licensed children's hospital  
14 to provide cardiology services to adults for  
15 congenital heart disease under certain circumstances  
16 without obtaining additional licensure as a provider  
17 of adult cardiology services; providing an exception;  
18 amending s. 400.471, F.S.; prohibiting the Agency for  
19 Health Care Administration from renewing a license of  
20 a home health agency in certain counties if the agency  
21 has been sanctioned for certain misconduct; providing  
22 limitations on licensing of home health agencies in  
23 certain counties; amending s. 400.474, F.S.;  
24 authorizing the Agency for Health Care Administration  
25 to deny, revoke, or suspend the license of or fine a  
26 home health agency that provides remuneration to  
27 certain facilities or bills the Medicaid program for  
28 medically unnecessary services; providing that certain  
29 discounts, compensations, waivers of payments, or

20091986er

30 payment practices; exempting nurse registries that  
31 meet certain conditions from a prohibition; creating  
32 s. 408.8065, F.S.; providing additional licensure  
33 requirements for home health agencies, home medical  
34 equipment providers, and health care clinics;  
35 requiring the posting of a surety bond in a specified  
36 minimum amount under certain circumstances; imposing  
37 criminal penalties against a person who knowingly  
38 submits misleading information to the Agency for  
39 Health Care Administration in connection with  
40 applications for certain licenses; amending s.  
41 400.506, F.S.; exempting certain items from a  
42 prohibition against providing remuneration to certain  
43 persons by a nurse registry; amending ss. 395.602 and  
44 408.07, F.S.; revising the definition of the term  
45 "rural hospital" relating to hospital licensing and  
46 regulation and health care administration; amending s.  
47 408.040, F.S.; providing an exception to the  
48 termination of certain certificates of need; creating  
49 s. 408.8065, F.S.; providing additional licensure  
50 requirements for home health agencies, home medical  
51 equipment providers, and health care clinics;  
52 requiring the posting of a surety bond in a specified  
53 minimum amount under certain circumstances; providing  
54 a penalty; amending s. 408.810, F.S.; revising  
55 provisions relating to information required for  
56 licensure; requiring certain licensees to provide  
57 clients with a description of Medicaid fraud and the  
58 statewide toll-free telephone number for the central

20091986er

59 Medicaid fraud hotline; amending s. 408.815, F.S.;

60 providing additional grounds to deny an application

61 for a license; amending s. 409.905, F.S.; authorizing

62 the Agency for Health Care Administration to require

63 prior authorization of care based on utilization

64 rates; requiring a home health agency to submit a plan

65 of care and documentation of a recipient's medical

66 condition to the Agency for Health Care Administration

67 when requesting prior authorization; prohibiting the

68 Agency for Health Care Administration from paying for

69 home health services unless specified requirements are

70 satisfied; amending s. 409.907, F.S.; providing for

71 certain out-of-state providers to enroll as Medicaid

72 providers; amending s. 409.912, F.S.; requiring that

73 certain entities that provide comprehensive behavioral

74 health care services to certain Medicaid recipients be

75 licensed or authorized; requiring the Agency for

76 Health Care Administration to establish norms for the

77 utilization of Medicaid services; requiring the agency

78 to submit a report relating to the overutilization of

79 Medicaid services; revising the requirement for an

80 entity that contracts on a prepaid or fixed-sum basis

81 to meet certain surplus requirements; deleting the

82 requirement that an entity maintain certain

83 investments and restricted funds or deposits; revising

84 the circumstances in which the agency must prohibit

85 the entity from engaging in certain activities, cease

86 to process new enrollments, and not renew the entity's

87 contract; amending s. 409.913, F.S.; requiring that

20091986er

88 the annual report submitted by the Agency for Health  
89 Care Administration and the Medicaid Fraud Control  
90 Unit of the Department of Legal Affairs recommend  
91 changes necessary to prevent and detect Medicaid  
92 fraud; requiring the Agency for Health Care  
93 Administration to monitor patterns of overutilization  
94 of Medicaid services; requiring the agency to deny  
95 payment or require repayment for Medicaid services  
96 under certain circumstances; requiring the Agency for  
97 Health Care Administration to immediately terminate a  
98 Medicaid provider's participation in the Medicaid  
99 program as a result of certain adjudications against  
100 the provider or certain affiliated persons; requiring  
101 the Agency for Health Care Administration to suspend  
102 or terminate a Medicaid provider's participation in  
103 the Medicaid program if the provider or certain  
104 affiliated persons participating in the Medicaid  
105 program have been suspended or terminated by the  
106 Federal Government or another state; providing that a  
107 provider is subject to sanctions for violations of law  
108 as the result of actions or inactions of the provider  
109 or certain affiliated persons; requiring that the  
110 agency provide notice of certain administrative  
111 sanctions to other regulatory agencies within a  
112 specified period; requiring the Agency for Health Care  
113 Administration to withhold or deny Medicaid payments  
114 under certain circumstances; requiring the agency to  
115 terminate a provider's participation in the Medicaid  
116 program if the provider fails to repay certain

20091986er

117 overpayments from the Medicaid program; requiring the  
118 agency to provide at least annually information on  
119 Medicaid fraud in an explanation of benefits letter;  
120 requiring the Agency for Health Care Administration to  
121 post a list on its website of Medicaid providers and  
122 affiliated persons of providers who have been  
123 terminated or sanctioned; requiring the agency to take  
124 certain actions to improve the prevention and  
125 detection of health care fraud through the use of  
126 technology; amending s. 409.920, F.S.; defining the  
127 term "managed care organization"; providing criminal  
128 penalties and fines for Medicaid fraud; granting civil  
129 immunity to certain persons who report suspected  
130 Medicaid fraud; creating s. 409.9203, F.S.;

131 authorizing the payment of rewards to persons who  
132 report and provide information relating to Medicaid  
133 fraud; amending s. 456.004, F.S.; requiring the  
134 Department of Health to work cooperatively with the  
135 Agency for Health Care Administration and the judicial  
136 system to recover overpayments by the Medicaid  
137 program; amending s. 456.053, F.S.; excluding  
138 referrals to a sleep care provider for sleep related  
139 testing to the definition of a referral; amending s.  
140 456.041, F.S.; requiring the Department of Health to  
141 include a statement in the practitioner profile if a  
142 practitioner has been terminated from participating in  
143 the Medicaid program; creating s. 456.0635, F.S.;

144 prohibiting Medicaid fraud in the practice of health  
145 care professions; requiring the Department of Health

20091986er

146 or boards within the department to refuse to admit to  
147 exams and to deny licenses, permits, or certificates  
148 to certain persons who have engaged in certain acts;  
149 requiring health care practitioners to report  
150 allegations of Medicaid fraud; specifying that  
151 acceptance of the relinquishment of a license in  
152 anticipation of charges relating to Medicaid fraud  
153 constitutes permanent revocation of a license;  
154 amending s. 456.072, F.S.; creating additional grounds  
155 for the Department of Health to take disciplinary  
156 action against certain applicants or licensees for  
157 misconduct relating to a Medicaid program or to health  
158 care fraud; amending s. 456.074, F.S.; requiring the  
159 Department of Health to issue an emergency order  
160 suspending the license of a person who engages in  
161 certain criminal conduct relating to the Medicaid  
162 program; amending s. 465.022, F.S.; authorizing  
163 partnerships and corporations to obtain pharmacy  
164 permits; requiring applicants or certain persons  
165 affiliated with an applicant for a pharmacy permit to  
166 submit a set of fingerprints for a criminal history  
167 records check and pay the costs of the criminal  
168 history records check; requiring the Department of  
169 Health or Board of Pharmacy to deny an application for  
170 a pharmacy permit for certain misconduct by the  
171 applicant; or persons affiliated with the applicant;  
172 amending s. 465.023, F.S.; authorizing the Department  
173 of Health or the Board of Pharmacy to take  
174 disciplinary action against a permittee for certain

20091986er

175 misconduct by the permittee, or persons affiliated with  
176 the permittee; amending s. 825.103, F.S.; redefining  
177 the term "exploitation of an elderly person or  
178 disabled adult"; amending s. 921.0022, F.S.; revising  
179 the severity level ranking of Medicaid fraud under the  
180 Criminal Punishment Code; creating a pilot project to  
181 monitor and verify the delivery of home health  
182 services and provide for electronic claims for home  
183 health services; requiring the Agency for Health Care  
184 Administration to issue a report evaluating the pilot  
185 project; creating a pilot project for home health care  
186 management in Miami-Dade County; amending ss. 400.0077  
187 and 430.608, F.S.; conforming cross-references to  
188 changes made by the act; repealing s. 395.0199, F.S.,  
189 relating to private utilization review of health care  
190 services; amending ss. 395.405 and 400.0712, F.S.;  
191 conforming cross-references; repealing s. 400.118(2),  
192 F.S.; removing provisions requiring quality-of-care  
193 monitors for nursing facilities in agency district  
194 offices; amending s. 400.141, F.S.; deleting a  
195 requirement that licensed nursing home facilities  
196 provide the agency with a monthly report on the number  
197 of vacant beds in the facility; amending s. 400.147,  
198 F.S.; revising the definition of the term "adverse  
199 incident" for reporting purposes; requiring abuse,  
200 neglect, and exploitation to be reported to the agency  
201 and the Department of Children and Family Services;  
202 deleting a requirement that the agency submit an  
203 annual report on nursing home adverse incidents to the

20091986er

204 Legislature; amending s. 400.162, F.S.; revising  
205 requirements for policies and procedures regarding the  
206 safekeeping of a resident's personal effects and  
207 property; amending s. 400.191, F.S.; revising the  
208 information on the agency's Internet site regarding  
209 nursing homes; deleting the provision that requires  
210 the agency to provide information about nursing homes  
211 in printed form; amending s. 400.195, F.S.; conforming  
212 a cross-reference; amending s. 400.23, F.S.; deleting  
213 the requirement of the agency to adopt rules regarding  
214 the eating assistance provided to residents; amending  
215 s. 400.9935, F.S.; revising accreditation requirements  
216 for clinics providing magnetic resonance imaging  
217 services; amending s. 400.995, F.S.; revising agency  
218 responsibilities with respect to agency administrative  
219 penalties; amending s. 408.803, F.S.; revising  
220 definitions applicable to part II of ch. 408, F.S.,  
221 the "Health Care Licensing Procedures Act"; amending  
222 s. 408.806, F.S.; revising contents of and procedures  
223 relating to health care provider applications for  
224 licensure; providing an exception from certain  
225 licensure inspections for adult family-care homes;  
226 authorizing the agency to provide electronic access to  
227 certain information and documents; amending s.  
228 408.808, F.S.; providing for a provisional license to  
229 be issued to applicants applying for a change of  
230 ownership; providing a time limit on provisional  
231 licenses; amending s. 408.809, F.S.; revising  
232 provisions relating to background screening of



20091986er

233 specified employees; requiring health care providers  
234 to submit to the agency an affidavit of compliance  
235 with background screening requirements at the time of  
236 license renewal; deleting a provision to conform to  
237 changes made by the act; amending s. 408.811, F.S.;  
238 providing for certain inspections to be accepted in  
239 lieu of complete licensure inspections; granting  
240 agency access to records requested during an offsite  
241 review; providing timeframes for correction of certain  
242 deficiencies and submission of plans to correct the  
243 deficiencies; amending s. 408.813, F.S.; providing  
244 classifications of violations of part II of ch. 408,  
245 F.S.; providing for fines; amending s. 408.820, F.S.;  
246 revising applicability of certain exemptions from  
247 specified requirements of part II of ch. 408, F.S.;  
248 creating s. 408.821, F.S.; requiring entities  
249 regulated or licensed by the agency to designate a  
250 liaison officer for emergency operations; authorizing  
251 entities regulated or licensed by the agency to  
252 temporarily exceed their licensed capacity to act as  
253 receiving providers under specified circumstances;  
254 providing requirements that apply while such entities  
255 are in an overcapacity status; providing for issuance  
256 of an inactive license to such licensees under  
257 specified conditions; providing requirements and  
258 procedures with respect to the issuance and  
259 reactivation of an inactive license; authorizing the  
260 agency to adopt rules; amending s. 408.831, F.S.;  
261 deleting provisions relating to the authorization for

20091986er

262 entities regulated or licensed by the agency to exceed  
263 their licensed capacity to act as receiving facilities  
264 and issuance and reactivation of inactive licenses;  
265 amending s. 408.918, F.S.; revising the requirements  
266 of a provider to participate in the Florida 211  
267 network; requiring the Public Service Commission to  
268 request the Federal Communications Commission to  
269 direct the revocation of a 211 number under certain  
270 circumstances; deleting the requirement for the Agency  
271 for Health Care Administration to seek assistance in  
272 resolving jurisdictional disputes related to 211  
273 numbers; providing that the Florida Alliance of  
274 Information and Referral Services is the collaborative  
275 organization for the state; amending s. 409.221, F.S.;  
276 conforming a cross-reference; amending s. 409.901,  
277 F.S.; redefining the term "change of ownership" as it  
278 relates to Medicaid providers; repealing s. 429.071,  
279 F.S., relating to the intergenerational respite care  
280 assisted living facility pilot program; amending s.  
281 429.08, F.S.; authorizing the agency to provide  
282 information regarding licensed assisted living  
283 facilities on its Internet website; abolishing local  
284 coordinating workgroups established by agency field  
285 offices; amending s. 429.14, F.S.; conforming a  
286 reference; amending s. 429.19, F.S.; revising agency  
287 procedures for imposition of fines for violations of  
288 part I of ch. 429, F.S., the "Assisted Living  
289 Facilities Act"; amending s. 429.23, F.S.; redefining  
290 the term "adverse incident" for reporting purposes;

20091986er

291 requiring abuse, neglect, and exploitation to be  
292 reported to the agency and the Department of Children  
293 and Family Services; deleting a requirement that the  
294 agency submit an annual report on assisted living  
295 facility adverse incidents to the Legislature;  
296 repealing s. 429.26(9), F.S., relating to the removal  
297 of the requirement for a resident of an assisted  
298 living facility to undergo examinations and  
299 evaluations under certain circumstances; amending s.  
300 430.80, F.S.; conforming a cross-reference; amending  
301 ss. 435.04 and 435.05, F.S.; requiring employers of  
302 certain employees to submit an affidavit of compliance  
303 with level 2 screening requirements at the time of  
304 license renewal; amending s. 483.031, F.S.; revising a  
305 provision relating to the exemption of certain  
306 clinical laboratories, to conform to changes made by  
307 the act; amending s. 483.041, F.S.; redefining the  
308 term "waived test" as it is used in part I of ch. 483,  
309 F.S., the "Florida Clinical Laboratory Law"; repealing  
310 s. 483.106, F.S., relating to applications for  
311 certificates of exemption by clinical laboratories  
312 that perform certain tests; amending s. 483.172, F.S.;  
313 conforming provisions; amending s. 627.4239, F.S.;  
314 revising the term "standard reference compendium" for  
315 purposes of regulating the insurance coverage of drugs  
316 used in the treatment of cancer; amending s. 651.118,  
317 F.S.; conforming a cross-reference; creating s.  
318 409.91207; requiring the agency to develop a plan to  
319 create a medical home pilot project; providing waiver

20091986er

320 authority for the agency; providing an exception;  
321 requiring each medical home network to provide  
322 specified services; providing responsibilities of the  
323 agency; requiring the Secretary of the agency to  
324 appoint a task force; requiring the agency to submit a  
325 medical home implementation plan; specifying that  
326 implementation of the medical home pilot project is  
327 contingent upon legislative approval; authorizing the  
328 agency to develop rules; providing an effective date.  
329

330 Be It Enacted by the Legislature of the State of Florida:  
331

332 Section 1. The Legislature finds that:

333 (1) Immediate and proactive measures are necessary to  
334 prevent, reduce, and mitigate health care fraud, waste, and  
335 abuse and are essential to maintaining the integrity and  
336 financial viability of health care delivery systems, including  
337 those funded in whole or in part by the Medicare and Medicaid  
338 trust funds. Without these measures, health care delivery  
339 systems in this state will be depleted of necessary funds to  
340 deliver patient care, and taxpayers' dollars will be devalued  
341 and not used for their intended purposes.

342 (2) Sufficient justification exists for increased oversight  
343 of health care clinics, home health agencies, providers of home  
344 medical equipment, and other health care providers throughout  
345 the state, and in particular, in Miami-Dade County.

346 (3) The state's best interest is served by deterring health  
347 care fraud, abuse, and waste and identifying patterns of  
348 fraudulent or abusive Medicare and Medicaid activity early,

20091986er

349 especially in high-risk localities, such as Miami-Dade County,  
350 in order to prevent inappropriate expenditures of public funds  
351 and harm to the state's residents.

352 (4) The Legislature designates Miami-Dade County as a  
353 health care fraud crisis area for purposes of implementing  
354 increased scrutiny of home health agencies, home medical  
355 equipment providers, health care clinics, and other health care  
356 providers in Miami-Dade County in order to assist the state's  
357 efforts to prevent Medicaid fraud, waste, and abuse in the  
358 county and throughout the state.

359 Section 2. Section 68.085, Florida Statutes, is amended to  
360 read:

361 68.085 Awards to plaintiffs bringing action.—

362 (1) If the department proceeds with and prevails in an  
363 action brought by a person under this act, except as provided in  
364 subsection (2), the court shall order the distribution to the  
365 person of at least 15 percent but not more than 25 percent of  
366 the proceeds recovered under any judgment obtained by the  
367 department in an action under s. 68.082 or of the proceeds of  
368 any settlement of the claim, depending upon the extent to which  
369 the person substantially contributed to the prosecution of the  
370 action.

371 (2) If the department proceeds with an action which the  
372 court finds to be based primarily on disclosures of specific  
373 information, other than that provided by the person bringing the  
374 action, relating to allegations or transactions in a criminal,  
375 civil, or administrative hearing; a legislative, administrative,  
376 inspector general, or auditor general report, hearing, audit, or  
377 investigation; or from the news media, the court may award such

20091986er

378 sums as it considers appropriate, but in no case more than 10  
379 percent of the proceeds recovered under a judgment or received  
380 in settlement of a claim under this act, taking into account the  
381 significance of the information and the role of the person  
382 bringing the action in advancing the case to litigation.

383 (3) If the department does not proceed with an action under  
384 this section, the person bringing the action or settling the  
385 claim shall receive an amount which the court decides is  
386 reasonable for collecting the civil penalty and damages. The  
387 amount shall be not less than 25 percent and not more than 30  
388 percent of the proceeds recovered under a judgment rendered in  
389 an action under this act or in settlement of a claim under this  
390 act.

391 (4) Following any distributions under subsection (1),  
392 subsection (2), or subsection (3), the agency injured by the  
393 submission of a false or fraudulent claim shall be awarded an  
394 amount not to exceed its compensatory damages. If the action was  
395 based on a claim of funds from the state Medicaid program, 10  
396 percent of any remaining proceeds shall be deposited into the  
397 Legal Affairs Revolving Trust Fund to fund rewards for persons  
398 who report and provide information relating to Medicaid fraud  
399 pursuant to s. 409.9203. Any remaining proceeds, including civil  
400 penalties awarded under s. 68.082, shall be deposited in the  
401 General Revenue Fund.

402 (5) Any payment under this section to the person bringing  
403 the action shall be paid only out of the proceeds recovered from  
404 the defendant.

405 (6) Whether or not the department proceeds with the action,  
406 if the court finds that the action was brought by a person who

20091986er

407 planned and initiated the violation of s. 68.082 upon which the  
408 action was brought, the court may, to the extent the court  
409 considers appropriate, reduce the share of the proceeds of the  
410 action which the person would otherwise receive under this  
411 section, taking into account the role of the person in advancing  
412 the case to litigation and any relevant circumstances pertaining  
413 to the violation. If the person bringing the action is convicted  
414 of criminal conduct arising from his or her role in the  
415 violation of s. 68.082, the person shall be dismissed from the  
416 civil action and shall not receive any share of the proceeds of  
417 the action. Such dismissal shall not prejudice the right of the  
418 department to continue the action.

419 Section 3. Section 68.086, Florida Statutes, is amended to  
420 read:

421 68.086 Expenses; attorney's fees and costs.-

422 (1) If the department initiates an action under this act or  
423 assumes control of an action brought by a person under this act,  
424 the department shall be awarded its reasonable attorney's fees,  
425 expenses, and costs.

426 (2) If the court awards the person bringing the action  
427 proceeds under this act, the person shall also be awarded an  
428 amount for reasonable attorney's fees and costs. Payment for  
429 reasonable attorney's fees and costs shall be made from the  
430 recovered proceeds before the distribution of any award.

431 (3) If the department does not proceed with an action under  
432 this act and the person bringing the action conducts the action  
433 defendant is the prevailing party, the court may shall award to  
434 the defendant its reasonable attorney's fees and costs if the  
435 defendant prevails in the action and the court finds that the

20091986er

436 claim of ~~against~~ the person bringing the action was clearly  
437 frivolous, clearly vexatious, or brought primarily for purposes  
438 of harassment.

439 (4) No liability shall be incurred by the state government,  
440 the affected agency, or the department for any expenses,  
441 attorney's fees, or other costs incurred by any person in  
442 bringing or defending an action under this act.

443 Section 4. Subsection (6) of section 395.003, Florida  
444 Statutes, is amended to read:

445 395.003 Licensure; denial, suspension, and revocation.—

446 (6) A ~~No~~ specialty hospital may not ~~shall~~ provide any  
447 service or regularly serve any population group beyond those  
448 services or groups specified in its license. A specialty-  
449 licensed children's hospital that is authorized to provide  
450 pediatric cardiac catheterization and pediatric open heart  
451 surgery services may provide cardiovascular service to adults  
452 who, as children, were previously served by the hospital for  
453 congenital heart disease, or to those patients who are referred  
454 for a specialized procedure only for congenital heart disease by  
455 an adult hospital, without obtaining additional licensure as a  
456 provider of adult cardiovascular services. The agency may  
457 request documentation as needed to support patient selection and  
458 treatment. This subsection does not apply to a specialty-  
459 licensed children's hospital that is already licensed to provide  
460 adult cardiovascular services.

461 Section 5. Subsections (10) and (11) are added to section  
462 400.471, Florida Statutes, to read:

463 400.471 Application for license; fee.—

464 (10) The agency may not issue a renewal license for a home



20091986er

465 health agency in any county having at least one licensed home  
466 health agency and that has more than one home health agency per  
467 5,000 persons, as indicated by the most recent population  
468 estimates published by the Legislature's Office of Economic and  
469 Demographic Research, if the applicant or any controlling  
470 interest has been administratively sanctioned by the agency  
471 during the two years prior to the submission of the licensure  
472 renewal application for one or more of the following acts:

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

475 (b) Knowingly providing home health services in an  
476 unlicensed assisted living facility or unlicensed adult family-  
477 care home, unless the home health agency or employee reports the  
478 unlicensed facility or home to the agency within 72 hours after  
479 providing the services;

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

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

489 (e) Demonstrating a pattern of falsifying documents  
490 relating to the training of home health aides or certified  
491 nursing assistants or demonstrating a pattern of falsifying  
492 health statements for staff who provide direct care to patients.

493 A pattern may be demonstrated by a showing of at least three

20091986er

494 fraudulent entries or documents;

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

499 (g) Demonstrating a pattern of failing to provide a service  
500 specified in the home health agency's written agreement with a  
501 patient or the patient's legal representative, or the plan of  
502 care for that patient, unless a reduction in service is mandated  
503 by Medicare, Medicaid, or a state program or as provided in s.  
504 400.492(3). A pattern may be demonstrated by a showing of at  
505 least three incidents, regardless of the patient or service, in  
506 which the home health agency did not provide a service specified  
507 in a written agreement or plan of care during a 3-month period;

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

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

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

522 (k) Providing services to residents in an assisted living

20091986er

523 facility for which the home health agency does not receive fair  
524 market value remuneration; or

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

528 (11) The agency may not issue an initial or change of  
529 ownership license to a home health agency under part III of  
530 chapter 400 or this part for the purpose of opening a new home  
531 health agency until July 1, 2010, in any county that has at  
532 least one actively licensed home health agency and a population  
533 of persons 65 years of age or older, as indicated in the most  
534 recent population estimates published by the Executive Office of  
535 the Governor, of fewer than 1,200 per home health agency. In  
536 such counties, for any application received by the agency prior  
537 to July 1, 2009, which has been deemed by the agency to be  
538 complete except for proof of accreditation, the agency may issue  
539 an initial or a change of ownership license only if the  
540 applicant has applied for accreditation before May 1, 2009, from  
541 an accrediting organization that is recognized by the agency.

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

544 400.474 Administrative penalties.—

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

548 (a) Gives remuneration for staffing services to:

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

551 2. A health services pool with which it has formal or

20091986er

552 informal patient-referral transactions or arrangements,  
553  
554 unless the home health agency has activated its comprehensive  
555 emergency management plan in accordance with s. 400.492. This  
556 paragraph does not apply to a Medicare-certified home health  
557 agency that provides fair market value remuneration for staffing  
558 services to a non-Medicare-certified home health agency that is  
559 part of a continuing care facility licensed under chapter 651  
560 for providing services to its own residents if each resident  
561 receiving home health services pursuant to this arrangement  
562 attests in writing that he or she made a decision without  
563 influence from staff of the facility to select, from a list of  
564 Medicare-certified home health agencies provided by the  
565 facility, that Medicare-certified home health agency to provide  
566 the services.

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

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

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

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

20091986er

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

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

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

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

592 4. The names and license numbers of nurses whose primary  
593 job responsibility is to provide home health services to  
594 patients and who received remuneration from the home health  
595 agency in excess of \$25,000 during the calendar quarter.

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

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

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

605 1. Be in writing and signed by both parties;

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

20091986er

610 that work; and

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

612

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

618 (j) Gives remuneration to:

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

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

622 3. An immediate family member of the physician,

623

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

627 (k) Fails to provide to the agency, upon request, copies of  
628 all contracts with a medical director which were executed within  
629 5 years before the request.

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

636

637 Nothing in paragraph (e) or paragraph (j) shall be interpreted  
638 as applying to or precluding any discount, compensation, waiver

20091986er

639 of payment, or payment practice permitted by 52 U.S.C. s. 1320a-  
640 7(b) or regulations adopted thereunder, including 42 C.F.R. s.  
641 1001.952, or 42 U.S.C. s. 1395nn or regulations adopted  
642 thereunder.

643 Section 7. Paragraph (a) of subsection (15) of section  
644 400.506, Florida Statutes, is amended to read:

645 400.506 Licensure of nurse registries; requirements;  
646 penalties.—

647 (15) (a) The agency may deny, suspend, or revoke the license  
648 of a nurse registry and shall impose a fine of \$5,000 against a  
649 nurse registry that:

650 1. Provides services to residents in an assisted living  
651 facility for which the nurse registry does not receive fair  
652 market value remuneration.

653 2. Provides staffing to an assisted living facility for  
654 which the nurse registry does not receive fair market value  
655 remuneration.

656 3. Fails to provide the agency, upon request, with copies  
657 of all contracts with assisted living facilities which were  
658 executed within the last 5 years.

659 4. Gives remuneration to a case manager, discharge planner,  
660 facility-based staff member, or third-party vendor who is  
661 involved in the discharge planning process of a facility  
662 licensed under chapter 395 or this chapter and from whom the  
663 nurse registry receives referrals. A nurse registry is exempt  
664 from this subparagraph if it does not bill the Florida Medicaid  
665 program or the Medicare program or share a controlling interest  
666 with any entity licensed, registered, or certified under part II  
667 of chapter 408 that bills the Florida Medicaid program or the

20091986er

668 Medicare program.

669       5. Gives remuneration to a physician, a member of the  
670 physician's office staff, or an immediate family member of the  
671 physician, and the nurse registry received a patient referral in  
672 the last 12 months from that physician or the physician's office  
673 staff. A nurse registry is exempt from this subparagraph if it  
674 does not bill the Florida Medicaid program or the Medicare  
675 program or share a controlling interest with any entity  
676 licensed, registered, or certified under part II of chapter 408  
677 that bills the Florida Medicaid program or the Medicare program.

678       Section 8. Section 408.8065, Florida Statutes, is created  
679 to read:

680       408.8065 Additional licensure requirements for home health  
681 agencies, home medical equipment providers, and health care  
682 clinics.-

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

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

694       (b) Submit pro forma financial statements, including a  
695 balance sheet, income and expense statement, and a statement of  
696 cash flows for the first 2 years of operation which provide



20091986er

697 evidence that the applicant has sufficient assets, credit, and  
698 projected revenues to cover liabilities and expenses.

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

708  
709 All documents required under this subsection must be prepared in  
710 accordance with generally accepted accounting principles and may  
711 be in a compilation form. The financial statements must be  
712 signed by a certified public accountant.

713 (2) For initial, renewal, or change of ownership licenses  
714 for a home health agency, a home medical equipment provider, or  
715 a health care clinic, applicants and controlling interests who  
716 are nonimmigrant aliens, as described in 8 U.S.C. s. 1101, must  
717 file a surety bond of at least \$500,000, payable to the agency,  
718 which guarantees that the home health agency, home medical  
719 equipment provider, or health care clinic will act in full  
720 conformity with all legal requirements for operation.

721 (3) In addition to the requirements of s. 408.812, any  
722 person who offers services that require licensure under part VII  
723 or part X of chapter 400, or who offers skilled services that  
724 require licensure under part III of chapter 400, without  
725 obtaining a valid license; any person who knowingly files a

20091986er

726 false or or misleading license or license renewal application or  
727 who submits false or misleading information related to such  
728 application, and any person who violates or conspires to violate  
729 this section, commits a felony of the third degree, punishable  
730 as provided in s. 775.082, s. 775.083, or s. 775.084.

731 Section 9. Subsection (3) and paragraph (a) of subsection  
732 (5) of section 408.810, Florida Statutes, are amended to read:

733 408.810 Minimum licensure requirements.—In addition to the  
734 licensure requirements specified in this part, authorizing  
735 statutes, and applicable rules, each applicant and licensee must  
736 comply with the requirements of this section in order to obtain  
737 and maintain a license.

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

744 (a) Information contained in the most recent application  
745 for licensure.

746 (b) Required insurance or bonds.

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

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

20091986er

755 please call toll-free (phone number)."

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

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

767  
768 The agency shall publish a minimum of a 90-day advance notice of  
769 a change in the toll-free telephone numbers.

770 Section 10. Subsection (4) is added to section 408.815,  
771 Florida Statutes, to read:

772 408.815 License or application denial; revocation.—

773 (4) In addition to the grounds provided in authorizing  
774 statutes, the agency shall deny an application for a license or  
775 license renewal if the applicant or a person having a  
776 controlling interest in an applicant has been:

777 (a) Convicted of, or enters a plea of guilty or nolo  
778 contendere to, regardless of adjudication, a felony under  
779 chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or  
780 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent  
781 period of probation for such convictions or plea ended more than  
782 fifteen years prior to the date of the application;

783 (b) Terminated for cause from the Florida Medicaid program

20091986er

784 pursuant to s. 409.913, unless the applicant has been in good  
785 standing with the Florida Medicaid program for the most recent  
786 five years; or

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

794 Section 11. Subsection (4) of section 409.905, Florida  
795 Statutes, is amended to read:

796 409.905 Mandatory Medicaid services.—The agency may make  
797 payments for the following services, which are required of the  
798 state by Title XIX of the Social Security Act, furnished by  
799 Medicaid providers to recipients who are determined to be  
800 eligible on the dates on which the services were provided. Any  
801 service under this section shall be provided only when medically  
802 necessary and in accordance with state and federal law.

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

811 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for  
812 nursing and home health aide services, supplies, appliances, and

20091986er

813 durable medical equipment, necessary to assist a recipient  
814 living at home. An entity that provides services pursuant to  
815 this subsection shall be licensed under part III of chapter 400.  
816 These services, equipment, and supplies, or reimbursement  
817 therefor, may be limited as provided in the General  
818 Appropriations Act and do not include services, equipment, or  
819 supplies provided to a person residing in a hospital or nursing  
820 facility.

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

830 (b) The agency shall implement a comprehensive utilization  
831 management program that requires prior authorization of all  
832 private duty nursing services, an individualized treatment plan  
833 that includes information about medication and treatment orders,  
834 treatment goals, methods of care to be used, and plans for care  
835 coordination by nurses and other health professionals. The  
836 utilization management program shall also include a process for  
837 periodically reviewing the ongoing use of private duty nursing  
838 services. The assessment of need shall be based on a child's  
839 condition, family support and care supplements, a family's  
840 ability to provide care, and a family's and child's schedule  
841 regarding work, school, sleep, and care for other family

20091986er

842 dependents. When implemented, the private duty nursing  
843 utilization management program shall replace the current  
844 authorization program used by the Agency for Health Care  
845 Administration and the Children's Medical Services program of  
846 the Department of Health. The agency may competitively bid on a  
847 contract to select a qualified organization to provide  
848 utilization management of private duty nursing services. The  
849 agency is authorized to seek federal waivers to implement this  
850 initiative.

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

853 1. The services are ordered by a physician.

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

858 3. The physician ordering the services is not employed,  
859 under contract with, or otherwise affiliated with the home  
860 health agency rendering the services. However, this subparagraph  
861 does not apply to a home health agency affiliated with a  
862 retirement community, of which the parent corporation or a  
863 related legal entity owns a rural health clinic certified under  
864 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed  
865 under part II of chapter 400, or an apartment or single-family  
866 home for independent living. For purposes of this subparagraph,  
867 the agency may, on a case-by-case basis, provide an exception  
868 for medically fragile children who are younger than 21 years of  
869 age.

870 4. The physician ordering the services has examined the

20091986er

871 recipient within the 30 days preceding the initial request for  
872 the services and biannually thereafter.

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

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

882 Section 12. Paragraph (a) of subsection (9) of section  
883 409.907, Florida Statutes, is amended to read:

884 409.907 Medicaid provider agreements.—The agency may make  
885 payments for medical assistance and related services rendered to  
886 Medicaid recipients only to an individual or entity who has a  
887 provider agreement in effect with the agency, who is performing  
888 services or supplying goods in accordance with federal, state,  
889 and local law, and who agrees that no person shall, on the  
890 grounds of handicap, race, color, or national origin, or for any  
891 other reason, be subjected to discrimination under any program  
892 or activity for which the provider receives payment from the  
893 agency.

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

898 (a) Enroll the applicant as a Medicaid provider upon  
899 approval of the provider application. The enrollment effective

20091986er

900 date shall be the date the agency receives the provider  
901 application. With respect to a provider that requires a Medicare  
902 certification survey, the enrollment effective date is the date  
903 the certification is awarded. With respect to a provider that  
904 completes a change of ownership, the effective date is the date  
905 the agency received the application, the date the change of  
906 ownership was complete, or the date the applicant became  
907 eligible to provide services under Medicaid, whichever date is  
908 later. With respect to a provider of emergency medical services  
909 transportation or emergency services and care, the effective  
910 date is the date the services were rendered. Payment for any  
911 claims for services provided to Medicaid recipients between the  
912 date of receipt of the application and the date of approval is  
913 contingent on applying any and all applicable audits and edits  
914 contained in the agency's claims adjudication and payment  
915 processing systems. The agency may enroll a provider located  
916 outside the State of Florida if the provider's location is no  
917 more than 50 miles from the Florida state line, or the agency  
918 determines a need for that provider type to ensure adequate  
919 access to care; or

920 Section 13. Paragraph (e) of subsection (2) of section  
921 395.602, Florida Statutes, is amended to read:

922 395.602 Rural hospitals.—

923 (2) DEFINITIONS.—As used in this part:

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

927 1. The sole provider within a county with a population  
928 density of no greater than 100 persons per square mile;



20091986er

929           2. An acute care hospital, in a county with a population  
930 density of no greater than 100 persons per square mile, which is  
931 at least 30 minutes of travel time, on normally traveled roads  
932 under normal traffic conditions, from any other acute care  
933 hospital within the same county;

934           3. A hospital supported by a tax district or subdistrict  
935 whose boundaries encompass a population of 100 persons or fewer  
936 per square mile;

937           4. A hospital in a constitutional charter county with a  
938 population of over 1 million persons that has imposed a local  
939 option health service tax pursuant to law and in an area that  
940 was directly impacted by a catastrophic event on August 24,  
941 1992, for which the Governor of Florida declared a state of  
942 emergency pursuant to chapter 125, and has 120 beds or less that  
943 serves an agricultural community with an emergency room  
944 utilization of no less than 20,000 visits and a Medicaid  
945 inpatient utilization rate greater than 15 percent;

946           5. A hospital with a service area that has a population of  
947 100 persons or fewer per square mile. As used in this  
948 subparagraph, the term "service area" means the fewest number of  
949 zip codes that account for 75 percent of the hospital's  
950 discharges for the most recent 5-year period, based on  
951 information available from the hospital inpatient discharge  
952 database in the Florida Center for Health Information and Policy  
953 Analysis at the Agency for Health Care Administration; or

954           6. A hospital designated as a critical access hospital, as  
955 defined in s. 408.07(15).

956

957 Population densities used in this paragraph must be based upon

20091986er

958 the most recently completed United States census. A hospital  
959 that received funds under s. 409.9116 for a quarter beginning no  
960 later than July 1, 2002, is deemed to have been and shall  
961 continue to be a rural hospital from that date through June 30,  
962 2015 ~~2012~~, if the hospital continues to have 100 or fewer  
963 licensed beds and an emergency room, or meets the criteria of  
964 subparagraph 4. An acute care hospital that has not previously  
965 been designated as a rural hospital and that meets the criteria  
966 of this paragraph shall be granted such designation upon  
967 application, including supporting documentation to the Agency  
968 for Health Care Administration.

969 Section 14. Paragraph (a) of subsection (2) of section  
970 408.040, Florida Statutes, is amended to read:

971 408.040 Conditions and monitoring.—

972 (2) (a) Unless the applicant has commenced construction, if  
973 the project provides for construction, unless the applicant has  
974 incurred an enforceable capital expenditure commitment for a  
975 project, if the project does not provide for construction, or  
976 unless subject to paragraph (b), a certificate of need shall  
977 terminate 18 months after the date of issuance, except a  
978 certificate of need of an entity which was issued on or before  
979 April 1, 2009, shall terminate 36 months after the date of  
980 issuance. The agency shall monitor the progress of the holder of  
981 the certificate of need in meeting the timetable for project  
982 development specified in the application, and may revoke the  
983 certificate of need, if the holder of the certificate is not  
984 meeting such timetable and is not making a good-faith effort, as  
985 defined by rule, to meet it.

986 Section 15. Subsection (43) of section 408.07, Florida

20091986er

987 Statutes, is amended to read:

988 408.07 Definitions.—As used in this chapter, with the  
989 exception of ss. 408.031-408.045, the term:

990 (43) "Rural hospital" means an acute care hospital licensed  
991 under chapter 395, having 100 or fewer licensed beds and an  
992 emergency room, and which is:

993 (a) The sole provider within a county with a population  
994 density of no greater than 100 persons per square mile;

995 (b) An acute care hospital, in a county with a population  
996 density of no greater than 100 persons per square mile, which is  
997 at least 30 minutes of travel time, on normally traveled roads  
998 under normal traffic conditions, from another acute care  
999 hospital within the same county;

1000 (c) A hospital supported by a tax district or subdistrict  
1001 whose boundaries encompass a population of 100 persons or fewer  
1002 per square mile;

1003 (d) A hospital with a service area that has a population of  
1004 100 persons or fewer per square mile. As used in this paragraph,  
1005 the term "service area" means the fewest number of zip codes  
1006 that account for 75 percent of the hospital's discharges for the  
1007 most recent 5-year period, based on information available from  
1008 the hospital inpatient discharge database in the Florida Center  
1009 for Health Information and Policy Analysis at the Agency for  
1010 Health Care Administration; or

1011 (e) A critical access hospital.

1012

1013 Population densities used in this subsection must be based upon  
1014 the most recently completed United States census. A hospital  
1015 that received funds under s. 409.9116 for a quarter beginning no

20091986er

1016 later than July 1, 2002, is deemed to have been and shall  
1017 continue to be a rural hospital from that date through June 30,  
1018 2015 ~~2012~~, if the hospital continues to have 100 or fewer  
1019 licensed beds and an emergency room, or meets the criteria of s.  
1020 395.602(2)(e)4. An acute care hospital that has not previously  
1021 been designated as a rural hospital and that meets the criteria  
1022 of this subsection shall be granted such designation upon  
1023 application, including supporting documentation, to the Agency  
1024 for Health Care Administration.

1025 Section 16. Paragraph (b) of subsection (4), subsection  
1026 (14), and subsection (17) of section 409.912, Florida Statutes,  
1027 are amended to read:

1028 409.912 Cost-effective purchasing of health care.—The  
1029 agency shall purchase goods and services for Medicaid recipients  
1030 in the most cost-effective manner consistent with the delivery  
1031 of quality medical care. To ensure that medical services are  
1032 effectively utilized, the agency may, in any case, require a  
1033 confirmation or second physician's opinion of the correct  
1034 diagnosis for purposes of authorizing future services under the  
1035 Medicaid program. This section does not restrict access to  
1036 emergency services or poststabilization care services as defined  
1037 in 42 C.F.R. part 438.114. Such confirmation or second opinion  
1038 shall be rendered in a manner approved by the agency. The agency  
1039 shall maximize the use of prepaid per capita and prepaid  
1040 aggregate fixed-sum basis services when appropriate and other  
1041 alternative service delivery and reimbursement methodologies,  
1042 including competitive bidding pursuant to s. 287.057, designed  
1043 to facilitate the cost-effective purchase of a case-managed  
1044 continuum of care. The agency shall also require providers to

20091986er

1045 minimize the exposure of recipients to the need for acute  
1046 inpatient, custodial, and other institutional care and the  
1047 inappropriate or unnecessary use of high-cost services. The  
1048 agency shall contract with a vendor to monitor and evaluate the  
1049 clinical practice patterns of providers in order to identify  
1050 trends that are outside the normal practice patterns of a  
1051 provider's professional peers or the national guidelines of a  
1052 provider's professional association. The vendor must be able to  
1053 provide information and counseling to a provider whose practice  
1054 patterns are outside the norms, in consultation with the agency,  
1055 to improve patient care and reduce inappropriate utilization.  
1056 The agency may mandate prior authorization, drug therapy  
1057 management, or disease management participation for certain  
1058 populations of Medicaid beneficiaries, certain drug classes, or  
1059 particular drugs to prevent fraud, abuse, overuse, and possible  
1060 dangerous drug interactions. The Pharmaceutical and Therapeutics  
1061 Committee shall make recommendations to the agency on drugs for  
1062 which prior authorization is required. The agency shall inform  
1063 the Pharmaceutical and Therapeutics Committee of its decisions  
1064 regarding drugs subject to prior authorization. The agency is  
1065 authorized to limit the entities it contracts with or enrolls as  
1066 Medicaid providers by developing a provider network through  
1067 provider credentialing. The agency may competitively bid single-  
1068 source-provider contracts if procurement of goods or services  
1069 results in demonstrated cost savings to the state without  
1070 limiting access to care. The agency may limit its network based  
1071 on the assessment of beneficiary access to care, provider  
1072 availability, provider quality standards, time and distance  
1073 standards for access to care, the cultural competence of the

20091986er

1074 provider network, demographic characteristics of Medicaid  
1075 beneficiaries, practice and provider-to-beneficiary standards,  
1076 appointment wait times, beneficiary use of services, provider  
1077 turnover, provider profiling, provider licensure history,  
1078 previous program integrity investigations and findings, peer  
1079 review, provider Medicaid policy and billing compliance records,  
1080 clinical and medical record audits, and other factors. Providers  
1081 shall not be entitled to enrollment in the Medicaid provider  
1082 network. The agency shall determine instances in which allowing  
1083 Medicaid beneficiaries to purchase durable medical equipment and  
1084 other goods is less expensive to the Medicaid program than long-  
1085 term rental of the equipment or goods. The agency may establish  
1086 rules to facilitate purchases in lieu of long-term rentals in  
1087 order to protect against fraud and abuse in the Medicaid program  
1088 as defined in s. 409.913. The agency may seek federal waivers  
1089 necessary to administer these policies.

1090 (4) The agency may contract with:

1091 (b) An entity that is providing comprehensive behavioral  
1092 health care services to certain Medicaid recipients through a  
1093 capitated, prepaid arrangement pursuant to the federal waiver  
1094 provided for by s. 409.905(5). Such ~~an~~ entity must be licensed  
1095 under chapter 624, chapter 636, or chapter 641, or authorized  
1096 under paragraph (c), and must possess the clinical systems and  
1097 operational competence to manage risk and provide comprehensive  
1098 behavioral health care to Medicaid recipients. As used in this  
1099 paragraph, the term "comprehensive behavioral health care  
1100 services" means covered mental health and substance abuse  
1101 treatment services that are available to Medicaid recipients.  
1102 The secretary of the Department of Children and Family Services

20091986er

1103 shall approve provisions of procurements related to children in  
1104 the department's care or custody before ~~prior to~~ enrolling such  
1105 children in a prepaid behavioral health plan. Any contract  
1106 awarded under this paragraph must be competitively procured. In  
1107 developing the behavioral health care prepaid plan procurement  
1108 document, the agency shall ensure that the procurement document  
1109 requires the contractor to develop and implement a plan to  
1110 ensure compliance with s. 394.4574 related to services provided  
1111 to residents of licensed assisted living facilities that hold a  
1112 limited mental health license. Except as provided in  
1113 subparagraph 8., and except in counties where the Medicaid  
1114 managed care pilot program is authorized pursuant to s.  
1115 409.91211, the agency shall seek federal approval to contract  
1116 with a single entity meeting these requirements to provide  
1117 comprehensive behavioral health care services to all Medicaid  
1118 recipients not enrolled in a Medicaid managed care plan  
1119 authorized under s. 409.91211 or a Medicaid health maintenance  
1120 organization in an AHCA area. In an AHCA area where the Medicaid  
1121 managed care pilot program is authorized pursuant to s.  
1122 409.91211 in one or more counties, the agency may procure a  
1123 contract with a single entity to serve the remaining counties as  
1124 an AHCA area or the remaining counties may be included with an  
1125 adjacent AHCA area and are ~~shall be~~ subject to this paragraph.  
1126 Each entity must offer a sufficient choice of providers in its  
1127 network to ensure recipient access to care and the opportunity  
1128 to select a provider with whom they are satisfied. The network  
1129 shall include all public mental health hospitals. To ensure  
1130 unimpaired access to behavioral health care services by Medicaid  
1131 recipients, all contracts issued pursuant to this paragraph must

20091986er

1132 ~~shall~~ require 80 percent of the capitation paid to the managed  
1133 care plan, including health maintenance organizations, to be  
1134 expended for the provision of behavioral health care services.  
1135 If ~~In the event~~ the managed care plan expends less than 80  
1136 percent of the capitation paid ~~pursuant to this paragraph~~ for  
1137 the provision of behavioral health care services, the difference  
1138 shall be returned to the agency. The agency shall provide the  
1139 ~~managed care~~ plan with a certification letter indicating the  
1140 amount of capitation paid during each calendar year for ~~the~~  
1141 ~~provision of~~ behavioral health care services pursuant to this  
1142 section. The agency may reimburse for substance abuse treatment  
1143 services on a fee-for-service basis until the agency finds that  
1144 adequate funds are available for capitated, prepaid  
1145 arrangements.

1146 1. By January 1, 2001, the agency shall modify the  
1147 contracts with the entities providing comprehensive inpatient  
1148 and outpatient mental health care services to Medicaid  
1149 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk  
1150 Counties, to include substance abuse treatment services.

1151 2. By July 1, 2003, the agency and the Department of  
1152 Children and Family Services shall execute a written agreement  
1153 that requires collaboration and joint development of all policy,  
1154 budgets, procurement documents, contracts, and monitoring plans  
1155 that have an impact on the state and Medicaid community mental  
1156 health and targeted case management programs.

1157 3. Except as provided in subparagraph 8., by July 1, 2006,  
1158 the agency and the Department of Children and Family Services  
1159 shall contract with managed care entities in each AHCA area  
1160 except area 6 or arrange to provide comprehensive inpatient and



20091986er

1161 outpatient mental health and substance abuse services through  
1162 capitated prepaid arrangements to all Medicaid recipients who  
1163 are eligible to participate in such plans under federal law and  
1164 regulation. In AHCA areas where eligible individuals number less  
1165 than 150,000, the agency shall contract with a single managed  
1166 care plan to provide comprehensive behavioral health services to  
1167 all recipients who are not enrolled in a Medicaid health  
1168 maintenance organization or a Medicaid capitated managed care  
1169 plan authorized under s. 409.91211. The agency may contract with  
1170 more than one comprehensive behavioral health provider to  
1171 provide care to recipients who are not enrolled in a Medicaid  
1172 capitated managed care plan authorized under s. 409.91211 or a  
1173 Medicaid health maintenance organization in AHCA areas where the  
1174 eligible population exceeds 150,000. In an AHCA area where the  
1175 Medicaid managed care pilot program is authorized pursuant to s.  
1176 409.91211 in one or more counties, the agency may procure a  
1177 contract with a single entity to serve the remaining counties as  
1178 an AHCA area or the remaining counties may be included with an  
1179 adjacent AHCA area and shall be subject to this paragraph.  
1180 Contracts for comprehensive behavioral health providers awarded  
1181 pursuant to this section shall be competitively procured. Both  
1182 for-profit and not-for-profit corporations are ~~shall be~~ eligible  
1183 to compete. Managed care plans contracting with the agency under  
1184 subsection (3) shall provide and receive payment for the same  
1185 comprehensive behavioral health benefits as provided in AHCA  
1186 rules, including handbooks incorporated by reference. In AHCA  
1187 area 11, the agency shall contract with at least two  
1188 comprehensive behavioral health care providers to provide  
1189 behavioral health care to recipients in that area who are

20091986er

1190 enrolled in, or assigned to, the MediPass program. One of the  
1191 behavioral health care contracts must ~~shall~~ be with the existing  
1192 provider service network pilot project, as described in  
1193 paragraph (d), for the purpose of demonstrating the cost-  
1194 effectiveness of the provision of quality mental health services  
1195 through a public hospital-operated managed care model. Payment  
1196 shall be at an agreed-upon capitated rate to ensure cost  
1197 savings. Of the recipients in area 11 who are assigned to  
1198 MediPass under ~~the provisions of~~ s. 409.9122(2)(k), a minimum of  
1199 50,000 of those MediPass-enrolled recipients shall be assigned  
1200 to the existing provider service network in area 11 for their  
1201 behavioral care.

1202 4. By October 1, 2003, the agency and the department shall  
1203 submit a plan to the Governor, the President of the Senate, and  
1204 the Speaker of the House of Representatives which provides for  
1205 the full implementation of capitated prepaid behavioral health  
1206 care in all areas of the state.

1207 a. Implementation shall begin in 2003 in those AHCA areas  
1208 of the state where the agency is able to establish sufficient  
1209 capitation rates.

1210 b. If the agency determines that the proposed capitation  
1211 rate in any area is insufficient to provide appropriate  
1212 services, the agency may adjust the capitation rate to ensure  
1213 that care will be available. The agency and the department may  
1214 use existing general revenue to address any additional required  
1215 match but may not over-obligate existing funds on an annualized  
1216 basis.

1217 c. Subject to any limitations provided ~~for~~ in the General  
1218 Appropriations Act, the agency, in compliance with appropriate

20091986er

1219 federal authorization, shall develop policies and procedures  
1220 that allow for certification of local and state funds.

1221 5. Children residing in a statewide inpatient psychiatric  
1222 program, or in a Department of Juvenile Justice or a Department  
1223 of Children and Family Services residential program approved as  
1224 a Medicaid behavioral health overlay services provider may ~~shall~~  
1225 not be included in a behavioral health care prepaid health plan  
1226 or any other Medicaid managed care plan pursuant to this  
1227 paragraph.

1228 6. In converting to a prepaid system of delivery, the  
1229 agency shall in its procurement document require an entity  
1230 providing only comprehensive behavioral health care services to  
1231 prevent the displacement of indigent care patients by enrollees  
1232 in the Medicaid prepaid health plan providing behavioral health  
1233 care services from facilities receiving state funding to provide  
1234 indigent behavioral health care, to facilities licensed under  
1235 chapter 395 which do not receive state funding for indigent  
1236 behavioral health care, or reimburse the unsubsidized facility  
1237 for the cost of behavioral health care provided to the displaced  
1238 indigent care patient.

1239 7. Traditional community mental health providers under  
1240 contract with the Department of Children and Family Services  
1241 pursuant to part IV of chapter 394, child welfare providers  
1242 under contract with the Department of Children and Family  
1243 Services in areas 1 and 6, and inpatient mental health providers  
1244 licensed pursuant to chapter 395 must be offered an opportunity  
1245 to accept or decline a contract to participate in any provider  
1246 network for prepaid behavioral health services.

1247 8. All Medicaid-eligible children, except children in area

20091986er

1248 1 and children in Highlands County, Hardee County, Polk County,  
1249 or Manatee County of area 6, that ~~who~~ are open for child welfare  
1250 services in the HomeSafeNet system, shall receive their  
1251 behavioral health care services through a specialty prepaid plan  
1252 operated by community-based lead agencies ~~either~~ through a  
1253 single agency or formal agreements among several agencies. The  
1254 specialty prepaid plan must result in savings to the state  
1255 comparable to savings achieved in other Medicaid managed care  
1256 and prepaid programs. Such plan must provide mechanisms to  
1257 maximize state and local revenues. The specialty prepaid plan  
1258 shall be developed by the agency and the Department of Children  
1259 and Family Services. The agency may ~~is authorized to~~ seek ~~any~~  
1260 federal waivers to implement this initiative. Medicaid-eligible  
1261 children whose cases are open for child welfare services in the  
1262 HomeSafeNet system and who reside in AHCA area 10 are exempt  
1263 from the specialty prepaid plan upon the development of a  
1264 service delivery mechanism for children who reside in area 10 as  
1265 specified in s. 409.91211(3) (dd).

1266 (14) (a) The agency shall operate or contract for the  
1267 operation of utilization management and incentive systems  
1268 designed to encourage cost-effective use of services and to  
1269 eliminate services that are medically unnecessary. The agency  
1270 shall track Medicaid provider prescription and billing patterns  
1271 and evaluate them against Medicaid medical necessity criteria  
1272 and coverage and limitation guidelines adopted by rule. Medical  
1273 necessity determination requires that service be consistent with  
1274 symptoms or confirmed diagnosis of illness or injury under  
1275 treatment and not in excess of the patient's needs. The agency  
1276 shall conduct reviews of provider exceptions to peer group norms

20091986er

1277 and shall, using statistical methodologies, provider profiling,  
1278 and analysis of billing patterns, detect and investigate  
1279 abnormal or unusual increases in billing or payment of claims  
1280 for Medicaid services and medically unnecessary provision of  
1281 services. Providers that demonstrate a pattern of submitting  
1282 claims for medically unnecessary services shall be referred to  
1283 the Medicaid program integrity unit for investigation. In its  
1284 annual report, required in s. 409.913, the agency shall report  
1285 on its efforts to control overutilization as described in this  
1286 paragraph.

1287 (b) The agency shall develop a procedure for determining  
1288 whether health care providers and service vendors can provide  
1289 the Medicaid program using a business case that demonstrates  
1290 whether a particular good or service can offset the cost of  
1291 providing the good or service in an alternative setting or  
1292 through other means and therefore should receive a higher  
1293 reimbursement. The business case must include, but need not be  
1294 limited to:

1295 1. A detailed description of the good or service to be  
1296 provided, a description and analysis of the agency's current  
1297 performance of the service, and a rationale documenting how  
1298 providing the service in an alternative setting would be in the  
1299 best interest of the state, the agency, and its clients.

1300 2. A cost-benefit analysis documenting the estimated  
1301 specific direct and indirect costs, savings, performance  
1302 improvements, risks, and qualitative and quantitative benefits  
1303 involved in or resulting from providing the service. The cost-  
1304 benefit analysis must include a detailed plan and timeline  
1305 identifying all actions that must be implemented to realize

20091986er

1306 expected benefits. The Secretary of Health Care Administration  
1307 shall verify that all costs, savings, and benefits are valid and  
1308 achievable.

1309 (c) If the agency determines that the increased  
1310 reimbursement is cost-effective, the agency shall recommend a  
1311 change in the reimbursement schedule for that particular good or  
1312 service. If, within 12 months after implementing any rate change  
1313 under this procedure, the agency determines that costs were not  
1314 offset by the increased reimbursement schedule, the agency may  
1315 revert to the former reimbursement schedule for the particular  
1316 good or service.

1317 (17) An entity contracting on a prepaid or fixed-sum basis  
1318 shall meet the, ~~in addition to meeting any applicable statutory~~  
1319 ~~surplus requirements of s. 641.225,~~ also maintain at all times  
1320 ~~in the form of cash, investments that mature in less than 180~~  
1321 ~~days allowable as admitted assets by the Office of Insurance~~  
1322 ~~Regulation, and restricted funds or deposits controlled by the~~  
1323 ~~agency or the Office of Insurance Regulation, a surplus amount~~  
1324 ~~equal to one and one-half times the entity's monthly Medicaid~~  
1325 ~~prepaid revenues. As used in this subsection, the term "surplus"~~  
1326 ~~means the entity's total assets minus total liabilities. If an~~  
1327 ~~entity's surplus falls below an amount equal to the surplus~~  
1328 ~~requirements of s. 641.225 one and one-half times the entity's~~  
1329 ~~monthly Medicaid prepaid revenues,~~ the agency shall prohibit the  
1330 entity from engaging in marketing and preenrollment activities,  
1331 shall cease to process new enrollments, and may ~~shall~~ not renew  
1332 the entity's contract until the required balance is achieved.  
1333 The requirements of this subsection do not apply:

1334 (a) Where a public entity agrees to fund any deficit

20091986er

1335 incurred by the contracting entity; or

1336 (b) Where the entity's performance and obligations are  
1337 guaranteed in writing by a guaranteeing organization which:

1338 1. Has been in operation for at least 5 years and has  
1339 assets in excess of \$50 million; or

1340 2. Submits a written guarantee acceptable to the agency  
1341 which is irrevocable during the term of the contracting entity's  
1342 contract with the agency and, upon termination of the contract,  
1343 until the agency receives proof of satisfaction of all  
1344 outstanding obligations incurred under the contract.

1345 Section 17. Section 409.91207, Florida Statutes, is created  
1346 to read:

1347 409.91207 Medical Home Pilot Project.-

1348 (1) The agency shall develop a plan to implement a medical  
1349 home pilot project that utilizes primary care case management  
1350 enhanced by medical home networks to provide coordinated and  
1351 cost-effective care that is reimbursed on a fee-for-service  
1352 basis and to compare the performance of the medical home  
1353 networks with other existing Medicaid managed care models. The  
1354 agency is authorized to seek a federal Medicaid waiver or an  
1355 amendment to any existing Medicaid waiver, except for the  
1356 current 1115 Medicaid waiver authorized in s. 409.91211, as  
1357 needed, to develop the pilot project created in this section but  
1358 must obtain approval of the Legislature prior to implementing  
1359 the pilot project.

1360 (2) Each medical home network shall:

1361 (a) Provide Medicaid recipients primary care, coordinated  
1362 services to control chronic illness, pharmacy services,  
1363 specialty physician services, and hospital outpatient and

20091986er

1364 inpatient services.

1365 (b) Coordinate with other health care providers, as  
1366 necessary, to ensure that Medicaid recipients receive efficient  
1367 and effective access to other needed medical services,  
1368 consistent with the scope of services provided to Medipass  
1369 recipients.

1370 (c) Consist of primary care physicians, federally qualified  
1371 health centers, clinics affiliated with Florida medical schools  
1372 or teaching hospitals, programs serving children with special  
1373 health care needs, medical school faculty, statutory teaching  
1374 hospitals, and other hospitals that agree to participate in the  
1375 network. A managed care organization is eligible to be  
1376 designated as a medical home network if it documents policies  
1377 and procedures consistent with subsection (3).

1378 (3) The medical home pilot project developed by the agency  
1379 must be designed to modify the processes and patterns of health  
1380 care service delivery in the Medicaid program by requiring a  
1381 medical home network to:

1382 (a) Assign a personal medical provider to lead an  
1383 interdisciplinary team of professionals who share the  
1384 responsibility for ongoing care to a specific panel of patients.

1385 (b) Require the personal medical provider to identify the  
1386 patient's health care needs and respond to those needs either  
1387 directly or through arrangements with other qualified providers.

1388 (c) Coordinate or integrate care across all parts of the  
1389 health care delivery system.

1390 (d) Integrate information technology into the health care  
1391 delivery system to enhance clinical performance and monitor  
1392 patient outcomes.



20091986er

1393       (4) The agency shall have the following duties, and  
1394 responsibilities with respect to the development of the medical  
1395 home pilot project:

1396       (a) To develop and recommend a medical home pilot project  
1397 in at least two geographic regions in the state that will  
1398 facilitate access to specialty services in the state's medical  
1399 schools and teaching hospitals.

1400       (b) To develop and recommend funding strategies that  
1401 maximize available state and federal funds, including:

1402       1. Enhanced primary care case management fees to  
1403 participating federally qualified health centers and primary  
1404 care clinics owned or operated by a medical school or teaching  
1405 hospital.

1406       2. Enhanced payments to participating medical schools  
1407 through the supplemental physician payment program using  
1408 certified funds.

1409       3. Reimbursement for facility costs, in addition to medical  
1410 services, for participating outpatient primary or specialty  
1411 clinics.

1412       4. Supplemental Medicaid payments through the low-income  
1413 pool and exempt fee-for-service rates for participating  
1414 hospitals.

1415       5. Enhanced capitation rates for managed care organizations  
1416 designated as medical home networks to reflect enhanced fee-for-  
1417 service payments to medical home network providers.

1418       (c) To develop and recommend criteria to designate medical  
1419 home networks as eligible to participate in the pilot program  
1420 and recommend incentives for medical home networks to  
1421 participate in the medical home pilot project, including bonus

20091986er

1422 payments and shared saving arrangements.

1423 (d) To develop a comprehensive fiscal estimate of the  
1424 medical home pilot project that includes, but is not limited to,  
1425 anticipated savings to the Medicaid program and any anticipated  
1426 administrative costs.

1427 (e) To develop and recommend which medical services the  
1428 medical home network would be responsible for providing to  
1429 enrolled Medicaid recipients.

1430 (f) To develop and recommend methodologies to measure the  
1431 performance of the medical home pilot project including patient  
1432 outcomes, cost-effectiveness, provider participation, recipient  
1433 satisfaction, and accountability to ensure the quality of the  
1434 medical care provided to Medicaid recipients enrolled in the  
1435 pilot.

1436 (g) To recommend policies and procedures for the medical  
1437 home pilot project administration including, but not limited to:  
1438 an implementation timeline, the Medicaid recipient enrollment  
1439 process, recruitment and enrollment of Medicaid providers, and  
1440 the reimbursement methodologies for participating Medicaid  
1441 providers.

1442 (h) To determine and recommend methods to evaluate the  
1443 medical home pilot project including but not limited to the  
1444 comparison of the Medicaid fee-for service system, Medipass  
1445 system, and other Medicaid managed care programs.

1446 (i) To develop and recommend standards and designation  
1447 requirements for a medical home network that include, but are  
1448 not limited to: medical care provided by the network, referral  
1449 arrangements, medical record requirements, health information  
1450 technology standards, follow-up care processes, and data

20091986er

1451 collection requirements.

1452 (5) The Secretary of Health Care Administration shall  
1453 appoint a task force by August 1, 2009, to assist the agency in  
1454 the development and implementation of the medical home pilot  
1455 project. The task force must include, but is not limited to,  
1456 representatives of providers who could potentially participate  
1457 in a medical home network, Medicaid recipients, and existing  
1458 Medipass and managed care providers. Members of the task force  
1459 shall serve without compensation but are entitled to  
1460 reimbursement for per diem and travel expenses as provided in s.  
1461 112.061.

1462 (6) The agency shall submit an implementation plan for the  
1463 medical home pilot project authorized in this section to the  
1464 Speaker of the House of Representatives, the President of the  
1465 Senate, and the Governor by February 1, 2010. The implementation  
1466 plan must include any approved waivers, waiver applications, or  
1467 state plan amendments necessary to implement the medical home  
1468 pilot project.

1469 (a) The agency shall post any waiver applications, or  
1470 waiver amendments, authorized under this section on its Internet  
1471 website 15 days before submitting the applications to the United  
1472 States Centers for Medicare and Medicaid Services.

1473 (b) The implementation of the medical home pilot project,  
1474 including any Medicaid waivers authorized in this section, is  
1475 contingent upon review and approval by the Legislature.

1476 (c) Upon legislative approval to implement the medical home  
1477 pilot project, the agency may initiate the adoption of  
1478 administrative rules to implement and administer the medical  
1479 home pilot project created in this section.

20091986er

1480 Section 18. Subsections (2), (7), (11), (13), (14), (15),  
1481 (24), (25), (27), (30), (31), and (36) of section 409.913,  
1482 Florida Statutes, are amended, and subsections (37) and (38) are  
1483 added to that section, to read:

1484 409.913 Oversight of the integrity of the Medicaid  
1485 program.—The agency shall operate a program to oversee the  
1486 activities of Florida Medicaid recipients, and providers and  
1487 their representatives, to ensure that fraudulent and abusive  
1488 behavior and neglect of recipients occur to the minimum extent  
1489 possible, and to recover overpayments and impose sanctions as  
1490 appropriate. Beginning January 1, 2003, and each year  
1491 thereafter, the agency and the Medicaid Fraud Control Unit of  
1492 the Department of Legal Affairs shall submit a joint report to  
1493 the Legislature documenting the effectiveness of the state's  
1494 efforts to control Medicaid fraud and abuse and to recover  
1495 Medicaid overpayments during the previous fiscal year. The  
1496 report must describe the number of cases opened and investigated  
1497 each year; the sources of the cases opened; the disposition of  
1498 the cases closed each year; the amount of overpayments alleged  
1499 in preliminary and final audit letters; the number and amount of  
1500 fines or penalties imposed; any reductions in overpayment  
1501 amounts negotiated in settlement agreements or by other means;  
1502 the amount of final agency determinations of overpayments; the  
1503 amount deducted from federal claiming as a result of  
1504 overpayments; the amount of overpayments recovered each year;  
1505 the amount of cost of investigation recovered each year; the  
1506 average length of time to collect from the time the case was  
1507 opened until the overpayment is paid in full; the amount  
1508 determined as uncollectible and the portion of the uncollectible

20091986er

1509 amount subsequently reclaimed from the Federal Government; the  
1510 number of providers, by type, that are terminated from  
1511 participation in the Medicaid program as a result of fraud and  
1512 abuse; and all costs associated with discovering and prosecuting  
1513 cases of Medicaid overpayments and making recoveries in such  
1514 cases. The report must also document actions taken to prevent  
1515 overpayments and the number of providers prevented from  
1516 enrolling in or reenrolling in the Medicaid program as a result  
1517 of documented Medicaid fraud and abuse and must include policy  
1518 recommendations ~~recommend changes~~ necessary to prevent or  
1519 recover overpayments and changes necessary to prevent and detect  
1520 Medicaid fraud. All policy recommendations in the report must  
1521 include a detailed fiscal analysis, including, but not limited  
1522 to, implementation costs, estimated savings to the Medicaid  
1523 program, and the return on investment. The agency must submit  
1524 the policy recommendations and fiscal analyses in the report to  
1525 the appropriate estimating conference, pursuant to s. 216.137,  
1526 by February 15 of each year. The agency and the Medicaid Fraud  
1527 Control Unit of the Department of Legal Affairs each must  
1528 include detailed unit-specific performance standards,  
1529 benchmarks, and metrics in the report, including projected cost  
1530 savings to the state Medicaid program during the following  
1531 fiscal year.

1532 (2) The agency shall conduct, or cause to be conducted by  
1533 contract or otherwise, reviews, investigations, analyses,  
1534 audits, or any combination thereof, to determine possible fraud,  
1535 abuse, overpayment, or recipient neglect in the Medicaid program  
1536 and shall report the findings of any overpayments in audit  
1537 reports as appropriate. At least 5 percent of all audits shall

20091986er

1538 be conducted on a random basis. As part of its ongoing fraud  
1539 detection activities, the agency shall identify and monitor, by  
1540 contract or otherwise, patterns of overutilization of Medicaid  
1541 services based on state averages. The agency shall track  
1542 Medicaid provider prescription and billing patterns and evaluate  
1543 them against Medicaid medical necessity criteria and coverage  
1544 and limitation guidelines adopted by rule. Medical necessity  
1545 determination requires that service be consistent with symptoms  
1546 or confirmed diagnosis of illness or injury under treatment and  
1547 not in excess of the patient's needs. The agency shall conduct  
1548 reviews of provider exceptions to peer group norms and shall,  
1549 using statistical methodologies, provider profiling, and  
1550 analysis of billing patterns, detect and investigate abnormal or  
1551 unusual increases in billing or payment of claims for Medicaid  
1552 services and medically unnecessary provision of services.

1553 (7) When presenting a claim for payment under the Medicaid  
1554 program, a provider has an affirmative duty to supervise the  
1555 provision of, and be responsible for, goods and services claimed  
1556 to have been provided, to supervise and be responsible for  
1557 preparation and submission of the claim, and to present a claim  
1558 that is true and accurate and that is for goods and services  
1559 that:

1560 (a) Have actually been furnished to the recipient by the  
1561 provider prior to submitting the claim.

1562 (b) Are Medicaid-covered goods or services that are  
1563 medically necessary.

1564 (c) Are of a quality comparable to those furnished to the  
1565 general public by the provider's peers.

1566 (d) Have not been billed in whole or in part to a recipient

20091986er

1567 or a recipient's responsible party, except for such copayments,  
1568 coinsurance, or deductibles as are authorized by the agency.

1569 (e) Are provided in accord with applicable provisions of  
1570 all Medicaid rules, regulations, handbooks, and policies and in  
1571 accordance with federal, state, and local law.

1572 (f) Are documented by records made at the time the goods or  
1573 services were provided, demonstrating the medical necessity for  
1574 the goods or services rendered. Medicaid goods or services are  
1575 excessive or not medically necessary unless both the medical  
1576 basis and the specific need for them are fully and properly  
1577 documented in the recipient's medical record.

1578  
1579 The agency shall ~~may~~ deny payment or require repayment for goods  
1580 or services that are not presented as required in this  
1581 subsection.

1582 (11) The agency shall ~~may~~ deny payment or require repayment  
1583 for inappropriate, medically unnecessary, or excessive goods or  
1584 services from the person furnishing them, the person under whose  
1585 supervision they were furnished, or the person causing them to  
1586 be furnished.

1587 (13) The agency shall immediately ~~may~~ terminate  
1588 participation of a Medicaid provider in the Medicaid program and  
1589 may seek civil remedies or impose other administrative sanctions  
1590 against a Medicaid provider, if the provider or any principal,  
1591 officer, director, agent, managing employee, or affiliated  
1592 person of the provider, or any partner or shareholder having an  
1593 ownership interest in the provider equal to 5 percent or  
1594 greater, has been:

1595 (a) Convicted of a criminal offense related to the delivery

20091986er

1596 of any health care goods or services, including the performance  
1597 of management or administrative functions relating to the  
1598 delivery of health care goods or services;

1599 (b) Convicted of a criminal offense under federal law or  
1600 the law of any state relating to the practice of the provider's  
1601 profession; or

1602 (c) Found by a court of competent jurisdiction to have  
1603 neglected or physically abused a patient in connection with the  
1604 delivery of health care goods or services.

1605  
1606 If the agency determines a provider did not participate or  
1607 acquiesce in an offense specified in paragraph (a), paragraph  
1608 (b), or paragraph (c), termination will not be imposed. If the  
1609 agency effects a termination under this subsection, the agency  
1610 shall issue an immediate final order pursuant to s.

1611 120.569(2)(n).

1612 (14) If the provider has been suspended or terminated from  
1613 participation in the Medicaid program or the Medicare program by  
1614 the Federal Government or any state, the agency must immediately  
1615 suspend or terminate, as appropriate, the provider's  
1616 participation in this state's ~~the Florida~~ Medicaid program for a  
1617 period no less than that imposed by the Federal Government or  
1618 any other state, and may not enroll such provider in this  
1619 state's ~~the Florida~~ Medicaid program while such foreign  
1620 suspension or termination remains in effect. The agency shall  
1621 also immediately suspend or terminate, as appropriate, a  
1622 provider's participation in this state's Medicaid program if the  
1623 provider participated or acquiesced in any action for which any  
1624 principal, officer, director, agent, managing employee, or



20091986er

1625 affiliated person of the provider, or any partner or shareholder  
1626 having an ownership interest in the provider equal to 5 percent  
1627 or greater, was suspended or terminated from participating in  
1628 the Medicaid program or the Medicare program by the Federal  
1629 Government or any state. This sanction is in addition to all  
1630 other remedies provided by law.

1631 (15) The agency shall ~~may~~ seek a ~~any~~ remedy provided by  
1632 law, including, but not limited to, any remedy ~~the remedies~~  
1633 provided in subsections (13) and (16) and s. 812.035, if:

1634 (a) The provider's license has not been renewed, or has  
1635 been revoked, suspended, or terminated, for cause, by the  
1636 licensing agency of any state;

1637 (b) The provider has failed to make available or has  
1638 refused access to Medicaid-related records to an auditor,  
1639 investigator, or other authorized employee or agent of the  
1640 agency, the Attorney General, a state attorney, or the Federal  
1641 Government;

1642 (c) The provider has not furnished or has failed to make  
1643 available such Medicaid-related records as the agency has found  
1644 necessary to determine whether Medicaid payments are or were due  
1645 and the amounts thereof;

1646 (d) The provider has failed to maintain medical records  
1647 made at the time of service, or prior to service if prior  
1648 authorization is required, demonstrating the necessity and  
1649 appropriateness of the goods or services rendered;

1650 (e) The provider is not in compliance with provisions of  
1651 Medicaid provider publications that have been adopted by  
1652 reference as rules in the Florida Administrative Code; with  
1653 provisions of state or federal laws, rules, or regulations; with

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1654 provisions of the provider agreement between the agency and the  
1655 provider; or with certifications found on claim forms or on  
1656 transmittal forms for electronically submitted claims that are  
1657 submitted by the provider or authorized representative, as such  
1658 provisions apply to the Medicaid program;

1659 (f) The provider or person who ordered or prescribed the  
1660 care, services, or supplies has furnished, or ordered the  
1661 furnishing of, goods or services to a recipient which are  
1662 inappropriate, unnecessary, excessive, or harmful to the  
1663 recipient or are of inferior quality;

1664 (g) The provider has demonstrated a pattern of failure to  
1665 provide goods or services that are medically necessary;

1666 (h) The provider or an authorized representative of the  
1667 provider, or a person who ordered or prescribed the goods or  
1668 services, has submitted or caused to be submitted false or a  
1669 pattern of erroneous Medicaid claims;

1670 (i) The provider or an authorized representative of the  
1671 provider, or a person who has ordered or prescribed the goods or  
1672 services, has submitted or caused to be submitted a Medicaid  
1673 provider enrollment application, a request for prior  
1674 authorization for Medicaid services, a drug exception request,  
1675 or a Medicaid cost report that contains materially false or  
1676 incorrect information;

1677 (j) The provider or an authorized representative of the  
1678 provider has collected from or billed a recipient or a  
1679 recipient's responsible party improperly for amounts that should  
1680 not have been so collected or billed by reason of the provider's  
1681 billing the Medicaid program for the same service;

1682 (k) The provider or an authorized representative of the

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1683 provider has included in a cost report costs that are not  
1684 allowable under a Florida Title XIX reimbursement plan, after  
1685 the provider or authorized representative had been advised in an  
1686 audit exit conference or audit report that the costs were not  
1687 allowable;

1688 (l) The provider is charged by information or indictment  
1689 with fraudulent billing practices. The sanction applied for this  
1690 reason is limited to suspension of the provider's participation  
1691 in the Medicaid program for the duration of the indictment  
1692 unless the provider is found guilty pursuant to the information  
1693 or indictment;

1694 (m) The provider or a person who has ordered, or prescribed  
1695 the goods or services is found liable for negligent practice  
1696 resulting in death or injury to the provider's patient;

1697 (n) The provider fails to demonstrate that it had available  
1698 during a specific audit or review period sufficient quantities  
1699 of goods, or sufficient time in the case of services, to support  
1700 the provider's billings to the Medicaid program;

1701 (o) The provider has failed to comply with the notice and  
1702 reporting requirements of s. 409.907;

1703 (p) The agency has received reliable information of patient  
1704 abuse or neglect or of any act prohibited by s. 409.920; or

1705 (q) The provider has failed to comply with an agreed-upon  
1706 repayment schedule.

1707  
1708 A provider is subject to sanctions for violations of this  
1709 subsection as the result of actions or inactions of the  
1710 provider, or actions or inactions of any principal, officer,  
1711 director, agent, managing employee, or affiliated person of the

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1712 provider, or any partner or shareholder having an ownership  
1713 interest in the provider equal to 5 percent or greater, in which  
1714 the provider participated or acquiesced.

1715 (24) If the agency imposes an administrative sanction  
1716 pursuant to subsection (13), subsection (14), or subsection  
1717 (15), except paragraphs (15) (e) and (o), upon any provider or  
1718 any principal, officer, director, agent, managing employee, or  
1719 affiliated person of the provider ~~other person~~ who is regulated  
1720 by another state entity, the agency shall notify that other  
1721 entity of the imposition of the sanction within 5 business days.  
1722 Such notification must include the provider's or person's name  
1723 and license number and the specific reasons for sanction.

1724 (25) (a) The agency shall ~~may~~ withhold Medicaid payments, in  
1725 whole or in part, to a provider upon receipt of reliable  
1726 evidence that the circumstances giving rise to the need for a  
1727 withholding of payments involve fraud, willful  
1728 misrepresentation, or abuse under the Medicaid program, or a  
1729 crime committed while rendering goods or services to Medicaid  
1730 recipients. If it is determined that fraud, willful  
1731 misrepresentation, abuse, or a crime did not occur, the payments  
1732 withheld must be paid to the provider within 14 days after such  
1733 determination with interest at the rate of 10 percent a year.  
1734 Any money withheld in accordance with this paragraph shall be  
1735 placed in a suspended account, readily accessible to the agency,  
1736 so that any payment ultimately due the provider shall be made  
1737 within 14 days.

1738 (b) The agency shall ~~may~~ deny payment, or require  
1739 repayment, if the goods or services were furnished, supervised,  
1740 or caused to be furnished by a person who has been suspended or

20091986er

1741 terminated from the Medicaid program or Medicare program by the  
1742 Federal Government or any state.

1743 (c) Overpayments owed to the agency bear interest at the  
1744 rate of 10 percent per year from the date of determination of  
1745 the overpayment by the agency, and payment arrangements must be  
1746 made at the conclusion of legal proceedings. A provider who does  
1747 not enter into or adhere to an agreed-upon repayment schedule  
1748 may be terminated by the agency for nonpayment or partial  
1749 payment.

1750 (d) The agency, upon entry of a final agency order, a  
1751 judgment or order of a court of competent jurisdiction, or a  
1752 stipulation or settlement, may collect the moneys owed by all  
1753 means allowable by law, including, but not limited to, notifying  
1754 any fiscal intermediary of Medicare benefits that the state has  
1755 a superior right of payment. Upon receipt of such written  
1756 notification, the Medicare fiscal intermediary shall remit to  
1757 the state the sum claimed.

1758 (e) The agency may institute amnesty programs to allow  
1759 Medicaid providers the opportunity to voluntarily repay  
1760 overpayments. The agency may adopt rules to administer such  
1761 programs.

1762 (27) When the Agency for Health Care Administration has  
1763 made a probable cause determination and alleged that an  
1764 overpayment to a Medicaid provider has occurred, the agency,  
1765 after notice to the provider, shall ~~may~~:

1766 (a) Withhold, and continue to withhold during the pendency  
1767 of an administrative hearing pursuant to chapter 120, any  
1768 medical assistance reimbursement payments until such time as the  
1769 overpayment is recovered, unless within 30 days after receiving

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1770 notice thereof the provider:

1771 1. Makes repayment in full; or

1772 2. Establishes a repayment plan that is satisfactory to the  
1773 Agency for Health Care Administration.

1774 (b) Withhold, and continue to withhold during the pendency  
1775 of an administrative hearing pursuant to chapter 120, medical  
1776 assistance reimbursement payments if the terms of a repayment  
1777 plan are not adhered to by the provider.

1778 (30) The agency shall ~~may~~ terminate a provider's  
1779 participation in the Medicaid program if the provider fails to  
1780 reimburse an overpayment that has been determined by final  
1781 order, not subject to further appeal, within 35 days after the  
1782 date of the final order, unless the provider and the agency have  
1783 entered into a repayment agreement.

1784 (31) If a provider requests an administrative hearing  
1785 pursuant to chapter 120, such hearing must be conducted within  
1786 90 days following assignment of an administrative law judge,  
1787 absent exceptionally good cause shown as determined by the  
1788 administrative law judge or hearing officer. Upon issuance of a  
1789 final order, the outstanding balance of the amount determined to  
1790 constitute the overpayment shall become due. If a provider fails  
1791 to make payments in full, fails to enter into a satisfactory  
1792 repayment plan, or fails to comply with the terms of a repayment  
1793 plan or settlement agreement, the agency shall ~~may~~ withhold  
1794 medical assistance reimbursement payments until the amount due  
1795 is paid in full.

1796 (36) At least three times a year, the agency shall provide  
1797 to each Medicaid recipient or his or her representative an  
1798 explanation of benefits in the form of a letter that is mailed

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1799 to the most recent address of the recipient on the record with  
1800 the Department of Children and Family Services. The explanation  
1801 of benefits must include the patient's name, the name of the  
1802 health care provider and the address of the location where the  
1803 service was provided, a description of all services billed to  
1804 Medicaid in terminology that should be understood by a  
1805 reasonable person, and information on how to report  
1806 inappropriate or incorrect billing to the agency or other law  
1807 enforcement entities for review or investigation. At least once  
1808 a year, the letter also must include information on how to  
1809 report criminal Medicaid fraud, the Medicaid Fraud Control  
1810 Unit's toll-free hotline number, and information about the  
1811 rewards available under s. 409.9203. The explanation of benefits  
1812 may not be mailed for Medicaid independent laboratory services  
1813 as described in s. 409.905(7) or for Medicaid certified match  
1814 services as described in ss. 409.9071 and 1011.70.

1815 (37) The agency shall post on its website a current list of  
1816 each Medicaid provider, including any principal, officer,  
1817 director, agent, managing employee, or affiliated person of the  
1818 provider, or any partner or shareholder having an ownership  
1819 interest in the provider equal to 5 percent or greater, who has  
1820 been terminated for cause from the Medicaid program or  
1821 sanctioned under this section. The list must be searchable by a  
1822 variety of search parameters and provide for the creation of  
1823 formatted lists that may be printed or imported into other  
1824 applications, including spreadsheets. The agency shall update  
1825 the list at least monthly.

1826 (38) In order to improve the detection of health care  
1827 fraud, use technology to prevent and detect fraud, and maximize

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1828 the electronic exchange of health care fraud information, the  
1829 agency shall:

1830 (a) Compile, maintain, and publish on its website a  
1831 detailed list of all state and federal databases that contain  
1832 health care fraud information and update the list at least  
1833 biannually;

1834 (b) Develop a strategic plan to connect all databases that  
1835 contain health care fraud information to facilitate the  
1836 electronic exchange of health information between the agency,  
1837 the Department of Health, the Department of Law Enforcement, and  
1838 the Attorney General's Office. The plan must include recommended  
1839 standard data formats, fraud-identification strategies, and  
1840 specifications for the technical interface between state and  
1841 federal health care fraud databases;

1842 (c) Monitor innovations in health information technology,  
1843 specifically as it pertains to Medicaid fraud prevention and  
1844 detection; and

1845 (d) Periodically publish policy briefs that highlight  
1846 available new technology to prevent or detect health care fraud  
1847 and projects implemented by other states, the private sector, or  
1848 the Federal Government which use technology to prevent or detect  
1849 health care fraud.

1850 Section 19. Subsections (1) and (2) of section 409.920,  
1851 Florida Statutes, are amended, present subsections (8) and (9)  
1852 of that section are renumbered as subsections (9) and (10),  
1853 respectively, and a new subsection (8) is added to that section,  
1854 to read:

1855 409.920 Medicaid provider fraud.—

1856 (1) For the purposes of this section, the term:



20091986er

1857 (a) "Agency" means the Agency for Health Care  
1858 Administration.

1859 (b) "Fiscal agent" means any individual, firm, corporation,  
1860 partnership, organization, or other legal entity that has  
1861 contracted with the agency to receive, process, and adjudicate  
1862 claims under the Medicaid program.

1863 (c) "Item or service" includes:

1864 1. Any particular item, device, medical supply, or service  
1865 claimed to have been provided to a recipient and listed in an  
1866 itemized claim for payment; or

1867 2. In the case of a claim based on costs, any entry in the  
1868 cost report, books of account, or other documents supporting  
1869 such claim.

1870 (d) "Knowingly" means that the act was done voluntarily and  
1871 intentionally and not because of mistake or accident. As used in  
1872 this section, the term "knowingly" also includes the word  
1873 "willfully" or "willful" which, as used in this section, means  
1874 that an act was committed voluntarily and purposely, with the  
1875 specific intent to do something that the law forbids, and that  
1876 the act was committed with bad purpose, either to disobey or  
1877 disregard the law.

1878 (e) "Managed care plans" means a health insurer authorized  
1879 under chapter 624, an exclusive provider organization authorized  
1880 under chapter 627, a health maintenance organization authorized  
1881 under chapter 641, the Children's Medical Services Network  
1882 authorized under chapter 391, a prepaid health plan authorized  
1883 under chapter 409, a provider service network authorized under  
1884 chapter 409, a minority physician network authorized under  
1885 chapter 409, and an emergency department diversion program

20091986er

1886 authorized under chapter 409 or the General Appropriations Act,  
1887 providing health care services pursuant to a contract with the  
1888 Medicaid program.

1889 (2) (a) A person may not ~~It is unlawful to:~~

1890 1. (a) Knowingly make, cause to be made, or aid and abet in  
1891 the making of any false statement or false representation of a  
1892 material fact, by commission or omission, in any claim submitted  
1893 to the agency or its fiscal agent or a managed care plan for  
1894 payment.

1895 2. (b) Knowingly make, cause to be made, or aid and abet in  
1896 the making of a claim for items or services that are not  
1897 authorized to be reimbursed by the Medicaid program.

1898 3. (c) Knowingly charge, solicit, accept, or receive  
1899 anything of value, other than an authorized copayment from a  
1900 Medicaid recipient, from any source in addition to the amount  
1901 legally payable for an item or service provided to a Medicaid  
1902 recipient under the Medicaid program or knowingly fail to credit  
1903 the agency or its fiscal agent for any payment received from a  
1904 third-party source.

1905 4. (d) Knowingly make or in any way cause to be made any  
1906 false statement or false representation of a material fact, by  
1907 commission or omission, in any document containing items of  
1908 income and expense that is or may be used by the agency to  
1909 determine a general or specific rate of payment for an item or  
1910 service provided by a provider.

1911 5. (e) Knowingly solicit, offer, pay, or receive any  
1912 remuneration, including any kickback, bribe, or rebate, directly  
1913 or indirectly, overtly or covertly, in cash or in kind, in  
1914 return for referring an individual to a person for the

20091986er

1915 furnishing or arranging for the furnishing of any item or  
1916 service for which payment may be made, in whole or in part,  
1917 under the Medicaid program, or in return for obtaining,  
1918 purchasing, leasing, ordering, or arranging for or recommending,  
1919 obtaining, purchasing, leasing, or ordering any goods, facility,  
1920 item, or service, for which payment may be made, in whole or in  
1921 part, under the Medicaid program.

1922 6.~~(f)~~ Knowingly submit false or misleading information or  
1923 statements to the Medicaid program for the purpose of being  
1924 accepted as a Medicaid provider.

1925 7.~~(g)~~ Knowingly use or endeavor to use a Medicaid  
1926 provider's identification number or a Medicaid recipient's  
1927 identification number to make, cause to be made, or aid and abet  
1928 in the making of a claim for items or services that are not  
1929 authorized to be reimbursed by the Medicaid program.

1930 (b)1. A person who violates this subsection and receives or  
1931 endeavors to receive anything of value of:

1932 a. Ten thousand dollars or less commits a felony of the  
1933 third degree, punishable as provided in s. 775.082, s. 775.083,  
1934 or s. 775.084.

1935 b. More than \$10,000, but less than \$50,000, commits a  
1936 felony of the second degree, punishable as provided in s.  
1937 775.082, s. 775.083, or s. 775.084.

1938 c. Fifty thousand dollars or more commits a felony of the  
1939 first degree, punishable as provided in s. 775.082, s. 775.083,  
1940 or s. 775.084.

1941 2. The value of separate funds, goods, or services that a  
1942 person received or attempted to receive pursuant to a scheme or  
1943 course of conduct may be aggregated in determining the degree of

20091986er

1944 the offense.

1945 3. In addition to the sentence authorized by law, a person  
1946 who is convicted of a violation of this subsection shall pay a  
1947 fine in an amount equal to five times the pecuniary gain  
1948 unlawfully received or the loss incurred by the Medicaid program  
1949 or managed care organization, whichever is greater.

1950 (8) A person who provides the state, any state agency, any  
1951 of the state's political subdivisions, or any agency of the  
1952 state's political subdivisions with information about fraud or  
1953 suspected fraud by a Medicaid provider, including a managed care  
1954 organization, is immune from civil liability for providing the  
1955 information unless the person acted with knowledge that the  
1956 information was false or with reckless disregard for the truth  
1957 or falsity of the information.

1958 Section 20. Section 409.9203, Florida Statutes, is created  
1959 to read:

1960 409.9203 Rewards for reporting Medicaid fraud.-

1961 (1) The Department of Law Enforcement or director of the  
1962 Medicaid Fraud Control Unit shall, subject to availability of  
1963 funds, pay a reward to a person who furnishes original  
1964 information relating to and reports a violation of the state's  
1965 Medicaid fraud laws, unless the person declines the reward, if  
1966 the information and report:

1967 (a) Is made to the Office of the Attorney General, the  
1968 Agency for Health Care Administration, the Department of Health,  
1969 or the Department of Law Enforcement;

1970 (b) Relates to criminal fraud upon Medicaid funds or a  
1971 criminal violation of Medicaid laws by another person; and

1972 (c) Leads to a recovery of a fine, penalty, or forfeiture

20091986er

1973 of property.

1974 (2) The reward may not exceed the lesser of 25 percent of  
1975 the amount recovered or \$500,000 in a single case.

1976 (3) The reward shall be paid from the Legal Affairs  
1977 Revolving Trust Fund from moneys collected pursuant to s.  
1978 68.085.

1979 (4) A person who receives a reward pursuant to this section  
1980 is not eligible to receive any funds pursuant to the Florida  
1981 False Claims Act for Medicaid fraud for which a reward is  
1982 received pursuant to this section.

1983 Section 21. Subsection (11) is added to section 456.004,  
1984 Florida Statutes, to read:

1985 456.004 Department; powers and duties.—The department, for  
1986 the professions under its jurisdiction, shall:

1987 (11) Work cooperatively with the Agency for Health Care  
1988 Administration and the judicial system to recover Medicaid  
1989 overpayments by the Medicaid program. The department shall  
1990 investigate and prosecute health care practitioners who have not  
1991 remitted amounts owed to the state for an overpayment from the  
1992 Medicaid program pursuant to a final order, judgment, or  
1993 stipulation or settlement.

1994 Section 22. Present subsections (6) through (10) of section  
1995 456.041, Florida Statutes, are renumbered as subsections (7)  
1996 through (11), respectively, and a new subsection (6) is added to  
1997 that section, to read:

1998 456.041 Practitioner profile; creation.—

1999 (6) The Department of Health shall provide in each  
2000 practitioner profile for every physician or advanced registered  
2001 nurse practitioner terminated for cause from participating in

20091986er

2002 the Medicaid program, pursuant to s. 409.913, or sanctioned by  
2003 the Medicaid program a statement that the practitioner has been  
2004 terminated from participating in the Florida Medicaid program or  
2005 sanctioned by the Medicaid program.

2006 Section 23. Paragraph (o) of subsection (3) of section  
2007 456.053, Florida Statutes, is amended to read:

2008 456.053 Financial arrangements between referring health  
2009 care providers and providers of health care services.—

2010 (3) DEFINITIONS.—For the purpose of this section, the word,  
2011 phrase, or term:

2012 (o) "Referral" means any referral of a patient by a health  
2013 care provider for health care services, including, without  
2014 limitation:

2015 1. The forwarding of a patient by a health care provider to  
2016 another health care provider or to an entity which provides or  
2017 supplies designated health services or any other health care  
2018 item or service; or

2019 2. The request or establishment of a plan of care by a  
2020 health care provider, which includes the provision of designated  
2021 health services or other health care item or service.

2022 3. The following orders, recommendations, or plans of care  
2023 shall not constitute a referral by a health care provider:

2024 a. By a radiologist for diagnostic-imaging services.

2025 b. By a physician specializing in the provision of  
2026 radiation therapy services for such services.

2027 c. By a medical oncologist for drugs and solutions to be  
2028 prepared and administered intravenously to such oncologist's  
2029 patient, as well as for the supplies and equipment used in  
2030 connection therewith to treat such patient for cancer and the

20091986er

2031 complications thereof.

2032 d. By a cardiologist for cardiac catheterization services.

2033 e. By a pathologist for diagnostic clinical laboratory  
2034 tests and pathological examination services, if furnished by or  
2035 under the supervision of such pathologist pursuant to a  
2036 consultation requested by another physician.

2037 f. By a health care provider who is the sole provider or  
2038 member of a group practice for designated health services or  
2039 other health care items or services that are prescribed or  
2040 provided solely for such referring health care provider's or  
2041 group practice's own patients, and that are provided or  
2042 performed by or under the direct supervision of such referring  
2043 health care provider or group practice; provided, however, that  
2044 effective July 1, 1999, a physician licensed pursuant to chapter  
2045 458, chapter 459, chapter 460, or chapter 461 may refer a  
2046 patient to a sole provider or group practice for diagnostic  
2047 imaging services, excluding radiation therapy services, for  
2048 which the sole provider or group practice billed both the  
2049 technical and the professional fee for or on behalf of the  
2050 patient, if the referring physician has no investment interest  
2051 in the practice. The diagnostic imaging service referred to a  
2052 group practice or sole provider must be a diagnostic imaging  
2053 service normally provided within the scope of practice to the  
2054 patients of the group practice or sole provider. The group  
2055 practice or sole provider may accept no more than 15 percent of  
2056 their patients receiving diagnostic imaging services from  
2057 outside referrals, excluding radiation therapy services.

2058 g. By a health care provider for services provided by an  
2059 ambulatory surgical center licensed under chapter 395.

20091986er

2060 h. By a urologist for lithotripsy services.

2061 i. By a dentist for dental services performed by an  
2062 employee of or health care provider who is an independent  
2063 contractor with the dentist or group practice of which the  
2064 dentist is a member.

2065 j. By a physician for infusion therapy services to a  
2066 patient of that physician or a member of that physician's group  
2067 practice.

2068 k. By a nephrologist for renal dialysis services and  
2069 supplies, except laboratory services.

2070 l. By a health care provider whose principal professional  
2071 practice consists of treating patients in their private  
2072 residences for services to be rendered in such private  
2073 residences, except for services rendered by a home health agency  
2074 licensed under chapter 400. For purposes of this sub-  
2075 subparagraph, the term "private residences" includes patient's  
2076 private homes, independent living centers, and assisted living  
2077 facilities, but does not include skilled nursing facilities.

2078 m. By a health care provider for sleep related testing.

2079 Section 24. Section 456.0635, Florida Statutes, is created  
2080 to read:

2081 456.0635 Medicaid fraud; disqualification for license,  
2082 certificate, or registration.—

2083 (1) Medicaid fraud in the practice of a health care  
2084 profession is prohibited.

2085 (2) Each board within the jurisdiction of the department,  
2086 or the department if there is no board, shall refuse to admit a  
2087 candidate to any examination and refuse to issue or renew a  
2088 license, certificate, or registration to any applicant if the



20091986er

2089 candidate or applicant or any principle, officer, agent,  
2090 managing employee, or affiliated person of the applicant, has  
2091 been:

2092 (a) Convicted of, or entered a plea of guilty or nolo  
2093 contendere to, regardless of adjudication, a felony under  
2094 chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or  
2095 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent  
2096 period of probation for such conviction or pleas ended more than  
2097 fifteen years prior to the date of the application;

2098 (b) Terminated for cause from the Florida Medicaid program  
2099 pursuant to s. 409.913, unless the applicant has been in good  
2100 standing with the Florida Medicaid program for the most recent  
2101 five years;

2102 (c) Terminated for cause, pursuant to the appeals  
2103 procedures established by the state or Federal Government, from  
2104 any other state Medicaid program or the federal Medicare  
2105 program, unless the applicant has been in good standing with a  
2106 state Medicaid program or the federal Medicare program for the  
2107 most recent five years and the termination occurred at least 20  
2108 years prior to the date of the application.

2109 (3) Licensed health care practitioners shall report  
2110 allegations of Medicaid fraud to the department, regardless of  
2111 the practice setting in which the alleged Medicaid fraud  
2112 occurred.

2113 (4) The acceptance by a licensing authority of a  
2114 candidate's relinquishment of a license which is offered in  
2115 response to or anticipation of the filing of administrative  
2116 charges alleging Medicaid fraud or similar charges constitutes  
2117 the permanent revocation of the license.

20091986er

2118 Section 25. Paragraphs (ii), (jj), (kk), and (ll) are added  
2119 to subsection (1) of section 456.072, Florida Statutes, to read:

2120 456.072 Grounds for discipline; penalties; enforcement.—

2121 (1) The following acts shall constitute grounds for which  
2122 the disciplinary actions specified in subsection (2) may be  
2123 taken:

2124 (ii) Being convicted of, or entering a plea of guilty or  
2125 nolo contendere to, any misdemeanor or felony, regardless of  
2126 adjudication, under 18 U.S.C. s. 669, ss. 285-287, s. 371, s.  
2127 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518,  
2128 or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.

2129 (jj) Failing to remit the sum owed to the state for an  
2130 overpayment from the Medicaid program pursuant to a final order,  
2131 judgment, or stipulation or settlement.

2132 (kk) Being terminated from the state Medicaid program  
2133 pursuant to s. 409.913, any other state Medicaid program, or the  
2134 federal Medicare program, unless eligibility to participate in  
2135 the program from which the practitioner was terminated has been  
2136 restored.

2137 (ll) Being convicted of, or entering a plea of guilty or  
2138 nolo contendere to, any misdemeanor or felony, regardless of  
2139 adjudication, a crime in any jurisdiction which relates to  
2140 health care fraud.

2141 Section 26. Subsection (1) of section 456.074, Florida  
2142 Statutes, is amended to read:

2143 456.074 Certain health care practitioners; immediate  
2144 suspension of license.—

2145 (1) The department shall issue an emergency order  
2146 suspending the license of any person licensed under chapter 458,

20091986er

2147 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,  
2148 chapter 464, chapter 465, chapter 466, or chapter 484 who pleads  
2149 guilty to, is convicted or found guilty of, or who enters a plea  
2150 of nolo contendere to, regardless of adjudication, to:

2151 (a) A felony under chapter 409, chapter 817, or chapter 893  
2152 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396;  
2153 or-

2154 (b) A misdemeanor or felony under 18 U.S.C. s. 669, ss.  
2155 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s.  
2156 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b, relating to the  
2157 Medicaid program.

2158 Section 27. Subsections (2) and (3) of section 465.022,  
2159 Florida Statutes, are amended, present subsections (4), (5),  
2160 (6), and (7) of that section are renumbered as subsections (5),  
2161 (6), (7), and (8), respectively, and a new subsection (4) is  
2162 added to that section, to read:

2163 465.022 Pharmacies; general requirements; fees.-

2164 (2) A pharmacy permit shall be issued only to a person who  
2165 is at least 18 years of age, a partnership whose partners are  
2166 all at least 18 years of age, or to a corporation that ~~which~~ is  
2167 registered pursuant to chapter 607 or chapter 617 whose  
2168 officers, directors, and shareholders are at least 18 years of  
2169 age.

2170 (3) Any person, partnership, or corporation before engaging  
2171 in the operation of a pharmacy shall file with the board a sworn  
2172 application on forms provided by the department.

2173 (a) An application for a pharmacy permit must include a set  
2174 of fingerprints from each person having an ownership interest of  
2175 5 percent or greater and from any person who, directly or

20091986er

2176 indirectly, manages, oversees, or controls the operation of the  
2177 applicant, including officers and members of the board of  
2178 directors of an applicant that is a corporation. The applicant  
2179 must provide payment in the application for the cost of state  
2180 and national criminal history records checks.

2181 1. For corporations having more than \$100 million of  
2182 business taxable assets in this state, in lieu of these  
2183 fingerprint requirements, the department shall require the  
2184 prescription department manager who will be directly involved in  
2185 the management and operation of the pharmacy to submit a set of  
2186 fingerprints.

2187 2. A representative of a corporation described in  
2188 subparagraph 1. satisfies the requirement to submit a set of his  
2189 or her fingerprints if the fingerprints are on file with the  
2190 department or the Agency for Health Care Administration, meet  
2191 the fingerprint specifications for submission by the Department  
2192 of Law Enforcement, and are available to the department.

2193 (b) The department shall submit the fingerprints provided  
2194 by the applicant to the Department of Law Enforcement for a  
2195 state criminal history records check. The Department of Law  
2196 Enforcement shall forward the fingerprints to the Federal Bureau  
2197 of Investigation for a national criminal history records check.

2198 (4) The department or board shall deny an application for a  
2199 pharmacy permit if the applicant or an affiliated person,  
2200 partner, officer, director, or prescription department manager  
2201 of the applicant has:

2202 (a) Obtained a permit by misrepresentation or fraud;

2203 (b) Attempted to procure, or has procured, a permit for any  
2204 other person by making, or causing to be made, any false

20091986er

2205 representation;

2206 (c) Been convicted of, or entered a plea of guilty or nolo  
2207 contendere to, regardless of adjudication, a crime in any  
2208 jurisdiction which relates to the practice of, or the ability to  
2209 practice, the profession of pharmacy;

2210 (d) Been convicted of, or entered a plea of guilty or nolo  
2211 contendere to, regardless of adjudication, a crime in any  
2212 jurisdiction which relates to health care fraud;

2213 (e) Been terminated for cause, pursuant to the appeals  
2214 procedures established by the state or Federal Government, from  
2215 any state Medicaid program or the federal Medicare program,  
2216 unless the applicant has been in good standing with a state  
2217 Medicaid program or the federal Medicare program for the most  
2218 recent five years and the termination occurred at least 20 years  
2219 ago; or

2220 (f) Dispensed any medicinal drug based upon a communication  
2221 that purports to be a prescription as defined by s. 465.003(14)  
2222 or s. 893.02 when the pharmacist knows or has reason to believe  
2223 that the purported prescription is not based upon a valid  
2224 practitioner-patient relationship that includes a documented  
2225 patient evaluation, including history and a physical examination  
2226 adequate to establish the diagnosis for which any drug is  
2227 prescribed and any other requirement established by board rule  
2228 under chapter 458, chapter 459, chapter 461, chapter 463,  
2229 chapter 464, or chapter 466.

2230 Section 28. Subsection (1) of section 465.023, Florida  
2231 Statutes, is amended to read:

2232 465.023 Pharmacy permittee; disciplinary action.—

2233 (1) The department or the board may revoke or suspend the

20091986er

2234 permit of any pharmacy permittee, and may fine, place on  
2235 probation, or otherwise discipline any pharmacy permittee if the  
2236 permittee, or any affiliated person, partner, officer, director,  
2237 or agent of the permittee, including a person fingerprinted  
2238 under s. 465.022(3), ~~who~~ has:

2239 (a) Obtained a permit by misrepresentation or fraud or  
2240 through an error of the department or the board;

2241 (b) Attempted to procure, or has procured, a permit for any  
2242 other person by making, or causing to be made, any false  
2243 representation;

2244 (c) Violated any of the requirements of this chapter or any  
2245 of the rules of the Board of Pharmacy; of chapter 499, known as  
2246 the "Florida Drug and Cosmetic Act"; of 21 U.S.C. ss. 301-392,  
2247 known as the "Federal Food, Drug, and Cosmetic Act"; of 21  
2248 U.S.C. ss. 821 et seq., known as the Comprehensive Drug Abuse  
2249 Prevention and Control Act; or of chapter 893;

2250 (d) Been convicted or found guilty, regardless of  
2251 adjudication, of a felony or any other crime involving moral  
2252 turpitude in any of the courts of this state, of any other  
2253 state, or of the United States; ~~or~~

2254 (e) Been convicted or disciplined by a regulatory agency of  
2255 the Federal Government or a regulatory agency of another state  
2256 for any offense that would constitute a violation of this  
2257 chapter;

2258 (f) Been convicted of, or entered a plea of guilty or nolo  
2259 contendere to, regardless of adjudication, a crime in any  
2260 jurisdiction which relates to the practice of, or the ability to  
2261 practice, the profession of pharmacy;

2262 (g) Been convicted of, or entered a plea of guilty or nolo

20091986er

2263 contendere to, regardless of adjudication, a crime in any  
2264 jurisdiction which relates to health care fraud; or

2265 (h)~~(e)~~ Dispensed any medicinal drug based upon a  
2266 communication that purports to be a prescription as defined by  
2267 s. 465.003(14) or s. 893.02 when the pharmacist knows or has  
2268 reason to believe that the purported prescription is not based  
2269 upon a valid practitioner-patient relationship that includes a  
2270 documented patient evaluation, including history and a physical  
2271 examination adequate to establish the diagnosis for which any  
2272 drug is prescribed and any other requirement established by  
2273 board rule under chapter 458, chapter 459, chapter 461, chapter  
2274 463, chapter 464, or chapter 466.

2275 Section 29. Section 825.103, Florida Statutes, is amended  
2276 to read:

2277 825.103 Exploitation of an elderly person or disabled  
2278 adult; penalties.—

2279 (1) "Exploitation of an elderly person or disabled adult"  
2280 means:

2281 (a) Knowingly, by deception or intimidation, obtaining or  
2282 using, or endeavoring to obtain or use, an elderly person's or  
2283 disabled adult's funds, assets, or property with the intent to  
2284 temporarily or permanently deprive the elderly person or  
2285 disabled adult of the use, benefit, or possession of the funds,  
2286 assets, or property, or to benefit someone other than the  
2287 elderly person or disabled adult, by a person who:

2288 1. Stands in a position of trust and confidence with the  
2289 elderly person or disabled adult; or

2290 2. Has a business relationship with the elderly person or  
2291 disabled adult; ~~or~~

20091986er

2292 (b) Obtaining or using, endeavoring to obtain or use, or  
2293 conspiring with another to obtain or use an elderly person's or  
2294 disabled adult's funds, assets, or property with the intent to  
2295 temporarily or permanently deprive the elderly person or  
2296 disabled adult of the use, benefit, or possession of the funds,  
2297 assets, or property, or to benefit someone other than the  
2298 elderly person or disabled adult, by a person who knows or  
2299 reasonably should know that the elderly person or disabled adult  
2300 lacks the capacity to consent; ~~or-~~

2301 (c) Breach of a fiduciary duty to an elderly person or  
2302 disabled adult by the person's guardian or agent under a power  
2303 of attorney which results in an unauthorized appropriation,  
2304 sale, or transfer of property.

2305 (2) (a) If the funds, assets, or property involved in the  
2306 exploitation of the elderly person or disabled adult is valued  
2307 at \$100,000 or more, the offender commits a felony of the first  
2308 degree, punishable as provided in s. 775.082, s. 775.083, or s.  
2309 775.084.

2310 (b) If the funds, assets, or property involved in the  
2311 exploitation of the elderly person or disabled adult is valued  
2312 at \$20,000 or more, but less than \$100,000, the offender commits  
2313 a felony of the second degree, punishable as provided in s.  
2314 775.082, s. 775.083, or s. 775.084.

2315 (c) If the funds, assets, or property involved in the  
2316 exploitation of an elderly person or disabled adult is valued at  
2317 less than \$20,000, the offender commits a felony of the third  
2318 degree, punishable as provided in s. 775.082, s. 775.083, or s.  
2319 775.084.

2320 Section 30. Paragraphs (g) and (i) of subsection (3) of



20091986er

2321 section 921.0022, Florida Statutes, are amended to read:  
2322 921.0022 Criminal Punishment Code; offense severity ranking  
2323 chart.—

2324 (3) OFFENSE SEVERITY RANKING CHART

2325 (g) LEVEL 7

Florida Felony

Statute Degree Description

2326 316.027(1)(b) 1st Accident involving death, failure to  
stop; leaving scene.

2327 316.193(3)(c)2. 3rd DUI resulting in serious bodily  
injury.

2328 316.1935(3)(b) 1st Causing serious bodily injury or  
death to another person; driving at  
high speed or with wanton disregard  
for safety while fleeing or  
attempting to elude law enforcement  
officer who is in a patrol vehicle  
with siren and lights activated.

2329 327.35(3)(c)2. 3rd Vessel BUI resulting in serious  
bodily injury.

2330 402.319(2) 2nd Misrepresentation and negligence or  
intentional act resulting in great  
bodily harm, permanent disfigurement,  
permanent disability, or death.

20091986er

2331	409.920 (2) <u>(b) 1.a.</u>	3rd	Medicaid provider fraud; <u>\$10,000 or less.</u>
2332	<u>409.920 (2) (b) 1.b.</u>	<u>2nd</u>	<u>Medicaid provider fraud; more than \$10,000, but less than \$50,000.</u>
2333	456.065 (2)	3rd	Practicing a health care profession without a license.
2334	456.065 (2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
2335	458.327 (1)	3rd	Practicing medicine without a license.
2336	459.013 (1)	3rd	Practicing osteopathic medicine without a license.
2337	460.411 (1)	3rd	Practicing chiropractic medicine without a license.
2338	461.012 (1)	3rd	Practicing podiatric medicine without a license.
2339	462.17	3rd	Practicing naturopathy without a license.
2340			

20091986er

2341	463.015 (1)	3rd	Practicing optometry without a license.
2342	464.016 (1)	3rd	Practicing nursing without a license.
2343	465.015 (2)	3rd	Practicing pharmacy without a license.
2344	466.026 (1)	3rd	Practicing dentistry or dental hygiene without a license.
2345	467.201	3rd	Practicing midwifery without a license.
2346	468.366	3rd	Delivering respiratory care services without a license.
2347	483.828 (1)	3rd	Practicing as clinical laboratory personnel without a license.
2348	483.901 (9)	3rd	Practicing medical physics without a license.
2349	484.013 (1) (c)	3rd	Preparing or dispensing optical devices without a prescription.
2350	484.053	3rd	Dispensing hearing aids without a license.

20091986er

2351	494.0018(2)	1st	Conviction of any violation of ss. 494.001-494.0077 in which the total money and property unlawfully obtained exceeded \$50,000 and there were five or more victims.
2352	560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding \$300 but less than \$20,000 by a money services business.
2353	560.125(5)(a)	3rd	Money services business by unauthorized person, currency or payment instruments exceeding \$300 but less than \$20,000.
2354	655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding \$300 but less than \$20,000 by financial institution.
2355	775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver's license or identification card; other registration violations.
2356	775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.

20091986er

2357	775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.
2358	782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
2359	782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
2360	782.071	2nd	Killing of a human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide).
2361	782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
2362	784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
2363	784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.

20091986er

2364	784.045 (1) (b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
2365	784.048 (4)	3rd	Aggravated stalking; violation of injunction or court order.
2366	784.048 (7)	3rd	Aggravated stalking; violation of court order.
2367	784.07 (2) (d)	1st	Aggravated battery on law enforcement officer.
2368	784.074 (1) (a)	1st	Aggravated battery on sexually violent predators facility staff.
2369	784.08 (2) (a)	1st	Aggravated battery on a person 65 years of age or older.
2370	784.081 (1)	1st	Aggravated battery on specified official or employee.
2371	784.082 (1)	1st	Aggravated battery by detained person on visitor or other detainee.
2372	784.083 (1)	1st	Aggravated battery on code inspector.
	790.07 (4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).

20091986er

2373	790.16(1)	1st	Discharge of a machine gun under specified circumstances.
2374	790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
2375	790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
2376	790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
2377	790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
2378	790.23	1st, PBL	Possession of a firearm by a person who qualifies for the penalty enhancements provided for in s. 874.04.
2379	794.08(4)	3rd	Female genital mutilation; consent by a parent, guardian, or a person in custodial authority to a victim

20091986er

2380			younger than 18 years of age.
2380	796.03	2nd	Procuring any person under 16 years for prostitution.
2381			
2381	800.04 (5) (c) 1.	2nd	Lewd or lascivious molestation; victim less than 12 years of age; offender less than 18 years.
2382			
2382	800.04 (5) (c) 2.	2nd	Lewd or lascivious molestation; victim 12 years of age or older but less than 16 years; offender 18 years or older.
2383			
2383	806.01 (2)	2nd	Maliciously damage structure by fire or explosive.
2384			
2384	810.02 (3) (a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
2385			
2385	810.02 (3) (b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
2386			
2386	810.02 (3) (d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
2387			
2387	810.02 (3) (e)	2nd	Burglary of authorized emergency vehicle.
2388			



20091986er

2389	812.014 (2) (a) 1.	1st	Property stolen, valued at \$100,000 or more or a semitrailer deployed by a law enforcement officer; property stolen while causing other property damage; 1st degree grand theft.
2390	812.014 (2) (b) 2.	2nd	Property stolen, cargo valued at less than \$50,000, grand theft in 2nd degree.
2391	812.014 (2) (b) 3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
2392	812.014 (2) (b) 4.	2nd	Property stolen, law enforcement equipment from authorized emergency vehicle.
2393	812.0145 (2) (a)	1st	Theft from person 65 years of age or older; \$50,000 or more.
2394	812.019 (2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
2395	812.131 (2) (a)	2nd	Robbery by sudden snatching.
	812.133 (2) (b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.

20091986er

2396	817.234 (8) (a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
2397	817.234 (9)	2nd	Organizing, planning, or participating in an intentional motor vehicle collision.
2398	817.234 (11) (c)	1st	Insurance fraud; property value \$100,000 or more.
2399	817.2341 (2) (b) & (3) (b)	1st	Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity which are a significant cause of the insolvency of that entity.
2400	825.102 (3) (b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.
2401	825.103 (2) (b)	2nd	Exploiting an elderly person or disabled adult and property is valued at \$20,000 or more, but less than \$100,000.
2402	827.03 (3) (b)	2nd	Neglect of a child causing great

20091986er

			bodily harm, disability, or disfigurement.
2403	827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
2404	837.05(2)	3rd	Giving false information about alleged capital felony to a law enforcement officer.
2405	838.015	2nd	Bribery.
2406	838.016	2nd	Unlawful compensation or reward for official behavior.
2407	838.021(3)(a)	2nd	Unlawful harm to a public servant.
2408	838.22	2nd	Bid tampering.
2409	847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.
2410	847.0135(4)	2nd	Traveling to meet a minor to commit an unlawful sex act.
2411	872.06	2nd	Abuse of a dead human body.
2412			

20091986er

2413	874.10	1st,PBL	Knowingly initiates, organizes, plans, finances, directs, manages, or supervises criminal gang-related activity.
2414	893.13(1)(c)1.	1st	Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4.) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
2415	893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., within 1,000 feet of property used for religious services or a specified business site.
2416	893.13(4)(a)	1st	Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
2416	893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.

20091986er

2417	893.135(1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.
2418	893.135(1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams.
2419	893.135(1)(d)1.	1st	Trafficking in phencyclidine, more than 28 grams, less than 200 grams.
2420	893.135(1)(e)1.	1st	Trafficking in methaqualone, more than 200 grams, less than 5 kilograms.
2421	893.135(1)(f)1.	1st	Trafficking in amphetamine, more than 14 grams, less than 28 grams.
2422	893.135(1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
2423	893.135(1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
2424	893.135(1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.
2425	893.135(1)(k)2.a.	1st	Trafficking in Phenethylamines, 10

20091986er

2426			grams or more, less than 200 grams.
	893.1351(2)	2nd	Possession of place for trafficking in or manufacturing of controlled substance.
2427			
	896.101(5)(a)	3rd	Money laundering, financial transactions exceeding \$300 but less than \$20,000.
2428			
	896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding \$300 but less than \$20,000.
2429			
	943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.
2430			
	943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.
2431			
	943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.
2432			
	943.0435(13)	3rd	Failure to report or providing false information about a sexual offender;

20091986er

2433			harbor or conceal a sexual offender.
	943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
2434			
	944.607(9)	3rd	Sexual offender; failure to comply with reporting requirements.
2435			
	944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
2436			
	944.607(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
2437			
	944.607(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
2438			
	985.4815(10)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
2439			
	985.4815(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
2440			
	985.4815(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to

20091986er

address verification.

2441

2442

(i) LEVEL 9

Florida Felony

Statute Degree

Description

2443

316.193(3)(c)3.b. 1st DUI manslaughter; failing to render aid or give information.

2444

327.35(3)(c)3.b. 1st DUI manslaughter; failing to render aid or give information.

2445

409.920(2)(b)1.c. 1st Medicaid provider fraud; \$50,000 or more.

2446

499.0051(9) 1st Knowing sale or purchase of contraband prescription drugs resulting in great bodily harm.

2447

560.123(8)(b)3. 1st Failure to report currency or payment instruments totaling or exceeding \$100,000 by money transmitter.

2448

560.125(5)(c) 1st Money transmitter business by unauthorized person, currency, or payment instruments totaling or exceeding \$100,000.

2449

655.50(10)(b)3. 1st Failure to report financial



20091986er

transactions totaling or exceeding  
\$100,000 by financial institution.

2450

775.0844 1st Aggravated white collar crime.

2451

782.04(1) 1st Attempt, conspire, or solicit to commit  
premeditated murder.

2452

782.04(3) 1st,PBL Accomplice to murder in connection with  
arson, sexual battery, robbery,  
burglary, and other specified felonies.

2453

782.051(1) 1st Attempted felony murder while  
perpetrating or attempting to  
perpetrate a felony enumerated in s.  
782.04(3).

2454

782.07(2) 1st Aggravated manslaughter of an elderly  
person or disabled adult.

2455

787.01(1)(a)1. 1st,PBL Kidnapping; hold for ransom or reward  
or as a shield or hostage.

2456

787.01(1)(a)2. 1st,PBL Kidnapping with intent to commit or  
facilitate commission of any felony.

2457

787.01(1)(a)4. 1st,PBL Kidnapping with intent to interfere  
with performance of any governmental or  
political function.

20091986er

2458	787.02 (3) (a)	1st	False imprisonment; child under age 13; perpetrator also commits aggravated child abuse, sexual battery, or lewd or lascivious battery, molestation, conduct, or exhibition.
2459	790.161	1st	Attempted capital destructive device offense.
2460	790.166 (2)	1st, PBL	Possessing, selling, using, or attempting to use a weapon of mass destruction.
2461	794.011 (2)	1st	Attempted sexual battery; victim less than 12 years of age.
2462	794.011 (2)	Life	Sexual battery; offender younger than 18 years and commits sexual battery on a person less than 12 years.
2463	794.011 (4)	1st	Sexual battery; victim 12 years or older, certain circumstances.
2464	794.011 (8) (b)	1st	Sexual battery; engage in sexual conduct with minor 12 to 18 years by person in familial or custodial authority.
2465			

20091986er

2466	794.08(2)	1st	Female genital mutilation; victim younger than 18 years of age.
2467	800.04(5)(b)	Life	Lewd or lascivious molestation; victim less than 12 years; offender 18 years or older.
2468	812.13(2)(a)	1st,PBL	Robbery with firearm or other deadly weapon.
2469	812.133(2)(a)	1st,PBL	Carjacking; firearm or other deadly weapon.
2470	812.135(2)(b)	1st	Home-invasion robbery with weapon.
2471	817.568(7)	2nd,PBL	Fraudulent use of personal identification information of an individual under the age of 18 by his or her parent, legal guardian, or person exercising custodial authority.
2472	827.03(2)	1st	Aggravated child abuse.
2473	847.0145(1)	1st	Selling, or otherwise transferring custody or control, of a minor.
2474	847.0145(2)	1st	Purchasing, or otherwise obtaining custody or control, of a minor.

20091986er

2475 859.01 1st Poisoning or introducing bacteria,  
radioactive materials, viruses, or  
chemical compounds into food, drink,  
medicine, or water with intent to kill  
or injure another person.

2476 893.135 1st Attempted capital trafficking offense.

2477 893.135(1)(a)3. 1st Trafficking in cannabis, more than  
10,000 lbs.

2478 893.135(1)(b)1.c. 1st Trafficking in cocaine, more than 400  
grams, less than 150 kilograms.

2479 893.135(1)(c)1.c. 1st Trafficking in illegal drugs, more  
than 28 grams, less than 30 kilograms.

2480 893.135(1)(d)1.c. 1st Trafficking in phencyclidine, more  
than 400 grams.

2481 893.135(1)(e)1.c. 1st Trafficking in methaqualone, more than  
25 kilograms.

2482 893.135(1)(f)1.c. 1st Trafficking in amphetamine, more than  
200 grams.

2483 893.135(1)(h)1.c. 1st Trafficking in gamma-hydroxybutyric  
acid (GHB), 10 kilograms or more.

20091986er

2484 893.135(1)(j)1.c. 1st Trafficking in 1,4-Butanediol, 10  
kilograms or more.

2485 893.135(1)(k)2.c. 1st Trafficking in Phenethylamines, 400  
grams or more.

2486 896.101(5)(c) 1st Money laundering, financial instruments  
totaling or exceeding \$100,000.

2487 896.104(4)(a)3. 1st Structuring transactions to evade  
reporting or registration requirements,  
2488 financial transactions totaling or  
2489 exceeding \$100,000.

2487  
2488 Section 31. Pilot project to monitor home health services.-  
2489 The Agency for Health Care Administration shall develop and  
2490 implement a home health agency monitoring pilot project in  
2491 Miami-Dade County by January 1, 2010. The agency shall contract  
2492 with a vendor to verify the utilization and delivery of home  
2493 health services and provide an electronic billing interface for  
2494 home health services. The contract must require the creation of  
2495 a program to submit claims electronically for the delivery of  
2496 home health services. The program must verify telephonically  
2497 visits for the delivery of home health services using voice  
2498 biometrics. The agency may seek amendments to the Medicaid state  
2499 plan and waivers of federal laws, as necessary, to implement the  
2500 pilot project. Notwithstanding s. 287.057(5)(f), Florida  
2501 Statutes, the agency must award the contract through the  
2502 competitive solicitation process. The agency shall submit a

20091986er

2503 report to the Governor, the President of the Senate, and the  
2504 Speaker of the House of Representatives evaluating the pilot  
2505 project by February 1, 2011.

2506 Section 32. Pilot project for home health care management.-  
2507 The Agency for Health Care Administration shall implement a  
2508 comprehensive care management pilot project for home health  
2509 services by January 1, 2010, which includes face-to-face  
2510 assessments by a nurse licensed pursuant to chapter 464, Florida  
2511 Statutes, consultation with physicians ordering services to  
2512 substantiate the medical necessity for services, and on-site or  
2513 desk reviews of recipients' medical records in Miami-Dade  
2514 County. The agency may enter into a contract with a qualified  
2515 organization to implement the pilot project. The agency may seek  
2516 amendments to the Medicaid state plan and waivers of federal  
2517 laws, as necessary, to implement the pilot project.

2518 Section 33. Subsection (6) of section 400.0077, Florida  
2519 Statutes, is amended to read:

2520 400.0077 Confidentiality.-

2521 (6) This section does not limit the subpoena power of the  
2522 Attorney General pursuant to s. 409.920(10)(b) ~~s. 409.920(9)(b).~~

2523 Section 34. Subsection (2) of section 430.608, Florida  
2524 Statutes, is amended to read:

2525 430.608 Confidentiality of information.-

2526 (2) This section does not, however, limit the subpoena  
2527 authority of the Medicaid Fraud Control Unit of the Department  
2528 of Legal Affairs pursuant to s. 409.920(10)(b) ~~s. 409.920(9)(b).~~

2529 Section 35. Section 395.0199, Florida Statutes, is  
2530 repealed.

2531 Section 36. Section 395.405, Florida Statutes, is amended

20091986er

2532 to read:

2533 395.405 Rulemaking.—The department shall adopt and enforce  
2534 all rules necessary to administer ss. ~~395.0199~~, 395.401,  
2535 395.4015, 395.402, 395.4025, 395.403, 395.404, and 395.4045.

2536 Section 37. Subsection (1) of section 400.0712, Florida  
2537 Statutes, is amended to read:

2538 400.0712 Application for inactive license.—

2539 (1) As specified in ~~s. 408.831(4)~~ and this section, the  
2540 agency may issue an inactive license to a nursing home facility  
2541 for all or a portion of its beds. Any request by a licensee that  
2542 a nursing home or portion of a nursing home become inactive must  
2543 be submitted to the agency in the approved format. The facility  
2544 may not initiate any suspension of services, notify residents,  
2545 or initiate inactivity before receiving approval from the  
2546 agency; and a licensee that violates this provision may not be  
2547 issued an inactive license.

2548 Section 38. Subsection (2) of section 400.118, Florida  
2549 Statutes, is repealed.

2550 Section 39. Section 400.141, Florida Statutes, is amended  
2551 to read:

2552 400.141 Administration and management of nursing home  
2553 facilities.—

2554 (1) Every licensed facility shall comply with all  
2555 applicable standards and rules of the agency and shall:

2556 (a) ~~(1)~~ Be under the administrative direction and charge of  
2557 a licensed administrator.

2558 (b) ~~(2)~~ Appoint a medical director licensed pursuant to  
2559 chapter 458 or chapter 459. The agency may establish by rule  
2560 more specific criteria for the appointment of a medical

20091986er

2561 director.

2562 (c)~~(3)~~ Have available the regular, consultative, and  
2563 emergency services of physicians licensed by the state.

2564 (d)~~(4)~~ Provide for resident use of a community pharmacy as  
2565 specified in s. 400.022(1)(q). Any other law to the contrary  
2566 notwithstanding, a registered pharmacist licensed in Florida,  
2567 that is under contract with a facility licensed under this  
2568 chapter or chapter 429, shall repackage a nursing facility  
2569 resident's bulk prescription medication which has been packaged  
2570 by another pharmacist licensed in any state in the United States  
2571 into a unit dose system compatible with the system used by the  
2572 nursing facility, if the pharmacist is requested to offer such  
2573 service. In order to be eligible for the repackaging, a resident  
2574 or the resident's spouse must receive prescription medication  
2575 benefits provided through a former employer as part of his or  
2576 her retirement benefits, a qualified pension plan as specified  
2577 in s. 4972 of the Internal Revenue Code, a federal retirement  
2578 program as specified under 5 C.F.R. s. 831, or a long-term care  
2579 policy as defined in s. 627.9404(1). A pharmacist who correctly  
2580 repackages and relabels the medication and the nursing facility  
2581 which correctly administers such repackaged medication under ~~the~~  
2582 ~~provisions of this~~ paragraph may subsection shall not be held  
2583 liable in any civil or administrative action arising from the  
2584 repackaging. In order to be eligible for the repackaging, a  
2585 nursing facility resident for whom the medication is to be  
2586 repackaged shall sign an informed consent form provided by the  
2587 facility which includes an explanation of the repackaging  
2588 process and which notifies the resident of the immunities from  
2589 liability provided in this paragraph ~~herein~~. A pharmacist who



20091986er

2590 repackages and relabels prescription medications, as authorized  
2591 under this paragraph ~~subsection~~, may charge a reasonable fee for  
2592 costs resulting from the implementation of this provision.

2593 (e) ~~(5)~~ Provide for the access of the facility residents to  
2594 dental and other health-related services, recreational services,  
2595 rehabilitative services, and social work services appropriate to  
2596 their needs and conditions and not directly furnished by the  
2597 licensee. When a geriatric outpatient nurse clinic is conducted  
2598 in accordance with rules adopted by the agency, outpatients  
2599 attending such clinic shall not be counted as part of the  
2600 general resident population of the nursing home facility, nor  
2601 shall the nursing staff of the geriatric outpatient clinic be  
2602 counted as part of the nursing staff of the facility, until the  
2603 outpatient clinic load exceeds 15 a day.

2604 (f) ~~(6)~~ Be allowed and encouraged by the agency to provide  
2605 other needed services under certain conditions. If the facility  
2606 has a standard licensure status, and has had no class I or class  
2607 II deficiencies during the past 2 years or has been awarded a  
2608 Gold Seal under the program established in s. 400.235, it may be  
2609 encouraged by the agency to provide services, including, but not  
2610 limited to, respite and adult day services, which enable  
2611 individuals to move in and out of the facility. A facility is  
2612 not subject to any additional licensure requirements for  
2613 providing these services. Respite care may be offered to persons  
2614 in need of short-term or temporary nursing home services.  
2615 Respite care must be provided in accordance with this part and  
2616 rules adopted by the agency. However, the agency shall, by rule,  
2617 adopt modified requirements for resident assessment, resident  
2618 care plans, resident contracts, physician orders, and other

20091986er

2619 provisions, as appropriate, for short-term or temporary nursing  
2620 home services. The agency shall allow for shared programming and  
2621 staff in a facility which meets minimum standards and offers  
2622 services pursuant to this paragraph ~~subsection~~, but, if the  
2623 facility is cited for deficiencies in patient care, may require  
2624 additional staff and programs appropriate to the needs of  
2625 service recipients. A person who receives respite care may not  
2626 be counted as a resident of the facility for purposes of the  
2627 facility's licensed capacity unless that person receives 24-hour  
2628 respite care. A person receiving either respite care for 24  
2629 hours or longer or adult day services must be included when  
2630 calculating minimum staffing for the facility. Any costs and  
2631 revenues generated by a nursing home facility from  
2632 nonresidential programs or services shall be excluded from the  
2633 calculations of Medicaid per diems for nursing home  
2634 institutional care reimbursement.

2635 (g) ~~(7)~~ If the facility has a standard license or is a Gold  
2636 Seal facility, exceeds the minimum required hours of licensed  
2637 nursing and certified nursing assistant direct care per resident  
2638 per day, and is part of a continuing care facility licensed  
2639 under chapter 651 or a retirement community that offers other  
2640 services pursuant to part III of this chapter or part I or part  
2641 III of chapter 429 on a single campus, be allowed to share  
2642 programming and staff. At the time of inspection and in the  
2643 semiannual report required pursuant to paragraph (o) ~~subsection~~  
2644 ~~(15)~~, a continuing care facility or retirement community that  
2645 uses this option must demonstrate through staffing records that  
2646 minimum staffing requirements for the facility were met.

2647 Licensed nurses and certified nursing assistants who work in the

20091986er

2648 nursing home facility may be used to provide services elsewhere  
2649 on campus if the facility exceeds the minimum number of direct  
2650 care hours required per resident per day and the total number of  
2651 residents receiving direct care services from a licensed nurse  
2652 or a certified nursing assistant does not cause the facility to  
2653 violate the staffing ratios required under s. 400.23(3)(a).  
2654 Compliance with the minimum staffing ratios shall be based on  
2655 total number of residents receiving direct care services,  
2656 regardless of where they reside on campus. If the facility  
2657 receives a conditional license, it may not share staff until the  
2658 conditional license status ends. This paragraph ~~subsection~~ does  
2659 not restrict the agency's authority under federal or state law  
2660 to require additional staff if a facility is cited for  
2661 deficiencies in care which are caused by an insufficient number  
2662 of certified nursing assistants or licensed nurses. The agency  
2663 may adopt rules for the documentation necessary to determine  
2664 compliance with this provision.

2665 (h) ~~(8)~~ Maintain the facility premises and equipment and  
2666 conduct its operations in a safe and sanitary manner.

2667 (i) ~~(9)~~ If the licensee furnishes food service, provide a  
2668 wholesome and nourishing diet sufficient to meet generally  
2669 accepted standards of proper nutrition for its residents and  
2670 provide such therapeutic diets as may be prescribed by attending  
2671 physicians. In making rules to implement this paragraph  
2672 ~~subsection~~, the agency shall be guided by standards recommended  
2673 by nationally recognized professional groups and associations  
2674 with knowledge of dietetics.

2675 (j) ~~(10)~~ Keep full records of resident admissions and  
2676 discharges; medical and general health status, including medical

20091986er

2677 records, personal and social history, and identity and address  
2678 of next of kin or other persons who may have responsibility for  
2679 the affairs of the residents; and individual resident care plans  
2680 including, but not limited to, prescribed services, service  
2681 frequency and duration, and service goals. The records shall be  
2682 open to inspection by the agency.

2683 (k)~~(11)~~ Keep such fiscal records of its operations and  
2684 conditions as may be necessary to provide information pursuant  
2685 to this part.

2686 (l)~~(12)~~ Furnish copies of personnel records for employees  
2687 affiliated with such facility, to any other facility licensed by  
2688 this state requesting this information pursuant to this part.  
2689 Such information contained in the records may include, but is  
2690 not limited to, disciplinary matters and any reason for  
2691 termination. Any facility releasing such records pursuant to  
2692 this part shall be considered to be acting in good faith and may  
2693 not be held liable for information contained in such records,  
2694 absent a showing that the facility maliciously falsified such  
2695 records.

2696 (m)~~(13)~~ Publicly display a poster provided by the agency  
2697 containing the names, addresses, and telephone numbers for the  
2698 state's abuse hotline, the State Long-Term Care Ombudsman, the  
2699 Agency for Health Care Administration consumer hotline, the  
2700 Advocacy Center for Persons with Disabilities, the Florida  
2701 Statewide Advocacy Council, and the Medicaid Fraud Control Unit,  
2702 with a clear description of the assistance to be expected from  
2703 each.

2704 (n)~~(14)~~ Submit to the agency the information specified in  
2705 s. 400.071(1)(b) for a management company within 30 days after

20091986er

2706 the effective date of the management agreement.

2707 (o)~~1.(15)~~ Submit semiannually to the agency, or more  
2708 frequently if requested by the agency, information regarding  
2709 facility staff-to-resident ratios, staff turnover, and staff  
2710 stability, including information regarding certified nursing  
2711 assistants, licensed nurses, the director of nursing, and the  
2712 facility administrator. For purposes of this reporting:

2713 a.~~(a)~~ Staff-to-resident ratios must be reported in the  
2714 categories specified in s. 400.23(3)(a) and applicable rules.  
2715 The ratio must be reported as an average for the most recent  
2716 calendar quarter.

2717 b.~~(b)~~ Staff turnover must be reported for the most recent  
2718 12-month period ending on the last workday of the most recent  
2719 calendar quarter prior to the date the information is submitted.  
2720 The turnover rate must be computed quarterly, with the annual  
2721 rate being the cumulative sum of the quarterly rates. The  
2722 turnover rate is the total number of terminations or separations  
2723 experienced during the quarter, excluding any employee  
2724 terminated during a probationary period of 3 months or less,  
2725 divided by the total number of staff employed at the end of the  
2726 period for which the rate is computed, and expressed as a  
2727 percentage.

2728 c.~~(c)~~ The formula for determining staff stability is the  
2729 total number of employees that have been employed for more than  
2730 12 months, divided by the total number of employees employed at  
2731 the end of the most recent calendar quarter, and expressed as a  
2732 percentage.

2733 d.~~(d)~~ A nursing facility that has failed to comply with  
2734 state minimum-staffing requirements for 2 consecutive days is

20091986er

2735 prohibited from accepting new admissions until the facility has  
2736 achieved the minimum-staffing requirements for a period of 6  
2737 consecutive days. For the purposes of this sub-subparagraph  
2738 ~~paragraph~~, any person who was a resident of the facility and was  
2739 absent from the facility for the purpose of receiving medical  
2740 care at a separate location or was on a leave of absence is not  
2741 considered a new admission. Failure to impose such an admissions  
2742 moratorium constitutes a class II deficiency.

2743 e. ~~(e)~~ A nursing facility which does not have a conditional  
2744 license may be cited for failure to comply with the standards in  
2745 s. 400.23(3) (a)1.a. only if it has failed to meet those  
2746 standards on 2 consecutive days or if it has failed to meet at  
2747 least 97 percent of those standards on any one day.

2748 f. ~~(f)~~ A facility which has a conditional license must be in  
2749 compliance with the standards in s. 400.23(3) (a) at all times.

2750 2. ~~Nothing in This paragraph does not section shall~~ limit  
2751 the agency's ability to impose a deficiency or take other  
2752 actions if a facility does not have enough staff to meet the  
2753 residents' needs.

2754 ~~(16) Report monthly the number of vacant beds in the~~  
2755 ~~facility which are available for resident occupancy on the day~~  
2756 ~~the information is reported.~~

2757 (p) ~~(17)~~ Notify a licensed physician when a resident  
2758 exhibits signs of dementia or cognitive impairment or has a  
2759 change of condition in order to rule out the presence of an  
2760 underlying physiological condition that may be contributing to  
2761 such dementia or impairment. The notification must occur within  
2762 30 days after the acknowledgment of such signs by facility  
2763 staff. If an underlying condition is determined to exist, the

20091986er

2764 facility shall arrange, with the appropriate health care  
2765 provider, the necessary care and services to treat the  
2766 condition.

2767 (q)~~(18)~~ If the facility implements a dining and hospitality  
2768 attendant program, ensure that the program is developed and  
2769 implemented under the supervision of the facility director of  
2770 nursing. A licensed nurse, licensed speech or occupational  
2771 therapist, or a registered dietitian must conduct training of  
2772 dining and hospitality attendants. A person employed by a  
2773 facility as a dining and hospitality attendant must perform  
2774 tasks under the direct supervision of a licensed nurse.

2775 (r)~~(19)~~ Report to the agency any filing for bankruptcy  
2776 protection by the facility or its parent corporation,  
2777 divestiture or spin-off of its assets, or corporate  
2778 reorganization within 30 days after the completion of such  
2779 activity.

2780 (s)~~(20)~~ Maintain general and professional liability  
2781 insurance coverage that is in force at all times. In lieu of  
2782 general and professional liability insurance coverage, a state-  
2783 designated teaching nursing home and its affiliated assisted  
2784 living facilities created under s. 430.80 may demonstrate proof  
2785 of financial responsibility as provided in s. 430.80(3)(h).

2786 (t)~~(21)~~ Maintain in the medical record for each resident a  
2787 daily chart of certified nursing assistant services provided to  
2788 the resident. The certified nursing assistant who is caring for  
2789 the resident must complete this record by the end of his or her  
2790 shift. This record must indicate assistance with activities of  
2791 daily living, assistance with eating, and assistance with  
2792 drinking, and must record each offering of nutrition and

20091986er

2793 hydration for those residents whose plan of care or assessment  
2794 indicates a risk for malnutrition or dehydration.

2795 (u)~~(22)~~ Before November 30 of each year, subject to the  
2796 availability of an adequate supply of the necessary vaccine,  
2797 provide for immunizations against influenza viruses to all its  
2798 consenting residents in accordance with the recommendations of  
2799 the United States Centers for Disease Control and Prevention,  
2800 subject to exemptions for medical contraindications and  
2801 religious or personal beliefs. Subject to these exemptions, any  
2802 consenting person who becomes a resident of the facility after  
2803 November 30 but before March 31 of the following year must be  
2804 immunized within 5 working days after becoming a resident.

2805 Immunization shall not be provided to any resident who provides  
2806 documentation that he or she has been immunized as required by  
2807 this paragraph ~~subsection~~. This paragraph ~~subsection~~ does not  
2808 prohibit a resident from receiving the immunization from his or  
2809 her personal physician if he or she so chooses. A resident who  
2810 chooses to receive the immunization from his or her personal  
2811 physician shall provide proof of immunization to the facility.  
2812 The agency may adopt and enforce any rules necessary to comply  
2813 with or implement this subsection.

2814 (v)~~(23)~~ Assess all residents for eligibility for  
2815 pneumococcal polysaccharide vaccination (PPV) and vaccinate  
2816 residents when indicated within 60 days after the effective date  
2817 of this act in accordance with the recommendations of the United  
2818 States Centers for Disease Control and Prevention, subject to  
2819 exemptions for medical contraindications and religious or  
2820 personal beliefs. Residents admitted after the effective date of  
2821 this act shall be assessed within 5 working days of admission



20091986er

2822 and, when indicated, vaccinated within 60 days in accordance  
2823 with the recommendations of the United States Centers for  
2824 Disease Control and Prevention, subject to exemptions for  
2825 medical contraindications and religious or personal beliefs.  
2826 Immunization shall not be provided to any resident who provides  
2827 documentation that he or she has been immunized as required by  
2828 this paragraph ~~subsection~~. This paragraph ~~subsection~~ does not  
2829 prohibit a resident from receiving the immunization from his or  
2830 her personal physician if he or she so chooses. A resident who  
2831 chooses to receive the immunization from his or her personal  
2832 physician shall provide proof of immunization to the facility.  
2833 The agency may adopt and enforce any rules necessary to comply  
2834 with or implement this paragraph ~~subsection~~.

2835 (w) ~~(24)~~ Annually encourage and promote to its employees the  
2836 benefits associated with immunizations against influenza viruses  
2837 in accordance with the recommendations of the United States  
2838 Centers for Disease Control and Prevention. The agency may adopt  
2839 and enforce any rules necessary to comply with or implement this  
2840 paragraph ~~subsection~~.

2841 (2) Facilities that have been awarded a Gold Seal under the  
2842 program established in s. 400.235 may develop a plan to provide  
2843 certified nursing assistant training as prescribed by federal  
2844 regulations and state rules and may apply to the agency for  
2845 approval of their program.

2846 Section 40. Subsections (5), (9), (10), (11), (12), (13),  
2847 (14), and (15) of section 400.147, Florida Statutes, are amended  
2848 to read:

2849 400.147 Internal risk management and quality assurance  
2850 program.—

20091986er

2851 (5) For purposes of reporting to the agency under this  
2852 section, the term "adverse incident" means:

2853 (a) An event over which facility personnel could exercise  
2854 control and which is associated in whole or in part with the  
2855 facility's intervention, rather than the condition for which  
2856 such intervention occurred, and which results in one of the  
2857 following:

2858 1. Death;

2859 2. Brain or spinal damage;

2860 3. Permanent disfigurement;

2861 4. Fracture or dislocation of bones or joints;

2862 5. A limitation of neurological, physical, or sensory  
2863 function;

2864 6. Any condition that required medical attention to which  
2865 the resident has not given his or her informed consent,  
2866 including failure to honor advanced directives; ~~or~~

2867 7. Any condition that required the transfer of the  
2868 resident, within or outside the facility, to a unit providing a  
2869 more acute level of care due to the adverse incident, rather  
2870 than the resident's condition prior to the adverse incident; or

2871 8. An event that is reported to law enforcement or its  
2872 personnel for investigation; or

2873 ~~(b) Abuse, neglect, or exploitation as defined in s.~~  
2874 ~~415.102;~~

2875 ~~(c) Abuse, neglect and harm as defined in s. 39.01;~~

2876 (b)(d) Resident elopement, if the elopement places the  
2877 resident at risk of harm or injury. ~~;~~ ~~or~~

2878 ~~(e) An event that is reported to law enforcement.~~

2879 (9) Abuse, neglect, or exploitation must be reported to the

20091986er

2880 agency as required by 42 C.F.R. s. 483.13(c) and to the  
2881 department as required by chapters 39 and 415.

2882 (10)~~(9)~~ By the 10th of each month, each facility subject to  
2883 this section shall report any notice received pursuant to s.  
2884 400.0233(2) and each initial complaint that was filed with the  
2885 clerk of the court and served on the facility during the  
2886 previous month by a resident or a resident's family member,  
2887 guardian, conservator, or personal legal representative. The  
2888 report must include the name of the resident, the resident's  
2889 date of birth and social security number, the Medicaid  
2890 identification number for Medicaid-eligible persons, the date or  
2891 dates of the incident leading to the claim or dates of  
2892 residency, if applicable, and the type of injury or violation of  
2893 rights alleged to have occurred. Each facility shall also submit  
2894 a copy of the notices received pursuant to s. 400.0233(2) and  
2895 complaints filed with the clerk of the court. This report is  
2896 confidential as provided by law and is not discoverable or  
2897 admissible in any civil or administrative action, except in such  
2898 actions brought by the agency to enforce the provisions of this  
2899 part.

2900 (11)~~(10)~~ The agency shall review, as part of its licensure  
2901 inspection process, the internal risk management and quality  
2902 assurance program at each facility regulated by this section to  
2903 determine whether the program meets standards established in  
2904 statutory laws and rules, is being conducted in a manner  
2905 designed to reduce adverse incidents, and is appropriately  
2906 reporting incidents as required by this section.

2907 (12)~~(11)~~ There is no monetary liability on the part of, and  
2908 a cause of action for damages may not arise against, any risk

20091986er

2909 manager for the implementation and oversight of the internal  
2910 risk management and quality assurance program in a facility  
2911 licensed under this part as required by this section, or for any  
2912 act or proceeding undertaken or performed within the scope of  
2913 the functions of such internal risk management and quality  
2914 assurance program if the risk manager acts without intentional  
2915 fraud.

2916 (13)~~(12)~~ If the agency, through its receipt of the adverse  
2917 incident reports prescribed in subsection (7), or through any  
2918 investigation, has a reasonable belief that conduct by a staff  
2919 member or employee of a facility is grounds for disciplinary  
2920 action by the appropriate regulatory board, the agency shall  
2921 report this fact to the regulatory board.

2922 (14)~~(13)~~ The agency may adopt rules to administer this  
2923 section.

2924 ~~(14) The agency shall annually submit to the Legislature a~~  
2925 ~~report on nursing home adverse incidents. The report must~~  
2926 ~~include the following information arranged by county:~~

2927 ~~(a) The total number of adverse incidents.~~

2928 ~~(b) A listing, by category, of the types of adverse~~  
2929 ~~incidents, the number of incidents occurring within each~~  
2930 ~~category, and the type of staff involved.~~

2931 ~~(c) A listing, by category, of the types of injury caused~~  
2932 ~~and the number of injuries occurring within each category.~~

2933 ~~(d) Types of liability claims filed based on an adverse~~  
2934 ~~incident or reportable injury.~~

2935 ~~(e) Disciplinary action taken against staff, categorized by~~  
2936 ~~type of staff involved.~~

2937 (15) Information gathered by a credentialing organization

20091986er

2938 under a quality assurance program is not discoverable from the  
2939 credentialing organization. This subsection does not limit  
2940 discovery of, access to, or use of facility records, including  
2941 those records from which the credentialing organization gathered  
2942 its information.

2943 Section 41. Subsection (3) of section 400.162, Florida  
2944 Statutes, is amended to read:

2945 400.162 Property and personal affairs of residents.—

2946 (3) A licensee shall provide for the safekeeping of  
2947 personal effects, funds, and other property of the resident in  
2948 the facility. Whenever necessary for the protection of  
2949 valuables, or in order to avoid unreasonable responsibility  
2950 therefor, the licensee may require that such valuables be  
2951 excluded or removed from the facility and kept at some place not  
2952 subject to the control of the licensee. At the request of a  
2953 resident, the facility shall mark the resident's personal  
2954 property with the resident's name or another type of  
2955 identification, without defacing the property. Any theft or loss  
2956 of a resident's personal property shall be documented by the  
2957 facility. The facility shall develop policies and procedures to  
2958 minimize the risk of theft or loss of the personal property of  
2959 residents. A copy of the policy shall be provided to every  
2960 employee and to each resident and the resident's representative  
2961 if appropriate at admission and when revised. Facility policies  
2962 must include provisions related to reporting theft or loss of a  
2963 resident's property to law enforcement and any facility waiver  
2964 of liability for loss or theft. ~~The facility shall post notice~~  
2965 ~~of these policies and procedures, and any revision thereof, in~~  
2966 ~~places accessible to residents.~~

20091986er

2967           Section 42. Paragraphs (a) and (b) of subsection (2) of  
2968 section 400.191, Florida Statutes, are amended to read:

2969           400.191 Availability, distribution, and posting of reports  
2970 and records.—

2971           (2) The agency shall publish the Nursing Home Guide  
2972 ~~annually in consumer-friendly printed form and~~ quarterly in  
2973 electronic form to assist consumers and their families in  
2974 comparing and evaluating nursing home facilities.

2975           (a) The agency shall provide an Internet site which shall  
2976 include at least the following information either directly or  
2977 indirectly through a link to another established site or sites  
2978 of the agency's choosing:

2979           1. A section entitled "Have you considered programs that  
2980 provide alternatives to nursing home care?" which shall be the  
2981 first section of the Nursing Home Guide and which shall  
2982 prominently display information about available alternatives to  
2983 nursing homes and how to obtain additional information regarding  
2984 these alternatives. The Nursing Home Guide shall explain that  
2985 this state offers alternative programs that permit qualified  
2986 elderly persons to stay in their homes instead of being placed  
2987 in nursing homes and shall encourage interested persons to call  
2988 the Comprehensive Assessment Review and Evaluation for Long-Term  
2989 Care Services (CARES) Program to inquire if they qualify. The  
2990 Nursing Home Guide shall list available home and community-based  
2991 programs which shall clearly state the services that are  
2992 provided and indicate whether nursing home services are included  
2993 if needed.

2994           2. A list by name and address of all nursing home  
2995 facilities in this state, including any prior name by which a

20091986er

2996 facility was known during the previous 24-month period.

2997 3. Whether such nursing home facilities are proprietary or  
2998 nonproprietary.

2999 4. The current owner of the facility's license and the year  
3000 that that entity became the owner of the license.

3001 5. The name of the owner or owners of each facility and  
3002 whether the facility is affiliated with a company or other  
3003 organization owning or managing more than one nursing facility  
3004 in this state.

3005 6. The total number of beds in each facility and the most  
3006 recently available occupancy levels.

3007 7. The number of private and semiprivate rooms in each  
3008 facility.

3009 8. The religious affiliation, if any, of each facility.

3010 9. The languages spoken by the administrator and staff of  
3011 each facility.

3012 10. Whether or not each facility accepts Medicare or  
3013 Medicaid recipients or insurance, health maintenance  
3014 organization, Veterans Administration, CHAMPUS program, or  
3015 workers' compensation coverage.

3016 11. Recreational and other programs available at each  
3017 facility.

3018 12. Special care units or programs offered at each  
3019 facility.

3020 13. Whether the facility is a part of a retirement  
3021 community that offers other services pursuant to part III of  
3022 this chapter or part I or part III of chapter 429.

3023 14. Survey and deficiency information, including all  
3024 federal and state recertification, licensure, revisit, and

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3025 complaint survey information, for each facility for the past 30  
3026 months. For noncertified nursing homes, state survey and  
3027 deficiency information, including licensure, revisit, and  
3028 complaint survey information for the past 30 months shall be  
3029 provided.

3030 ~~15. A summary of the deficiency data for each facility over~~  
3031 ~~the past 30 months. The summary may include a score, rating, or~~  
3032 ~~comparison ranking with respect to other facilities based on the~~  
3033 ~~number of citations received by the facility on recertification,~~  
3034 ~~licensure, revisit, and complaint surveys; the severity and~~  
3035 ~~scope of the citations; and the number of recertification~~  
3036 ~~surveys the facility has had during the past 30 months. The~~  
3037 ~~score, rating, or comparison ranking may be presented in either~~  
3038 ~~numeric or symbolic form for the intended consumer audience.~~

3039 ~~(b) The agency shall provide the following information in~~  
3040 ~~printed form:~~

3041 ~~1. A section entitled "Have you considered programs that~~  
3042 ~~provide alternatives to nursing home care?" which shall be the~~  
3043 ~~first section of the Nursing Home Guide and which shall~~  
3044 ~~prominently display information about available alternatives to~~  
3045 ~~nursing homes and how to obtain additional information regarding~~  
3046 ~~these alternatives. The Nursing Home Guide shall explain that~~  
3047 ~~this state offers alternative programs that permit qualified~~  
3048 ~~elderly persons to stay in their homes instead of being placed~~  
3049 ~~in nursing homes and shall encourage interested persons to call~~  
3050 ~~the Comprehensive Assessment Review and Evaluation for Long Term~~  
3051 ~~Care Services (CARES) Program to inquire if they qualify. The~~  
3052 ~~Nursing Home Guide shall list available home and community based~~  
3053 ~~programs which shall clearly state the services that are~~



20091986er

3054 ~~provided and indicate whether nursing home services are included~~  
3055 ~~if needed.~~

3056 ~~2. A list by name and address of all nursing home~~  
3057 ~~facilities in this state.~~

3058 ~~3. Whether the nursing home facilities are proprietary or~~  
3059 ~~nonproprietary.~~

3060 ~~4. The current owner or owners of the facility's license~~  
3061 ~~and the year that entity became the owner of the license.~~

3062 ~~5. The total number of beds, and of private and semiprivate~~  
3063 ~~rooms, in each facility.~~

3064 ~~6. The religious affiliation, if any, of each facility.~~

3065 ~~7. The name of the owner of each facility and whether the~~  
3066 ~~facility is affiliated with a company or other organization~~  
3067 ~~owning or managing more than one nursing facility in this state.~~

3068 ~~8. The languages spoken by the administrator and staff of~~  
3069 ~~each facility.~~

3070 ~~9. Whether or not each facility accepts Medicare or~~  
3071 ~~Medicaid recipients or insurance, health maintenance~~  
3072 ~~organization, Veterans Administration, CHAMPUS program, or~~  
3073 ~~workers' compensation coverage.~~

3074 ~~10. Recreational programs, special care units, and other~~  
3075 ~~programs available at each facility.~~

3076 ~~11. The Internet address for the site where more detailed~~  
3077 ~~information can be seen.~~

3078 ~~12. A statement advising consumers that each facility will~~  
3079 ~~have its own policies and procedures related to protecting~~  
3080 ~~resident property.~~

3081 ~~13. A summary of the deficiency data for each facility over~~  
3082 ~~the past 30 months. The summary may include a score, rating, or~~

20091986er

3083 ~~comparison ranking with respect to other facilities based on the~~  
3084 ~~number of citations received by the facility on recertification,~~  
3085 ~~licensure, revisit, and complaint surveys; the severity and~~  
3086 ~~scope of the citations; the number of citations; and the number~~  
3087 ~~of recertification surveys the facility has had during the past~~  
3088 ~~30 months. The score, rating, or comparison ranking may be~~  
3089 ~~presented in either numeric or symbolic form for the intended~~  
3090 ~~consumer audience.~~

3091 Section 43. Paragraph (d) of subsection (1) of section  
3092 400.195, Florida Statutes, is amended to read:

3093 400.195 Agency reporting requirements.—

3094 (1) For the period beginning June 30, 2001, and ending June  
3095 30, 2005, the Agency for Health Care Administration shall  
3096 provide a report to the Governor, the President of the Senate,  
3097 and the Speaker of the House of Representatives with respect to  
3098 nursing homes. The first report shall be submitted no later than  
3099 December 30, 2002, and subsequent reports shall be submitted  
3100 every 6 months thereafter. The report shall identify facilities  
3101 based on their ownership characteristics, size, business  
3102 structure, for-profit or not-for-profit status, and any other  
3103 characteristics the agency determines useful in analyzing the  
3104 varied segments of the nursing home industry and shall report:

3105 (d) Information regarding deficiencies cited, including  
3106 information used to develop the Nursing Home Guide WATCH LIST  
3107 pursuant to s. 400.191, and applicable rules, a summary of data  
3108 generated on nursing homes by Centers for Medicare and Medicaid  
3109 Services Nursing Home Quality Information Project, and  
3110 information collected pursuant to s. 400.147(10) ~~s. 400.147(9)~~,  
3111 relating to litigation.

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3112 Section 44. Subsection (3) of section 400.23, Florida  
3113 Statutes, is amended to read:

3114 400.23 Rules; evaluation and deficiencies; licensure  
3115 status.—

3116 (3) (a) 1. The agency shall adopt rules providing minimum  
3117 staffing requirements for nursing homes. These requirements  
3118 shall include, for each nursing home facility:

3119 a. A minimum certified nursing assistant staffing of 2.6  
3120 hours of direct care per resident per day beginning January 1,  
3121 2003, and increasing to 2.7 hours of direct care per resident  
3122 per day beginning January 1, 2007. Beginning January 1, 2002, no  
3123 facility shall staff below one certified nursing assistant per  
3124 20 residents, and a minimum licensed nursing staffing of 1.0  
3125 hour of direct care per resident per day but never below one  
3126 licensed nurse per 40 residents.

3127 b. Beginning January 1, 2007, a minimum weekly average  
3128 certified nursing assistant staffing of 2.9 hours of direct care  
3129 per resident per day. For the purpose of this sub-subparagraph,  
3130 a week is defined as Sunday through Saturday.

3131 2. Nursing assistants employed under s. 400.211(2) may be  
3132 included in computing the staffing ratio for certified nursing  
3133 assistants only if their job responsibilities include only  
3134 nursing-assistant-related duties.

3135 3. Each nursing home must document compliance with staffing  
3136 standards as required under this paragraph and post daily the  
3137 names of staff on duty for the benefit of facility residents and  
3138 the public.

3139 4. The agency shall recognize the use of licensed nurses  
3140 for compliance with minimum staffing requirements for certified

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3141 nursing assistants, provided that the facility otherwise meets  
3142 the minimum staffing requirements for licensed nurses and that  
3143 the licensed nurses are performing the duties of a certified  
3144 nursing assistant. Unless otherwise approved by the agency,  
3145 licensed nurses counted toward the minimum staffing requirements  
3146 for certified nursing assistants must exclusively perform the  
3147 duties of a certified nursing assistant for the entire shift and  
3148 not also be counted toward the minimum staffing requirements for  
3149 licensed nurses. If the agency approved a facility's request to  
3150 use a licensed nurse to perform both licensed nursing and  
3151 certified nursing assistant duties, the facility must allocate  
3152 the amount of staff time specifically spent on certified nursing  
3153 assistant duties for the purpose of documenting compliance with  
3154 minimum staffing requirements for certified and licensed nursing  
3155 staff. In no event may the hours of a licensed nurse with dual  
3156 job responsibilities be counted twice.

3157 ~~(b) The agency shall adopt rules to allow properly trained~~  
3158 ~~staff of a nursing facility, in addition to certified nursing~~  
3159 ~~assistants and licensed nurses, to assist residents with eating.~~  
3160 ~~The rules shall specify the minimum training requirements and~~  
3161 ~~shall specify the physiological conditions or disorders of~~  
3162 ~~residents which would necessitate that the eating assistance be~~  
3163 ~~provided by nursing personnel of the facility.~~ Nonnursing staff  
3164 providing eating assistance to residents ~~under the provisions of~~  
3165 ~~this subsection~~ shall not count toward compliance with minimum  
3166 staffing standards.

3167 (c) Licensed practical nurses licensed under chapter 464  
3168 who are providing nursing services in nursing home facilities  
3169 under this part may supervise the activities of other licensed

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3170 practical nurses, certified nursing assistants, and other  
3171 unlicensed personnel providing services in such facilities in  
3172 accordance with rules adopted by the Board of Nursing.

3173 Section 45. Paragraph (a) of subsection (7) of section  
3174 400.9935, Florida Statutes, is amended to read:

3175 400.9935 Clinic responsibilities.—

3176 (7) (a) Each clinic engaged in magnetic resonance imaging  
3177 services must be accredited by the Joint Commission on  
3178 Accreditation of Healthcare Organizations, the American College  
3179 of Radiology, or the Accreditation Association for Ambulatory  
3180 Health Care, within 1 year after licensure. A clinic that is  
3181 accredited by the American College of Radiology or is within the  
3182 original 1-year period after licensure and replaces its core  
3183 magnetic resonance imaging equipment shall be given 1 year after  
3184 the date on which the equipment is replaced to attain  
3185 accreditation. However, a clinic may request a single, 6-month  
3186 extension if it provides evidence to the agency establishing  
3187 that, for good cause shown, such clinic cannot ~~can not~~ be  
3188 accredited within 1 year after licensure, and that such  
3189 accreditation will be completed within the 6-month extension.  
3190 After obtaining accreditation as required by this subsection,  
3191 each such clinic must maintain accreditation as a condition of  
3192 renewal of its license. A clinic that files a change of  
3193 ownership application must comply with the original  
3194 accreditation timeframe requirements of the transferor. The  
3195 agency shall deny a change of ownership application if the  
3196 clinic is not in compliance with the accreditation requirements.  
3197 When a clinic adds, replaces, or modifies magnetic resonance  
3198 imaging equipment and the accreditation agency requires new

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3199 accreditation, the clinic must be accredited within 1 year after  
3200 the date of the addition, replacement, or modification but may  
3201 request a single, 6-month extension if the clinic provides  
3202 evidence of good cause to the agency.

3203 Section 46. Subsection (6) of section 400.995, Florida  
3204 Statutes, is amended to read:

3205 400.995 Agency administrative penalties.—

3206 (6) During an inspection, ~~the agency, as an alternative to~~  
3207 ~~or in conjunction with an administrative action against a clinic~~  
3208 ~~for violations of this part and adopted rules,~~ shall make a  
3209 reasonable attempt to discuss each violation ~~and recommended~~  
3210 ~~corrective action~~ with the owner, medical director, or clinic  
3211 director of the clinic, prior to written notification. ~~The~~  
3212 ~~agency, instead of fixing a period within which the clinic shall~~  
3213 ~~enter into compliance with standards, may request a plan of~~  
3214 ~~corrective action from the clinic which demonstrates a good~~  
3215 ~~faith effort to remedy each violation by a specific date,~~  
3216 ~~subject to the approval of the agency.~~

3217 Section 47. Subsections (5), (9), and (13) of section  
3218 408.803, Florida Statutes, are amended to read:

3219 408.803 Definitions.—As used in this part, the term:

3220 (5) "Change of ownership" means:

3221 (a) An event in which the licensee sells or otherwise  
3222 transfers its ownership ~~changes~~ to a different individual or  
3223 legal entity as evidenced by a change in federal employer  
3224 identification number or taxpayer identification number; or

3225 (b) An event in which 51 45 percent or more of the  
3226 ownership, ~~voting~~ shares, membership, or controlling interest of  
3227 a licensee is in any manner transferred or otherwise assigned.

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3228 This paragraph does not apply to a licensee that is publicly  
3229 traded on a recognized stock exchange ~~in a corporation whose~~  
3230 ~~shares are not publicly traded on a recognized stock exchange is~~  
3231 ~~transferred or assigned, including the final transfer or~~  
3232 ~~assignment of multiple transfers or assignments over a 2-year~~  
3233 ~~period that cumulatively total 45 percent or greater.~~

3234  
3235 A change solely in the management company or board of directors  
3236 is not a change of ownership.

3237 (9) "Licensee" means an individual, corporation,  
3238 partnership, firm, association, ~~or~~ governmental entity, or other  
3239 entity that is issued a permit, registration, certificate, or  
3240 license by the agency. The licensee is legally responsible for  
3241 all aspects of the provider operation.

3242 (13) "Voluntary board member" means a board member or  
3243 officer of a not-for-profit corporation or organization who  
3244 serves solely in a voluntary capacity, does not receive any  
3245 remuneration for his or her services on the board of directors,  
3246 and has no financial interest in the corporation or  
3247 organization. ~~The agency shall recognize a person as a voluntary~~  
3248 ~~board member following submission of a statement to the agency~~  
3249 ~~by the board member and the not-for-profit corporation or~~  
3250 ~~organization that affirms that the board member conforms to this~~  
3251 ~~definition. The statement affirming the status of the board~~  
3252 ~~member must be submitted to the agency on a form provided by the~~  
3253 ~~agency.~~

3254 Section 48. Paragraph (a) of subsection (1), subsection  
3255 (2), paragraph (c) of subsection (7), and subsection (8) of  
3256 section 408.806, Florida Statutes, are amended to read:

20091986er

3257 408.806 License application process.—

3258 (1) An application for licensure must be made to the agency  
3259 on forms furnished by the agency, submitted under oath, and  
3260 accompanied by the appropriate fee in order to be accepted and  
3261 considered timely. The application must contain information  
3262 required by authorizing statutes and applicable rules and must  
3263 include:

3264 (a) The name, address, and social security number of:

3265 1. The applicant;

3266 2. The administrator or a similarly titled person who is  
3267 responsible for the day-to-day operation of the provider;

3268 3. The financial officer or similarly titled person who is  
3269 responsible for the financial operation of the licensee or  
3270 provider; and

3271 4. Each controlling interest if the applicant or  
3272 controlling interest is an individual.

3273 (2) (a) The applicant for a renewal license must submit an  
3274 application that must be received by the agency at least 60 days  
3275 but no more than 120 days before ~~prior to~~ the expiration of the  
3276 current license. An application received more than 120 days  
3277 before the expiration of the current license shall be returned  
3278 to the applicant. If the renewal application and fee are  
3279 received prior to the license expiration date, the license shall  
3280 not be deemed to have expired if the license expiration date  
3281 occurs during the agency's review of the renewal application.

3282 (b) The applicant for initial licensure due to a change of  
3283 ownership must submit an application that must be received by  
3284 the agency at least 60 days prior to the date of change of  
3285 ownership.



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3286 (c) For any other application or request, the applicant  
3287 must submit an application or request that must be received by  
3288 the agency at least 60 days but no more than 120 days before  
3289 ~~prior to~~ the requested effective date, unless otherwise  
3290 specified in authorizing statutes or applicable rules. An  
3291 application received more than 120 days before the requested  
3292 effective date shall be returned to the applicant.

3293 (d) The agency shall notify the licensee by mail or  
3294 electronically at least 90 days before ~~prior to~~ the expiration  
3295 of a license that a renewal license is necessary to continue  
3296 operation. The failure to timely submit a renewal application  
3297 and license fee shall result in a \$50 per day late fee charged  
3298 to the licensee by the agency; however, the aggregate amount of  
3299 the late fee may not exceed 50 percent of the licensure fee or  
3300 \$500, whichever is less. If an application is received after the  
3301 required filing date and exhibits a hand-canceled postmark  
3302 obtained from a United States post office dated on or before the  
3303 required filing date, no fine will be levied.

3304 (7)

3305 (c) If an inspection is required by the authorizing statute  
3306 for a license application other than an initial application, the  
3307 inspection must be unannounced. This paragraph does not apply to  
3308 inspections required pursuant to ss. 383.324, 395.0161(4),  
3309 429.67(6), and 483.061(2).

3310 (8) The agency may establish procedures for the electronic  
3311 notification and submission of required information, including,  
3312 but not limited to:

3313 (a) Licensure applications.

3314 (b) Required signatures.

20091986er

3315 (c) Payment of fees.

3316 (d) Notarization of applications.

3317  
3318 Requirements for electronic submission of any documents required  
3319 by this part or authorizing statutes may be established by rule.  
3320 As an alternative to sending documents as required by  
3321 authorizing statutes, the agency may provide electronic access  
3322 to information or documents.

3323 Section 49. Subsection (2) of section 408.808, Florida  
3324 Statutes, is amended to read:

3325 408.808 License categories.—

3326 (2) PROVISIONAL LICENSE.—A provisional license may be  
3327 issued to an applicant pursuant to s. 408.809(3). An applicant  
3328 against whom a proceeding denying or revoking a license is  
3329 pending at the time of license renewal may be issued a  
3330 provisional license effective until final action not subject to  
3331 further appeal. A provisional license may also be issued to an  
3332 applicant applying for a change of ownership. A provisional  
3333 license shall be limited in duration to a specific period of  
3334 time, not to exceed 12 months, as determined by the agency.

3335 Section 50. Subsection (5) of section 408.809, Florida  
3336 Statutes, is amended, and subsection (6) is added to that  
3337 section, to read:

3338 408.809 Background screening; prohibited offenses.—

3339 (5) Effective October 1, 2009, in addition to the offenses  
3340 listed in ss. 435.03 and 435.04, all persons required to undergo  
3341 background screening pursuant to this part or authorizing  
3342 statutes must not have been found guilty of, regardless of  
3343 adjudication, or entered a plea of nolo contendere or guilty to,

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3344 any of the following offenses or any similar offense of another  
3345 jurisdiction:

3346 (a) Any authorizing statutes, if the offense was a felony.

3347 (b) This chapter, if the offense was a felony.

3348 (c) Section 409.920, relating to Medicaid provider fraud,  
3349 if the offense was a felony.

3350 (d) Section 409.9201, relating to Medicaid fraud, if the  
3351 offense was a felony.

3352 (e) Section 741.28, relating to domestic violence.

3353 (f) Chapter 784, relating to assault, battery, and culpable  
3354 negligence, if the offense was a felony.

3355 (g) Section 810.02, relating to burglary.

3356 (h) Section 817.034, relating to fraudulent acts through  
3357 mail, wire, radio, electromagnetic, photoelectronic, or  
3358 photooptical systems.

3359 (i) Section 817.234, relating to false and fraudulent  
3360 insurance claims.

3361 (j) Section 817.505, relating to patient brokering.

3362 (k) Section 817.568, relating to criminal use of personal  
3363 identification information.

3364 (l) Section 817.60, relating to obtaining a credit card  
3365 through fraudulent means.

3366 (m) Section 817.61, relating to fraudulent use of credit  
3367 cards, if the offense was a felony.

3368 (n) Section 831.01, relating to forgery.

3369 (o) Section 831.02, relating to uttering forged  
3370 instruments.

3371 (p) Section 831.07, relating to forging bank bills, checks,  
3372 drafts, or promissory notes.

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3373 (q) Section 831.09, relating to uttering forged bank bills,  
3374 checks, drafts, or promissory notes.

3375 (r) Section 831.30, relating to fraud in obtaining  
3376 medicinal drugs.

3377 (s) Section 831.31, relating to the sale, manufacture,  
3378 delivery, or possession with the intent to sell, manufacture, or  
3379 deliver any counterfeit controlled substance, if the offense was  
3380 a felony.

3381  
3382 A person who serves as a controlling interest of or is employed  
3383 by a licensee on September 30, 2009, is not required by law to  
3384 submit to rescreening if that licensee has in its possession  
3385 written evidence that the person has been screened and qualified  
3386 according to the standards specified in s. 435.03 or s. 435.04.  
3387 However, if such person has a disqualifying offense listed in  
3388 this section, he or she may apply for an exemption from the  
3389 appropriate licensing agency before September 30, 2009, and if  
3390 agreed to by the employer, may continue to perform his or her  
3391 duties until the licensing agency renders a decision on the  
3392 application for exemption for offenses listed in this section.  
3393 Exemptions from disqualification may be granted pursuant to s.  
3394 435.07. ~~Background screening is not required to obtain a~~  
3395 ~~certificate of exemption issued under s. 483.106.~~

3396 (6) The attestations required under ss. 435.04(5) and  
3397 435.05(3) must be submitted at the time of license renewal,  
3398 notwithstanding the provisions of ss. 435.04(5) and 435.05(3)  
3399 which require annual submission of an affidavit of compliance  
3400 with background screening requirements.

3401 Section 51. Section 408.811, Florida Statutes, is amended

20091986er

3402 to read:

3403 408.811 Right of inspection; copies; inspection reports;  
3404 plan for correction of deficiencies.—

3405 (1) An authorized officer or employee of the agency may  
3406 make or cause to be made any inspection or investigation deemed  
3407 necessary by the agency to determine the state of compliance  
3408 with this part, authorizing statutes, and applicable rules. The  
3409 right of inspection extends to any business that the agency has  
3410 reason to believe is being operated as a provider without a  
3411 license, but inspection of any business suspected of being  
3412 operated without the appropriate license may not be made without  
3413 the permission of the owner or person in charge unless a warrant  
3414 is first obtained from a circuit court. Any application for a  
3415 license issued under this part, authorizing statutes, or  
3416 applicable rules constitutes permission for an appropriate  
3417 inspection to verify the information submitted on or in  
3418 connection with the application.

3419 (a) All inspections shall be unannounced, except as  
3420 specified in s. 408.806.

3421 (b) Inspections for relicensure shall be conducted  
3422 biennially unless otherwise specified by authorizing statutes or  
3423 applicable rules.

3424 (2) Inspections conducted in conjunction with  
3425 certification, comparable licensure requirements, or a  
3426 recognized or approved accreditation organization may be  
3427 accepted in lieu of a complete licensure inspection. However, a  
3428 licensure inspection may also be conducted to review any  
3429 licensure requirements that are not also requirements for  
3430 certification.

20091986er

3431 (3) The agency shall have access to and the licensee shall  
3432 provide, or if requested send, copies of all provider records  
3433 required during an inspection or other review at no cost to the  
3434 agency, including records requested during an offsite review.

3435 (4) A deficiency must be corrected within 30 calendar days  
3436 after the provider is notified of inspection results unless an  
3437 alternative timeframe is required or approved by the agency.

3438 (5) The agency may require an applicant or licensee to  
3439 submit a plan of correction for deficiencies. If required, the  
3440 plan of correction must be filed with the agency within 10  
3441 calendar days after notification unless an alternative timeframe  
3442 is required.

3443 (6) (a) ~~(4) (a)~~ Each licensee shall maintain as public  
3444 information, available upon request, records of all inspection  
3445 reports pertaining to that provider that have been filed by the  
3446 agency unless those reports are exempt from or contain  
3447 information that is exempt from s. 119.07(1) and s. 24(a), Art.  
3448 I of the State Constitution or is otherwise made confidential by  
3449 law. Effective October 1, 2006, copies of such reports shall be  
3450 retained in the records of the provider for at least 3 years  
3451 following the date the reports are filed and issued, regardless  
3452 of a change of ownership.

3453 (b) A licensee shall, upon the request of any person who  
3454 has completed a written application with intent to be admitted  
3455 by such provider, any person who is a client of such provider,  
3456 or any relative, spouse, or guardian of any such person, furnish  
3457 to the requester a copy of the last inspection report pertaining  
3458 to the licensed provider that was issued by the agency or by an  
3459 accrediting organization if such report is used in lieu of a

20091986er

3460 licensure inspection.

3461 Section 52. Section 408.813, Florida Statutes, is amended  
3462 to read:

3463 408.813 Administrative fines; violations.—As a penalty for  
3464 any violation of this part, authorizing statutes, or applicable  
3465 rules, the agency may impose an administrative fine.

3466 (1) Unless the amount or aggregate limitation of the fine  
3467 is prescribed by authorizing statutes or applicable rules, the  
3468 agency may establish criteria by rule for the amount or  
3469 aggregate limitation of administrative fines applicable to this  
3470 part, authorizing statutes, and applicable rules. Each day of  
3471 violation constitutes a separate violation and is subject to a  
3472 separate fine. For fines imposed by final order of the agency  
3473 and not subject to further appeal, the violator shall pay the  
3474 fine plus interest at the rate specified in s. 55.03 for each  
3475 day beyond the date set by the agency for payment of the fine.

3476 (2) Violations of this part, authorizing statutes, or  
3477 applicable rules shall be classified according to the nature of  
3478 the violation and the gravity of its probable effect on clients.  
3479 The scope of a violation may be cited as an isolated, patterned,  
3480 or widespread deficiency. An isolated deficiency is a deficiency  
3481 affecting one or a very limited number of clients, or involving  
3482 one or a very limited number of staff, or a situation that  
3483 occurred only occasionally or in a very limited number of  
3484 locations. A patterned deficiency is a deficiency in which more  
3485 than a very limited number of clients are affected, or more than  
3486 a very limited number of staff are involved, or the situation  
3487 has occurred in several locations, or the same client or clients  
3488 have been affected by repeated occurrences of the same deficient

20091986er

3489 practice but the effect of the deficient practice is not found  
3490 to be pervasive throughout the provider. A widespread deficiency  
3491 is a deficiency in which the problems causing the deficiency are  
3492 pervasive in the provider or represent systemic failure that has  
3493 affected or has the potential to affect a large portion of the  
3494 provider's clients. This subsection does not affect the  
3495 legislative determination of the amount of a fine imposed under  
3496 authorizing statutes. Violations shall be classified on the  
3497 written notice as follows:

3498 (a) Class "I" violations are those conditions or  
3499 occurrences related to the operation and maintenance of a  
3500 provider or to the care of clients which the agency determines  
3501 present an imminent danger to the clients of the provider or a  
3502 substantial probability that death or serious physical or  
3503 emotional harm would result therefrom. The condition or practice  
3504 constituting a class I violation shall be abated or eliminated  
3505 within 24 hours, unless a fixed period, as determined by the  
3506 agency, is required for correction. The agency shall impose an  
3507 administrative fine as provided by law for a cited class I  
3508 violation. A fine shall be levied notwithstanding the correction  
3509 of the violation.

3510 (b) Class "II" violations are those conditions or  
3511 occurrences related to the operation and maintenance of a  
3512 provider or to the care of clients which the agency determines  
3513 directly threaten the physical or emotional health, safety, or  
3514 security of the clients, other than class I violations. The  
3515 agency shall impose an administrative fine as provided by law  
3516 for a cited class II violation. A fine shall be levied  
3517 notwithstanding the correction of the violation.



20091986er

3518           (c) Class "III" violations are those conditions or  
3519 occurrences related to the operation and maintenance of a  
3520 provider or to the care of clients which the agency determines  
3521 indirectly or potentially threaten the physical or emotional  
3522 health, safety, or security of clients, other than class I or  
3523 class II violations. The agency shall impose an administrative  
3524 fine as provided in this section for a cited class III  
3525 violation. A citation for a class III violation must specify the  
3526 time within which the violation is required to be corrected. If  
3527 a class III violation is corrected within the time specified, a  
3528 fine may not be imposed.

3529           (d) Class "IV" violations are those conditions or  
3530 occurrences related to the operation and maintenance of a  
3531 provider or to required reports, forms, or documents that do not  
3532 have the potential of negatively affecting clients. These  
3533 violations are of a type that the agency determines do not  
3534 threaten the health, safety, or security of clients. The agency  
3535 shall impose an administrative fine as provided in this section  
3536 for a cited class IV violation. A citation for a class IV  
3537 violation must specify the time within which the violation is  
3538 required to be corrected. If a class IV violation is corrected  
3539 within the time specified, a fine may not be imposed.

3540           Section 53. Subsections (11), (12), (13), (14), (15), (16),  
3541 (17), (18), (19), (20), (21), (22), (23), (24), (25), (26),  
3542 (27), (28), and (29) of section 408.820, Florida Statutes, are  
3543 amended to read:

3544           408.820 Exemptions.—Except as prescribed in authorizing  
3545 statutes, the following exemptions shall apply to specified  
3546 requirements of this part:

20091986er

3547 ~~(11) Private review agents, as provided under part I of~~  
3548 ~~chapter 395, are exempt from ss. 408.806(7), 408.810, and~~  
3549 ~~408.811.~~

3550 (11)~~(12)~~ Health care risk managers, as provided under part  
3551 I of chapter 395, are exempt from ss. 408.806(7), 408.810(4)-  
3552 (10) ~~408.810~~, and 408.811.

3553 (12)~~(13)~~ Nursing homes, as provided under part II of  
3554 chapter 400, are exempt from ss. 408.810(7) and 408.813(2) ~~s.~~  
3555 ~~408.810(7).~~

3556 (13)~~(14)~~ Assisted living facilities, as provided under part  
3557 I of chapter 429, are exempt from s. 408.810(10).

3558 (14)~~(15)~~ Home health agencies, as provided under part III  
3559 of chapter 400, are exempt from s. 408.810(10).

3560 (15)~~(16)~~ Nurse registries, as provided under part III of  
3561 chapter 400, are exempt from s. 408.810(6) and (10).

3562 (16)~~(17)~~ Companion services or homemaker services  
3563 providers, as provided under part III of chapter 400, are exempt  
3564 from s. 408.810(6)-(10).

3565 (17)~~(18)~~ Adult day care centers, as provided under part III  
3566 of chapter 429, are exempt from s. 408.810(10).

3567 (18)~~(19)~~ Adult family-care homes, as provided under part II  
3568 of chapter 429, are exempt from s. 408.810(7)-(10).

3569 (19)~~(20)~~ Homes for special services, as provided under part  
3570 V of chapter 400, are exempt from s. 408.810(7)-(10).

3571 (20)~~(21)~~ Transitional living facilities, as provided under  
3572 part V of chapter 400, are exempt from s. 408.810(10) ~~s.~~  
3573 ~~408.810(7)-(10).~~

3574 (21)~~(22)~~ Prescribed pediatric extended care centers, as  
3575 provided under part VI of chapter 400, are exempt from s.

20091986er

3576 408.810(10).

3577 (22)~~(23)~~ Home medical equipment providers, as provided  
3578 under part VII of chapter 400, are exempt from s. 408.810(10).

3579 (23)~~(24)~~ Intermediate care facilities for persons with  
3580 developmental disabilities, as provided under part VIII of  
3581 chapter 400, are exempt from s. 408.810(7).

3582 (24)~~(25)~~ Health care services pools, as provided under part  
3583 IX of chapter 400, are exempt from s. 408.810(6)-(10).

3584 (25)~~(26)~~ Health care clinics, as provided under part X of  
3585 chapter 400, are exempt from s. 408.810(6), (7), (10) ss.  
3586 ~~408.809 and 408.810(1), (6), (7), and (10).~~

3587 (26)~~(27)~~ Clinical laboratories, as provided under part I of  
3588 chapter 483, are exempt from s. 408.810(5)-(10).

3589 (27)~~(28)~~ Multiphasic health testing centers, as provided  
3590 under part II of chapter 483, are exempt from s. 408.810(5)-  
3591 (10).

3592 (28)~~(29)~~ Organ and tissue procurement agencies, as provided  
3593 under chapter 765, are exempt from s. 408.810(5)-(10).

3594 Section 54. Section 408.821, Florida Statutes, is created  
3595 to read:

3596 408.821 Emergency management planning; emergency  
3597 operations; inactive license.-

3598 (1) A licensee required by authorizing statutes to have an  
3599 emergency operations plan must designate a safety liaison to  
3600 serve as the primary contact for emergency operations.

3601 (2) An entity subject to this part may temporarily exceed  
3602 its licensed capacity to act as a receiving provider in  
3603 accordance with an approved emergency operations plan for up to  
3604 15 days. While in an overcapacity status, each provider must

20091986er

3605 furnish or arrange for appropriate care and services to all  
3606 clients. In addition, the agency may approve requests for  
3607 overcapacity in excess of 15 days, which approvals may be based  
3608 upon satisfactory justification and need as provided by the  
3609 receiving and sending providers.

3610 (3) (a) An inactive license may be issued to a licensee  
3611 subject to this section when the provider is located in a  
3612 geographic area in which a state of emergency was declared by  
3613 the Governor if the provider:

3614 1. Suffered damage to its operation during the state of  
3615 emergency.

3616 2. Is currently licensed.

3617 3. Does not have a provisional license.

3618 4. Will be temporarily unable to provide services but is  
3619 reasonably expected to resume services within 12 months.

3620 (b) An inactive license may be issued for a period not to  
3621 exceed 12 months but may be renewed by the agency for up to 12  
3622 additional months upon demonstration to the agency of progress  
3623 toward reopening. A request by a licensee for an inactive  
3624 license or to extend the previously approved inactive period  
3625 must be submitted in writing to the agency, accompanied by  
3626 written justification for the inactive license, which states the  
3627 beginning and ending dates of inactivity and includes a plan for  
3628 the transfer of any clients to other providers and appropriate  
3629 licensure fees. Upon agency approval, the licensee shall notify  
3630 clients of any necessary discharge or transfer as required by  
3631 authorizing statutes or applicable rules. The beginning of the  
3632 inactive licensure period shall be the date the provider ceases  
3633 operations. The end of the inactive period shall become the

20091986er

3634 license expiration date, and all licensure fees must be current,  
3635 must be paid in full, and may be prorated. Reactivation of an  
3636 inactive license requires the prior approval by the agency of a  
3637 renewal application, including payment of licensure fees and  
3638 agency inspections indicating compliance with all requirements  
3639 of this part and applicable rules and statutes.

3640 (4) The agency may adopt rules relating to emergency  
3641 management planning, communications, and operations. Licensees  
3642 providing residential or inpatient services must utilize an  
3643 online database approved by the agency to report information to  
3644 the agency regarding the provider's emergency status, planning,  
3645 or operations.

3646 Section 55. Section 408.831, Florida Statutes, is amended  
3647 to read:

3648 408.831 Denial, suspension, or revocation of a license,  
3649 registration, certificate, or application.—

3650 (1) In addition to any other remedies provided by law, the  
3651 agency may deny each application or suspend or revoke each  
3652 license, registration, or certificate of entities regulated or  
3653 licensed by it:

3654 (a) If the applicant, licensee, or a licensee subject to  
3655 this part which shares a common controlling interest with the  
3656 applicant has failed to pay all outstanding fines, liens, or  
3657 overpayments assessed by final order of the agency or final  
3658 order of the Centers for Medicare and Medicaid Services, not  
3659 subject to further appeal, unless a repayment plan is approved  
3660 by the agency; or

3661 (b) For failure to comply with any repayment plan.

3662 (2) In reviewing any application requesting a change of

20091986er

3663 ownership or change of the licensee, registrant, or  
3664 certificateholder, the transferor shall, prior to agency  
3665 approval of the change, repay or make arrangements to repay any  
3666 amounts owed to the agency. Should the transferor fail to repay  
3667 or make arrangements to repay the amounts owed to the agency,  
3668 the issuance of a license, registration, or certificate to the  
3669 transferee shall be delayed until repayment or until  
3670 arrangements for repayment are made.

3671 ~~(3) An entity subject to this section may exceed its~~  
3672 ~~licensed capacity to act as a receiving facility in accordance~~  
3673 ~~with an emergency operations plan for clients of evacuating~~  
3674 ~~providers from a geographic area where an evacuation order has~~  
3675 ~~been issued by a local authority having jurisdiction. While in~~  
3676 ~~an overcapacity status, each provider must furnish or arrange~~  
3677 ~~for appropriate care and services to all clients. In addition,~~  
3678 ~~the agency may approve requests for overcapacity beyond 15 days,~~  
3679 ~~which approvals may be based upon satisfactory justification and~~  
3680 ~~need as provided by the receiving and sending facilities.~~

3681 ~~(4) (a) An inactive license may be issued to a licensee~~  
3682 ~~subject to this section when the provider is located in a~~  
3683 ~~geographic area where a state of emergency was declared by the~~  
3684 ~~Governor if the provider:~~

3685 ~~1. Suffered damage to its operation during that state of~~  
3686 ~~emergency.~~

3687 ~~2. Is currently licensed.~~

3688 ~~3. Does not have a provisional license.~~

3689 ~~4. Will be temporarily unable to provide services but is~~  
3690 ~~reasonably expected to resume services within 12 months.~~

3691 ~~(b) An inactive license may be issued for a period not to~~

20091986er

3692 ~~exceed 12 months but may be renewed by the agency for up to 12~~  
3693 ~~additional months upon demonstration to the agency of progress~~  
3694 ~~toward reopening. A request by a licensee for an inactive~~  
3695 ~~license or to extend the previously approved inactive period~~  
3696 ~~must be submitted in writing to the agency, accompanied by~~  
3697 ~~written justification for the inactive license, which states the~~  
3698 ~~beginning and ending dates of inactivity and includes a plan for~~  
3699 ~~the transfer of any clients to other providers and appropriate~~  
3700 ~~licensure fees. Upon agency approval, the licensee shall notify~~  
3701 ~~clients of any necessary discharge or transfer as required by~~  
3702 ~~authorizing statutes or applicable rules. The beginning of the~~  
3703 ~~inactive licensure period shall be the date the provider ceases~~  
3704 ~~operations. The end of the inactive period shall become the~~  
3705 ~~licensee expiration date, and all licensure fees must be~~  
3706 ~~current, paid in full, and may be prorated. Reactivation of an~~  
3707 ~~inactive license requires the prior approval by the agency of a~~  
3708 ~~renewal application, including payment of licensure fees and~~  
3709 ~~agency inspections indicating compliance with all requirements~~  
3710 ~~of this part and applicable rules and statutes.~~

3711 (3)~~(5)~~ This section provides standards of enforcement  
3712 applicable to all entities licensed or regulated by the Agency  
3713 for Health Care Administration. This section controls over any  
3714 conflicting provisions of chapters 39, 383, 390, 391, 394, 395,  
3715 400, 408, 429, 468, 483, and 765 or rules adopted pursuant to  
3716 those chapters.

3717 Section 56. Subsection (2) of section 408.918, Florida  
3718 Statutes, is amended, and subsection (3) is added to that  
3719 section, to read:

3720 408.918 Florida 211 Network; uniform certification

20091986er

3721 requirements.-

3722 (2) In order to participate in the Florida 211 Network, a  
3723 211 provider must be fully accredited by the National certified  
3724 ~~by the Agency for Health Care Administration. The agency shall~~  
3725 ~~develop criteria for certification, as recommended by the~~  
3726 Florida Alliance of Information and Referral Services or have  
3727 received approval to operate, pending accreditation, from its  
3728 affiliate, the Florida Alliance of Information and Referral  
3729 Services, and shall ~~adopt the criteria as administrative rules.~~

3730 (a) If any provider of information and referral services or  
3731 other entity leases a 211 number from a local exchange company  
3732 and is not authorized as described in this section, ~~certified by~~  
3733 ~~the agency, the agency shall, after consultation with the local~~  
3734 ~~exchange company and the Public Service Commission shall,~~  
3735 request that the Federal Communications Commission direct the  
3736 local exchange company to revoke the use of the 211 number.

3737 (b) ~~The agency shall seek the assistance and guidance of~~  
3738 ~~the Public Service Commission and the Federal Communications~~  
3739 ~~Commission in resolving any disputes arising over jurisdiction~~  
3740 ~~related to 211 numbers.~~

3741 (3) The Florida Alliance of Information and Referral  
3742 Services is the 211 collaborative organization for the state  
3743 which is responsible for studying, designing, implementing,  
3744 supporting, and coordinating the Florida 211 Network and for  
3745 receiving federal grants.

3746 Section 57. Paragraph (e) of subsection (4) of section  
3747 409.221, Florida Statutes, is amended to read:

3748 409.221 Consumer-directed care program.-

3749 (4) CONSUMER-DIRECTED CARE.-



20091986er

3750 (e) *Services*.—Consumers shall use the budget allowance only  
3751 to pay for home and community-based services that meet the  
3752 consumer's long-term care needs and are a cost-efficient use of  
3753 funds. Such services may include, but are not limited to, the  
3754 following:

3755 1. Personal care.

3756 2. Homemaking and chores, including housework, meals,  
3757 shopping, and transportation.

3758 3. Home modifications and assistive devices which may  
3759 increase the consumer's independence or make it possible to  
3760 avoid institutional placement.

3761 4. Assistance in taking self-administered medication.

3762 5. Day care and respite care services, including those  
3763 provided by nursing home facilities pursuant to s. 400.141(1)(f)  
3764 ~~s. 400.141(6)~~ or by adult day care facilities licensed pursuant  
3765 to s. 429.907.

3766 6. Personal care and support services provided in an  
3767 assisted living facility.

3768 Section 58. Subsection (5) of section 409.901, Florida  
3769 Statutes, is amended to read:

3770 409.901 Definitions; ss. 409.901-409.920.—As used in ss.  
3771 409.901-409.920, except as otherwise specifically provided, the  
3772 term:

3773 (5) "Change of ownership" means:

3774 (a) An event in which the provider ownership changes to a  
3775 different individual legal entity as evidenced by a change in  
3776 federal employer identification number or taxpayer  
3777 identification number; ~~or~~

3778 (b) An event in which 51 ~~45~~ percent or more of the

20091986er

3779 ownership, ~~voting~~ shares, membership, or controlling interest of  
3780 a provider is in any manner transferred or otherwise assigned.  
3781 This paragraph does not apply to a licensee that is publicly  
3782 traded on a recognized stock exchange; or

3783 (c) When the provider is licensed or registered by the  
3784 agency, an event considered a change of ownership for licensure  
3785 as defined in s. 408.803 in a corporation whose shares are not  
3786 publicly traded on a recognized stock exchange is transferred or  
3787 assigned, including the final transfer or assignment of multiple  
3788 transfers or assignments over a 2-year period that cumulatively  
3789 total 45 percent or more.

3790  
3791 A change solely in the management company or board of directors  
3792 is not a change of ownership.

3793 Section 59. Section 429.071, Florida Statutes, is repealed.

3794 Section 60. Paragraph (e) of subsection (1) and subsections  
3795 (2) and (3) of section 429.08, Florida Statutes, are amended to  
3796 read:

3797 429.08 Unlicensed facilities; referral of person for  
3798 residency to unlicensed facility; penalties; verification of  
3799 licensure status.—

3800 (1)

3801 (e) The agency shall publish ~~provide to the department's~~  
3802 ~~elder information and referral providers~~ a list, by county, of  
3803 licensed assisted living facilities, ~~to assist persons who are~~  
3804 ~~considering an assisted living facility placement in locating a~~  
3805 ~~licensed facility.~~ This information may be provided  
3806 electronically or through the agency's Internet site.

3807 ~~(2) Each field office of the Agency for Health Care~~

20091986er

3808 ~~Administration shall establish a local coordinating workgroup~~  
3809 ~~which includes representatives of local law enforcement~~  
3810 ~~agencies, state attorneys, the Medicaid Fraud Control Unit of~~  
3811 ~~the Department of Legal Affairs, local fire authorities, the~~  
3812 ~~Department of Children and Family Services, the district long-~~  
3813 ~~term care ombudsman council, and the district human rights~~  
3814 ~~advocacy committee to assist in identifying the operation of~~  
3815 ~~unlicensed facilities and to develop and implement a plan to~~  
3816 ~~ensure effective enforcement of state laws relating to such~~  
3817 ~~facilities. The workgroup shall report its findings, actions,~~  
3818 ~~and recommendations semiannually to the Director of Health~~  
3819 ~~Quality Assurance of the agency.~~

3820 (2)~~(3)~~ It is unlawful to knowingly refer a person for  
3821 residency to an unlicensed assisted living facility; to an  
3822 assisted living facility the license of which is under denial or  
3823 has been suspended or revoked; or to an assisted living facility  
3824 that has a moratorium pursuant to part II of chapter 408. ~~Any~~  
3825 ~~person who violates this subsection commits a noncriminal~~  
3826 ~~violation, punishable by a fine not exceeding \$500 as provided~~  
3827 ~~in s. 775.083.~~

3828 (a) Any health care practitioner, as defined in s. 456.001,  
3829 who is aware of the operation of an unlicensed facility shall  
3830 report that facility to the agency. Failure to report a facility  
3831 that the practitioner knows or has reasonable cause to suspect  
3832 is unlicensed shall be reported to the practitioner's licensing  
3833 board.

3834 (b) Any provider as defined in s. 408.803 ~~hospital or~~  
3835 ~~community mental health center licensed under chapter 395 or~~  
3836 ~~chapter 394~~ which knowingly discharges a patient or client to an

20091986er

3837 unlicensed facility is subject to sanction by the agency.

3838 (c) Any employee of the agency or department, or the  
3839 Department of Children and Family Services, who knowingly refers  
3840 a person for residency to an unlicensed facility; to a facility  
3841 the license of which is under denial or has been suspended or  
3842 revoked; or to a facility that has a moratorium pursuant to part  
3843 II of chapter 408 is subject to disciplinary action by the  
3844 agency or department, or the Department of Children and Family  
3845 Services.

3846 (d) The employer of any person who is under contract with  
3847 the agency or department, or the Department of Children and  
3848 Family Services, and who knowingly refers a person for residency  
3849 to an unlicensed facility; to a facility the license of which is  
3850 under denial or has been suspended or revoked; or to a facility  
3851 that has a moratorium pursuant to part II of chapter 408 shall  
3852 be fined and required to prepare a corrective action plan  
3853 designed to prevent such referrals.

3854 ~~(e) The agency shall provide the department and the~~  
3855 ~~Department of Children and Family Services with a list of~~  
3856 ~~licensed facilities within each county and shall update the list~~  
3857 ~~at least quarterly.~~

3858 ~~(f) At least annually, the agency shall notify, in~~  
3859 ~~appropriate trade publications, physicians licensed under~~  
3860 ~~chapter 458 or chapter 459, hospitals licensed under chapter~~  
3861 ~~395, nursing home facilities licensed under part II of chapter~~  
3862 ~~400, and employees of the agency or the department, or the~~  
3863 ~~Department of Children and Family Services, who are responsible~~  
3864 ~~for referring persons for residency, that it is unlawful to~~  
3865 ~~knowingly refer a person for residency to an unlicensed assisted~~

20091986er

3866 ~~living facility and shall notify them of the penalty for~~  
3867 ~~violating such prohibition. The department and the Department of~~  
3868 ~~Children and Family Services shall, in turn, notify service~~  
3869 ~~providers under contract to the respective departments who have~~  
3870 ~~responsibility for resident referrals to facilities. Further,~~  
3871 ~~the notice must direct each noticed facility and individual to~~  
3872 ~~contact the appropriate agency office in order to verify the~~  
3873 ~~licensure status of any facility prior to referring any person~~  
3874 ~~for residency. Each notice must include the name, telephone~~  
3875 ~~number, and mailing address of the appropriate office to~~  
3876 ~~contact.~~

3877 Section 61. Paragraph (e) of subsection (1) of section  
3878 429.14, Florida Statutes, is amended to read:

3879 429.14 Administrative penalties.—

3880 (1) In addition to the requirements of part II of chapter  
3881 408, the agency may deny, revoke, and suspend any license issued  
3882 under this part and impose an administrative fine in the manner  
3883 provided in chapter 120 against a licensee of an assisted living  
3884 facility for a violation of any provision of this part, part II  
3885 of chapter 408, or applicable rules, or for any of the following  
3886 actions by a licensee of an assisted living facility, for the  
3887 actions of any person subject to level 2 background screening  
3888 under s. 408.809, or for the actions of any facility employee:

3889 (e) A citation of any of the following deficiencies as  
3890 specified ~~defined~~ in s. 429.19:

- 3891 1. One or more cited class I deficiencies.
- 3892 2. Three or more cited class II deficiencies.
- 3893 3. Five or more cited class III deficiencies that have been  
3894 cited on a single survey and have not been corrected within the

20091986er

3895 times specified.

3896 Section 62. Section 429.19, Florida Statutes, is amended to  
3897 read:

3898 429.19 Violations; imposition of administrative fines;  
3899 grounds.—

3900 (1) In addition to the requirements of part II of chapter  
3901 408, the agency shall impose an administrative fine in the  
3902 manner provided in chapter 120 for the violation of any  
3903 provision of this part, part II of chapter 408, and applicable  
3904 rules by an assisted living facility, for the actions of any  
3905 person subject to level 2 background screening under s. 408.809,  
3906 for the actions of any facility employee, or for an intentional  
3907 or negligent act seriously affecting the health, safety, or  
3908 welfare of a resident of the facility.

3909 (2) Each violation of this part and adopted rules shall be  
3910 classified according to the nature of the violation and the  
3911 gravity of its probable effect on facility residents. The agency  
3912 shall indicate the classification on the written notice of the  
3913 violation as follows:

3914 (a) Class "I" violations are defined in s. 408.813 ~~those~~  
3915 ~~conditions or occurrences related to the operation and~~  
3916 ~~maintenance of a facility or to the personal care of residents~~  
3917 ~~which the agency determines present an imminent danger to the~~  
3918 ~~residents or guests of the facility or a substantial probability~~  
3919 ~~that death or serious physical or emotional harm would result~~  
3920 ~~therefrom. The condition or practice constituting a class I~~  
3921 ~~violation shall be abated or eliminated within 24 hours, unless~~  
3922 ~~a fixed period, as determined by the agency, is required for~~  
3923 ~~correction.~~ The agency shall impose an administrative fine for a

20091986er

3924 cited class I violation in an amount not less than \$5,000 and  
3925 not exceeding \$10,000 for each violation. ~~A fine may be levied~~  
3926 ~~notwithstanding the correction of the violation.~~

3927 (b) Class "II" violations are defined in s. 408.813 ~~those~~  
3928 ~~conditions or occurrences related to the operation and~~  
3929 ~~maintenance of a facility or to the personal care of residents~~  
3930 ~~which the agency determines directly threaten the physical or~~  
3931 ~~emotional health, safety, or security of the facility residents,~~  
3932 ~~other than class I violations.~~ The agency shall impose an  
3933 administrative fine for a cited class II violation in an amount  
3934 not less than \$1,000 and not exceeding \$5,000 for each  
3935 violation. ~~A fine shall be levied notwithstanding the correction~~  
3936 ~~of the violation.~~

3937 (c) Class "III" violations are defined in s. 408.813 ~~those~~  
3938 ~~conditions or occurrences related to the operation and~~  
3939 ~~maintenance of a facility or to the personal care of residents~~  
3940 ~~which the agency determines indirectly or potentially threaten~~  
3941 ~~the physical or emotional health, safety, or security of~~  
3942 ~~facility residents, other than class I or class II violations.~~  
3943 The agency shall impose an administrative fine for a cited class  
3944 III violation in an amount not less than \$500 and not exceeding  
3945 \$1,000 for each violation. ~~A citation for a class III violation~~  
3946 ~~must specify the time within which the violation is required to~~  
3947 ~~be corrected. If a class III violation is corrected within the~~  
3948 ~~time specified, no fine may be imposed, unless it is a repeated~~  
3949 ~~offense.~~

3950 (d) Class "IV" violations are defined in s. 408.813 ~~those~~  
3951 ~~conditions or occurrences related to the operation and~~  
3952 ~~maintenance of a building or to required reports, forms, or~~

20091986er

3953 ~~documents that do not have the potential of negatively affecting~~  
3954 ~~residents. These violations are of a type that the agency~~  
3955 ~~determines do not threaten the health, safety, or security of~~  
3956 ~~residents of the facility.~~ The agency shall impose an  
3957 administrative fine for a cited class IV violation in an amount  
3958 not less than \$100 and not exceeding \$200 for each violation. A  
3959 ~~citation for a class IV violation must specify the time within~~  
3960 ~~which the violation is required to be corrected. If a class IV~~  
3961 ~~violation is corrected within the time specified, no fine shall~~  
3962 ~~be imposed. Any class IV violation that is corrected during the~~  
3963 ~~time an agency survey is being conducted will be identified as~~  
3964 ~~an agency finding and not as a violation.~~

3965 (3) For purposes of this section, in determining if a  
3966 penalty is to be imposed and in fixing the amount of the fine,  
3967 the agency shall consider the following factors:

3968 (a) The gravity of the violation, including the probability  
3969 that death or serious physical or emotional harm to a resident  
3970 will result or has resulted, the severity of the action or  
3971 potential harm, and the extent to which the provisions of the  
3972 applicable laws or rules were violated.

3973 (b) Actions taken by the owner or administrator to correct  
3974 violations.

3975 (c) Any previous violations.

3976 (d) The financial benefit to the facility of committing or  
3977 continuing the violation.

3978 (e) The licensed capacity of the facility.

3979 (4) Each day of continuing violation after the date fixed  
3980 for termination of the violation, as ordered by the agency,  
3981 constitutes an additional, separate, and distinct violation.



20091986er

3982 (5) Any action taken to correct a violation shall be  
3983 documented in writing by the owner or administrator of the  
3984 facility and verified through followup visits by agency  
3985 personnel. The agency may impose a fine and, in the case of an  
3986 owner-operated facility, revoke or deny a facility's license  
3987 when a facility administrator fraudulently misrepresents action  
3988 taken to correct a violation.

3989 (6) Any facility whose owner fails to apply for a change-  
3990 of-ownership license in accordance with part II of chapter 408  
3991 and operates the facility under the new ownership is subject to  
3992 a fine of \$5,000.

3993 (7) In addition to any administrative fines imposed, the  
3994 agency may assess a survey fee, equal to the lesser of one half  
3995 of the facility's biennial license and bed fee or \$500, to cover  
3996 the cost of conducting initial complaint investigations that  
3997 result in the finding of a violation that was the subject of the  
3998 complaint or monitoring visits conducted under s. 429.28(3)(c)  
3999 to verify the correction of the violations.

4000 (8) During an inspection, the agency, ~~as an alternative to~~  
4001 ~~or in conjunction with an administrative action against a~~  
4002 ~~facility for violations of this part and adopted rules,~~ shall  
4003 make a reasonable attempt to discuss each violation and  
4004 ~~recommended corrective action~~ with the owner or administrator of  
4005 the facility, prior to written notification. ~~The agency, instead~~  
4006 ~~of fixing a period within which the facility shall enter into~~  
4007 ~~compliance with standards,~~ may request a plan of corrective  
4008 ~~action from the facility which demonstrates a good faith effort~~  
4009 ~~to remedy each violation by a specific date, subject to the~~  
4010 ~~approval of the agency.~~

20091986er

4011 (9) The agency shall develop and disseminate an annual list  
4012 of all facilities sanctioned or fined ~~\$5,000 or more~~ for  
4013 violations of state standards, the number and class of  
4014 violations involved, the penalties imposed, and the current  
4015 status of cases. The list shall be disseminated, at no charge,  
4016 to the Department of Elderly Affairs, the Department of Health,  
4017 the Department of Children and Family Services, the Agency for  
4018 Persons with Disabilities, the area agencies on aging, the  
4019 Florida Statewide Advocacy Council, and the state and local  
4020 ombudsman councils. The Department of Children and Family  
4021 Services shall disseminate the list to service providers under  
4022 contract to the department who are responsible for referring  
4023 persons to a facility for residency. The agency may charge a fee  
4024 commensurate with the cost of printing and postage to other  
4025 interested parties requesting a copy of this list. This  
4026 information may be provided electronically or through the  
4027 agency's Internet site.

4028 Section 63. Subsections (2) and (6) of section 429.23,  
4029 Florida Statutes, are amended to read:

4030 429.23 Internal risk management and quality assurance  
4031 program; adverse incidents and reporting requirements.—

4032 (2) Every facility licensed under this part is required to  
4033 maintain adverse incident reports. For purposes of this section,  
4034 the term, "adverse incident" means:

4035 (a) An event over which facility personnel could exercise  
4036 control rather than as a result of the resident's condition and  
4037 results in:

- 4038 1. Death;
- 4039 2. Brain or spinal damage;

20091986er

- 4040 3. Permanent disfigurement;
- 4041 4. Fracture or dislocation of bones or joints;
- 4042 5. Any condition that required medical attention to which
- 4043 the resident has not given his or her consent, including failure
- 4044 to honor advanced directives;
- 4045 6. Any condition that requires the transfer of the resident
- 4046 from the facility to a unit providing more acute care due to the
- 4047 incident rather than the resident's condition before the
- 4048 incident; or-
- 4049 7. An event that is reported to law enforcement or its
- 4050 personnel for investigation; or
- 4051 ~~(b) Abuse, neglect, or exploitation as defined in s.~~
- 4052 ~~415.102;~~
- 4053 ~~(c) Events reported to law enforcement; or~~
- 4054 (b)(d) Resident elopement, if the elopement places the
- 4055 resident at risk of harm or injury.
- 4056 (6) Abuse, neglect, or exploitation must be reported to the
- 4057 Department of Children and Family Services as required under
- 4058 chapter 415 ~~The agency shall annually submit to the Legislature~~
- 4059 ~~a report on assisted living facility adverse incident reports.~~
- 4060 ~~The report must include the following information arranged by~~
- 4061 ~~county:~~
- 4062 ~~(a) A total number of adverse incidents;~~
- 4063 ~~(b) A listing, by category, of the type of adverse~~
- 4064 ~~incidents occurring within each category and the type of staff~~
- 4065 ~~involved;~~
- 4066 ~~(c) A listing, by category, of the types of injuries, if~~
- 4067 ~~any, and the number of injuries occurring within each category;~~
- 4068 ~~(d) Types of liability claims filed based on an adverse~~

20091986er

4069 ~~incident report or reportable injury; and~~

4070 ~~(c) Disciplinary action taken against staff, categorized by~~  
4071 ~~the type of staff involved.~~

4072 Section 64. Subsection (9) of section 429.26, Florida  
4073 Statutes, is repealed.

4074 Section 65. Subsection (3) of section 430.80, Florida  
4075 Statutes, is amended to read:

4076 430.80 Implementation of a teaching nursing home pilot  
4077 project.—

4078 (3) To be designated as a teaching nursing home, a nursing  
4079 home licensee must, at a minimum:

4080 (a) Provide a comprehensive program of integrated senior  
4081 services that include institutional services and community-based  
4082 services;

4083 (b) Participate in a nationally recognized accreditation  
4084 program and hold a valid accreditation, such as the  
4085 accreditation awarded by the Joint Commission on Accreditation  
4086 of Healthcare Organizations;

4087 (c) Have been in business in this state for a minimum of 10  
4088 consecutive years;

4089 (d) Demonstrate an active program in multidisciplinary  
4090 education and research that relates to gerontology;

4091 (e) Have a formalized contractual relationship with at  
4092 least one accredited health profession education program located  
4093 in this state;

4094 (f) Have a formalized contractual relationship with an  
4095 accredited hospital that is designated by law as a teaching  
4096 hospital; and

4097 (g) Have senior staff members who hold formal faculty

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4098 appointments at universities, which must include at least one  
4099 accredited health profession education program.

4100 (h) Maintain insurance coverage pursuant to s.  
4101 400.141(1)(s) ~~s. 400.141(20)~~ or proof of financial  
4102 responsibility in a minimum amount of \$750,000. Such proof of  
4103 financial responsibility may include:

4104 1. Maintaining an escrow account consisting of cash or  
4105 assets eligible for deposit in accordance with s. 625.52; or  
4106 2. Obtaining and maintaining pursuant to chapter 675 an  
4107 unexpired, irrevocable, nontransferable and nonassignable letter  
4108 of credit issued by any bank or savings association organized  
4109 and existing under the laws of this state or any bank or savings  
4110 association organized under the laws of the United States that  
4111 has its principal place of business in this state or has a  
4112 branch office which is authorized to receive deposits in this  
4113 state. The letter of credit shall be used to satisfy the  
4114 obligation of the facility to the claimant upon presentment of a  
4115 final judgment indicating liability and awarding damages to be  
4116 paid by the facility or upon presentment of a settlement  
4117 agreement signed by all parties to the agreement when such final  
4118 judgment or settlement is a result of a liability claim against  
4119 the facility.

4120 Section 66. Subsection (5) of section 435.04, Florida  
4121 Statutes, is amended to read:

4122 435.04 Level 2 screening standards.—

4123 (5) Under penalty of perjury, all employees in such  
4124 positions of trust or responsibility shall attest to meeting the  
4125 requirements for qualifying for employment and agreeing to  
4126 inform the employer immediately if convicted of any of the

20091986er

4127 disqualifying offenses while employed by the employer. Each  
4128 employer of employees in such positions of trust or  
4129 responsibilities which is licensed or registered by a state  
4130 agency shall submit to the licensing agency annually or at the  
4131 time of license renewal, under penalty of perjury, an affidavit  
4132 of compliance with the provisions of this section.

4133 Section 67. Subsection (3) of section 435.05, Florida  
4134 Statutes, is amended to read:

4135 435.05 Requirements for covered employees.—Except as  
4136 otherwise provided by law, the following requirements shall  
4137 apply to covered employees:

4138 (3) Each employer required to conduct level 2 background  
4139 screening must sign an affidavit annually or at the time of  
4140 license renewal, under penalty of perjury, stating that all  
4141 covered employees have been screened or are newly hired and are  
4142 awaiting the results of the required screening checks.

4143 Section 68. Subsection (2) of section 483.031, Florida  
4144 Statutes, is amended to read:

4145 483.031 Application of part; exemptions.—This part applies  
4146 to all clinical laboratories within this state, except:

4147 (2) A clinical laboratory that performs only waived tests  
4148 ~~and has received a certificate of exemption from the agency~~  
4149 ~~under s. 483.106.~~

4150 Section 69. Subsection (10) of section 483.041, Florida  
4151 Statutes, is amended to read:

4152 483.041 Definitions.—As used in this part, the term:

4153 (10) "Waived test" means a test that the federal Centers  
4154 for Medicare and Medicaid Services Health Care Financing  
4155 ~~Administration~~ has determined qualifies for a certificate of

20091986er

4156 waiver under the federal Clinical Laboratory Improvement  
4157 Amendments of 1988, and the federal rules adopted thereunder.

4158 Section 70. Section 483.106, Florida Statutes, is repealed.

4159 Section 71. Subsection (3) of section 483.172, Florida  
4160 Statutes, is amended to read:

4161 483.172 License fees.—

4162 (3) The agency shall assess ~~a biennial fee of \$100 for a~~  
4163 ~~certificate of exemption and a \$100 biennial~~ license fee under  
4164 this section for facilities surveyed by an approved accrediting  
4165 organization.

4166 Section 72. Paragraph (b) of subsection (1) of section  
4167 627.4239, Florida Statutes, is amended to read:

4168 627.4239 Coverage for use of drugs in treatment of cancer.—

4169 (1) DEFINITIONS.—As used in this section, the term:

4170 (b) "Standard reference compendium" means authoritative  
4171 compendia identified by the Secretary of the United States  
4172 Department of Health and Human Services and recognized by the  
4173 federal Centers for Medicare and Medicaid Services;

4174 ~~1. The United States Pharmacopeia Drug Information;~~

4175 ~~2. The American Medical Association Drug Evaluations; or~~

4176 ~~3. The American Hospital Formulary Service Drug~~  
4177 ~~Information.~~

4178 Section 73. Subsection (13) of section 651.118, Florida  
4179 Statutes, is amended to read:

4180 651.118 Agency for Health Care Administration; certificates  
4181 of need; sheltered beds; community beds.—

4182 (13) Residents, as defined in this chapter, are not  
4183 considered new admissions for the purpose of s. 400.141

4184 (1) (o) 1.d. s. 400.141 (15) (d).

20091986er

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Section 74. This act shall take effect July 1, 2009.